Hilltown Community Health Center
Board of Directors Meeting
Thursday, March 12, 2020
Huntington Health Center Conference Room
5:30 p.m. – 7:30 p.m.

AGENDA

Time	Topic	Purpose	Presenter
5:30 PM	**Call to Order and Approval of Minutes**	**Vote Needed**	John Follet
5:35 PM	**Finance Committee Report**	**Vote Needed**	Treasurer Frank Mertes
5:50 PM	**Staff Presentation** • HCHC Fundraising and Development	Inform	Alex Niefer, Development Director
6:05 PM	**Committee Reports** • Executive Committee • Quality Improvement/Risk Management • Fundraising Committee • Personnel • Facilities • Recruitment Orientation and Nomination • Strategic Planning	**Vote Needed**	 John Follet Kathryn Jensen Nancy Brenner John Follet Alan Gaitenby Wendy Long Alan Gaitenby
6:20 PM	**Senior Management Reports** • Credentialing and Privileging Report • CEO Report	 **Vote Needed** Inform/Discussion	 Michael Purdy Eliza Lake
6:50 PM	**New Business** • HRSA UDS Report Approval • Conflict of Interest/Disclosure Form • HIPAA Policies • Board Self-Evaluation • COVID-19 Update	 **Vote Needed** Inform **Vote Needed** Inform/Discussion Inform/Discussion	 Frank Mertes Eliza Lake Eliza Lake Eliza Lake John Follet Michael Purdy
7:15 PM	**Old Business** • Changes to QI Program and Bylaws	 **Vote Needed**	 John Follet
7:20 PM	**Executive Session** (if needed)	Discussion	John Follet
7:30 PM	**Adjourn**	**Vote Needed**	John Follet

Upcoming Meetings

- April 9, 2020 – John P. Musante Health Center, Bangs Community Center, Amherst, MA 01002
- May 14, 2020 – Worthington Health Center, 58 Old North Road, Worthington, MA 010198
- Date TBD – HCHC Annual Meeting

BOARD MEETING MINUTES
Date/Time: 2/13/2020 5:30pm
Cooley Dickinson Hospital
Cancer Center Conference Room

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

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Minutes 1/9/2020	John Follet called the meeting to order at 5:37 pm. The minutes from the meeting of January 9, 2020 were reviewed. **Alan Gaitenby moved to approve the January Board minutes. Kathryn Jensen seconded the motion.**	January 9, 2020 Board minutes were approved by all present
Finance Committee	• John Follet reported that in December there was a deficit but with a positive $1,180 on the bottom line. For the year, we are $8K better than budget. This deficit was offset by some positive developments, including the final agreement on the Amherst license/lease agreement and an earmark from the state being made available. All departments were performing under budget, which led to the deficit in December. John noted that finances are still doing better than last year this time and overall for the year. The finances were cash flow neutral for the year due to depreciation, a noncash item, that is large due to the expansion of Amherst ($331K). • John reported that Deb Leonczyk resigned from the board earlier in the month. He responded and thanked her for	The Board voted unanimously to approve the finance committee report.

	her time on the board. Lee Manchester volunteered to be interim treasurer. **Wendy Long moved to approve the Finance report, Nancy Brenner seconded the motion.**	
Executive Committee	• John Follet reported that this committee is working to finalize the CEO evaluation, and will gather feedback from the full board in Executive Session. The evaluation will be sent to Eliza upon finalization and a vote to approve.	
Recruitment, Orientation & Nominating (RON) Committee	• Wendy reported that the committee did hear back from Sony Bolton and he choose not to join the board due to time constraints. Eliza reported that Jenicca is reconnecting us with the Amherst Chamber of Commerce, and Eliza will meet with Mindy Domb, and dental staff looking for Board member recommendations.	
Facilities Committee	• Alan reported that this committee has not met but will meet soon to help in the strategic planning process.	
Personnel Committee	• This committee has not met.	
Strategic Planning	• This committee met last month to review the process that was used in 2017 and decided to use the same format, utilizing a Capital Link toolkit. The committee also reviewed the previous SWOT analysis done by staff and will do another similar one. The committee is hoping to do community forums this year, which would serve a number of purposes. In Amherst, we would only reconvene the group of invested community groups and individuals, to engage community there in thinking about our future goals. The goal is to be complete by fall of 2020. Eliza noted that strategic planning was discussed at the managers meeting, at which the managers talked over the proposed process.	
Fundraising Committee	• Nancy Brenner reported that the committee will meet at the end of the month to move along the mailing for the Annual Report.	
Committee Reports	**Kathryn Jensen moved that the committee reports be approved. Lee Manchester seconded the motion.**	Committee reports presented at this meeting

		were approved unanimously.
Credentialing and Privileging	• Michael presented the following new employees that were credentialed and privileged: 1. Anthony Lecours, NP 2. Jackson Goodfield, Dental Assistant 3. Kathryn Benson, FNP (*locum tenens*) 4. Marcia Jackson, NP 5. James Sitler, RN 6. Yupin Sirikanjanachi, Medical Assistant Re-credentialed/ Re-Privileged: 1. Lori Canfora, RN **Seth Gemme motioned to approve the Credentialing and Privileging report, Nancy Brenner seconded the motion.**	The Credentialing and Privileging report was approved unanimously.
Quality Improvement / Risk Management	• Michael reported that Kathryn Jensen still holds the chair of the committee pending changes in the By-Laws and then the QI program. Kathryn reported that the minutes in the packet for the December QI Meeting were previously discussed. A discussion ensued on the logistics of reporting on approved minutes versus minute drafts of the more recent month. The board decided to keep the reporting method the same. • Michael reported on risk management, which continues to be the staffing crisis felt in every department except eye care. He also discussed the QI committee looking to focus on PDSA and quality improvement projects. **Nancy Brenner motioned to approve the QI/RM Committee report, Matt Bannister seconded the motion.**	Eliza will look into the need of the board to approve the QI committee minutes versus a QI report. The QI/RM Committee report was approved unanimously.
CEO Report	• Eliza Lake reported that by request of the executive committee, she made her report more closely match the strategic plan. She will work on sending it out earlier, by the Friday before the board meeting week. Eliza opened up a discussion with the board on how her report could be more useful to everyone. The board agreed that using	

	the strategic plan as guardrails in the written report is helpful. The board would like to see more discussion at meeting on more problematic areas or areas of risk. Therefore, only certain topic will be expanded upon at the meeting at the request of the board at the time of the meeting, and noted in the minutes. • Eliza provided follow up on the ACO. She reported that the ACO recognized last year that the budgets for each health center was based on historical spending, and over time was supposed to be based on market. However, the vast major of health centers ended up losing money through this method while the ACO was making money, which the ACO recognized as being unfair. The ACO then changed between using historical vs. market-based budgets. A challenge is that the state keeps changing the numbers for 2018, and won't finalize them until Spring 2020. These numbers have been wrong with inaccurate assumptions, especially in behavioral health, substance use treatment, and the acuity of MassHealth patients. The Model B ACOs are paid by fee for service, while the Model A's received a capitated budget. Frank noted that within C3, each health center could take different levels of risk; HCHC took the lowest risk tier. The ACO is working to figure out how to try to reform the model. Frank also noted that HCHC is still learning the process of improving quality measures, to help increase money received for these quality measures reached. Overall, Eliza felt that joining the ACO was the right decision, for reasons such as having knowledge of HCHC's data, the growth of C3, and the political attention the ACO is receiving currently. • Eliza discussed the Williamsburg project in more detail and the recent meeting with Cooley Dickinson on moving forward, and what next steps will be taken. • Eliza discussed the conversation with MGH briefly, with more positive news to come soon from that conversation.	
Staff Presentations	• John reported that staff presentations have been added to the agenda. John has requested that feedback on any	

	departments or programs that particularly interest anyone to present first. These will be 10-minute presentation at the beginning of the agenda with 10 minutes of discussion with the staff member and the board. Some requests for presentations were from the Development Director on fundraising, any of the new management positions (once they are up and running), the lead of the tele-psychiatry. In general, it was decided that there will be a rotation of programs/departments to present throughout the year.	
Other Business	• Eliza also shared a recent glowing review of the SBHC and the wonderful work they do there. This was followed up by Wendy Long discussing the crucial role that the hiring of Kiirsten Cooper, Program Manager has taken to grow and manage the very successful department. Eliza agreed on the importance her role, and the difference she has made in that position.	
Old Business	• There was no old business to report.	
New Business	• Eliza reported the HRSA 330 Grant Non- Compete Application (NCC) included in the meeting packet is completed for financial purposes and to explain any major changes in quality measures. This is formatted more like a report than a grant application. **Nancy Brenner motioned that the NCC was received by the Board and approved its submission, Wendy Long seconded the motion.** • John reported that there was a simple change of dropping QI out of the committee structure in the By-Laws, and the changes in QI policy are included as an explanation of that change. The QI policy change also included how Senior Management will report to the board for QI. • The 2020 policy review schedule was reviewed; no changes or clarifications were needed. • Frank presented the FY2020 Budget. Frank discussed the budget assumptions (as listed in the summary). They are	Eliza will make edits to the QI policy to change the chair of the QI committee to the COO instead of the CCCSO.

	points that are different or important to note, and are not perfect assumptions and may changing throughout the year. Frank budgeted a loss of $281K and overall loss $81K, but this budget is a cash flow neutral budget (even with the loss). This budget is very similar to where the budget ended up this year. Frank discussed the two sheets included which include one that is broken down by department and the other listing out the past actuals versus the budget. There are some built in risks in this budget including a projected increase in visits and revenue per visit in medical. Frank also noted that the increase in the MHC lease agreement is included in this budget. **Kathryn Jensen moved the approval of the FY 2020 Budget and Nancy Brenner seconded the motion.**	Tabitha will upload the 2020 Policy Review Schedule to the board portal. The Board unanimously approved the budget as presented.
Executive Session	**Matt Bannister moved that the Board move to Executive Session and Lee Manchester seconded the motion.**	The Board unanimously voted to enter Executive Session, and then voted to exit Executive Session.
CEO Evaluation	**Wendy Long move to approve the CEO evaluation as amended, Alan Gaitenby seconded the motion.** The Executive Committee will send the evaluation to Eliza for her comments.	The Board unanimously approved the CEO Evaluation as presented.
Next Meeting	**With no further business to discuss, Nancy Brenner made a motion to adjourn the meeting, Alan Gaitenby seconded the motion. The motion was approved.** The meeting adjourned at 7:27pm. The next scheduled meeting is set for March 12, 2020 at 5:30pm at the Huntington Health Center, in the Conference Room.	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis	0	0	0

Section M - Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented	3490	3490	1042

Section N - Dental Sealants for Children between 6-9 Years

Line	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	134	134	79

Table 7 - Health Outcomes and Disparities

Deliveries and Birth Weight

BYLAWS

of

HILLTOWN COMMUNITY HEALTH CENTERS, INC.

As Amended Effective

_____, 2019

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BYLAWS OF

HILLTOWN COMMUNITY HEALTH CENTERS, INC.

As Amended Effective _____, 2019

ARTICLE I
Name and Purposes

Section 1.1 Name and Purposes. The name and purposes of this Corporation, Hilltown Community Health Centers, Inc., shall be as set forth in its articles of organization, as may be amended or restated from time to time. The Corporation is organized exclusively for charitable, educational, and scientific purposes within the meaning of Massachusetts General Laws, Chapter 180 and Section 501(c)(3) of the Internal Revenue Code, as amended, and to carry on activities in furtherance of such purposes.

Section 1.2 Mission Statement. Hilltown Community Health Center's mission is "Creating access to high quality integrated health care and promoting well-being for individuals, families, and our communities."

ARTICLE II
No Members

Section 2.1 No Members. The Corporation shall have no members. Any action or vote required or permitted by Massachusetts General Laws, Chapter 180, as may be amended, to be taken by members shall be taken by action or vote of the same percentage of directors of the Corporation in accordance with Section 3 of said Chapter, as may be amended.

ARTICLE III
Board of Directors

Section 3.1 Number, Term, and Election. The number of directors shall be at least nine and no more than fifteen of which at least 51 percent shall be users of the services of the Corporation. The Directors that are users of the Corporation's services shall reasonably represent the individuals who are served by the health center in terms of race, gender, and ethnicity. Of the non-patient Directors, no more than 50 percent shall be persons who derive ten percent or more of their income from the direct providing of health care, and they shall be members of the communities served by the health center or the health center's service area, and they shall provide relevant expertise and skills. The term of a director shall be three years, and directors are eligible for re-election. The Chief Executive Officer shall also serve ex-officio as a non-voting member of the Board. Health center employees and immediate family members (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage) of employees may not be Directors. The Directors may elect individuals to the Board of Directors at the annual meeting of the directors or at any monthly meeting of the directors. Individuals shall be elected to the Board of Directors so that the terms of approximately one-third (or as close as practicable) of the directors shall expire each year.

