Hilltown Community Health Center
Board of Directors Meeting
October 8, 2020
https://hchcweb-org.zoom.us/j/590224751 -- ID: 590 224 751
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**	Lee Manchester
5:35 PM	**Finance Committee Report**	**Vote Needed**	John Follet John Melehov
5:50 PM	**Committee Reports**	**Vote Needed**	
	• Executive Committee		Lee Manchester
	• Fundraising Committee		Nancy Brenner
	• Personnel		John Follet
	• Facilities		Alan Gaitenby
	• Recruitment Orientation and Nomination		Wendy Long
	• Strategic Planning		Alan Gaitenby
6:05 PM	**Board Strategic Planning Session**	Discussion	Eliza Lake
6:45 PM	**Senior Management Reports**		
	• Credentialing and Privileging Report	**Vote Needed**	Michael Purdy
	• Quality Improvement/Risk Management	**Vote Needed**	Michael Purdy
	• CEO Report	Inform/Discussion	Eliza Lake
7:00 PM	**New Business**		
	• Policy Review	**Vote Needed**	Eliza Lake
	o Anti-Discrimination Policy		
	o Sexual Harassment Policy		
	o Code of Conduct Policy		
	o Immunization Against Communicable Diseases Policy		
	o Credentialing and Privileging Policy		
	o HIPAA Privacy and Security Policies		
	o Corporate Compliance Program		
7:15 PM	**Old Business**		
7:20 PM	**Executive Session** (if needed)	Discussion	Lee Manchester
7:30 PM	**Adjourn**	**Vote Needed**	Lee Manchester

Upcoming Meetings

- November 12th, 5:30 PM by Zoom
- December 10th, 5:30 PM by Zoom
- January 14th, 5:30 PM by Zoom

HCHC BOARD OF DIRECTORS MEETING
Date/Time: 9/10/2020 5:30pm
Zoom Meeting

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

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Minutes 8/13/2020	Lee Manchester called the meeting to order at 5:33 pm. Correction noted on page 5 by Lee Manchester that in the follow-up column the vote for the FTCA application needs to be deleted as this was not discussed in August. **Alan Gaitenby moved to approve the August Board minutes as amended. John Follet seconded the motion, which was approved by those present. Wendy Long reclused herself from the vote due to not being present for the August meeting.**	The Board voted unanimously to approve the August 13, 2020 Board minutes as amended.
Finance Committee	• John Follet reported on the August financials. The highlights were discussed as presented in the Interim Financial Statement Presentation by John Melehov, CFO. As presented, the operating loss was $120K in July with a net loss of $250K for the year. John explained that Federal financial assistance has helped keep financials afloat with the low patient revenue during the pandemic. The patient revenue in medical services were down in July from June. Senior Management will gather more details as to why the patient revenue continues to decline, as services should be resuming. Overall, for the year the revenue is down 14% across all departments. Salary expenses continue to be low for the year, but slightly up from the month before. There was a positive number in bad debt, as there has not been as much	The Board voted unanimously to approve the corporate resolution authorizing Eliza Lake, CEO, to sign for the $500K line of credit with PeoplesBank.

	billed out therefore less to write off as bad debt. In conclusion, the overall deficit is growing from last year. The cash flow shows a decrease in cash on hand of $161K but there is still a significant amount available at this time. This is still remnants of the PPP loan being paid out. The current ratio has slightly decreased from June, as there was more spending. • John Melehov, CFO, followed up that the finance department is slowly making the transfer of accounts to PeoplesBank, as discussed in previous meetings. • A corporate resolution that authorizes Eliza Lake, CEO, to sign for the $500K line of credit with PeoplesBank was presented by the John Follet as recommended from the Finance Committee. The interest rate is half a percent above prime. This is a larger line of credit then we have had in the past and will give HCHC the ability to cover payroll in an emergency. • There will be no changes to the Collections Policy as the procedures are being improved, not the policy. **Alan Gaitenby approve the corporate resolution that will enable us to obtain to the line of credit. Jenicca Gallagher seconded the motion.** **Kathryn Jensen moved to approve the Finance Committee report. Wendy Long seconded the motion.**	The Board voted unanimously to approve the Finance Committee report
CEO Report	• Eliza discussed some updates in telehealth, and staffing shortages. • The 340B pharmacy program is under attack by pharmaceutical companies, which are severely limited the ability of contracted 340B pharmacies to dispense certain drugs, particularly to uninsured patients. Both the Mass League and NACHC are working to address this issue, which could have a significant impact on community health centers' revenue. While not a huge revenue source for HCHC, it would certainly result in a cut, and staff are very concerned about the impact on patients. • Several staff volunteered to join the DEI committee. Senior management is working on being able to support those staff by ensuring time availability in their schedule for this committee. Potentially looking at grant	

	opportunities to support the work of the committee. DEI committee could potentially have Board participation, Eliza encourage any member interested in participating to reach out to her. • Eliza reported that the Rural Council on Health is working on addressing racial inequity in primarily majority white rural communities, which could be very helpful in addressing these issues in the Hilltowns. • A survey went out to all staff asking about the impact of schools closing for those with children. This survey is meant to encourage staff to talk to their managers to plan for changes in school systems' COVID planning. • Vickie Dempesy, COO noted that there is a task force coming together to develop a flu clinic. The tentative plan is to vaccinate patients, and then explore opportunities to vaccinate the community. Wendy Long suggested that when parents come to pick up lunches at Gateway schools three days a week, that help to facilitate a flu clinic during those times. There is also a SBHC task force, including school representatives coming together to plan the reopening.	
Executive Committee	• Lee Manchester reported that the committee did not meet. However, ice cream treats were placed at each site for staff and were well received.	
Recruitment, Orientation & Nominating (RON) Committee	• Wendy Long reported that the committee has not met. Eliza Lake recommended that when the DEI committee is back up and running to have it help with recruitment. This will be discussed more with the committee.	
Facilities Committee	• Alan Gaitenby reported that the committee will meet next week and will report next month.	
Personnel Committee	• John Follet reported that this committee has not met.	
Strategic Planning	• Alan Gaitenby reported that the committee met and discussed data collection, primarily reviewing a draft survey for community stakeholders. Some discussion was had on options for collection data from staff. The committee will meet before next month's Board meeting.	

Fundraising Committee	• This committee has not met. Eliza Lake provided a preview of the annual report that should be finalized very soon that will be solely electronic, and postcards directing people this electronic report will be going out to all donors. The finalized report will be sent to the fundraising committee for final comments and edits, once completed.	
Committee Reports	• **Jenicca Gallagher moved that the committee reports be approved. Matt Bannister seconded the motion.**	The Board voted unanimously to approve the Committee Reports
Quality Improvement/ Risk Management	• Michael Purdy reported that the QI committee and infection control team report echoes many of the same issues of last month. Primarily working to identify staffing shortages and developing strategies to mitigate those short falls. As noted in the CEO report, the DEI committee recruitment is in progress and the telehealth group continues to work towards rolling out audio-visual appointments in the medical department. **Kathryn Jensen moved to accept the QI/RM report, Jenicca Gallagher seconded.**	The Board voted unanimously to approve the QI/ Risk Management Report.
Credentialing/ Privileging Report	• Michael Purdy informed the Board that the following employees were being presented for initial credentialing: o Alice Oshima, BH Intern o Emily Magnifico, LSW BH Intern o Chelsea Merritt, PA-C **John Follet moved to approve the initial credentialing of the slate of employees as presented, Wendy Long seconded the motion.**	The Board voted unanimously to approve the initial credentialing of the slate of employees. Bridget Rida to notify employees of the granted credentials.
New Business	• Eliza Lake presented the edited reporting schedule to provide an update on anticipated policies for review.	The Board voted unanimously to

	• The red line versions of the administrative policies were reviewed in the meeting packet. Lee Manchester presented a question on ADM-04 regarding the language of a "contact form" instead of simply referring to it as an "email link." The language was edited to remove the use of "contact form." **Wendy Long moved to approve the slate of administrative policies, and Jenicca Gallagher seconded the motion.** • The Board policies were reviewed and edited during the meeting. Lee Manchester noted on the BOD-2, the language seemed ambitious and did not reflect the reality of the orientation of a new member. This language was kept with the additional of "as possible" to incorporate the chance that all orientation processes cannot be met within the timeline (due to social distancing, scheduling, etc). The BOD-3 seemed circular in language, and that not all grants/contracts need to be brought to the board, as it has historically been at the discretion of the CEO. The language was corrected grammatically and to include discretion of the CEO to bring forward grants to the board as deemed appropriate. **Jenicca Gallagher moved to approve the slate of Board policies, and Wendy Long seconded the motion.** • John Melehov informed the board of the decision to retain Adelson as the auditing company for the upcoming year. No comments or further discussion. **Kathryn Jensen moved to approve the retention of Adelson auditing company for another year, and Jenicca Gallagher seconded the motion.**	approve the slate of administrative policies. The Board voted unanimously to approve the slate of board policies.
Old Business	• No old business was discussed	
Executive Session	• Alan Gaitenby moved to go into Executive Session and Wendy Long seconded the motion.	
Next Meeting	**John Follet moved the meeting be adjourned. Lee Manchester seconded the motion, which was approved by those present.** The meeting was adjourned at 7:18 pm. The next scheduled meeting, which will be October 8, 2020 via Zoom.	The Board voted unanimously to approve adjourn.