Section 3.2 Powers. The Board of Directors shall have and may exercise all the powers of the Corporation, consistent with relevant law and the Articles of Organization, as may be amended from time to time. Unrestricted authorities, functions, and responsibilities of the Board include:

- Approval of the selection and dismissal of the Chief Executive Officer of the health center;
- Performing an annual performance evaluation of the Chief Executive Officer, which shall be conducted by the Executive Committee and reviewed and approved by the full Board;
- Regularly attend meetings and participate at a committee level;
- Approval of the health center's sites, hours of operation, and services to be provided by the center, including decisions to subaward or contract for a substantial portion of the health center's services;
- Approval of all of the center's HRSA grant applications including the section 330 grant application;
- Approval of the center's annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue;
- Review of the results of the annual audit, and ensuring appropriate follow-up actions are taken;
- Approval of the sliding fee scale, nominal fee, and yearly federal poverty guidelines;
- Establishment of general policies for the center (including personnel, health care, fiscal, and quality assurance/improvement policies), including approval of the Quality Improvement Program and Billing and Collections policies;
- Monitoring organizational assets and performance, fiscal and clinical, including evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management;
- Conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs;
- Conduct self-evaluations annually;
- Ensuring that the health center is operating in accordance with applicable federal, state and local laws and regulations, as well as its own established policies and procedures;
- Measurement and evaluation of the organization's progress in meeting its annual and long-term programmatic goals;
- Oversight of the measurement and monitoring of patient satisfaction.

Section 3.3 Chief Executive Officer. The Board of Directors shall select a Chief Executive Officer and shall determine the terms of his or her employment. The duties and powers of the Chief Executive Officer shall be those generally assigned to the chief executive officer or executive director of a non-profit corporation, and shall include the general charge and supervision of the affairs of the Corporation and the power and responsibility to enforce these bylaws and any rules and regulations made by or under the authority of the Board of Directors or the Executive Committee, to see that all requirements of law and appropriate governmental authorities are duly observed in the conduct of the affairs of the Corporation, and to execute in

the name of the Corporation all deeds, leases, contracts, and similar documents. It shall also be the duty of the Chief Executive Officer to plan, organize, maintain and control the operation of the Corporation within the policies established by the Board of Directors. The Chief Executive Officer shall analyze, report, and advise the Board of all material matters on a timely basis, and shall attend and participate in all appropriate committee meetings in order to maintain a high degree of communication and cooperation within the Corporation. The Chief Executive Officer may also be included in executive session meetings, provided the session is not pertaining to the Chief Executive Officer. The Chief Executive Officer shall normally be the official representative and spokesperson for the Corporation.

Section 3.4 Annual and Regular Meetings. The annual meeting and regular meetings of the Board of Directors shall be held at such places, within or without the Commonwealth of Massachusetts, and at such times as the Board of Directors may by vote from time to time determine. Regular meetings shall be held monthly, and must contain a quorum of voting members. No notice shall be required for any annual or regular meeting held at a time and place fixed in advance by vote of the Board of Directors.

Section 3.5 Special Meeting. Special meetings of the Board of Directors may be held at any time and at any place, within or without the Commonwealth of Massachusetts, when called by the Chair or by two or more directors, reasonable notice thereof, stating the purposes of such meeting, being given to each director by the Clerk, or, in case of the death, absence, incapacity or refusal, of the Clerk, by the Chair or by the directors calling the meeting, or at any time without call or formal notice, provided all the directors are present or waive notice thereof by a writing which is filed with the records of the meeting. In any case, it shall be deemed sufficient notice to a director to send notice by mail (paper or electronic) at least three (3) days before the meeting, addressed to the director at his or her usual or last known business or residence address.

Section 3.6 Quorum. At any meeting of the directors, a majority of the directors then in office shall constitute a quorum. When a quorum is present at any meeting, the affirmative vote of a majority of the directors present or represented at such meeting and voting on the matter shall, except where a larger vote is required by law, by the Articles of Organization or by these Bylaws, decide any matter brought before such meeting. If a quorum is not present at any meeting, such a meeting shall only be an informational meeting.

Section 3.7 Consent in Lieu of Meeting. Any action by the directors may be taken without a meeting if a written consent thereto is signed by all the directors and filed with the records of the directors' meetings. Such consent shall be treated as a vote of the directors for all purposes. Board members may not vote by proxy.

Section 3.8 Presence and Voting through Communication Equipment. Unless otherwise prohibited by law or the Articles of Organization, members of the Board of Directors may participate in a meeting of the Board by means of a conference telephone or similar communication equipment by means of which all persons participating in the meeting can hear and speak to each other at the same time, and participation by such means shall constitute presence in person at a meeting. In rare circumstances, Directors may vote via

electronic means (eg, email) on an item that follows the same rules of procedure and quorum as during an in-person meeting. Such votes will be then be placed on the agenda for the next full Board meeting to be entered into the minutes.

Section 3.9 Resignations and Removal. Any director or committee member may resign at any time by delivering his or her resignation in writing to the Chair or Clerk or to a meeting of the Board of Directors. The Directors may, by two-thirds vote at any meeting called for that purpose, remove from office any director or committee member, with or without cause.

ARTICLE IV
Committees

Section 4.1 Committees. There shall be an Executive Committee, a Finance Committee, a Corporate Compliance Committee, and such other standing or ad hoc committees of the Board as the Board may determine. Except as otherwise set forth in these Bylaws, the Chair of the Board shall nominate the chair and members of any such committee, who shall be appointed by and shall serve at the pleasure of Board of Directors. Except as otherwise set forth in these Bylaws or as may be determined by the directors, committees shall conduct their affairs in the same manner as is provided in these Bylaws for the directors. Each committee shall keep regular minutes of its meetings and report the same to the Board of Directors.

Deleted: a Quality Improvement Committee

Section 4.2 Scope of Committees. The Executive Committee shall be chaired by the Chair of the Corporation and shall consist of the Chair, Vice-Chair, Treasurer and Clerk of the Corporation. Unless the directors shall otherwise determine prior to any such action by the Executive Committee, the Executive Committee, between meetings of the Board of Directors, shall be entitled to act all matters as to which the Board of Directors would have been entitled to act and as to which it is permitted under law, these Bylaws, and the Articles of Organization, to delegate to the Executive Committee. The Executive Committee will report its actions back to the full Board at the next Board meeting

The Treasurer shall serve as the chair of the Finance Committee. The Finance Committee shall provide advice and recommendations to the Board in all matters pertaining to the fiscal affairs of the Corporation, including the annual budget. The Corporate Compliance Committee shall consist of the same individuals serving on the Executive Committee, and shall provide advice and recommendations to the Board in all matters pertaining to corporate compliance.

Deleted: The Quality Improvement Committee shall assure that quality care is given in all clinical areas through peer review, dashboard metric review, and patient complaint review and ensures that the Corporation is compliant with federal and state data reporting requirements with regard to quality of care.

ARTICLE V
Officers

Section 5.1 Election. The officers of the Corporation shall consist of a Chair, Vice-Chair, Treasurer, Clerk and such other officers as the Board of Directors may determine. All officers shall have one year terms and shall be eligible for reelection. All officers shall be elected by the directors at the annual meeting of the directors, or at any meeting of the directors called for that purpose, and shall serve at the pleasure of the directors. Vacancies in

any office shall be filled by thedirectors.

Section 5.2 Qualification and Powers. Officers shall be directors. So far as is permitted by law, any two or more offices may be filled by the same person. Subject to law, to the Articles of Organization, and to these Bylaws, each officer shall hold office until his or her successor is elected, or until such officer sooner dies, resigns, is removed, or becomes disqualified. Each officer shall, subject to these Bylaws, have in addition to the duties and powers herein set forth, such duties and powers as are commonly incident to such office, and such duties and powers as the Board of Directors may from time to time designate.

Section 5.3 Chair. The Chair shall preside at all meetings of the Board of Directors and shall be, ex officio, a member of all committees with the right to vote.

Section 5.4 Vice Chair. The Vice Chair shall have and may exercise all the duties and powers of the Chair during the absence of the Chair or in the event of the Chair's incapacity or other inability to act. The Vice Chair shall have such other duties and powers as the directors maydetermine.

Section 5.5 Treasurer. The Treasurer shall, subject to the direction and under the supervision of the Board of Directors, have general oversight of the financial concerns of the Corporation.

Section 5.6 Clerk. The Clerk shall be responsible for the keeping of a record of all meetings of the Board of Directors. In the absence of the Clerk from any such meeting, the Assistant Clerk, if any, or a Temporary Clerk designated by the directors, shall perform the duties of theClerk. The Clerk shall also ensure that all minutes of board and committee meetings are stored with the Board of Directors files, after their approval by the Board.

Section 5.7 Resignation and Removal. Any officer may resign at any time by delivering his or her resignation in writing to the Chair or Clerk or to a meeting of the Board of Directors. The Directors may, by two-thirds vote at any meeting called for that purpose, remove from officer any officer with or without cause.

ARTICLE VI
Distribution Upon Dissolution

Section 6.1 Distribution Upon Dissolution. Upon the liquidation or dissolution of the Corporation, after payment of all liabilities of the Corporation or due provision therefore, all of the assets of the Corporation shall be distributed to one or more organizations exempt from federal income tax under the provisions of Section 501(3)(c) of the Internal Revenue Code (or described in any corresponding provision of any successor statute). Such organizations shall be determined by the directors of the Corporation at or before the time of such liquidation or dissolution, and in accordance with Chapter 180 of the General Laws of the Commonwealth of Massachusetts.

ARTICLE VII
Fiscal Year

Section 7.1 Fiscal Year. Except as may be from time to time otherwise determined by the Board of Directors, the fiscal year of the corporation shall end on the last day of December.

ARTICLE VIII
Indemnification

Section 8.1 Officers and Directors. The Corporation shall, to the extent legally permissible, indemnify its officers and directors, and their respective heirs, executors, administrators or other representatives from any costs, expenses, attorneys' fees, amounts reasonably paid in settlement, fines, penalties, liabilities and judgments incurred while in office or thereafter by reason of any such officer or director being or having been an officer or director of the Corporation or by reason of such officer or director's serving or having served at the request of the Corporation as committee member, officer, director, trustee, employee, or other agent of another organization, or in any capacity with respect to any employee benefit plan, unless, with respect to the matter as to which indemnification is sought, the officer or director shall have been or is adjudicated in any proceeding not to have acted in good faith in the reasonable belief that his or her action was in the best interests of the Corporation, or, to the extent that such matter relates to service with respect to an employee benefit plan, in the best interests of the participants or beneficiaries of such employee benefit plan. Such indemnification may include payment by the Corporation of expenses incurred in defending a civil or criminal action or proceeding in advance of the final disposition of such action or proceeding upon receipt of an undertaking by the person to be indemnified to repay such payment if he or she shall be not entitled to indemnification under this paragraph.

Section 8.2 Employees and Agents. The Corporation, to the extent legally permissible, may indemnify its employees and other agents, including but not limited to its volunteers and persons acting as members of committees of the Corporation, from any costs, expenses, attorneys' fees, amounts reasonably paid in settlement, fines, penalties, liabilities and judgments incurred while in office or thereafter by reason of any such person's being or having been an employee or agent of the Corporation or by reason of such person's serving or having served at the request of the Corporation as committee member, officer, director, trustee, employee, or other agent of another organization, or in any capacity with respect to any employee benefit plan, unless, with respect to the matter as to which indemnification is sought, the employee or agent shall have been or is adjudicated in any proceeding not to have acted in good faith in the reasonable belief that his or her action was in the best interests of the Corporation, or, to the extent that such matter relates to service with respect to an employee benefit plan, in the best interests of the participants or beneficiaries of such employee benefit plan. Such indemnification may include a payment by the Corporation of expenses incurred in defending a civil or criminal action or proceeding in advance of the final disposition of such action or proceeding upon receipt of an undertaking by the person to be indemnified to repay such payment if he or she shall be not entitled to indemnification under this section. In determining whether to provide indemnification under this paragraph, the Corporation may consider, among other factors, whether and to what extent insurance is or was available to the

person seeking indemnification and whether and to what extent insurance is available to the Corporation for such indemnification.

ARTICLE IX
Conflicts

Section 9.1 Conflicts. Each director has the responsibility to disclose fully to the Board of Directors, at such time and in such a manner as may be appropriate and consistent with policies of the Corporation, either by voice at the meeting at which the measure concerned is to be considered or in writing to the Clerk prior to such meeting, the existence of any dual interest of such director in transactions or other matters involving the Corporation in which such director may have, directly or indirectly, a separate personal interest of any nature, and such further information as may be materially relevant for consideration by the Board of Directors concerning any such matter or transaction, and to refrain, except for such disclosure and as otherwise may be appropriate, from participating in such consideration and the decision of the Board of Directors with respect to such matter or transaction, in order that the Board of Directors may at all times continue to act in the best interests of the Corporation.

ARTICLE X
Amendments

Section 10.1 Amendments. The directors may, by vote of a majority of such directors then in office, at any duly called regular or special meeting, amend or repeal these Bylaws in whole or in part provided that: (1) the general substance of the proposed amendment to the Bylaws was discussed at the immediately prior duly called regular or special meeting of the Board of Directors, as reflected in the minutes of such meeting approved by the Board, and (2) notice of the proposed amendment to the Bylaws, including a copy of the general substance of such proposed amendment, is included in the notice provided to directors of the meeting at which such amendment vote is to take place.

ARTICLE XI
Anti-Discrimination

Section 11.1 Anti-Discrimination. In all matters of its operation including, without limitation, treatment of patients, selecting and dealing with employees and contractors and selecting members, directors and officers, the Corporation shall not discriminate against any person or the basis of race, religion, gender, sexual orientation, age or national origin. The Corporation shall also, consistent with law, encourage the utilization of minority contractors wherever possible.

I hereby certify that these By-laws of Hilltown Community Health Centers, Inc. are a complete and accurate copy of the original documents as adopted on _____, 2019.

_____ _____

Signature of Clerk Date

Printed Name

CEO Progress Report to the Board of Directors
Strategic and Programmatic Goals
March 2020

Goal Areas and Progress Reports

Goal 1: Health Care System Integration and Financing

1) ***Accountable Care Organization (ACO) Engagement***: The main activity at the moment is a recalibration of C3's expectations – as I have mentioned, they have requirements that may not be as relevant for the small health centers. Michael and Jon Liebman are working with their Medical Director to clarify what we should be prioritizing. has been very little activity around C3 this month, but Jon and I will attend an all-day retreat in Boston at the end of the month. The focus will be on the primary care landscape on the national and state level, with the head of MassHealth presenting the latter topic. We then have a dinner with the Medical Director of CVS speaking, which will be interesting due to their growth into the primary care space.
2) ***Hospital Engagement***: The focus of our work with hospitals right now is focused on the response to COVID-19, which I will include in my presentation at the meeting. We did meet with the Cooley Dickinson provider about a new relationship, which was a good start. We agreed that he would come with his two NPs to visit the Huntington clinic and learn more about our practice, but this has not been scheduled due to vacations and, now, understandably, everyone's shift of focus to COVID-19 preparedness. We have not heard back from Partners/MGH after our conversation last month – I have followed up every couple of week but haven't heard anything. I do not take this as a bad sign, just as proof that we are not at the top of their list of priorities.
3) ***Electronic Health Record (EHR) transitions***: No change at this time.
4) ***PCMH/NCQA/PCMH Prime certifications and transformation***: No change at this time.

Goal 2: HCHC Expansion

a) ***Expanded Services***:
   1) Office-Based Opioid Treatment (OBOT): No change at this time.
   2) Telehealth: We are now behind in implementing our telepsychiatry program, and with the amount of resources having to be focused on the response to COVID-19, there may not be much progress for a few weeks. There is, however, a lot of talk about the use of telehealth in dealing with the epidemic – keeping patients out of clinics to reduce the spread of the virus and increase capacity for providers in the office. The emergency funding bill that the President signed today does, according to news reports, include a provision that lifts restrictions on Medicare patients being seen through telehealth visits. I am waiting for more information on this from NACHC and the League.
   3) Specialty Care: No change at this time.
   4) Portable services: No change at this time in existing projects. We have not discussed this possibility yet, but I know that some countries have implemented mobile primary care in the community, again to reduce the spread of the virus. I will update you if we have any thoughts about moving in this direction.
   5) Pharmacy: No change at this time.

b) ***Expanded Sites/Service Areas***:
   1) Amherst/John P. Musante Health Center: No change at this time.
   2) Westfield, Northampton, Ware, or other sites: No change at this time.

c) *Patient Populations*: No change at this time.
d) *Community Collaborations*: No change at this time.

Goal 3: Improved Organizational Infrastructure

a) Financial Stability:
b) Staff Development and Support:

- A number of training opportunities have presented themselves recently, including the chance to send two nurse supervisors to a management training from the League. We also are looking at completing a number of trainings very soon for all staff on infection control, personal protective equipment, and hand hygiene.
- The managers met just before our last Board meeting and discussed what the elements of a good evaluation process may be, and will be working together to craft a new process. Having these meetings will be increasingly helpful for ensuring consistent messaging to staff in a possible time of crisis.
- Next week the staff who will be reporting to the new COO are having lunch with our top candidate, and then Senior Management is conducting our second in-person interview, so we hope to be able to extend an offer very soon.
- We are still moving forward with our negotiations with the physician/Medical Director candidate, and have another NP who is in the process of interviewing.
- We are in great need of another dentist and dental assistants. Mary Lou Stuart, the dental director, and Bridget Rida, HR Coordinator, came back from a dentist recruiting fair in Boston very optimistic about the level of engagement of the people they met there – we all have our fingers crossed.
- Patient feedback on the locum NP in Worthington has been very positive, and we are being asked to try to persuade her to stay. I'm not sure we'd be successful, but if clinical staff are in agreement, we can always try.

c) ***Facilities Improvement and Expansion:*** No change at this time.
d) ***Information Technology (IT) Improvement and Expansion:*** No change at this time.

Other reports:

a) HRSA OSV Follow-up: A draft of the final procedure required to remove our condition has been drafted, and hopefully will be completed in the next few weeks.

b) Legislative contacts: I have a meeting scheduled with State Representative Natalie Blais for the end of the month to discuss a wide variety of topics. I am supposed to go to DC on the 16th to meet with our Congressmen and Senators, but the status of that trip is up in air, due to the possible conference cancellation and growing travel restrictions.

Hilltown CHC
Dashboard And Summary Financial Results
January 2020

	Actual FY 2016	Actual FY 2017	Actual FY 2018	Actual FY 2019	Actual YTD Jan 2020	Notes on Trend	Cap Link TARGET	COMMENT
Liquidity Measures								
Operating Days Cash	16	7	9	4	1	Measures the number of days HCHC can cover daily operating cash needs.	> 30-45 Days	Not Meeting Benchmark
Current Ratio	1.96	1.24	0.83	0.99	0.93	Measures HCHC's ability to meet current obligations.	>1.25	Not Meeting Benchmark
Patient Services AR Days	33	33	36	27	33	Measures HCHC's ability to bill and collect patient receivables	< 60-75 Days	Doing Better than Benchmark
Accounts Payable Days	46	56	28	32	33	Measures HCHC's ability to pay bills	< 45 Days	Doing Better than Benchmark
Profitability Measures								
Net Operational Margin	-1.1%	-3.4%	-5.8%	-3.3%	-13.8%	Measures HCHC's Financial Health	> 1 to 3%	Not Meeting Benchmark
Bottom Line Margin	6.6%	9.6%	0.2%	1.0%	-13.8%	Measures HCHC's Financial Health but includes non-operational activities	> 3%	Not Meeting Benchmark
Leverage								
Total Liabilities to Total Net Assets	32.1%	29.2%	32.6%	25.1%	26.4%	Measures HCHC's total Liabilities to total Net Assets	< 30%	Doing Better than Benchmark
Operational Measures								
Medical Visits	18,122	18,727	18,166	17,397	1,386			
Net Medical Revenue per Visit	$ 142.69	$ 134.56	$ 143.59	$ 143.44	$ 140.50			
Dental Visits	14,398	14,880	15,537	16,198	1,361			
Net Dental Revenue per Visit	$ 104.66	$ 113.60	$ 112.76	$ 115.31	$ 107.22			
Behavioral Health Visits	2,928	3,809	4,306	4,151	393			
Net BH Revenue per Visit	$ 98.69	$ 95.70	$ 87.74	$ 89.46	$ 101.66			
Optometry Visits	2,282	2,329	2,381	2,324	219			
Net Optometry Revenue per Visit	$ 74.03	$ 79.61	$ 86.40	$ 89.42	$ 87.63			
Avg Salary Per Weekday	$ 22,757	$ 24,209	$ 25,226	$ 24,236	$ 24,408			

Hilltown Community Health Centers
Income Statement - All Departments
Period Ending Jan. 2020

	Jan. 2020 Actual	Jan. 2020 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	194,732	230,057	(35,325)	194,732	230,057	(35,325)	228,445	(33,713)
Visits	1,386	1,521	(135)	1,386	1,521	(135)	1,726	(340)
Revenue/Visit	$ 140.50	$ 151.25	$ (10.75)	$ 140.50	$ 151.25	$ (10.75)	$ 132.36	$ 8.14
Patient Services - Dental	145,933	162,206	(16,273)	145,933	162,206	(16,273)	161,360	(15,427)
Visits	1,361	1,380	(19)	1,361	1,380	(19)	1,476	(115)
Revenue/Visit	$ 107.22	$ 117.54	$ (10.32)	$ 107.22	$ 117.54	$ (10.32)	$ 109.32	$ (2.10)
Patient Services - Beh. Health	39,953	32,569	7,384	39,953	32,569	7,384	34,206	5,747
Visits	393	366	27	393	366	27	427	(34)
Revenue/Visit	$ 101.66	$ 88.99	$ 12.68	$ 101.66	$ 88.99	$ 12.68	$ 80.11	$ 21.55
Patient Services - Optometry	19,191	20,098	(907)	19,191	20,098	(907)	17,203	1,988
Visits	219	228	(9)	219	228	(9)	222	(3)
Revenue/Visit	$ 87.63	$ 88.15	$ (0.52)	$ 87.63	$ 88.15	$ (0.52)	$ 77.49	$ 10.14
Patient Services - Optometry Hardware	10,443	7,530	2,913	10,443	7,530	2,913	10,719	(276)
Patient Services - Pharmacy	7,260	20,916	(13,656)	7,260	20,916	(13,656)	1,598	5,662
Quality & Other Incentives	475	1,673	(1,198)	475	1,673	(1,198)	337	138
HRSA 330 Grant	136,455	157,015	(20,560)	136,455	157,015	(20,560)	125,425	11,030
Other Grants & Contracts	59,052	60,077	(1,025)	59,052	60,077	(1,025)	52,995	6,057
Int., Dividends Gain /(Loss) Investments	(2,424)	3,554	(5,978)	(2,424)	3,554	(5,978)	19,514	(21,939)
Rental & Misc. Income	4,002	3,004	998	4,002	3,004	998	2,466	1,536
Total Operating Revenue	615,073	698,699	(83,626)	615,073	698,699	(83,626)	654,269	(39,196)
Compensation and related expenses								
Salaries and wages	481,077	502,641	(21,564)	481,077	502,641	(21,564)	517,837	(36,760)
Payroll taxes	36,589	37,698	(1,109)	36,589	37,698	(1,109)	42,348	(5,759)
Fringe benefits	43,725	42,724	1,001	43,725	42,724	1,001	46,356	(2,631)
Total Compensation & related expenses	561,390	583,063	(21,673)	561,390	583,063	(21,673)	606,541	(45,150)
No . of week days	23	23	-	23	23	-	23	-
Staff cost per week day	$ 24,408	$ 25,351	$ (942)	$ 24,408	$ 25,351	$ (942)	$ 26,371	$ (1,963)

Hilltown Community Health Centers
Income Statement - All Departments
Period Ending Jan. 2020

	Jan. 2020 Actual	Jan. 2020 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	-	750	(750)	-	750	(750)	804	(804)
Bad debt	1,307	8,367	(7,059)	1,307	8,367	(7,059)	11,631	(10,324)
Computer support	7,088	6,617	471	7,088	6,617	471	6,806	281
Conference and meetings	248	715	(466)	248	715	(466)	65	183
Continuing education	2,368	2,396	(28)	2,368	2,396	(28)	2,068	301
Contracts and consulting	2,713	12,880	(10,167)	2,713	12,880	(10,167)	1,105	1,608
Depreciation and amortization	27,651	27,650	0	27,651	27,650	0	27,651	-
Dues and membership	2,355	2,729	(375)	2,355	2,729	(375)	2,645	(290)
Equipment leases	2,580	2,320	260	2,580	2,320	260	2,674	(94)
Insurance	2,128	2,110	17	2,128	2,110	17	2,112	16
Interest	1,289	1,358	(69)	1,289	1,358	(69)	1,409	(120)
Legal and accounting	2,500	2,625	(125)	2,500	2,625	(125)	2,188	313
Licenses and fees	4,115	3,831	283	4,115	3,831	283	4,622	(507)
Medical & dental lab and supplies	10,442	10,129	313	10,442	10,129	313	9,531	910
Merchant CC Fees	1,576	1,613	(37)	1,576	1,613	(37)	1,204	372
Office supplies and printing	2,304	3,294	(990)	2,304	3,294	(990)	3,858	(1,555)
Postage	117	12,106	(11,990)	117	12,106	(11,990)	28	88
Program supplies and materials	19,372	1,416	17,956	19,372	1,416	17,956	19,960	(588)
Pharmacy & Optometry COGS	7,980	19,001	(11,021)	7,980	19,001	(11,021)	6,571	1,409
Recruitment	4,049	1,700	2,349	4,049	1,700	2,349	-	4,049
Rent	6,964	7,068	(103)	6,964	7,068	(103)	7,123	(159)
Repairs and maintenance	13,597	13,731	(134)	13,597	13,731	(134)	10,755	2,841
Small equipment purchases	-	1,892	(1,892)	-	1,892	(1,892)	949	(949)
Telephone/Internet	10,928	13,145	(2,217)	10,928	13,145	(2,217)	13,619	(2,691)
Travel	1,947	2,417	(470)	1,947	2,417	(470)	1,496	450
Utilities	3,234	4,263	(1,029)	3,234	4,263	(1,029)	7,081	(3,847)
Loss on Disposal of Assets	-	-	-	-	-	-	-	-
Total Other Operating Expenses	138,848	166,120	(27,271)	138,848	166,120	(27,271)	147,955	(9,107)
Net Operating Surplus (Deficit)	**(85,166)**	**(50,484)**	**(34,682)**	**(85,166)**	**(50,484)**	**(34,682)**	**(100,227)**	**15,061**
NON-OPERATING ACTIVITIES								
Donations, Pledges & Contributions	120	-	120	120	-	120	-	120
Lease Forgiveness	-	-	-	-	-	-	-	-
Capital Grants	-	-	-	-	-	-	-	-
Net Non-operating Surplus (Deficit)	**120**	**-**	**120**	**120**	**-**	**120**	**-**	**120**
NET SURPLUS/(DEFICIT)	**(85,046)**	**(50,484)**	**(34,562)**	**(85,046)**	**(50,484)**	**(34,562)**	**(100,227)**	**15,181**

Hilltown Community Health Centers
Bad Debt as Percent of Revenue
YTD Ending January 2020

	Medical 1/1/2020 to 1/31/2020	Dental 1/1/2020 to 1/31/2020	BH 1/1/2020 to 1/31/2020	Optometry 1/1/2020 to 1/31/2020	Total 1/1/2020 to 1/31/2020	Total 1/1/2019 to 12/31/2019	Total 1/1/2018 to 12/31/2018
Revenue							
Patient Services	$194,733.00	$145,933.00	$39,953.00	$19,191.00	$399,810.00	$4,942,463.00	$4,943,979.00
Patient Services - Optometry Hardware	$0.00	$0.00	$0.00	$10,443.00	$10,443.00	$84,762.00	$83,791.00
Total Patient Revenue	$194,733.00	$145,933.00	$39,953.00	$29,634.00	$410,253.00	$5,027,225.00	$5,027,770.00
Bad debt	($1,903.00)	$3,866.00	($453.00)	($203.00)	$1,307.00	$103,914.00	$57,156.00
	-1.0%	2.6%	-1.1%	-0.7%	0.3%	2.1%	1.1%

Note Bad Debt expense includes current reserves for bad debt allowances and dirrect write off.