Respectfully submitted,

Tabitha Griswold, Executive Assistant
Approved by Board of Directors:

_____ _____

Chair, HCHC Board of Directors Date

Hilltown Community Health Center

Interim Financial Statement Presentation

August 2020 – Presented 10/8/2020

Highlights

- $66K Operating Loss in August.
- YTD Net $343K loss
- $75K negative cash flow
- Highest patient billings since March!
- September shows slight improvement
- Pharmacy program nets $79K!
- A long way to go before we break even…

Income Statement

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	YTD Total Actual	PY YTD Actual	$ Change	% Change	Sep (Preview)
OPERATING ACTIVITIES													
Revenue													
Patient Services - Medical	$194,733	$157,776	$162,144	$127,027	$132,581	$147,308	$105,190	$147,451	$1,174,211	$1,743,099	($568,888)	-33%	$147,640
Patient Services - Dental	$145,933	$123,425	$70,156	$17,187	$11,337	$26,937	$32,119	$57,754	$484,847	$1,290,078	($805,232)	-62%	$87,135
Patient Services - Beh. Health	$39,953	$37,463	$29,811	$29,864	$25,700	$30,858	$46,280	$22,958	$262,886	$242,004	$20,883	9%	$31,480
Patient Services - Optometry	$19,191	$13,103	$12,268	$4,184	$3,632	$3,162	$9,814	$16,594	$81,947	$137,999	($56,051)	-41%	$15,561
Patient Services - Optometry Hardware	$10,443	$4,945	$2,446	$998	$996	$3,574	$3,894	$5,390	$32,685	$61,735	($29,050)	-47%	$6,201
Patient Services - Pharmacy	$7,260	$6,065	$11,596	$18,350	$24,126	$27,724	$13,829	$79,287	$188,237	$83,490	$104,747	125%	x
Quality & Other Incentives	$475	$324	$24,149	$277	$25	$7,684	$279	$238	$33,452	$36,339	($2,887)	-8%	$217
HRSA 330 & Other Grant	$136,455	$138,372	$139,990	$225,857	$131,598	$155,075	$24,098	$88,619	$1,040,066	$1,228,701	($188,635)	-15%	x
Other Grants & Contracts	$59,052	$60,987	$64,025	$289,624	$187,345	$245,236	$200,559	$66,665	$1,173,494	$569,706	$603,788	106%	x
Int., Dividends Gain /Loss Investmenst	($2,424)	($22,104)	($40,933)	$27,765	$13,531	$7,243	$15,548	$16,824	$15,449	$35,813	($20,363)	-57%	x
Rental & Misc. Income	$4,002	$3,700	$1,132	$2,333	$2,567	$2,567	$4,002	$2,159	$22,462	$22,427	$34	0%	x
Total Operating Revenue	$615,073	$524,057	$476,784	$743,467	$533,437	$657,368	$455,612	$503,939	$4,509,736	$5,451,391	($941,655)	-17%	$288,235

- Patient billings at the highest level since March
- September shows gains in dental billing
- Pharmacy payments at an all time high!
- Grant payments will up-tick after we coordinate PPP application with other funds

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	YTD Total Actual	PY YTD Actual	$ Change	% Change
Compensation and related expenses												
Salaries and wages	($481,077)	($448,425)	($386,453)	($256,747)	($481,227)	($349,402)	($380,723)	($343,543)	($3,127,597)	($3,667,827)	$540,229	15%
Payroll taxes	($36,589)	($33,543)	($29,040)	($19,068)	($35,581)	($24,476)	($24,710)	($21,815)	($224,822)	($287,915)	$63,093	22%
Fringe benefits	($43,725)	($28,748)	($25,023)	($37,384)	($35,876)	($36,396)	($35,287)	($33,702)	($276,140)	($310,055)	$33,915	11%
Total Compensation & related exp	($561,390)	($510,716)	($440,516)	($313,198)	($552,684)	($410,274)	($440,720)	($399,060)	($3,628,559)	($4,265,796)	$637,237	15%

- Salary Expense YTD down 15% = $637K

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	YTD Total Actual	PY YTD Actual	$ Change	% Change
Other Operating Expenses												
Advertising and marketing	$0	$0	($99)	$0	$0	($240)	($341)	($255)	($935)	($7,044)	$6,109	87%
Bad debt	($1,307)	$6,292	($9,288)	($8,831)	($4,411)	($8,382)	$8,168	$988	($16,771)	($103,900)	$87,129	84%
Computer support	($7,088)	($6,199)	($21,428)	($9,589)	($12,655)	($8,388)	($8,388)	($1,948)	($75,684)	($54,821)	($20,862)	-38%
Conference and meetings	($248)	($1,350)	$0	$1,475	($1,882)	($480)	($30)	($2,636)	($5,152)	($5,978)	$827	14%
Continuing education	($2,368)	($1,092)	$0	$0	($308)	($1,733)	($275)	($496)	($6,273)	($24,184)	$17,911	74%
Contracts and consulting	($2,713)	($17,931)	($28,137)	($20,701)	($38,786)	($22,638)	($19,439)	($18,699)	($169,042)	($58,051)	($110,992)	-191%
Depreciation and amortization	($27,651)	($29,438)	($28,544)	($28,544)	($28,544)	($28,544)	($28,544)	($28,544)	($228,355)	($221,205)	($7,150)	-3%
Dues and membership	($2,355)	($3,243)	($2,355)	($2,530)	($2,405)	($7,955)	($3,247)	($6,692)	($30,780)	($24,439)	($6,341)	-26%
Equipment leases	($2,580)	($1,877)	($2,273)	($1,735)	($2,911)	($2,487)	($945)	($1,413)	($16,221)	($19,049)	$2,827	15%
Insurance	($2,128)	($2,202)	($2,202)	($2,192)	($2,192)	($2,192)	($2,192)	($2,192)	($17,491)	($16,882)	($609)	-4%
Interest	($1,289)	($1,279)	($1,187)	($1,258)	($1,209)	($1,238)	($1,187)	($1,723)	($10,370)	($10,777)	$407	4%
Legal and accounting	($2,500)	($2,500)	($2,626)	($2,500)	($2,895)	($2,668)	($2,500)	($2,500)	($20,689)	($18,517)	($2,173)	-12%
Licenses and fees	($4,115)	($6,952)	($4,006)	($2,898)	($2,959)	($3,504)	($3,794)	($3,775)	($32,001)	($31,674)	($328)	-1%
Medical & dental lab and supplies	($10,442)	($9,416)	($6,226)	($897)	($283)	($1,630)	($3,256)	($8,571)	($40,722)	($86,675)	$45,954	53%
Merchant CC Fees	($1,576)	($1,690)	($2,037)	($1,492)	($633)	($564)	($571)	($1,067)	($9,628)	($12,701)	$3,073	24%
Office supplies and printing	($2,304)	($3,052)	($1,899)	($7,188)	($1,530)	($7,637)	($7,234)	($13,799)	($44,643)	($27,992)	($16,651)	-59%
Postage	($117)	($2,051)	($2,240)	($151)	($2,233)	($2,040)	($511)	($28)	($9,371)	($10,976)	$1,604	15%
Program supplies and materials	($19,372)	($17,012)	($14,163)	($2,688)	($15,733)	($17,073)	($13,480)	($18,625)	($118,146)	($155,775)	$37,629	24%
Pharmacy & Optometry COGS	($7,980)	($10,963)	($4,699)	($3,785)	($3,420)	($9,287)	($6,308)	($19,791)	($66,233)	($68,428)	$2,195	3%
Recruitment	($4,049)	($527)	($90)	$0	$0	$0	$0	$0	($4,666)	($9,324)	$4,658	50%
Rent	($6,964)	($8,584)	($10,064)	($6,964)	($15,758)	($13,843)	($16,052)	($11,738)	($89,969)	($52,058)	($37,911)	-73%
Repairs and maintenance	($13,597)	($18,942)	($15,221)	($11,565)	($12,108)	($21,849)	($15,799)	($10,838)	($119,919)	($108,626)	($11,293)	-10%
Small equipment purchases	$0	($1,669)	$0	($1,299)	($4,240)	($12,046)	($7,050)	$0	($26,304)	($14,411)	($11,893)	-83%
Telephone	($10,928)	($13,895)	($14,263)	($15,336)	($14,707)	($14,343)	($13,859)	($14,701)	($112,032)	($102,879)	($9,153)	-9%
Travel	($1,947)	($1,348)	($940)	($639)	($327)	($1,076)	($1,171)	($1,050)	($8,498)	($15,951)	$7,452	47%
Utilities	($3,234)	($5,499)	($3,312)	($4,481)	($4,838)	($2,955)	($3,467)	($3,102)	($30,887)	($34,699)	$3,812	11%
Total Other Operating Expenses	($138,848)	($162,418)	($177,298)	($135,788)	($176,969)	($194,792)	($151,474)	($173,195)	($1,310,783)	($1,297,014)	($13,768)	-1%
NET OPERATING SURPLUS	**($85,166)**	**($149,077)**	**($141,031)**	**$294,481**	**($196,216)**	**$52,302**	**($136,583)**	**($68,317)**	**($429,606)**	**($111,419)**	**($318,186)**	**-286%**

Net Deficit (Income)