Hilltown CHC
Summary of Net Results By Dept.
January 2020
Net Results Gain (Deficit)

	Jan.	Jan. Budget	Over (Under) Budget	YTD	YTD Budget	Over (Under) Budget	PY YTD	Cur. v. PY YTD
Operating								
Medical	$ (35,768)	$ (51,035)	15,267	$ (35,768)	$ (51,035)	15,267	$ (59,056)	$ 23,288
Dental	(34,373)	(17,311)	(17,062)	(34,373)	(17,311)	(17,062)	(25,540)	$ (8,833)
Behavioral Health	11,277	16,040	(4,763)	11,277	16,040	(4,763)	968	$ 10,309
Optometry	(8,117)	(921)	(7,196)	(8,117)	(921)	(7,196)	(3,154)	$ (4,963)
Pharmacy	8,671	18,825	(10,154)	8,671	18,825	(10,154)	2,828	$ 5,843
Community	(7,364)	(9,117)	1,753	(7,364)	(9,117)	1,753	(10,950)	$ 3,586
Fundraising	2,976	(5,572)	8,548	2,976	(5,572)	8,548	(5,113)	$ 8,089
Admin. & OH	(22,468)	(1,392)	(21,076)	(22,468)	(1,392)	(21,076)	(210)	$ (22,258)
Net Operating Results	**$ (85,166)**	**$ (50,483)**	**$ (34,683)**	**$ (85,166)**	**$ (50,483)**	**$ (34,683)**	**$ (100,227)**	**$ 15,061**
Non Operating								
Donations	$ 120	$ -	$ 120	$ 120	$ -	$ 120	$ -	$ 120
Lease Forgivness	-	-	-	-	-	-	-	-
Capital Project Revenue	-	-	-	-	-	-	-	$ -
Total	**$ 120**	**$ -**	**$ 120**	**$ 120**	**$ -**	**$ 120**	**$ -**	**$ 120**
Net	**$ (85,046)**	**$ (50,483)**	**$ (34,563)**	**$ (85,046)**	**$ (50,483)**	**$ (34,563)**	**$ (100,227)**	**$ 15,181**

Hilltown Community Health Centers

Balance Sheet - Monthly Trend	**Actual Dec 2019**	**Actual Jan 2020**	**Budget Jan 2020**	**Over (Under) Jan 2020**
Assets				
Current Assets				
Cash - Operating Fund	$ 80,330	$ 23,578	$ 79,353	(55,775)
Cash - Internally Restricted	106,622	101,974	100,000	1,974
Patient Receivables	814,598	937,745	900,000	37,745
Less Allow. for Doubtful Accounts	(152,718)	(150,534)	(150,000)	(534)
Less Allow. for Contractual Allowances	(280,352)	(339,297)	(315,000)	(24,297)
A/R 340B-Pharmacist	24,643	17,720	10,000	7,720
A/R 340B-State	1,995	1,995	2,000	(5)
Contracts & Grants Receivable	147,205	144,263	145,000	(738)
Prepaid Expenses	22,557	12,494	12,500	(6)
A/R Pledges Receivable	14,910	13,410	12,000	1,410
Total Current Assets	779,789	763,347	795,853	(32,506)
Property & Equipment				
Land	204,506	204,506	204,506	-
Buildings	2,613,913	2,613,913	2,613,913	-
Improvements	929,483	929,483	929,483	-
Leasehold Improvements	1,933,674	1,933,674	1,933,674	-
Equipment	1,410,385	1,407,540	1,407,540	-
Construction in Progress	-	-	-	-
Total Property and Equipment	7,091,960	7,089,116	7,089,116	-
Less Accumulated Depreciation	(2,762,172)	(2,789,823)	(2,789,823)	0
Net Property & Equipment	4,329,788	4,299,293	4,299,293	0
Other Assets				
Restricted Cash	53,713	53,718	53,713	5
Pharmacy 340B and Optometry Inventory	11,684	11,778	12,000	(222)
Investments Restricted	8,729	8,729	8,729	0
Investment - Vanguard	291,960	289,499	294,393	(4,894)
Total Other Assets	366,087	363,723	368,835	(5,112)
Total Assets	**$ 5,475,664**	**$ 5,426,364**	**$ 5,463,981**	**(37,617)**
Liabilities & Fund Balance				
Current & Long Term Liabilities				
Current Liabilities				
Accounts Payable	$ 202,896	$ 194,687	$ 190,000	4,687
Notes Payable	143,172	128,912	128,912	0
Sales Tax Payable	39	24	23	1
Accrued Expenses	9,729	6,747	10,000	(3,253)
Accrued Payroll Expenses	358,092	439,874	440,000	(126)
Payroll Liabilities	16,814	14,339	17,285	(2,945)
Unemployment Escrow	826	826	826	-
Line of Credit ($100,000 Limit)	-	-	-	-
Deferred Contract Revenue	54,049	38,580	40,000	(1,420)
Total Current Liabilities	785,617	823,990	827,045	(3,055)
Long Term Liabilities				
Mortgage Payable United Bank	150,205	148,712	148,712	-
Mortgages Payable USDA Huntington	163,484	162,350	162,350	(0)
Total Long Term Liabilities	313,689	311,062	311,062	(0)
Total Liabilities	**1,099,306**	**1,135,052**	**1,138,107**	**(3,055)**
Fund Balance / Equity				
Fund Balance Prior Period	4,376,358	4,291,312	4,325,874	(34,562)
Total Fund Balance / Equity	4,376,358	4,291,312	4,325,874	(34,562)
Total Liabilities & Fund Balance	**$ 5,475,664**	**$ 5,426,364**	**$ 5,463,981**	**(37,617)**
Current Ratio	**0.99**	**0.93**	**0.96**	

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

Program Name: Health Center 330

Submission Status: Review In Progress

Date Requested: 02/25/2020 11:48 AM EST

Date of Last Report Refreshed: 02/25/2020 11:48 AM EST

UDS Report - 2019

Contact Information

Do you self-identify as an NMHC?: No

Title	Name	Phone	Fax	Email
UDS Contact	Frank Mertes	(413) 238 4116	(413) 238 5570	fmertes@HCHCweb.org
Project Director	Eliza Lake	(413) 238 4128	Not Available	elake@hchcweb.org
Clinical Director	Michael Purdy	(413) 667 3009 Ext. 270	(413) 238 5570	mpurdy@hchcweb.org
Chair Person	John Follet	(413) 441 6961	Not Available	jfollet@hchcweb.org
CEO	Eliza Lake	(413) 238 4128	Not Available	elake@hchcweb.org

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

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UDS Report - 2019

Patients by ZIP Code

ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
01050	43	297	244	646	**1230**
01085	40	329	171	399	**939**
01098	22	164	208	291	**685**
01002	45	416	68	138	**667**
01011	11	147	118	302	**578**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
01071	19	127	72	243	**461**
01026	16	140	113	171	**440**
01008	6	75	77	193	**351**
01235	10	84	63	97	**254**
01096	10	93	53	79	**235**
01070	9	59	84	72	**224**
01027	13	85	44	63	**205**
01060	17	104	24	34	**179**
01223	3	69	36	60	**168**
01012	7	44	42	68	**161**
01062	0	60	24	40	**124**
01201	5	54	25	38	**122**
01330	9	57	12	37	**115**
01034	9	38	18	40	**105**
01077	2	40	30	28	**100**
01089	2	33	19	44	**98**
01039	3	44	11	22	**80**
01040	4	46	7	21	**78**
01243	0	24	18	36	**78**
01035	6	45	12	6	**69**
01007	5	43	6	14	**68**
01375	8	39	3	18	**68**
01084	3	23	18	23	**67**
01073	4	13	15	33	**65**
01032	4	18	14	28	**64**
01247	0	40	9	15	**64**
01270	2	16	21	24	**63**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
01370	3	26	14	19	**62**
01220	2	34	12	12	**60**
01226	2	24	18	15	**59**
01001	1	7	16	32	**56**
01020	2	17	21	13	**53**
01029	1	22	11	17	**51**
01013	1	16	11	14	**42**
01030	2	15	6	16	**39**
01301	3	23	6	7	**39**
01075	1	15	6	16	**38**
01097	3	20	6	9	**38**
01339	1	16	10	9	**36**
01104	0	13	10	12	**35**
01054	0	26	1	3	**30**
01086	1	12	5	12	**30**
01256	1	9	10	10	**30**
01108	0	12	7	9	**28**
01373	4	10	3	9	**26**
01053	1	15	7	2	**25**
01038	0	12	5	5	**22**
01109	5	8	4	5	**22**
01118	0	3	9	9	**21**
01341	1	9	6	4	**20**
01253	2	7	1	9	**19**
01033	1	8	2	5	**16**
01106	0	2	5	9	**16**
01225	2	3	4	7	**16**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
01004	0	7	4	4	**15**
01129	0	2	6	7	**15**
01351	1	6	4	4	**15**
01088	1	9	3	1	**14**
01340	1	9	4	0	**14**
01028	0	1	4	8	**13**
01056	1	3	5	4	**13**
01072	1	6	2	4	**13**
01237	0	9	2	1	**12**
01238	0	6	2	4	**12**
01338	0	5	3	4	**12**
01376	0	6	2	3	**11**
01119	1	1	4	4	**10**
01267	0	6	4	0	**10**
01061	1	5	1	2	**9**
01095	0	2	3	4	**9**
01105	0	6	3	0	**9**
01107	1	4	3	1	**9**
01101	0	1	4	2	**7**
01090	0	3	1	2	**6**
01151	0	4	0	2	**6**
01245	2	1	2	1	**6**
01254	0	6	0	0	**6**
01360	1	1	3	1	**6**
01082	1	1	2	1	**5**
01379	0	5	0	0	**5**
02150	0	4	0	1	**5**

Other ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes	11	82	45	63	201
Unknown Residence					0
Total	400	3451	2011	3740	9602

Comments

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

Universal

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1	18	12
2	Age 1	21	15
3	Age 2	20	24
4	Age 3	29	22
5	Age 4	30	26
6	Age 5	38	43
7	Age 6	34	40
8	Age 7	54	49
9	Age 8	39	52
10	Age 9	46	54
11	Age 10	49	56
12	Age 11	43	37

Line	Age Groups	Male Patients (a)	Female Patients (b)
13	Age 12	55	51
14	Age 13	48	46
15	Age 14	59	49
16	Age 15	52	51
17	Age 16	57	54
18	Age 17	42	51
19	Age 18	50	38
20	Age 19	27	52
21	Age 20	37	61
22	Age 21	54	58
23	Age 22	43	51
24	Age 23	57	62
25	Age 24	41	53
26	Ages 25-29	238	351
27	Ages 30-34	271	360
28	Ages 35-39	248	343
29	Ages 40-44	230	299
30	Ages 45-49	229	332
31	Ages 50-54	286	377
32	Ages 55-59	416	518
33	Ages 60-64	399	538
34	Ages 65-69	367	458
35	Ages 70-74	284	312
36	Ages 75-79	148	162
37	Ages 80-84	74	87
38	Age 85 and over	39	86
39	**Total Patients (Sum of Lines 1-38)**	**4272**	**5330**

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Table 3B - Demographic Characteristics