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	YTD Total Actual	PY YTD Actual	$ Change	% Change
NON_OPERATING ACTIVITIES												
Donations, Pledges & Contributions	$120	$9,800	$20,725	$40,211	$4,657	$1,476	$7,740	$2,000	$86,730	$141,394	($54,665)	-39%
Capital Grants	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,274	($84,274)	-100%
NET NON-OPERATING SURPLUS	**$120**	**$9,800**	**$20,725**	**$40,211**	**$4,657**	**$1,476**	**$7,740**	**$2,000**	**$86,730**	**$225,668**	**($138,938)**	**-62%**
NET SURPLUS/(DEFICIT)	**($85,046)**	**($139,277)**	**($120,306)**	**$334,692**	**($191,559)**	**$53,778**	**($128,843)**	**($66,317)**	**($342,876)**	**$114,249**	**($457,125)**	**-400%**

- YTD Deficit still growing
- Cash should hold out for around 17 months at current levels
- 67 days cash on hand (how long the cash will last if income dried up)

Cash Flow

CASH FLOWS FROM OPERATING ACTIVITIES		
	NET SURPLUS/(DEFICIT) FOR PERIOD	($66,317)
	NET CASH PROVIDED (USED) BY OPERATING ACTI	($111,476)
CASH FLOWS FROM INVESTING ACTIVITIES		
	NET CASH PROVIDED (USED) BY INVESTING ACTIV	$35,999
	NET INCREASE/(DECREASE) IN CASH	**($75,477)**
	CASH AND CASH EQUIVALENTS AS OF 8/1/2020	**$2,160,690**
	CASH AND CASH EQUIVALENTS AS OF 8/31/2020	**$2,085,214**

- Cash on hand decreased $75K
- Cash on hand decreased $161K in July

Balance Sheet (as of 8/31/20)

ASSETS		
	Total Current Assets	$2,071,511
	Net Property & Equipment	$4,116,806
	Total Other Assets	$355,300
	TOTAL ASSETS	**$6,543,616**
Liabilities & Fund Balance		
	Total Current Liabilities	($2,370,624)
	Total Long Term Liabilities	($138,101)
	Total Liabilities	**($2,508,725)**
Fund Balance / Equity		
	Total Fund Balance / Equity	4,034,891
	Total Liabilities & Fund Balance	**6,543,616**

- Current Assets = $2.07 M
- Current Liabilities = $2.37 M
- Current Ratio = **0.87** down from **0.95** in June

(ratio is heavily weighted by PPP "loan" – forgiveness anticipated in December)

Other Items

- Unknown liability for missed retirement plan contributions
  - Change in plan document change from 2010 was not followed
  - True-ups at year end never performed
  - HCHC contributions based on annual salary – suspending contributions only defers liability
  - Contributions based on 24 (monthly) pays instead of 26 (52 weeks/2 weeks per pay)
  - Spitball estimate of $70K in total liability
  - More details to follow next month…

  - An alteration of the plan document is recommended

QI-RISK MANAGEMENT COMMITTEE

Location: Zoom Meeting
Date/Time: 5/28/2020 11:00am

TEAM MEMBERS: Jon Liebman, Medical Director; Franny Huberman, Behavioral Health Representative; Eliza Lake, CEO; Tabitha Griswold, Executive Assistant; Kim Savery, Community Programs Representative; Michael Purdy, CCCSO; Cynthia Magrath, Practice Manager; MaryLou Stuart, Dental Representative.

Agenda Item	Summary of Discussion	Decision/ Next Steps/ Person Responsible/ Due Date
Review of Past minutes from January 21, 2020	The minutes from January 21, 2020 meeting were reviewed. **Kim Savery motioned to approve the January minutes, Cynthia Magrath seconded the motion**	January 21, 2020 Minutes were approved unanimously.
Risk Management	• Michael Purdy reported on two incidents o Drug paraphernal found in the Huntington restroom. Reported by a Dentist. Monitoring restroom usage same as was being done. o Patient from CDH PT, fell entering Worthington building, into the bushes. This particular one does not warrant any further risk, was addressed at Department Head meeting. • Directors and Officer Insurance has a new section on sexual harassment and insurance does not cover agency. • FTCA application due July 15th. Material needed has been reviewed by Eliza and Tabitha, who will be working on completing that application.	
Department Reports	• COVID-19 Impacts: o Dental- Current risk of three chairs did not meet OSHA standards due to water lines, that is being addressed. The infection control is up to date, including the manual. Working on proper staffing for proper turnover of rooms to reduce contamination. Biggest concern at this time is getting staff back to work, which is going to be a slow process. A job description has been developed for a Lead Infection Control position, Lori Paquette is joining infection control team and will be leading that team. o Behavioral Health- Concern with need for additional training needed for best practices for tele-health, by doing more education and research. As well as needing a solid informed consent form. o Eye Care- Largest concern is the infrequency of emergencies happening, there is not a set schedule at this time, no pre-visit planning able to be done. Back log of patients waiting for routine care or non-emergency care, about 75 patients on the waitlist. o Community Programs- Increase number of meeting internally and externally to stay on top of latest regulations and resources. Resume work on capacity building quality initiatives. Primarily staff is working COVID response initiatives.	

	o Medical- Concerns with slower visits, and access problems. Lack of routine and preventative care, behind on those visits. Risk management issues with DEA- tele health need. Chart review has been ramped back up. o Operations- Concerns with staffing and furloughed staff. Doing tele-interviews for Worthington and Huntington front desk staff. o Telehealth Team is doing tremendous work on researching and developing the telehealth systems and technology.	
UDS	• Eliza Lake presented the UDS finalized copy. Number of patients increased from the previous year from 8400 to 9600, largest one-year increase. For the previous years the number had been going down, this increase is largely assumed to be due to the opening of Amherst. Hit HRSA goal for three-year period.	
QI 6 Month Report	• Eliza presented the QI-Risk Management 6-month report for July-December 2019. Discussed risk management and quality improvement discussions from that time period. Follow up actions were discussed and how those actions were addressed. **Jon Liebman moved to recommend this report the Board, Michael Purdy seconded**	The QI-Risk Mgmt. Report was recommended to the Board unanimously.
Reopening Plan	• Team has taken the Phase One attestation requirement, Ellen and Jon and Michael to go through each to see what was being done or not done. Most is being done, but it may not have been written down or changed slightly. Checked off each of requirement and where they stand. Employee and patient screen needs to be worked on, rough draft done. • With telehealth, choose Zoom as a platform. Rolling out this new system in conjunction with C3 to make sure work flows make sense. • Facilities Team has met and facility upgrades and changes being done.	
Adjourn	Michael Purdy moved that the meeting be adjourned, the meeting was adjourned at 10:03 am. The next meeting is scheduled for **Tuesday, February 18, 2020** at 9:15am at the Huntington Health Center.	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

QI-RISK MANAGEMENT COMMITTEE

Location: Zoom Meeting
Date/Time: 7/14/2020 11:30am

TEAM MEMBERS: Franny Huberman, Behavioral Health Representative; Eliza Lake, CEO; Tabitha Griswold, Executive Assistant; Kim Savery, Community Programs Representative; Michael Purdy, CCCSO; Cynthia Magrath, Practice Manager; MaryLou Stuart, Dental Representative.
ABSENT: Jon Liebman, Medical Director

Agenda Item	Summary of Discussion	Decision/ Next Steps/ Person Responsible/ Due Date
Review of past minutes from May 28, 2020	The minutes from May 28, 2020 were not sent to the committee prior to the meeting, therefore will be reviewed in next month's meeting.	
Risk Management	• Michael Purdy reported that the FTCA application has been submitted. It was sent back for minor changes needed with the diagnostic imaging tracking policy to add language that includes lab results. Those changes will be reviewed, changed appropriately and resubmitted with the application. • Michael reported on three incidents, although one incident might not rise to the level of an incident as all protocols were followed appropriately with no adverse outcomes. o The first incident resulted from an echocardiogram result being delayed, as they were not received. The patient came in for a follow up visit and at that time the results were discovered, and the patient had substantial congestive heart failure. The delay in receiving the results is due to the lack of the redundant system that was in place when staff were in the office, and not working remotely. The lab was under the impression that each provider had their own fax number, which is not the case and therefore the results were never sent to the central fax number to be put in the patient's chart. There was follow-up with the lab and they were educated that the main fax number works for all providers at HCHC, so that the redundant system works as it should even with providers working remotely. o The second incident involved a patient that called for change in asthma medication. The provider documented this change request in a telephone encounter but did not send that TE to the front desk to send the change out. Follow-up was provided to the provider, and a redundant system will be created to capture this issue. o The third incident involved a patient that was taken to Worthington Health Center by a family member as they were actively having a seizure in the back seat of the car. Protocol was followed by a RN, who	

	went out to evaluate the patient, called in a MD and then called emergency services. The patient was transported to CDH for further care. There were no adverse outcomes and all workflows were followed. • There is was a potential risk last holiday weekend when phones were not rolled over to the answering service on the Friday holiday and the phones were not manually rolled over for the weekend. Michael is working with Cynthia to create a system that ensures that does not happen again.	
Department Reports	• Eliza reminded department heads that quarterly reports on dashboards will be due next quarter. After changes made due to COVID, the dashboards might change to reflect pertinent reportable data to the current environment. Kim Savery also mentioned reporting on more C3 metrics, as they must be reported to C3 anyways. The regular QI meetings will follow the department head meetings, to make it easier for those that attend both. Tabitha and Eliza will look at the reporting schedule for those dashboards.	
Diabetes Initiatives	• Michael reported on the two diabetic initiatives. Joanna Martin, Nutritionist has submitted the quarter one and two reports for those initiatives. She has been able to identify patients with A1C's over 9 had not had any medication changes. She then generated a list to send to all providers of those patients without medication changes, to see if it is appropriate to change medications or offer alternatives.	
Adjourn	Michael Purdy moved that the meeting be adjourned, the meeting was adjourned at 12:05pm. The next meeting is scheduled for **Tuesday, July 21, 2020 via Zoom following the Department Head Meeting at 9:15 am.**	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

QI-RISK MANAGEMENT COMMITTEE

Location: Zoom Meeting
Date/Time: 7/21/2020 11:30am

TEAM MEMBERS: Franny Huberman, Behavioral Health Representative; Eliza Lake, CEO; Kim Savery, Community Programs Representative; Michael Purdy, CCCSO; Cynthia Magrath, Practice Manager; MaryLou Stuart, Dental Representative; Jon Liebman, Medical Director

Agenda Item	Summary of Discussion	Decision/ Next Steps/ Person Responsible/ Due Date
Review of past minutes	The minutes from the past two meetings will be reviewed at the following meeting, as they were not posted to the committee.	
Risk Management-FTCA	• The completed 2021 FTCA application was presented to the committee by Eliza Lake. The application was reviewed by the committee. No questions or comments made by the committee.	
Incident Reports	• Michael Purdy reported on two incidents. o The first incident reported involved a patient's telephone encounter in eCW not being re-assigned to the front desk for follow up. This issue was discovered when the patient called back several days later. The telephone encounter protocol was reviewed with provider following this incident. o The second incident involved a delay in receiving an ECHO report on a patient from a contracted vendor. Providers names and fax numbers were provided to Noble so that reports are faxed to correct providers, and this was followed up by Jon Liebman, Medical Director continuing conversations with Noble about DI and lab results.	
Adjourn	Michael Purdy moved that the meeting be adjourned, the meeting was adjourned at 12:05pm. The next meeting is scheduled for **Tuesday, August 18, 2020 via Zoom following the Department Head Meeting at 9:15 am.**	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

QI-RISK MANAGEMENT COMMITTEE

Location: Zoom Meeting
Date/Time: 8/18/2020 9:15am

TEAM MEMBERS: Franny Huberman, Behavioral Health Representative; Eliza Lake, CEO; Tabitha Griswold, Executive Assistant; Kim Savery, Community Programs Representative; Michael Purdy, CCCSO; Cynthia Magrath, Practice Manager; MaryLou Stuart, Dental Representative; Vickie Dempesy, COO; Jon Liebman, Medical Director

Agenda Item	Summary of Discussion	Decision/ Next Steps/ Person Responsible/ Due Date
Review of past minutes	The minutes for 2020 will be posted on a shared drive, along with quarterly dashboards for each department. These documents will be available for the committee to review before each meeting.	Tabitha will create a shared drive for the committee
Risk Management	• Michael Purdy began with a review of the structure and reporting schedule of this committee and the reporting requirements of the committee. The requirements being quarterly assessments from department heads based on a minimum of HRSA metrics but could include C3 and NCQA metrics. Also required are reports of incidents, risk management and FTCA issues. Department heads should also be reporting quality improvement projects, not just department reports. • Vickie Dempesy, COO will be the chair of the committee. She will be providing the QI report to the full board as well. • Michael opened the conversation up to department heads to discuss the struggles with each department's dashboards o Jon Liebman, Medical Director reported that medical data has quality issues. The data is currently not actionable due to variables being too complicated. His resolution being that a list of variables be developed and then choosing a few variables to focus on to get data quality improved and then actionable. Jon also wanted to include operational data in his future dashboards. o Franny Huberman, BH Director reported that it would be helpful to know what metrics would be useful for the committee to know. • Patient satisfaction survey was not completed the Spring of 2020 due the timing of the pandemic. Looking forward at the Fall 2020 Patient Satisfaction Survey by not having emails or phone number for every patient hampers the ability to get a better sample. Ideally, we would like to improve data collection around race, and health outcomes with these surveys. One such way to get data around health equity would be to use other smaller committees such as the DRIVE committee to report to QI. • Michael reported that there is a risk in the staffing shortage related to support staff, specifically front desk, medical assistants and dental assistants. This	

	includes keeping an eye on the behavioral health waitlist, when the number hits 50 people then the department will advertise for another provider. • Michael reported that CDC guidelines changed in regard to acceptable masks in the clinic. All staff are no longer using valve masks due to those changes for safety. • Michael reported that there have been recent issues with accuracy in identifying transgender individuals, more specifically with identified pronouns being used correctly through those patients visit and in services they are receiving. Trainings will be conducted to ensure proper pronouns are being used not just in person but also in documentation. Eliza added that she will follow up in getting the HEI trainings into health stream as a start to this conversation and then specific trainings can be developed. This highlights the need of the DRIVE committee to be reinitiated.	
Other Items	• Eliza Lake reported that the 2021 FTCA deeming application has been approved. • Provider schedules are being developed by Vickie Dempesy. The opening plan for the SBHC plays a big part in determining those schedules. The opening plan will determine where providers will be working out and their role in the clinic. Eliza and Cynthia are both on SBHC school meetings to better gauge the plan as it is developed. • Eliza added that quality improvement funds from HRSA will be based on 2019 data for NCQA sites. HRSA has announced that they do not know how they will be determining these funds next year as may quality measures will be disrupted by the pandemic. There is potential that more funds will be tied to DEI measures in the coming year.	
Adjourn	Michael Purdy moved that the meeting be adjourned, the meeting was adjourned at 12:05pm. The next meeting is scheduled for **Tuesday, September 15, 2020 via Zoom following the Department Head Meeting at 9:15 am.**	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

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

Goal Areas and Progress Reports

Goal 1: Health Care System Integration and Financing

1) ***Accountable Care Organization (ACO) Engagement***: Every year, C3 asks its members to choose a level of risk, or risk tier, for the coming year. As you may remember, HCHC has always chosen the lowest risk tier. This means that we do not receive as much funding to implement the model of care, that C3 hires a nurse to work at our site, and that we do not receive as much money back if we perform well, but we also do not have to pay as much if we do not either perform within our budget or don't do as well on our quality measures. I will be required to tell C3 this month what tier HCHC has chosen, and I will be asking the Board to vote tomorrow night to maintain our status with the lowest level. I cannot see us moving up to the middle tier for the foreseeable future, as it would require our systems to be operating at a level that may not be possible for an organization our size. Most if not all of the smaller members of C3 are also in the lowest tier.
2) ***Hospital Engagement***:
   I have begun a conversation with Cooley Dickinson about how they can better support the needs of Hampshire County residents that do not have health insurance. Our providers, particularly those who work in Amherst, note that there are specialty services that are not available in Western Mass to individuals enrolled in the state Health Safety Net program, and so these patients are sent to Worcestor or Boston for their care (if they can get it at all). As Cooley is very focused on health equity, I want to make sure that they understand that these barriers exist, and see if there are ways that we can work together to mitigate them. We have been asked to provide them with 3-5 examples of patients' struggles, and then we will have a meeting to discuss the possibilities. I am hopeful, although we have had similar meetings in the past that have not borne fruit, and they are potentially constrained by the policies and procedures of Mass General Brigham, which owns Cooley.

   Similarly, as the co-chair of the Noble Hospital Community Benefits Advisory Council, I have been talking with various leaders in the Westfield area about the representation of underserved and unserved populations in the Noble service area. I am hopeful that we will be able to bring more people to the table that represent the diversity of experience and circumstance in both the Westfield area and the Hilltowns.
3) ***Electronic Health Record (EHR)***: No update. John continues to work with our new consultant to improve our use of eCW for billing, and its integration with Dentrix. When this is accomplished, we anticipate it providing our Reception team with much more flexibility in staffing and integration of dental into the operations of all the other clinical departments.
4) ***PCMH/NCQA***: COO Vickie Dempesy and Alex Niefer are working with C3 staff, who have been offered to us free of charge as consultants, to move our re-certification process forward. They are having weekly meetings, at the moment, to ensure that they fully understand the new requirements. As certification is a requirement of membership in C3, we are very happy that they are willing to invest some time in this very important project.