Universal

Line	Patients by Race	Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1	Asian	2	117		**119**
2a	Native Hawaiian	0	6		**6**
2b	Other Pacific Islander	6	2		**8**
2	**Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)**	**6**	**8**		**14**
3	Black/African American	13	104		**117**
4	American Indian/Alaska Native	4	27		**31**
5	White	185	6681		**6866**
6	More than one race	0	1		**1**
7	Unreported/Refused to report race	131	83	2240	**2454**
8	**Total Patients (Sum of Lines 1 + 2 + 3 to 7)**	**341**	**7021**	**2240**	**9602**

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	303

Line	Patients by Sexual Orientation	Number (a)

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	87
14	Straight (not lesbian or gay)	9106
15	Bisexual	82
16	Something else	
17	Don't know	81
18	Chose not to disclose	246
19	**Total Patients (Sum of Lines 13 to 18)**	**9602**

Line	Patients by Gender Identity	Number (a)
20	Male	3074
21	Female	3855
22	Transgender Male/Female-to-Male	6
23	Transgender Female/Male-to-Female	4
24	Other	2618
25	Chose not to disclose	45
26	**Total Patients (Sum of Lines 20 to 25)**	**9602**

Table 4 - Selected Patient Characteristics

Universal

Income as Percent of Poverty Guideline

Line	Income as Percent of Poverty Guideline	Number of Patients (a)

Line	Income as Percent of Poverty Guideline	Number of Patients (a)
1	100% and below	831
2	101 - 150%	1427
3	151 - 200%	1801
4	Over 200%	2621
5	Unknown	2922
6	**TOTAL** (Sum of Lines 1-5)	**9602**

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**	30	370
8a	Medicaid (Title XIX)	778	2673
8b	CHIP Medicaid		
8	**Total Medicaid** (Line 8a + 8b)	**778**	**2673**
9a	Dually Eligible (Medicare and Medicaid)	1	535
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	12	1999
10a	**Other Public Insurance (Non-CHIP) (specify)**		
10b	Other Public Insurance CHIP		
10	**Total Public Insurance** (Line 10a + 10b)	**0**	**0**
11	**Private Insurance**	646	3094
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)	**1466**	**8136**

Managed Care Utilization

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months					
13b	Fee-for-service Member Months	15012			27090	42102
13c	**Total Member Months (Sum of Lines 13a + 13b)**	**15012**	**0**	**0**	**27090**	**42102**

Line	Special Populations	Number of Patients (a)
16	**Total Agricultural Workers or Dependents** (All health centers report this line)	
23	**Total Homeless** (All health centers report this line)	
24	**Total School-Based Health Center Patients** (All health centers report this line)	375
25	**Total Veterans** (All health centers report this line)	496
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	

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Table 5 - Staffing and Utilization

Universal

Medical Care Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	3.44	6231		
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1-7)	**3.44**	**6231**	**0**	
9a	Nurse Practitioners	5.78	9665	0	
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, PAs, and CNMs (Lines 9a-10)**	**5.78**	**9665**	**0**	
11	Nurses	7.27	1029		
12	Other Medical Personnel	10.87			
13	Laboratory Personnel				
14	X-ray Personnel				
15	**Total Medical** (Lines 8 + 10a through 14)	**27.36**	**16925**	**0**	**5730**

Dental Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
16	Dentists	5.29	8135	0	
17	Dental Hygienists	6.71	8041	0	
17a	Dental Therapists				
18	Other Dental Personnel	7.55			
19	**Total Dental Services** (Lines 16-18)	**19.55**	**16176**	**0**	**5404**

Mental Health Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers	5.26	4151		
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	**Total Mental Health** (Lines 20a-c)	**5.26**	**4151**	**0**	**547**

Substance Use Disorder Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21	**Substance Use Disorder Services**				

Other Professional Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22	**Other Professional Services** **Specify** Nutrition	0.43	472	0	158

Vision Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists				
22b	Optometrists	1.21	2324		
22c	Other Vision Care Staff				
22d	**Total Vision Services** (Lines 22a-c)	**1.21**	**2324**	**0**	**1529**

Pharmacy Personnel

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
23	**Pharmacy Personnel**	0			

Enabling Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
24	Case Managers	4.93	1520	0	
25	Patient/Community Education Specialists	2.47	2797	0	
26	Outreach Workers				
27	Transportation Staff				
27a	Eligibility Assistance Workers	2.36			
27b	Interpretation Staff				
27c	Community Health Workers				
28	**Other Enabling Services Specify**				
29	**Total Enabling Services** (Lines 24-28)	**9.76**	**4317**	**0**	**523**

Other Programs/Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
29a	**Other Programs/ Services Specify**				
29b	**Quality Improvement Staff**	1.58			

Administration and Facility

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
30a	Management and Support Staff	6.91			
30b	Fiscal and Billing Staff	7.14			
30c	IT Staff	1.08			
31	Facility Staff	0.8			
32	Patient Support Staff	17.28			
33	**Total Facility and Non-Clinical Support Staff (Lines 30a-32)**	**33.21**			

Grand Total

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
34	**Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29**	**98.36**	**44365**	**0**	

Selected Service Detail Addendum

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)	5	1500	0	753
20a02	Nurse Practitioners	10	2430	0	1055
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				

Substance Use Disorder Detail

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)	5	221		140
21b	Nurse Practitioners (Medical)	9	792		337
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers	6	267		14
21h	Other Licensed Mental Health Providers				

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Table 6A - Selected Diagnoses and Services Rendered

Universal

Selected Infectious and Parasitic Diseases

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	28	9
3	Tuberculosis	A15- through A19-, O98.0-	0	0
4	Sexually transmitted infections	A50- through A64- (exclude A63.0)	19	14
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	6	3
4b	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	28	15

Selected Diseases of the Respiratory System

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
5	Asthma	J45-	704	427
6	Chronic lower respiratory diseases	J40- through J44-, J47-	831	365

Selected Other Medical Conditions

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	111	79
8	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	30	25
9	Diabetes mellitus	E08- through E13-, O24-(exclude O24.41-)	1538	512
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	919	454
11	Hypertension	I10- through I16-, O10-, O11-	3033	1398
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	198	170
13	Dehydration	E86-	7	6
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-	3	3
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	1213	867

Selected Childhood Conditions (limited to ages 0 through 17)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
15	Otitis media and Eustachian tube disorders	H65- through H69-	61	45
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22-through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	5	4
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3	21	15

Selected Mental Health Conditions and Substance Use Disorders

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
18	Alcohol-related disorders	F10-, G62.1, O99.31-	365	143
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	283	75
19a	Tobacco use disorder	F17-, O99.33-	632	337
20a	Depression and other mood disorders	F30- through F39-	2604	754
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	4041	984
20c	Attention deficit and disruptive behavior disorders	F90- through F91-	511	130
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	1581	434

Selected Diagnostic Tests/Screening/Preventive Services

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
21	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806	0	0
21a	Hepatitis B test	**CPT-4:** 86704 through 86707, 87340, 87341, 87350	0	0
21b	Hepatitis C test	**CPT-4:** 86803, 86804, 87520 through 87522	0	0
22	Mammogram	**CPT-4:** 77065, 77066, 77067 OR **ICD-10:** Z12.31	0	0
23	Pap test	**CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	142	139
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4:** 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	695	631
24a	Seasonal flu vaccine	**CPT-4:** 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756	1216	1188
25	Contraceptive management	**ICD-10:** Z30-	325	217
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99381 through 99383, 99391 through 99393 **ICD-10:** Z00.1-	358	257
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4:** 83655	19	16
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0050	0	0
26c	Smoke and tobacco use cessation counseling	**CPT-4:** 99406, 99407 OR **HCPCS:** S9075 OR **CPT-II:** 4000F, 4001F, 4004F	0	0
26d	Comprehensive and intermediate eye exams	**CPT-4:** 92002, 92004, 92012, 92014	600	600

Selected Dental Services

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
27	Emergency services	**ADA:** D0140, D9110	1170	972
28	Oral exams	**ADA:** D0120, DO145, D0150, D0160, D0170, D0171, D0180	6295	4404
29	Prophylaxis-adult or child	**ADA:** D1110, D1120	6329	4103
30	Sealants	**ADA:** D1351	169	127
31	Fluoride treatment-adult or child	**ADA:** D1206, D1208 **CPT-4:**99188	1369	861
32	Restorative services	**ADA:** D21xx through D29xx	3335	1952
33	Oral surgery (extractions and other surgical procedures)	**ADA:**D7xxx	562	452
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	372	243

Sources of Codes:
ICD-10-CM (2019)-National Center for Health Statistics (NCHS)
CPT (2019)-American Medical Association (AMA)
Code on Dental Procedures and Nomenclature CDT Code (2019)-Dental Procedure Codes. American Dental Association (ADA)
Note: "X" in a code denotes any number including the absence of a number in that place. Dashes (-) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead, they are used to point out that other codes in the series are to be considered.

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Table 6B - Quality of Care Measures

Universal

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

Section A - Age Categories for Prenatal Care Patients:

Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)

Line	Age	Number of Patients (a)
1	Less than 15 years	0
2	Ages 15-19	0
3	Ages 20-24	2
4	Ages 25-44	11
5	Ages 45 and over	0
6	**Total Patients** (Sum of Lines 1-5)	**13**

Section B - Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7	First Trimester	13	0
8	Second Trimester	0	0
9	Third Trimester	0	0

Section C - Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	22	22	6

Section D - Cervical Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	1720	1720	567

Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented	531	531	118

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

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	4410	4410	1678

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

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention	3656	3656	3016

Section H - Use of Appropriate Medications for Asthma

Line	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	169	169	157

Section I - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	1141	1141	815

Section J - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	231	231	210

Section K - Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	2191	2191	1258

Section L - HIV Linkage to Care

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis	0	0	0

Section M - Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented	3490	3490	1042

Section N - Dental Sealants for Children between 6-9 Years

Line	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	134	134	79

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Table 7 - Health Outcomes and Disparities

Deliveries and Birth Weight

Line	Description	Patients (a)
0	HIV-Positive Pregnant Women	0
2	Deliveries Performed by Health Center's Providers	0

Hispanic/Latino

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
1a	Asian	0	0	0	0
1b1	Native Hawaiian	0	0	0	0
1b2	Other Pacific Islander	0	0	0	0
1c	Black/African American	0	0	0	0
1d	American Indian/Alaska Native	0	0	0	0
1e	White	0	0	0	0
1f	More than One Race	0	0	0	0
1g	Unreported/Refused to Report Race	0	0	0	0
	Subtotal Hispanic/Latino	**0**	**0**	**0**	**0**

Non-Hispanic/Latino

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
2a	Asian	0	0	0	0
2b1	Native Hawaiian	0	0	0	0
2b2	Other Pacific Islander	0	0	0	0
2c	Black/African American	0	0	0	0
2d	American Indian/Alaska Native	0	0	0	0
2e	White	1	0	0	1
2f	More than One Race	0	0	0	0
2g	Unreported/Refused to Report Race	0	0	0	0
	Subtotal Non-Hispanic/Latino	**1**	**0**	**0**	**1**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
h	Unreported/Refused to Report Race and Ethnicity	0	0	0	0
i	**Total**	**1**	**0**	**0**	**1**

Controlling High Blood Pressure

Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
1a	Asian	1	1	0
1b1	Native Hawaiian	0	0	0
1b2	Other Pacific Islander	0	0	0
1c	Black/African American	1	1	1
1d	American Indian/Alaska Native	0	0	0
1e	White	24	24	14
1f	More than One Race	0	0	0
1g	Unreported/Refused to Report Race	9	9	6
	Subtotal Hispanic/Latino	**35**	**35**	**21**

Non-Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
2a	Asian	11	11	9
2b1	Native Hawaiian	2	2	2
2b2	Other Pacific Islander	0	0	0
2c	Black/African American	19	19	12
2d	American Indian/Alaska Native	5	5	4
2e	White	1201	1201	830
2f	More than One Race	0	0	0
2g	Unreported/Refused to Report Race	11	11	8
	Subtotal Non-Hispanic/Latino	**1249**	**1249**	**865**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
h.	Unreported/Refused to Report Race and Ethnicity	35	35	25
i	**Total**	**1319**	**1319**	**911**

Diabetes: Hemoglobin A1c Poor Control

Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
1a	Asian	1	1	0
1b1	Native Hawaiian	0	0	0
1b2	Other Pacific Islander	1	1	0
1c	Black/African American	2	2	1
1d	American Indian/Alaska Native	0	0	0
1e	White	9	9	2
1f	More than One Race	0	0	0
1g	Unreported/Refused to Report Race	9	9	3
	Subtotal Hispanic/Latino	**22**	**22**	**6**

Non-Hispanic/Latino

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

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
2a	Asian	10	10	3
2b1	Native Hawaiian	1	1	0
2b2	Other Pacific Islander	0	0	0
2c	Black/African American	12	12	3
2d	American Indian/Alaska Native	4	4	2
2e	White	394	394	108
2f	More than One Race	0	0	0
2g	Unreported/Refused to Report Race	4	4	1
	Subtotal Non-Hispanic/Latino	**425**	**425**	**117**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
h	Unreported/Refused to Report Race and Ethnicity	11	11	3
i	**Total**	**458**	**458**	**126**

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Table 8A - Financial Costs

Universal

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

Financial Costs of Medical Care

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
1	Medical Staff	2144979	660867	**2805846**
2	Lab and X-ray			**0**
3	Medical/Other Direct	233433	398264	**631697**
4	**Total Medical Care Services** (Sum of Lines 1 through 3)	**2378412**	**1059131**	**3437543**