Goal 2: HCHC Expansion

1) ***Expanded Services:***
   a) Office-Based Opioid Treatment (OBOT): No change at this time.
   b) Telehealth: We are still not making a great deal of progress in shifting visits to video telehealth, but Vickie is moving forward with creating a specific position responsible for setting up the visits for providers. All attempts to make this part of the regular workflow for receptionists have not worked, and it is clear that this needs to be a dedicated position. The revenue difference between video and telephone telehealth visits is dramatic, so although more and more visits are being seen in person (which is higher reimbursement as well), we want to make sure that telehealth visits are video as often as possible. We do know that other local practices have not started ramping up their in-person visits, and there is reason to think that it the state COVID numbers get worse, we will have to transition back to mostly telehealth, so we need to be prepared.
   c) Specialty Care: No new developments.
   d) Portable services: We setting up meetings with the Amherst Health Department and Senior Center to determine how we can support the efforts to provide flu immunizations in that community, as well as continuing to look at flu clinics in the Hilltowns. The challenge is making sure to procure the correct amount of vaccine, without being wasteful or overpromising. We are currently offering flu shots to all of our adult patients, and will soon be able to offer them to all child patients. All staff are required to get their flu shot this year, unless they have a medical or religious exemption (subject to amending the policy).
   e) Pharmacy: The situation with the 340B program and pharmaceutical companies has not improved since the last meeting. I learned today that there is possible legal action being pursued, but in the meantime, we know that our Health Safety Net patients will not be able to get certain very common prescriptions filled unless they are able to pay the retail cost for the drug. We believe that we can designate the Walgreens in Westfield (where the largest number of HSN scripts written by our providers are filled) as a point of access, but this is not helpful to our patients in eastern Hampshire County. This is a national issue, and we are doing what we can to support the advocacy required to fight it.
2) ***Expanded Sites/Service Areas:***
   a) Amherst/John P. Musante Health Center: Our new provider, Chelsea Merritt, has started work in Amherst, and we anticipate that we should be at full operations very shortly. As was the case last month, we are still struggling with staffing for the front desk and medical assistants, which we know is a statewide program. Despite the high rate of unemployment, people who could fill those positions appear to be the hardest hit by school-aged children being at home, so there are not very many applicants. Vickie and Michael have taken on the hiring for these positions personally, and are making sure that we are not missing any opportunities.
   b) Westfield, Northampton, Ware, or other sites: No changes at this time.
3) ***Patient Populations*:** The new Diversity, Equity, and Inclusion (DEI) Committee began to meet last week, and has agreed to meet weekly to ensure that they get off the ground quickly. The group includes individuals from almost every department with a range of time working for HCHC. They have developed a structure for the meetings, including ground rules, agenda setting, facilitation, timekeeping, and record keeping, and have started the conversation about their charge. Next week the discussion will look at all the options, including continuing existing efforts around language access, transgender care, LGBTQI+ inclusion, etc, versus starting new initiatives directly related to this year's focus on the need for anti-racism work. I will continue to update you on their progress, but there already feels like there's a deep level of engagement.
4) ***Community Collaborations*:** Nothing new to report.

Goal 3: Improved Organizational Infrastructure

1) ***Financial Stability:*** While John will report on the August financials, and perhaps give a sneak peak at September's preliminary results, I will say that things appear to be moving in the right direction. Dental has now been able to bring back all of its staff, and schedules are full. Our new providers are doing very well, and have already seen many patients who report being very happy with their care. We are optimistic that these numbers will only improve as we address the telehealth and other operational issues that we have identified over the last year.
2) ***Staff Development and Support:*** We are starting to see the tension between getting back to full operations, and the need for more space for social distancing for safety. The empty Behavioral Health offices have been a tremendous boon for medical staff being able to spread out so there are not as many people in an office, but we're anticipating issues, given the change in weather, with staff all trying to find a safe place to eat during their shared lunch hour. We are getting many more requests for air filtration units, as spaces that held only one person will now need to hold more, and are trying to wrap our hands around the specific needs. Our infection Control Team is, at the same time, working very hard to address the obvious fatigue that staff are feeling around mask wearing – there have been increasing numbers of incidents of staff not being appropriately masked when they are outside of clinical areas. We will be talking over the next week about the tools available to us to reinforce, and enforce, the masking requirement.
3) ***Facilities Improvement and Expansion:*** No change at this time.
4) ***Information Technology (IT) Improvement and Expansion:*** Over the last month, it has become clear that the amount of bandwidth available to our programs, particularly in Worthington, is not sufficient. The dental department has seen a dramatic degradation in their ability to access x-rays on the Worthington server from other sites, sometimes requiring an hour just to download the image. We have signed a contract to increase our capacity by 250%, but the change will require new equipment and downtime during work hours. Vickie and John are working to ensure that this creates as little disruption as possible.

Other reports:

HRSA Update: I have just submitted our quarterly reports for the three HRSA COVID grants. We have completely spent out the original COVID-19 grant, using the entirety of it to support our locum tenens Nurse Practitioner, who continues to be a highly productive team player. The $650k CARES grant is being used to support staff salaries and utility costs, now that we have fully accounted for our PPP funds within the required 24 weeks. And we are using the Enhanced Testing Capacity (ECT) grant to support Vickie's work, purchases of PPE, and, once we have amended the budget with HRSA, the new providers' salaries. We orginally budgeted the funds for another locum tenens, but with our success in hiring the new providers, we will be using the money to support them. We may also move some of the funds into support for transportation for patients who need to be tested at Cooley Dickinson, but have no means to get there.

Retirement Plan Update: We will discuss this more during the Finance Committee report, but we have recently learned that in 2010, the documents for our 403b Employee Retirement Plan were changed to require that we do a "true up" every year, to ensure that we have appropriately matched employees' contributions to their retirement fund. The company who holds these funds appears to have only developed the capacity to do this true up in the last two years, and therefore we will need to have them look back ten years and determine if we owe employees, some of whom are no longer at the organization, more money for their retirement. We also learned that we had historically made contributions only twice a month, which is not allowed in the Plan document, and therefore will have to fix those contributions that should have occurred twice a year in the months with three payrolls. And finally, we learned that while the Board voted to stop matching contributions in the fall of 2018, due to cash concerns, we are not allowed to do so under the terms of the Plan, and we must now make those contributions as well. We do not know the total value of all of these fixes, but will certainly tell the Board as soon as that figure is determined.

Credentialing and Privileging Report for HCHC BOD

Month: October 2020

Name	Position/ Credentials	Start date	Date Credentialed	Special Certifications	Privileging Requests	Special Privileging Requests	Any items pending?	Other Info
Meredith Morgan	Family Nurse Practitioner	10/5/2020	9/24/2020	AANP Board Certified	None at this time	None at this time	None	None

Policy Title: Corporate Compliance Program	**Policy Number:** CC-01
Department: Administrative	**Policy status:** Active
Regulatory Reference: U.S. statutes and Federal and State Regulations	
Date Published: OCT 2012	
Dates Reviewed: OCT 2018	
Dates Revised: OCT 2020	

PURPOSE:

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

POLICY:

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

Corporate Compliance Program

I. Compliance Objectives

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

Violations, whether intentional or unintentional, may result in significant civil or criminal sanctions, or

both, for institutions and personnel that do not comply with the law. HCHC is committed to ensuring that it complies with these laws and regulations.

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

- Identifies the federal and state laws and regulations governing the organization and ensures compliance with these mandates.
- Develops and maintains written policies and procedures, Standards of Conduct, and advances quality improvement programs throughout the organization.
- Performs periodic self-audits to monitor its compliance with applicable laws and policies governing the organization.
- Conducts ongoing, relevant, and comprehensive education and training for all Individuals Affiliated with HCHC.
- Guides implementation of corrective action plans to improve HCHC's operations and practices.

II. Elements of HCHC's Corporate Compliance Program

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

A. Appointment of a Compliance Officer

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

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

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

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

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

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

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

1. Annex 1: Standards of Conduct
2. Annex 2: Legal Statutes and Regulations
3. Annex 3: Billing, Claims and Records
4. Annex 4: Procurement and Referrals
5. Annex 5: Audits, Investigation and Organizational Response

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

C. Education and Training

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

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

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

D. Maintaining Open Lines of Communication

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

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

may also send the Compliance Officer written reports, which may be sent through intra-office mail.

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

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

E. Monitoring, Audits and Evaluation

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

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

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

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

G. Corrective Action and Disciplinary Standards

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

III. Employee and Affiliated Individuals' Responsibilities

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

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

potential non-compliance.

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

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

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

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

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

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Annex 1: HCHC Standards of Conduct

In general, HCHC expects that all Individuals Affiliated with HCHC will behave in a professional and courteous manner. In addition, these Standards of Conduct describe specific standards to which individuals are expected to adhere.

A. Confidentiality of Information

Individuals Affiliated with HCHC may acquire confidential or proprietary information by virtue of their positions within, or affiliation with, HCHC. The term "confidential or proprietary information" shall mean any and all information (whether written, oral, or contained electronic media) relating to the governance, business, operation, and financial condition of HCHC and/or any of its vendors or collaboration partners, as well as any and all other information determined to be confidential. All information communicated at executive sessions or other closed sessions of the HCHC's Board of Directors is confidential and proprietary information. HCHC's Board of Directors or its CEO may determine that other information, including information shared in Board and/or committee meetings, is confidential or proprietary on a case-by-case basis. Confidential or proprietary information may not be:

1) Disclosed outside of HCHC without appropriate authorization from the CEO (or in the case of Board members, by the Board Chair in conjunction with the CEO);
2) Used for personal gain or for the benefit of a third party. Individuals Affiliated with HCHC are expected to exercise reasonable care to avoid the inadvertent disclosure of confidential information and, as applicable, will be bound by (and required to comply with) the confidentiality provisions contained in agreements executed between HCHC and other organizations and/or individuals, as well as HCHC's internal confidentiality policies and procedures.

Individuals Affiliated with HCHC will be required to sign a Confidentiality Agreement (attached as Appendix A) and/or Business Associate Agreement, as appropriate, that specifically limits the context in which, and persons to whom, confidential information may be communicated. Officers and members of the Board also have a fiduciary duty to not communicate confidential information about HCHC to anyone who is not also an officer or member of the Board, respectively, absent the explicit authorization of the full Board of Directors.

B. Conflicts of Interest

1) General Prohibition

Individuals Affiliated with HCHC must strive to make decisions fairly and objectively and always act in the best interests of HCHC, without regard to any personal pecuniary benefit or any benefit to a third party, and with undivided allegiance. As HCHC is a federal grantee under the Department of Health and Human Services (DHHS), these standards for managing Conflicts of Interest are also necessary to comply with the Federal Uniform Administrative Requirements set forth at 2 C.F.R. §200.318(c) and DHHS regulations found at 45 C.F.R. §75.327(c). No Individuals Affiliated with HCHC shall participate in HCHC's selection, award, or administration of any contract or grant, paid in whole or in part with federal funds, when a real or apparent conflict of interest (as defined below) is involved.

2) Definitions

Interest. A person has an "Interest" if he or she has, directly, or indirectly through a family member or business partner:

- a business relationship (*e.g.*, an actual or forthcoming compensation arrangement whether by contract or employment) with: (1) HCHC; (2) an entity with which HCHC has entered (or is negotiating to enter) a transaction or arrangement; or (3) an entity that is a competitor or potential competitor of HCHC;
- a financial relationship (*e.g.*, a controlling or material ownership, or investment interest, employment relationship or other relationship that a reasonable person would deem significant) with or a tangible personal benefit from: (1) an entity with which HCHC has entered (or is negotiating to enter) a transaction or arrangement; or (2) an entity that is a competitor or potential competitor of HCHC;
- a fiduciary relationship (*e.g.*, Board member or trustee) with: (1) an entity with which HCHC has entered (or is negotiating to enter) a transaction or arrangement; (2) an entity that is a competitor or potential competitor of HCHC; or
- a personal relationship with an individual who has a business, financial or fiduciary relationship as defined above. A personal relationship means a relationship based on family, business partnership, friendship or romance.

Any interest in a company through publicly-traded stocks, bonds or mutual funds available to the general public shall not constitute an Interest, provided the ownership or investment interest is less than one percent of the company's shares.

Conflict of Interest. A "Conflict of Interest" arises whenever the interest of a person competes with or has the potential to compete with the best interests of HCHC. A conflict of interest is presumed to exist if a person with an interest is involved in any way in the transaction or arrangement in which he or she has such interest.

3) <u>Affirmative Disclosure Requirements</u>

It is the policy of HCHC that all interests shall be fully disclosed by any Individual Affiliated with HCHC regardless of whether a conflict of interest is determined to exist.

Annual Disclosures. HCHC requires that Board members and corporate officers of HCHC disclose in writing: (1) all interests that may create an actual or potential conflict of interest, and (2) where applicable, provide a statement suggesting how such conflict of interest could be avoided or mitigated. In order to facilitate such full disclosure, HCHC requires that Board members, corporate officers and persons seeking to affiliate with HCHC complete the Disclosure Form (attached as Appendix B). Completion of a Disclosure Form does not relieve individuals of the obligation to comply with these Standards of Conduct with regard to disclosure of interests that may occur after the filing of the Disclosure Form (*e.g.,* with respect to a particular transaction).

Supplemental Income. HCHC requires that corporate officers of HCHC, as well as all contracted employees, disclose in writing any specifics of any plans to accept supplemental income outside HCHC employment so that HCHC may determine whether such outside employment or consultancy conflicts, or has the potential or appearance to conflict, with the interests of HCHC. HCHC's prior approval of such outside employment or consultancy is required.

Continuing Obligation. HCHC requires that all Individuals Affiliated with HCHC and persons seeking to affiliate with HCHC disclose interests that arise after the annual filing of the Disclosure Form.

Recipients of Disclosures.

- Members of, and candidates for membership on, the Board of Directors shall make disclosures to the Chair of the Board of Directors. If the Chair has such an interest, they must make disclosure to the Vice President, who will, in turn, be responsible for advising the Board.
- The CEO shall make disclosures to the Chair of the Board, who will be responsible for advising the Board of such disclosure.
- All other Individuals Affiliated with HCHC shall make disclosures in writing to the CEO.

4) Determining Whether a Conflict of Interest Exists

In the case of a potentially conflicted person who is either a Board member or the CEO, that person may make a presentation to the Board regarding whether he or she has a conflict of interest and may respond to related questions from the Board. However, after such presentation, they shall leave the meeting during any discussion of, or vote on, whether a conflict of interest exists, and if such conflict of interest is determined by the Board to exist, they shall leave the meeting during any discussion of, and voting on, the transaction or arrangement that involves the conflict of interest. For all other potentially conflicted persons who are Individuals Affiliated with HCHC, the CEO shall determine whether a conflict of interest exists.

5) Procedures for Addressing the Conflict of Interest

Procurement. If the conflict of interest involves procurement by HCHC, the process shall be conducted in accordance with Section B of these Standards of Conduct and with HCHC's Board-approved Financial Policy's section on Procurement.

Alternative Arrangements. In other instances, the Board shall, as it may deem appropriate, appoint the CEO to investigate alternatives to the proposed transaction or arrangement and make recommendations. After exercising due diligence, the Board or, in the case of Individuals Affiliated with HCHC who are not Board members or the CEO, the CEO shall determine whether HCHC can obtain an equivalent (or more advantageous) transaction or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict of interest.

HCHC's Best Interests. If an alternative transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the Board or CEO, as applicable, shall determine (if Board, then by a majority vote of the disinterested Board members) whether, notwithstanding the conflict of interest, the transaction or arrangement is in HCHC's best interest, for its own benefit and whether the transaction is fair and reasonable to HCHC such that it would constitute an "arms-length" transaction (and be consistent with 45 C.F.R. Part 75 standards, as may be amended from time to time).

Pervasive Conflicts of Interest. In circumstances where there are material continuing or pervasive conflicts of interest, an individual may be required by the Board of HCHC or the CEO, as applicable, to withdraw from his or her position with HCHC unless the individual, family member or business associate chooses to disassociate from the outside position that causes the conflict of interest.

6) Violations of the Standards of Managing Conflicts of Interest

If the Board or CEO, as applicable, has reasonable cause to believe that a person has failed to disclose an interest, the person shall be informed of the basis for such belief and afforded an opportunity to explain the alleged failure to disclose. If, after hearing the response of the individual who failed to disclose an interest, and making such further investigation as may be warranted in the circumstances,

the Board or CEO determines that the individual has in fact failed to disclose an interest in accordance with these Standards of Conduct, appropriate corrective and/or disciplinary action shall be taken, including removal of the individual from the selection, negotiation, or administration of any contracts or grants to which HCHC is a party, and/or admonishment or removal from the Board in accordance with the then current HCHC By-laws.

7) Records of Proceedings

The minutes of the Board and all committees with Board-delegated powers and those records as determined by the CEO shall contain:

Conflicts of Interest. The names of the people who disclosed or otherwise were found to have an interest in connection with an actual or potential conflict of interest and the nature of the interest; any action taken to determine whether a conflict of interest was present; and the Board or CEO's decision, as applicable, as to whether a conflict of interest in fact existed.

Management of Conflicts. For transactions where a conflict of interest has been disclosed or otherwise found to exist, the names of the persons who were present for discussions and votes relating to the transaction or arrangement, and the names of the persons who recused themselves; the content of the discussion, including any alternatives to the proposed transaction or arrangement or HCHC's best interest; and a record of any votes taken in connection therewith.

C. Vendors and Procurement Standards

HCHC will conduct all procurement transactions in a manner to provide, to the maximum extent possible, practical, open, and free competition in accordance with HCHC's Board-approved Financial Policy's Procurement section, and will address, among other things, the following principles:

- No Individual Affiliated with HCHC may participate in the selection, award, or administration of a contract supported by federal funds, in whole or in part, if a real or apparent Conflict of Interest (as defined in Section B, 2 above) would be involved.
- HCHC will be sensitive to, and seek to avoid, Organizational Conflicts of Interest. Organizational Conflicts of Interest mean that because of relationships with a parent company, affiliate, or subsidiary organization, HCHC is unable or appears to be unable to be impartial in conducting a procurement action involving a related organization.
- HCHC will be sensitive to, and seek to avoid, non-competitive practices among contractors. In order to ensure objective contractor performance and eliminate unfair competitive advantage, contractors/consultants that develop or draft grant applications, or contract specifications, requirements, statements of work, invitations for bids and/or requests for proposals shall be excluded from competing for such procurements.
- Awards will be made to the bidder whose bid is responsive to the solicitation and most advantageous to HCHC, in terms of price, quality, and other factors. HCHC retains the right to reject any and all bids or offers when it is in HCHC's interest to do so.

D. Nepotism

Except under extenuating circumstances, as determined by the CEO, HCHC will not hire any individual (or assign, transfer or promote a current employee) who is related to one of its employees or contractors, if in the position being applied for (or assigned, transferred or promoted to), the applicant will supervise, be supervised by, or have a direct reporting relationship with the related employee or contractor. Every applicant for employment or consultancy with HCHC must disclose any and all family, business and personal relationships with any Individual Affiliated with HCHC. Members

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

E. Gifts

No Individuals Affiliated with HCHC may solicit or accept gifts, gratuities, favors or anything of value from any current or potential patient, vendor or contractor of HCHC, or any current or potential party to a sub-agreement with HCHC. Every Individual Affiliated with HCHC will decline or return any gift and notify the CEO of such gift.

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

F. Bribery

HCHC will immediately dismiss, remove and, as applicable, terminate the employment or contract of any Individuals Affiliated with HCHC who offered or accepted a bribe to secure funding or other benefits for or from HCHC.