Financial Costs of Other Clinical Services

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
5	Dental	1854259	830582	**2684841**
6	Mental Health	323036	188936	**511972**
7	Substance Use Disorder			**0**
8a	Pharmacy not including pharmaceuticals	5605	1727	**7332**
8b	Pharmaceuticals	104743		**104743**
9	**Other Professional Specify:** Nutrition	31943	14312	**46255**
9a	Vision	247411	120932	**368343**
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)	**2566997**	**1156489**	**3723486**

Financial Costs of Enabling and Other Services

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
11a	Case Management	331547		**331547**
11b	Transportation			**0**
11c	Outreach			**0**
11d	Patient and Community Education	145618		**145618**
11e	Eligibility Assistance	125136		**125136**
11f	Interpretation Services			**0**
11g	**Other Enabling Services Specify:**			**0**
11h	Community Health Workers			**0**
11	**Total Enabling Services Cost (Sum of Lines 11a through 11h)**	**602301**	**194510**	**796811**
12	**Other Related Services Specify:**			**0**
12a	Quality Improvement	127522	39289	**166811**
13	**Total Enabling and Other Services (Sum of Lines 11, 12, and 12a)**	**729823**	**233799**	**963622**

Facility and Non-Clinical Support Services and Totals

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
14	Facility	683504		
15	Non-Clinical Support Services	1765915		
16	**Total Facility and Non-Clinical Support Services (Sum of Lines 14 and 15)**	**2449419**		
17	**Total Accrued Costs (Sum of Lines 4 + 10 + 13 + 16)**	**8124651**		**8124651**
18	**Value of Donated Facilities, Services, and Supplies Specify:** Space donated by Gateway School for School-based services.			30000
19	**Total with Donations (Sum of Lines 17 and 18)**			**8154651**

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Table 9D - Patient Related Revenue

Universal

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wrap-Around Current Year (c1)	Collection of Reconciliati Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
1	Medicaid Non-Managed Care	1592649	962918					630757		
2a	Medicaid Managed Care (capitated)									

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wrap-Around Current Year (c1)	Collection of Reconciliati Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
2b	Medicaid Managed Care (fee-for-service)	1036632	846312					200589		
3	**Total Medicaid (Sum of Lines 1 + 2a + 2b)**	**2629281**	**1809230**	**0**	**0**	**0**	**0**	**831346**		
4	Medicare Non-Managed Care	1798908	872344					945505		
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare (Sum of Lines 4 + 5a + 5b)**	**1798908**	**872344**	**0**	**0**	**0**	**0**	**945505**		
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									
9	**Total Other Public (Sum of Lines 7 + 8a + 8b)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		
10	Private Non-Managed Care	1873087	1122744					726632		
11a	Private Managed Care (capitated)									

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wrap-Around Current Year (c1)	Collection of Reconciliati Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
11b	Private Managed Care (fee-for-service)	706641	431616			42483		294591		
12	**Total Private (Sum of Lines 10 + 11a + 11b)**	**2579728**	**1554360**			**42483**	**0**	**1021223**		
13	**Self-pay**	1160996	640870						561347	103915
14	**TOTAL (Sum of Lines 3 + 6 + 9 + 12 + 13)**	**8168913**	**4876804**	**0**	**0**	**42483**	**0**	**2798074**	**561347**	**103915**

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Table 9E - Other Revenues

Universal

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

Line	Source	Amount (a)

Line	Source	Amount (a)
1a	Migrant Health Center	
1b	Community Health Center	1790870
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum Lines 1a through 1e)	**1790870**
1k	Capital Development Grants, including School-Based Health Center Capital Grants	51034
1	**Total BPHC Grants** (Sum of Lines 1g + 1k)	**1841904**

Other Federal Grants

Line	Source	Amount (a)
2	Ryan White Part C HIV Early Intervention	
3	**Other Federal Grants Specify:**	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Provider	25500
5	**Total Other Federal Grants** (Sum of Lines 2-3a)	**25500**

Non-Federal Grants Or Contracts

Line	Source	Amount (a)

Line	Source	Amount (a)
6	**State Government Grants and Contracts Specify:** Pharmacy Supplemental, Dept. of Early Ed. & Care, DPH School-Based services, Mass Office of Victim Assistance, State Navigator, DPH Legislative Earmark	483124
6a	**State/Local Indigent Care Programs Specify:** State Free Care	351625
7	**Local Government Grants and Contracts Specify:** Collaborative for Educational Services, Pioneer Valley Planning Commission, Hilltown Community Development Corp, Safe Passage, Highland Valley Elder Services	144575
8	**Foundation/Private Grants and Contracts Specify:** Mass Development, Blue Cross Blue Shield Foundation of MA, Community Foundation of Western MA, Cooley Dickinson Healthy communities, Mass General Hospital, Mass League of Community Health Centers, Friends of Hilltown Safety at Home, C3-Community Care Cooperative, United Way	285818
9	**Total Non-Federal Grants and Contracts (Sum of Lines 6 + 6A + 7 + 8)**	**1265142**
10	**Other Revenue (non-patient related revenue not reported elsewhere) Specify:** Dividend Income, Unrealized gain/loss on investments, Mavis Rolland Trust, Donations, Pledges, Rental income, Lease adjustment, medical report income	321790
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	**3454336**

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Health Center Health Information Technology (HIT) Capabilities

HIT

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

[X]: Yes, installed at all sites and used by all providers

[_]: Yes, but only installed at some sites or used by some providers

[_]: No

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

[X]: Yes

[_]: No

1a1.Vendor: eClinicalWorks, LLC

Other (Please specify):

1a2.Product Name: eCW Version

1a3.Version Number: 11

1a4.ONC-certified Health IT Product List Number: 15.04.04.2883.eCli.11.00.1.171228

1a1.Vendor: Select one

Other (Please specify):

1a2.Product Name:

1a3.Version Number:

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

[_]: Yes

[X]: No

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

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

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

[_]: a. 3 months

[_]: b. 6 months

[_]: c. 1 Year or more

[_]: d. Not planned

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

[X]: Yes

[_]: No

[_]: Not Sure

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

[X]: Yes

[_]: No

[_]: Not Sure

4. With which of the following key providers/health care settings does your center electronically exchange clinical information? (Select all that apply):

[X]: Hospitals/Emergency rooms

[X]: Specialty clinicians

[X]: Other primary care providers

[_]: None of the above

[_]: Other (please describe)

Other (please describe):

5. Does your center engage patients through health IT in any of the following ways? (Select all that apply):

[X]: Patient portals

[_]: Kiosks

[X]: Secure messaging

[_]: Other (please describe)

[_]: No, we do not engage patients using HIT

Other (please describe):

6. Question removed.

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

[_]: We use the EHR to extract automated reports

[_]: We use the EHR but only to access individual patient charts

[X]: We use the EHR in combination with another data analytic system

[_]: We do not use the EHR

8. Question removed.

9. Question removed.

10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply):

[X]: Quality improvement

[X]: Population health management

[X]: Program evaluation

[_]: Research

[_]: Other (please describe)

[_]: We do not utilize HIT or EHR data beyond direct patient care

Other (please describe):

11. Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?:

[X]: Yes

[_]: No, but we are in planning stages to collect this information

[_]: No, we are not planning to collect this information

12. Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply):

[_]: Accountable Health Communities Screening Tools

[_]: Upstream Risks Screening Tool and Guide

[_]: iHELP

[_]: Recommend Social and Behavioral Domains for EHRs

[X]: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

[_]: Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)

[_]: WellRx

[_]: Other (please describe)

[_]: We do not use a standardized screener

Other (please describe):

Other Data Elements

Other Data Elements

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

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

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

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

[_]: Yes

[X]: No

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

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

[_]: Specialists outside your organization (e.g., specialists at referral centers)

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

[_]: Real-time telehealth (e.g., live videoconferencing)

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

[_]: Remote patient monitoring

[_]: Mobile Health (mHealth)

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

[_]: Primary care

[_]: Oral health

[_]: Behavioral health: Mental health

[_]: Behavioral health: Substance use disorder
[_]: Dermatology
[_]: Chronic conditions
[_]: Disaster management
[_]: Consumer health education
[_]: Provider-to-provider consultation
[_]: Radiology
[_]: Nutrition and dietary counseling
[_]: Other (Please specify)

Other (Please specify):

2b. If you did not have telemedicine services, please comment why (Select all that apply):
[_]: Have not considered/unfamiliar with telehealth service options
[X]: Policy barriers (Select all that apply)
[_]: Inadequate broadband/telecommunication service (Select all that apply)
[_]: Lack of funding for telehealth equipment
[X]: Lack of training for telehealth services
[_]: Not needed
[_]: Other (Please specify)

Other (Please specify):

Policy barriers (Select all that apply):
[X]: Lack of or limited reimbursement
[_]: Credentialing, licensing, or privileging
[_]: Privacy and security
[_]: Other (Please specify)

Other (Please specify):

Inadequate broadband/telecommunication service (Select all that apply):
[_]: Cost of service
[_]: Lack of infrastructure
[_]: Other (Please specify)

Other (Please specify):

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

Enter number of assists: 793

[1] With the enactment of the Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs) and physician assistants (PAs).

Workforce

Workforce

1. Does your health center provide health professional education/training? Health professional education/training does not include continuing education units.:

[X]: Yes

[_]: No

1a. If yes, which category best describes your health center's role in the health professional education/training process?:

[_]: Sponsor [2]

[X]: Training site partner [3]

[_]: Other (please describe)

Other (please describe):

2. Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category within the last year.

	Medical	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
1.	Physicians	0	
	a. Family Physicians		
	b. General Practitioners		
	c. Internists		
	d. Obstetrician/Gynecologists		
	e. Pediatricians		
	f. Other Specialty Physicians		
2.	Nurse Practitioners	0	
3.	Physician Assistants	0	
4.	Certified Nurse Midwives	0	
5.	Registered Nurses	0	
6.	Licensed Practical Nurses/Vocational Nurses	0	
7.	Medical Assistants	0	

	Dental	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
8.	Dentists	0	
9.	Dental Hygienists	0	
10.	Dental Therapists	0	

	Mental Health and Substance Use Disorder	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
11.	Psychiatrists		
12.	Clinical Psychologists	0	
13.	Clinical Social Workers	1	
14.	Professional Counselors	0	
15.	Marriage and Family Therapists	0	
16.	Psychiatric Nurse Specialists	0	
17.	Mental Health Nurse Practitioners	0	
18.	Mental Health Physician Assistants	0	
19.	Substance Use Disorder Personnel	0	

	Vision	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
20.	Ophthalmologists		
21.	Optometrists		

	Other Professionals	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
22.	Chiropractors		
23.	Dieticians/Nutritionists		
24.	Pharmacists		
25.	**Other please specify**		

3. Provide the number of health center staff serving as preceptors at your health center.: 2

4. Provide the number of health center staff (non-preceptors) supporting health center training programs.: 0

5. How often does your health center implement satisfaction surveys for providers?:

[_]: Monthly

[_]: Quarterly

[_]: Annually

[X]: We do not currently conduct provider satisfaction surveys

[_]: Other (please describe)

Other (please describe):

6. How often does your health center implement satisfaction surveys for general staff?:

[_]: Monthly

[_]: Quarterly

[X]: Annually

[_]: We do not currently conduct staff satisfaction surveys

[_]: Other (please describe)

Other (please describe):

[2] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).

[3] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).

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

Program Name: Health Center 330

Submission Status: Review In Progress

Date Requested: 02/25/2020 11:48 AM EST

Date of Last Report Refreshed: 02/25/2020 11:48 AM EST

UDS Report - 2019

Data Audit Report

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

Edit 03951: Numbers Questioned For Patients Aged 65+ - Patients aged 65 and older is outside the typical range when compared to total patients. Please correct or explain. Persons aged 65 and older: (2017); Total Patients(9602); Ratio of Persons aged 65+ to Total Patients(0.21)

Related Tables: Table 3A(UR)

Julie Hook (Reviewer) on 02/14/2020 4:40 PM EST: consistent with PYs.

Table 3B-Demographic Characteristics

Edit 07247: Unreported/Refused to Report greater than 25% of Total Patients - Patients reported on the 'Unreported/Refused to Report' Line 7 (2454) is greater than 25% of total patients (Line 8) (9602). Please correct or explain.

Related Tables: Table 3B(UR)

Julie Hook (Reviewer) on 02/14/2020 4:44 PM EST: consistent with PYs.

Edit 05142: Unreported Race/Ethnicity in Question - A large proportion of patients (23.33)% are reported as having no race or ethnicity on Line 7 Col c: Unreported/Refused to report race. Please correct or explain.

Related Tables: Table 3B(UR)

Julie Hook (Reviewer) on 02/14/2020 4:44 PM EST: consistent with PYs.

Table 4-Selected Patient Characteristics

Edit 03860: Income as Percent of Poverty Level in Question. - Number of patients reported with income over 200% FPL Line 4 Column (a) (2621) is greater than 25% of the total patients reported (9602). Income must be verified. If income is not verified, please report patients under unknown income. Please correct or explain.