G. Cooperation and Honest Dealing with Government Officials

No Individuals Affiliated with HCHC will attempt to influence actions or decisions made by government bodies, officials, employees, or contractors, unless specifically authorized to do so consistent with applicable HCHC policy. Individuals Affiliated with HCHC will be cooperative and truthful in their dealings with any governmental inquiries or requests, including audits, surveys, and certification reviews. Except where otherwise approved, Individuals Affiliated with HCHC who are not authorized to speak on behalf of HCHC will not respond to any governmental inquiries or requests, including audits, surveys, and certification reviews, and will promptly report any such inquiries or requests to HCHC's CEO, Compliance Officer or other member of senior management.

H. Political Activities

Individuals Affiliated with HCHC will not participate or intervene in any political campaign in support of or in opposition to any candidate for elected public office while at work during business hours or when acting in his/her official capacity/position as an Individual Affiliated with HCHC. A political campaign is deemed to begin when an individual announces his or her candidacy for an elective public office, or is proposed by others for an elective public office. Individuals Affiliated with HCHC may not use HCHC's name, logo (or other means of identification as affiliated with HCHC), facility or any resources in connection with political campaign activities.

I. Lobbying

Lobbying is generally defined as a communication (written or oral) that is an attempt to influence (for or against) specific legislation including appropriations. Any lobbying activities proposed to be undertaken by HCHC or by any Individuals Affiliated with HCHC on behalf of HCHC shall require the prior approval of the CEO. Any Individuals Affiliated with HCHC undertaking lobbying activities will work with the CEO, or his or her designee, to ensure that such activities are supported by non-federal resources and that all disclosures and reporting of lobbying activities required by state or federal law

are submitted in a timely manner.

Annex 2: Legal Statutes and Regulations

The health care industry is subject to many federal and state laws and regulations that govern all aspects of the delivery of and payment for health care services.

The following list represents the laws and regulations that HCHC incorporates into its Compliance Program. It is not an exhaustive list of all the requirements with which HCHC will comply, but rather describes those laws most relevant to its fraud and abuse compliance activities. The list will be updated as the laws change and HCHC's Compliance Officer will update its policies and procedures to reflect these changes. Additional information regarding some of these laws follows the listing.

- Civil False Claims Act: 31 U.S.C. §§ 3729-3733
- Criminal False Claims Act: 18 U.S.C. § 287
- Anti-Kickback Statute and Regulations: 42 U.S.C. § 1320a-7b(b); 42 C.F.R. § 1001.952
- Civil Monetary Penalties Statute and Regulations: 42 U.S.C. § 1320a-7a; 42 C.F.R.§ 1003, et seq.
- Exclusion of Entities from Government Health Care Programs: 42 U.S.C. § 1320a-7
- Health Care Benefit Program False Statements Statute: 18 U.S.C. § 1035
- Health Care Fraud Statute: 18 U.S.C. § 1347
- Theft or Embezzlement in Connection with Health Care: 18 U.S.C. § 669
- Obstruction of Criminal Investigations of Health Care Offenses: 18 U.S.C. § 1518
- Medicaid Managed Care Regulations: 42 C.F.R. § 438, et seq.
- Special Fraud and Abuse Alerts and Advisory Bulletins: www.oig.hhs.gov
- Advisory Opinion Materials: www.oig.hhs.gov
- Office of Inspector General Compliance Program Guidances: www.oig.hhs.gov
- Mandatory Compliance Programs as a Condition of Enrollment in Medicare, Medicaid, and CHIP: 42 U.S.C. § 1320a-7k

A. Fraud and Abuse Laws

Civil False Claims (31 U.S.C. §§ 3729-3733)
Criminal False Claims (18 U.S.C. § 287) and Mass. Gen. 1. chap. 175H, §2 (private insurance) and Mass. Gen.1. chap. 118E, § 40 (Medicaid))

HCHC, HCHC Employees and HCHC Agents shall not knowingly and willfully make or cause to be made any false statement or representation of material fact in any claim or application for benefits under any federal health care program or health care benefit program. In addition, HCHC, HCHC Employees and HCHC Agents shall not, with knowledge and fraudulent intent, retain federal health care program or health care benefit program funds, which have not been properly paid.

Examples of prohibited conduct include, but are not limited to: misrepresenting services that were rendered; falsely certifying that services were medically necessary; "up-coding;" billing for services not actually rendered; making false statements to governmental agencies about HCHC's compliance with any state or federal rules; making false statements concerning the condition or operation of HCHC programs for which licensure/certification is required; billing federal health programs rates in excess of applicable federal health care programestablished rates; repeatedly violating the terms of a participating physician agreement; and failing to refund overpayments made by a federal health care program.

B. Anti-Kickback Laws

42 U.S.C. §1320a-7b(b), Mass. Gen. 1. chap. 118E, §41, and Mass. Gen. 1. chap.175H§ 3 (private insurance)

HCHC, HCHC Employees and HCHC Agents shall not knowingly and willfully solicit, offer to pay, assist payer in receiving any remuneration, either directly or indirectly, overtly or covertly, in cash or in kind, in return for:

1. Referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment maybe made, in whole or in part, under any federal health care program;
2. Purchasing, leasing, ordering, or arranging for, or recommending the purchasing, leasing, or ordering of any good, facility, service or item for which payment maybe made in whole or in part, under any federal health care program. Remuneration may include not only kickback payments and bribes, but also rebates, refunds, educational grants and other benefits to consumers.

Certain legally permitted practices, such as group purchasing agreements and price reductions to health plans, among others, are excluded from this prohibition.

C. Civil Monetary Penalties Act (42 U.S.C. §1320a-7a)

HCHC, HCHC Employees and HCHC Agents shall not knowingly present a claim to any federal health care program or health care benefit program for an item or service the person knows or should have known, was not provided, was fraudulent, or was not medically necessary. No claim for an item or service shall be submitted that is based on a code that the person knows or should know will result in greater payment than the code the person knows or should know is applicable to the item or service actually provided. HCHC, its Employees and HCHC Agents shall not offer to transfer, or transfer, any remuneration to a beneficiary under a federal or state health care program, that the person knows or should know is likely to influence the beneficiary to order or receive any item or service from a particular provider, practitioner or supplier, for which payment maybe made, in whole or in part, under a federal health care program. Remuneration includes the waiver of coinsurance and deductible amounts, except as otherwise provided, and transfers of items or services for free or for less than fair market value.

D. Ethics in Patient Referrals Act of 1989 (42 U.S.C. §1395nn) ("Stark II")

Physicians (the definition of which also includes psychologists) who have an ownership or compensation relationship with an entity that provides "designated health services" shall not refer a patient in need of designated health services for which payment maybe made under Medicare or Medicaid to such entities unless that ownership or compensation arrangement is specifically permitted under the Stark II laws and regulations.

E. Health Care Fraud (18 U.S.C.§1347)

HCHC, HCHC Employees and HCHC Agents shall not knowingly or willfully execute or attempt to execute, a scheme or artifice to:

1) Defraud any health care benefit program.

2) Obtain, by means of false or fraudulent pretense, representation or promise any of the money or property owned by or under the custody or control of any health care benefit program, in connection with the delivery of, or payment for, health care benefits, items or services.

F. False Statement and False Claims Laws

Criminal False Statements Related to Health Care Matters (18 U.S.c. §1035)
HCHC, HCHC Employees and HCHC Agents shall not knowingly and willfully make or use any false, fictitious, or fraudulent statements, representations, writings or documents regarding a material fact in connection with the delivery of, or payment for, health care benefits, items or services. HCHC, HCHC Employees and HCHC Agents shall not knowingly and willfully falsify, conceal or cover up a material fact by any trick, scheme or device.

Civil False Claims Act (31 U.S.C. §3729(a) and Mass. Gen. L. Chapter 118E, §40)
HCHC, HCHC Employees and HCHC Agents shall not:

a) Knowingly file a false or fraudulent claim for payments to a governmental agency, or health care benefit program;
b) Knowingly use a false record or statement to obtain payment on a false or fraudulent claim from a governmental agency or health care benefit program; or
c) Conspire to defraud a governmental agency or health care benefit program by attempting to have a false or fraudulent claim paid.

Examples of false or fraudulent claims include, but are not limited to, double billing, upcoding, unbundling, submitting or processing claims for items or services not provided and submitting or processing claims for items or services not medically necessary.

Criminal False Claims Act (18 U.S.C. §§286, 287)
HCHC, HCHC Employees and HCHC Agents shall not conspire to defraud another agency or health care benefit program. Conspiring to defraud a governmental agency or health care benefit program is also prohibited.

G. Legislative Mandates

Consolidated Appropriations Act, 2020 (Public Law 115116-14194), commonly referred to as the "Legislative Mandates."
HCHC's Legislative Mandates policy is a formal documented process to provide safeguards to ensure HCHC compliance with the Legislative Mandates. The current Legislative Mandates, which remain in effect until a new Appropriations Act is passed, include the following:

FY 2020 Legislative Mandates are as follows:
Division A, Title II

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

Division A, Title V

(3) Anti-Lobbying (Section 503)
(4) Acknowledgment of Federal Funding (Section 505)
(5) Restriction on Abortions (Section 506)
(6) Exceptions to Restriction on Abortions (Section 507)
(7) Ban on Funding Human Embryo Research (Section 508)
(8) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)
(9) Restriction of Pornography on Computer Networks (Section 521)
(10) Restriction on Funding ACORN (Section 522)
(11) Restriction on Distribution of Sterile Needles (Section 527)

Division C, Title VII

(12) Confidentiality Agreements (Section 742)

A complete description of the Legislative Mandates for fiscal year 2020 is included in HRSA Bulletin 2020-04E (February 7, 2020), which can be found at https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/grants-policy-bulletin-2020-04E.pdf

H. Other Federal and State Laws

HCHC is subject to a range of other federal and state laws including wire and mail fraud, obstruction of criminal investigations, conspiracy laws and the Federal Racketeering Act, which includes criminal and civil penalties, and State administrative sanctions on providers who violate the rules, regulations and laws governing the Medical Assistance program (130 CMR 450.238).