Related Tables: Table 4(UR)

Frank Mertes (Health Center) on 02/13/2020 10:24 AM EST: This is correct, HCHC has a large private insurance population who have income > 200%. This is consistent with PY's.

Edit 03852: Inter-year change in patients - The percentage of Uninsured patients to total patients has significantly decreased when compared to prior year. Current Year ((4.17)%, (400)); Prior Year ((9.14)%, (783). Please review the insurance reporting to ensure the information reported is patient's primary medical care insurance. Please correct or explain.

Related Tables: Table 4(UR)

Frank Mertes (Health Center) on 02/13/2020 10:26 AM EST: Yes this is accurate, we have seen more patients covered in the MA HEALTH ACO

Table 5-Staffing and Utilization

Edit 04124: Dental Hygienists Productivity Questioned - A significant change in Productivity (visits/FTE) of Dental Hygienists Line 17 (1198.36) is reported from the prior year (855.12). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Frank Mertes (Health Center) on 02/13/2020 10:41 AM EST: We noted that in PY's we were misreporting some Hygienist visits as DEntist visits, this has been corrected in CY.

Edit 06349: Mental Health Visit per Patient in Question - On Universal - Mental Health visits per mental health patient varies substantially from national average. CY (7.59); PY National Average (4.80). Please correct or explain.

Related Tables: Table 5(UR)

Frank Mertes (Health Center) on 02/13/2020 10:46 AM EST: We verified the numbers and they appear accurate, we did note that this is reduced from PY of 9.12 to the CY of 7.59.

Edit 06387: Enabling Visit per Patient in Question - On Universal - Enabling visits per enabling patient varies substantially from national average. CY (8.25); PY National Average (2.51). Please correct or explain.

Related Tables: Table 5(UR)

Frank Mertes (Health Center) on 02/13/2020 11:05 AM EST: We verified CY numbers and we believe they are due to the number of visits recorded in the family center preschool program.

Edit 04149: Inter-year Patients questioned - On Universal - A large change in Enabling Services patients from the prior year is reported on Line 29 Column C. (PY = (1054), CY = (523)). Please correct or explain.

Related Tables: Table 5(UR)

Frank Mertes (Health Center) on 02/13/2020 10:53 AM EST: We verified CY numbers and we believe the problem is with the PY. In the PY the enabling service department manager was out on leave and we had trouble collecting the data, Due to staff some confusion on which service should be counted.

Table 6A-Selected Diagnoses and Services Rendered

Edit 02170: Pap Test Patients Questioned - The number of patients who had a pap test reported on Table 6A Line 23 Column (b) (139), is unreasonably low based on the number of women aged 21-64 reported on Table 3A (3342). Check to be sure that you are using the CPT Code or the ICD Code, not both. Please correct or explain.

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

Julie Hook (Reviewer) on 02/14/2020 5:06 PM EST: consistent with PYs.

Table 6B-Quality of Care Indicators

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

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

Eliza Lake (Health Center) on 02/13/2020 1:13 PM EST: We have checked the records, and this number is correct and in line with previous years.

Edit 06157: Line 21 Universe in Question - You are reporting (66.83)% of total possible medical patients in the universe for Patients Screened For Depression and Follow-up (Line 21 Column A). This appears low compared to estimated medical patients in the age group being measured. Please review and correct or explain.

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

Frank Mertes (Health Center) on 02/13/2020 2:06 PM EST: We believe the analysis/estimate of total possible medical patients in the universe is impacted by a large number of unique Dental Patients (2,820) included in the universe of unique patients.

Table 8A-Financial Costs

Edit 04126: Cost Per Visit Questioned - Mental Health Cost Per Visit is substantially different than the prior year. Current Year (123.34); Prior Year (111.53).

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

Frank Mertes (Health Center) on 02/13/2020 11:19 AM EST: Verified this is due to added raises and costs.

Edit 04136: Costs and FTE Questioned - Other Professional Services are reported on Table 8A, Line 9 (31943)(Nutrition) and Table 5, Line 22 (0.43)(Nutrition) . Review and confirm that FTEs relate to costs or correct.

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

Frank Mertes (Health Center) on 02/13/2020 11:15 AM EST: Verified this is accurate for our nutritionist.

Edit 06306: Costs and FTE Questioned - Quality Improvement is reported on Table 8A, Line 12a (127522) and Table 5, Line 29b (1.58). Review and confirm that FTEs relate to costs or correct.

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

Frank Mertes (Health Center) on 02/13/2020 11:30 AM EST: Verified FTE and related costs are correct.

Edit 03945: Inter-Year variance questioned - Current Year Non-Clinical Support costs, Line 15 Column (a) (1765915) varies substantially from cost on the same

line last year (1535592). Please correct or explain.

Related Tables: Table 8A

Frank Mertes (Health Center) on 02/13/2020 11:16 AM EST: This is correct it is due to our new facility.

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

Edit 03989: Self-pay numbers questioned - more collections and write-offs than charges - More collections and write-offs are reported than charges for self-pay, Line 13. Please review that proper re-allocations of all deductibles and co-payments to the self-pay category is being done. Please correct or explain. Current Year Accounts Receivable (-145136); Prior Year Accounts Receivable (156585);

Related Tables: Table 9D

Frank Mertes (Health Center) on 02/13/2020 11:36 AM EST: This is due to the timing and increase of Health Safety net Payments which included a large retro adjustment payment.

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

Program Name: Health Center 330

Submission Status: Review In Progress

Date Requested: 02/25/2020 11:48 AM EST

Date of Last Report Refreshed: 02/25/2020 11:48 AM EST

UDS Report - 2019

Comments

Report Comments

None

Table 3A Comments

We serve an older population in the Hilltowns, this is an accurate number.

Table 6B Comments

- this was the first full year of operation for a new site, so we have more patients who have not had a regular source of care in the last year(s) than usual. These patients will have had a negative impact on our numbers overall. - the number of children who meet the definition for Section C - Immunizations is so small that having a small number of parents decide to space out the immunizations has an out-sized impact on our numbers. Our investigation through case review has determined that this is the reason for the decrease. - we implemented the use of a new smart form in the EHR this year for tobacco use screening and intervention (Section G), which contributed to a large increase in this measure - the Statin use measure change (Section I) is due both to staffing shortages' impact on optimal patient recall rates, and due to some differences between HCHC medical criteria and UDS definitions of need - Cervical cancer screening is also negatively impacted by staffing shortages

Table 7 Comments

HCHC does not provide pre-natal care, and therefore does not see women again after confirmation of pregnancy, and usually they continue postpartum care with the mid-wives or OB practices. We also have a fairly limited pediatric practice, so the babies are not returning to the health center after the birth, which would be an opportunity to gather the birth weight information. Of the 13 women we know were pregnant, we only knew of due dates for seven, one of which was in 2020. We only received delivery information on one; given our current staffing shortage, follow-up with hospitals for delivery information was affected, but will be addressed in 2020.

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: improvement of clinical care and organizational sustainability.

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

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/RISK MANAGEMENT (QI/RM) COMMITTEE

1. Responsibilities of the Quality Improvement/Risk Management 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 center’s 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 Chief Operating Officer (COO), independently or in conjunction with the

QI/RM Committee, will report semi-annually to the Board of Directors: (1) the results of patient satisfaction surveys (2) departmental clinical goals as reported to the Bureau of Primary Health Care and progress made towards these goals and (3) a trend analysis of quality indicators and a plan to improve those indicators.

f. The CCCSO will report to the Board the minutes from any six QI/RM meetings, evidencing oversight of QI/RM 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 QI/RM Committee

The QI Committee is a staff-level committee and will be chaired by the COO. Other permanent members of the Committee are:

a. Chief Executive Officer
b. Chief Operations Officer
c. Medical Director
d. Dental Director
e. Director of Behavioral Health
f. Community Programs Director
g. Eye Care Director
h. Dental Operations Manager
i. Clinical Operations Manager

Other staff members may be asked to attend meetings or assist the team as deemed appropriate. Board members are welcome to attend one meeting each year.

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/RM Committee for discussion.

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

D. MECHANISMS

1. Meeting focus will follow the *QI/RM 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 collected through AZARA and other third-party aggregators
   d. National benchmarks and standards, including Health People 2020
   e. Patient satisfaction surveys
   f. 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/RM Committee will assess indicators by systematically evaluating HCHC performance against standardized quality measures. As the QI/RM Committee identifies opportunities for improvement they will direct the appropriate department to take action and report back with their action plan for improvement. Efforts will be made in those areas to improve performance through rigorous project selection with measurable results and clear operational accountability
   This action plan must be data driven.

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

6. Minutes shall be maintained by a QI Committee designee, reviewed and voted upon by the Committee, and be signed by the Chair.

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: Continuity of Operation Plan (COOP)	**Policy Number:** ADM-
Department: All Departments	**Policy status:**
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: 2014, 2015, 2017, 2018, 2019	
Dates Revised: March 2020	

PURPOSE:

In the event that the health center is affected by an epidemic infectious agent or other unanticipated hazards such as weather related closure, regional power failures, subsequent damage to infrastructure or systems causing significant multi-day and extended disruption to our mission, Hilltown Community Health Center will make every effort to continue operations subject to limitations on resources including human resources, materials and equipment and capital.

This plan outlines a comprehensive approach to ensure the continuity of essential services during such an event while ensuring the safety and well-being of employees, the emergency delegation of authority, the safekeeping of records vital to the agency and its clients, emergency acquisition of resources necessary for business resumption, and the capabilities to work remotely or at alternative work sites until normal operations can be resumed.

POLICY:

1. HCHC will follow the procedures outlined in this policy in the event of a significant reduction in staffing, either in a specific department or across the organization.
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 their absence, the Incident Commander will be the first individual present and available following the list of succession in Appendix A.

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 (EMP).
5. This policy will be used in conjunction, as appropriate, with the Health Center Closure Policy ADM-10, the Illness at Work policy, and the EMP. This includes in the case of 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.

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:

Section 1: COOP Assumptions

Plans to continue operations will need to be flexible to address the effects of the serious disruption of normal operations.

An infectious agent associated with a viral or bacterial epidemic, bio-terror attack, and outbreak of food-borne illness, severe weather incident or similar event may cause serious reductions in the availability of staff available for work and/or limit the stamina and work capacity of individuals. In such cases, a staff contingency plan must be developed to address critical functions throughout the health center.

The following list of assumptions outlines the potential impact on the health center's capacity to continue operations.

- Staff levels may be significantly reduced due to high levels of illness and hospitalization
- Staff may be lost due to significant mortality associated with disease
- Remaining workers may be psychologically affected by disease, family concerns, concerns about economic loss, or fear.
- Staffing may be reduced by the need for some workers to attend to family illness or to children remaining at home due to school closures.
- Human resource reductions may be temporary or may be long-term depending on the severity of the epidemic or similar event.
- There may be suspended function of building infrastructure due to power failure or damage as a result of inclement weather, including breach of the physical structure.

Section 2: General Information

2.A. Purpose: This Continuity of Operations Plan (COOP) provides policy and guidance to ensure the execution of essential functions in the event that core health center functions are threatened by an epidemic or similar event.

2.B. Applicability and Scope: This document applies to all personnel and associates of Hilltown Community Health Centers, Inc. (HCHC) including each of its sites in Worthington, Huntington, Amherst, School-Based programs, and Hilltown Community Center.

2.C. Responsibilities

The Chief Executive Officer (CEO) is responsible for the development of viable and executable contingency plans for the health center. The contingency plans will identify essential functions and the individuals to support them.

If the COOP is activated the Incident Commander, will be the CEO or, in their absence or unavailability, the Chief Operating Officer, Chief Financial Officer, Chief Clinical and

Community Services Officer or other designated Incident Commander will use the Emergency Management Plan (EMP) for full Incident Command activation and procedures.

Section 3: Operational Concept

3.A. Objective: Staff Resources
The objective of this plan for human resources is to ensure the execution of HCHC's essential functions during any crisis and to provide for the safety and wellbeing of the employees during any emergency when a sudden or ongoing and severe reduction in staff/human resources critical to the safe and effective operation of the organization threatened occurs. Specific objectives of this plan include:

1. Ensuring the continuous performance of essential functions during an emergency;
2. Protecting the safety and productivity of working staff;
3. Reducing or mitigating disruptions to operations;
4. Addressing behavioral health issues that may affect the organization;
5. Pre-planning for potentially critical losses of staff through scheduling, identification of alternate resources, and temporary business reduction efforts;
6. Reducing loss of life and minimizing damage and losses;
7. Achieving a timely and orderly recovery from an emergency and resumption of full service to customers.

3.B. Concept of Execution
Emergencies, or threatened emergencies, may adversely affect the ability of HCHC to continue to carry out core functions and operations (as defined in Section 3.D). Infectious diseases, terrorist agents, and natural disasters may contribute to high morbidity and mortality among staff or reduced or complete cessation of services due to a compromise of the internal systems. An epidemic, for example, could affect 40% of the workforce, which would decrease existing staff levels to critically low levels and threaten the capacity of the organization to continue operations. Likewise, reduced capacity to provide care may result if essential systems are damaged or rendered inoperable for a period of time.

The following levels of emergencies are defined for planning purposes for this section of the COOP:

> ***Level 1 Emergency***: Less than 15% of the workforce necessary to carry out one or more core functions is unavailable due to illness, quarantine, caring for family members, impassable roadways, etc. Capacity reductions may be in place due to power failure or Internet Service Provider (ISP) interruptions. May require mandatory overtime for available staff and/or minor/temporary reductions in non-essential services. Temporary but more time-consuming systems may be enacted to allow essential care delivery.
>
> ***Level 2 Emergency*:** Between 15% and 40% of the workforce necessary to carry out one or more core functions is unavailable due to illness, quarantine, caring for family members, impassable roadways, etc. May require mandatory overtime for available staff and/or significant reduction in non-essential services and hours of operation. Multiple

days of service interruption due to adverse weather conditions may result in decreases of workforce availability due to impassable roadways or failures of the power infrastructure or ISP.

***Level 3 Emergency*:** 40% or more of the workforce necessary to carry out one or more core functions is unavailable due to illness, quarantine, caring for family members, impassable roadways, etc. May require cessation of essential services and redeployment of available personnel to resource pools managed by local, state, or federal emergency agencies. These may include but are not limited to, mass immunization sites, overflow treatment centers, and distribution sites for antivirals and other medications. Other incidents include cessation of essential services due to adverse weather events resulting in systems and/or utilities interruption.

There are numerous scenarios in which the COOP will need to be activated, including:

Infectious Disease Epidemic: Epidemic is defined as an event with widespread morbidity and mortality due to a highly contagious and dangerous virus resulting in an epidemic disease event. Staff reduction levels may reach 40% or more over a period of many months depending on incidence of disease within area of worksite/facility. Staff reductions may occur due to staff illness due to disease or family responsibilities, closure of schools, lack of caregiver support, or similar instances that prevent employees from coming to work.

HCHC may direct full or partial activation of the COOP. Activation of the plan may involve the transfer of essential functions or the deployment of pre-identified personnel and equipment/supplies. Activation of the plan may also involve significant alteration of work plans and assignments of staff to critical work areas; use of contractors; extension of overtime for well workers, and similar alternatives to offset staff reduction.

While an epidemic will most likely be preceded by up to a period time before the disease affects staff levels, staff reductions may be sudden and severe, and would likely occur across organizations. HCHC will maintain routine awareness of the threat environment through communications from the federal and state governments, local media, the Mass League of Community Health Centers (MLCHC), the Hampshire Public Health Preparedness Coalition (HPHPC), the regional Health and Medical Coordinating Council (HMCC), and other Emergency Preparedness partners. Developing situations should be closely followed, with emphasis on worsening situations that could develop into crisis conditions.

It is expected that HCHC will receive a warning from the Massachusetts Department of Public Health (MDPH) prior to declaration of an epidemic; however, an epidemic may last several months. Under this circumstance, the process of activation would normally enable the partial or full activation of the COOP with a complete and orderly alert, notification, and deployment of pre-designated personnel, equipment/supplies, and/or temporary transfer of selected core functions.

Weather Related Disaster: Extreme weather conditions preventing staff from reaching the facility may result in partial or complete reduction of capacity to provide care for indeterminate amounts of time. Accompanying this may be cessation of power, both situations may result in a full or partial activation of the COOP, as well as the Health Center Closure policy. It is expected that HCHC will be notified through the National Weather Service (NWS), Massachusetts Health and Homeland Alert Network (HHAN), the MDPH, and the HMCC of an impending weather event that is anticipated to carry enough force requiring activation of the COOP.

In any of the situations outlined above, without a warning the process becomes less routine and potentially more serious and difficult to address. The clinical and leadership teams will identify key individuals who can realistically commit to reporting for work under any anticipated conditions related to the above circumstances.

If the epidemic, weather related disaster or other incident results in loss of life, a major consideration becomes reconstitution of key leadership positions with personnel drawn from surviving departmental locations and elements, in accordance with the Order of Succession outlined in Appendix B.

3.C. Staff Resource Contingency Plan

Each Department Head, in consultation with Practice Management and their Senior Manager, will assess staffing needs for each site and develop a contingency plan to provide for alternative staffing in the event of an epidemic or any other event with major staff reduction. This includes:

1. Identification of functions necessary for continuity of operations (e.g., clinical providers, receptionists, management staff, finance staff, etc.) that are necessary for business to continue.
2. Plans for service reduction based on need, critical nature of function as a support for organization or local population, and other factors.
3. Reassignment of staff to critical areas of health center functioning or other sites from their current role or place of work. Evaluation of potential health and safety issues that might arise through diversion of staff to new job roles and loss of critical staff in various operational positions.
4. Identification of work options available through “telecommuting” or other off-site possibilities.
5. Assessment of flexible leave options that would allow employees to address family needs while continuing to support the employing organization through a flexible work plan where feasible.
6. Training of workers on an annual basis about contingency planning and the need for personal back up plans for transportation, family needs, etc.
7. Possibility of hiring temporary staff as required and possible from temporary staffing agencies.

3.D. Essential Functions

HCHC shall ensure essential function continuity or resumption as rapidly and efficiently as possible in the event of a staff reduction.

HCHC core functions have been prioritized as follows:

1. Medical Primary Care, including:
    a. Provision of urgent medical care and management of chronic diseases, including medication management; and
    b. 24-hour provider coverage of the practice's primary care patients
2. Dental primary and restorative care, with a focus on emergency care
    a. 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.
3. Behavioral health services, with a focus on crisis management
    a. Behavioral health requires only one provider to deliver some service. They will continue to see urgent patients only.
4. Community services that support the provision of primary care and patient access.
    a. CHWs will focus on facilitating patient and community communication.
5. Optometry, with a focus on emergency care
    a. The eye care department will remain open as long as there is one optometrist available and the exam lanes are not needed for urgent medical visits

Administrative staffing, including billing, HR, and IT, will be prioritized as appropriate and required to support core functions. Any task in any department not deemed essential will be deferred until additional personnel and resources are available.

3.E. Direction and Control Succession

The following is an order of succession for Chief Executive Officer if they are no longer able to carry out their functions according to Appendix B. Delegation of authority will be to one of the leadership team members who are listed in Appendix B in the order in which they are listed. The delegation will last in auto-renewing 30-day periods or until revoked by the CEO or the Chair of the Board of Directors, and if unavailable, another Board officer (see Appendix C for Board Executive Committee members' contact information.

3.F. Operating Hours

During a COOP activation period, new hours of operation and/or changed hours of work for personnel may be necessary. However, to the extent possible, working hours of most staff will be similar to those during normal non-emergency periods. Hours of operation may be reduced at the discretion of the Chief Executive Officer or designee during periods of COOP activation.

Section 4: COOP Activation/Termination

4.A. COOP Activation

The COOP may be activated under several situations if adequate staff are not available for work in order to keep critical business interests operational. It should be kept in mind that the COOP is NOT an evacuation plan; rather it is a deliberate and planned deployment of pre-identified and trained personnel and/or the transfer of essential functions.

Should a full or partial activation of the plan be necessary, the Chief Executive Officer will disseminate notification of the COOP activation with appropriate information and instructions, by email and text, as possible. If public notification is necessary, HCHC will use available means including social media, radio, television, telephone or e-mail. Pre-identified personnel should follow the instructions given and or in accordance with the instructions contained in this policy.

The COOP will be activated upon notification of the CEO or any one of the leadership team listed in Appendix B in the order that they are listed if the CEO is unavailable. Upon activation the CEO or designee will convene a leadership team to implement the COOP plan and assign responsibilities, using the Incident Command System as outlined in the EMP.

4.B. Initial Actions

Following COOP activation, the Incident Command Team will complete:

- Review of mission critical functions for the organization
- Evaluation of current staffing levels and resource deployment
- Evaluation of immediate and ongoing staff needs based on existing and predicted levels of human resources available.
- Notification of human resources, managers, and other key personnel as to status and plan implementation
- Notification of employees as to plan activation and process
- Implementation of alternative staff resource options
- Inventory of epidemic supplies, including special infection control masks. If supply chains are disrupted, Incident Commander or designated staff person will maintain communication with HMCC, Mass League, DPH, HPHPC, etc. to ensure that adequate supplied are secured.
- Consideration as to whether as many services as possible might need to be relocated to another of our facilities (e.g., Worthington to Huntington, Huntington to Amherst, etc.)
- Notification of emergency and community partners, including the Mass League, HMCC, local Board of Health and town government, local EMS, HPHPC, etc.
- Public notification and dissemination of infectious disease or other relevant safety information by means of mail, social media, press releases, etc. based on the most current information available from the Massachusetts Department of Public Health and the CDC.

4.C. Transition of Responsibilities to Redeployed staff

Transition of responsibilities according to job function analysis will occur throughout the course of an epidemic, infectious agent emergency or other identified hazard. Redeployment of personnel should be evaluated on a regular basis to ensure continuity of critical operations. This evaluation will be carried out by the senior management team convened by the organization's Incident Commander.

4.D. Deactivation/Termination of the COOP

Following the incident, the primary effort will be the resumption of services at HCHC's sites with adequate personnel to restore complete business operations. When sufficient functions have been restored at the original work site and/or other occupied space or a reconstituted facility(s) and notification that an imminent threat of disease or disaster no longer exists, the Chief Executive Officer or their designated successor can order the termination of COOP operations.

Section 5: COOP Responsibilities

5-1 Responsibilities of Senior Management

The responsibilities of senior management personnel in the event of staff loss to an epidemic or other such event will be to implement the COOP and EMP to support loss of management capabilities across the organization.

5.B. Responsibilities of Clinical Personnel

The responsibilities of clinical personnel will be to support critical operations at maximum feasible capacity as identified by Senior Management. Clinical personnel may be redeployed to programs requiring assistance outside of their standard functional job definition.

5.C. Responsibilities of Non-Clinical Supervisors

Administrative personnel will be responsible for providing support across the organization for key operations such as payroll, vital records maintenance, phone and internet service, customer support, database management, and similar functions, and may be redeployed to other programs requiring additional assistance.

5.D. Responsibilities of Support Personnel

Support personnel will be responsible for providing services across the organization as necessary and may be re-deployed to other programs requiring additional assistance.

6: Coordinating Instructions

6.A. Vital Records and Databases

Personnel will be deployed during an emergency to ensure the protection and ready availability of electronic and hardcopy documents, references, records, and information systems needed to support essential functions under the full spectrum of emergencies. All Health Center personnel with an identified role in the activation of the COOP must be identified before an emergency in order to have full access to use records and systems to conduct their essential functions. Categories of such records may include:

- ***Emergency Operating Records***: These are defined as vital records essential to the continued functioning or reconstitution of an agency during and after an emergency regardless of medium (paper, electronic, etc.). Included are emergency plans and directives; orders of succession; job action sheets; delegations of authority; staffing assignments; and related records of a policy or procedural nature that provide staff with guidance and information resources necessary for conducting operations during an emergency and for resuming formal operations at its conclusion.
- ***Legal and financial records***: These are defined as vital records, regardless of medium, critical to carrying out an organization's essential legal and financial functions and activities and protecting the legal and financial rights of individuals directly affected by its activities. Included are records having such value that their loss would significantly impair the conduct of essential agency functions, to the detriment of the legal or financial rights or entitlements of the organization or of the affected individuals.

6.B. IT and Billing Activities

As a backup to our critical IT infrastructure, HCHC has an informal arrangement with Cooley Dickinson Health Care, which hosts the EHR on its servers, to provide critical IT support during the activation period.

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.

6.C. Tests, Training and Exercises

Tests, training and exercises should be carried out regularly or at least annually to evaluate the COOP and improve the ability of HCHC to activate the COOP effectively. Testing will include team training of agency COOP staff and emergency personnel to ensure current knowledge and integration of skills necessary for plan execution; agency testing of COOP plans and procedures to ensure the ability of the agency to perform essential and mission critical functions; and testing of alert and notification procedures and systems.

6.D. Communications

Every member of the leadership team will have at least two different and independent ways of being contacted. In addition, staff will be notified as necessary by their direct supervisor, according to the Emergency Contact list maintained by HCHC Human Resources.

6.E. Security

Security of agency facilities, records, materials and other resources will be continuously evaluated to determine the effect of staff losses on security levels. All facilities are under security badge access to designated areas, restricted to authorized personnel.

Personnel will wear HCHC-issued badges at all times while on health center properties and while representing HCHC externally and shall continue to wear their identification during COOP operations. Temporary staff shall be issued badges as well, so that the leader of each work area can ensure that only health center personnel are in restricted areas and having patient contact.

APPENDIX B

Leadership Contact List

Commented [EL1]: We will redesign this to show the succession plan by department/division. Tabitha is taking a stab at it and we can refine it to make the most sense. Managers should share with her who they feel are the top three individuals in the department to be listed here.

Name	Title	Work Telephone	Cell phone	Work Email	Personal Email
Eliza Lake	CEO	413-238-4128	617-413-8604	elake@hchcweb.org	eliza@elizalake.net
Michael Purdy	CCCSO	413-667-3009 ext. 270			

CRITICAL TEAM MEMBERS – list to be moved into table above

- CEO — Eliza Lake — 617-413-8604 (cell)
- CFO — 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)
- Reception — Patti Igel — 413-977-6615 (cell)
- Facilities — Russ Jordan — 413-992-7021 (cell)