Annex 3: Billing, Claims and Records

HCHC recognizes that a third-party billing agency is an HCHC Agent and HCHC is responsible for ensuring the accuracy of its billing regardless of how the billing is submitted or by whom. While this Plan does not address every situation that may arise in the billing, coding and documentation requirements for outpatient medical, dental and mental health or substance abuse services, the following are some of the specific risk areas for which HCHC Employees and HCHC Agents will receive training and supervision:

- Billing for items or services not actually rendered.
- Billing for medically unnecessary services.
- Duplicate billing.
- Insufficient documentation to evidence that services were performed and thus supporting reimbursement.
- Billing for services provided by unqualified or unlicensed clinical personnel.
- Untimely and/or forged physician certifications on plans of care.
- Failure to adhere to licensing requirements and Medicare conditions of participation.
- Knowing failure to return overpayments made by health care programs.
- Failure to refund credit balances.

A. Documentation

All services rendered must have substantiating medical documentation. If the appropriate documentation is not provided, the service is not considered rendered.

Medical records may not be erased or altered. Medical records may be amended to correct an error or to complete documentation, but only in accordance with established medical records procedures.

Clinical, administrative or clerical employees and agents involved in the preparation and/or submission of charge or billing data must be trained in coding and documentation practices. Employees and Agents who suspect that inaccurate billing or documentation is occurring should immediately contact a Compliance Contact.

B. Billing and Claims

HCHC bills only for services actually rendered. Services rendered must be documented and completely coded, and billing must comply with the requirements of state and federal laws and guidelines, and conform to all payer contracts and agreements.

C. Records

Federal law requires HCHC to ensure that its books and records are accurate. It is against HCHC policy for any person to knowingly cause HCHC books and records to describe inaccurately the true nature of a business or clinical transaction. The following activities are also unethical and against HCHC policy:

- Making records appear as though payments were made to one person when they were made to another;
- Submitting expense accounts that do not accurately reflect expenses;
- Creating any other records that do not accurately reflect the true nature of the transaction;
- Making false entries in HCHC'S books and records, or in any public record, for any reason
- Altering in any way permanent entries in HCHC'S records;
- Knowing that others are falsifying records and not reporting it.

D. Payments/Receipts

The Employees and Agents of HCHC may not receive or make any payments on behalf of the corporation without fully understanding their purpose. The purpose must be the same as described in the documents supporting the transaction.

E. Retaining Records

Billing data must be retained for periods provided by law and by approved policies of HCHC. Employees and Agents of HCHC may not destroy or dispose of records or files without permission. Laws and regulations provide how long certain records must be kept, particularly when the records involve tax, personnel, health and safety, environmental, contract and corporate issues. It is also important to keep all records that are or maybe involved in any government investigation, audits or legal action.

Destroying such records before the matter is closed, or destroying records so that they may not be used in legal proceedings, is illegal.

Annex 4: Procurement and Referrals

In addition to the board-approved Financial Policy, and its section on Procurement, the following applies to all HCHC Employees and Agents who work with businesses or providers that supply referrals, products or services. These individuals may face a variety of ethical or even legal problems if they do not comply with all HCHC policies and procedures. The following additional guidelines address the boundaries of ethical conduct:

A. Kickbacks and Rebates

These perks can take many forms and are not limited to cash payments or credits. Any time an Employee or Agent of HCHC or a member of his/her family is offered something of value as a result of purchasing any product or service or as a result of consideration of such purchase, the Employee or Agent should question both the ethics and legality of the offer. In general, if an Employee or Agent of HCHC stands to gain personally from an organizational business transaction, that transaction is prohibited, and in many cases, may be illegal.

B. Reciprocity

In some instances, HCHC may purchase goods and services from a supplier who also buys goods and services from HCHC. Any form of pressure for reciprocal business from a supplier is not ethical and maybe illegal. HCHC Employees and Agents should never ask a supplier to buy services from them in return for the opportunity to do business with HCHC.

C. Gifts or Gratuities

In general, HCHC Employees and Agents and members of their immediate families are discouraged from accepting gifts. In the event unsolicited gifts are offered, the following circumstances identify when a gift maybe accepted:

- The gift is primarily an advertisement or promotion of a product/service, orThe gift is a textbook or another product that will benefit patient care.

The Employees and Agents of HCHC may never accept money from companies or individuals doing business with the Agency. It is also unethical to ask businesses for personal gifts or favors.

D. Entertainment by Businesses

The Employees and Agents of HCHC may accept entertainment offers from outside businesses only if the entertainment is reasonable, helps to strengthen the business relationship, and does not involve significant expenses. It is unethical to encourage or ask for entertainment from any person or company who does business with HCHC. The Employees and Agents of HCHC should avoid any offer that is intended primarily to gain favor or influence.

E. Payments to Agents, Representatives and Consultants

Any agreement with agents, sales representatives or outside consultants must be reasonable in amount, in the value of the service provided, and in comparison to trade practices.

F. Payments to Government Employees

It is illegal to offer any government official or employee a payment of money, gifts, services, entertainment or anything else of value.

G. Other Improper Payments

The use of HCHC's funds or assets for any unlawful or unethical purpose is prohibited. It does not matter if Employees and Agents make the payment directly, indirectly or by a third-party agent on behalf of HCHC, such payments are prohibited.

Annex 5: Audits, Investigation and Organizational Response

A. Audits

The Compliance Officer or delegated representative shall supervise all auditing systems. Annual audit procedures will be implemented which are designed primarily to determine accuracy and validity of coding and billing submitted to Medicare / Medicaid, other federal and state health programs and other payers, and detect other instances of potential misconduct by HCHC Employees and Agents as quickly as possible. The Compliance Officer will submit written reports of actual or suspected fraud to the CEO and/or the Corporate Compliance Committee.

A brief report from each auditor will be submitted each time audits occur. Random samplings of records drawn from a cross section of each department will be conducted on an annual basis by the internal auditor in coordination with the Compliance Officer. In addition, attention will be given to reviewing the reasons given for claim denials, to reviewing significant increases in the use of certain procedure codes and to analyze other facts that may suggest inappropriate conduct.

The auditor shall pay close attention to at least the following risk areas:

- Written standards and policies and procedures;
- Coding and billing;
- Documentation;
- Reasonable and necessary services; and
- Improper inducements, kickbacks and self-referrals.

The Compliance Officer or their designee shall determine the number of charts of all claims to be reviewed in each department.

The auditing process will involve contact with the Billing Manager who supervises billing staff, and, as appropriate, billing staff. The Compliance Officer shall review publications and updates received, including OIG Special Fraud Alerts, to identify failures to comply with any applicable requirements, and review updates received to applicable statutes and regulations including those pertaining to fraud and abuse, COBRA, Medical Record Coding, Medicare/Medicaid billing and anti-trust.

HCHC shall promptly repay any discovered overpayments. HCHC shall establish a reserve account to hold any disputed funds until the results of an internal investigation determine whether the money is an overpayment to be repaid or whether it was properly paid and should be returned to the general fund. **HCHC and HCHC Agents shall retain all billing records for six (6) years.**

Any suspected incidents of non-compliance shall be reported for review and action to the Compliance Officer and the Department Director of the department where such suspected noncompliance is occurring. The Compliance Officer will then report such issues to the CEO and/or the Corporate Compliance Committee.

B. Investigation

The purpose of an investigation is to identify situations in which applicable federal or state laws, including the laws, regulations and standards of the Medicare and Medicaid Programs, or the requirements of HCHC's Compliance Program, may not have been followed; to identify individuals who may have knowingly or inadvertently violated the law or HCHC's Compliance Program requirements; to

facilitate the correction of any violations or misconduct; to implement procedures necessary to ensure future compliance; to protect HCHC in the event of civil or criminal enforcement actions; and to reserve and protect HCHC's assets.

1) **Control of Investigations:** All reports of alleged non-compliance must be forwarded to the Compliance Officer. Serious or otherwise sensitive matters for investigations will be conducted under the direction of or by HCHC's legal counsel. If the involvement of legal counsel is warranted, the Compliance Officer will be responsible for requesting that legal counsel initiate an investigation, prepare a report of findings for the Compliance Officer and recommend the appropriate actions to be taken. HCHC Employees and Agents are expected to fully cooperate with any investigations undertaken by the Compliance Officer and/or legal counsel.
2) **Investigative Process**: Upon receipt of information concerning alleged misconduct, the Compliance Officer or his or her designee will:
    a. Complete an Incident Report Form that includes, if known, the name of the employee who made the report, the date of the report and a summary of the Employee or Agent's concern. Anonymity of the reporting individual, if requested, and confidentiality will be maintained, if at all possible.
    b. Notify the CEO of the nature of the alleged improper conduct and if the involvement of legal counsel is warranted, obtain authorization to request legal counsel to initiate an investigation.
    c. Ensure that the investigation is initiated not more than three business days following the receipt of the information. The investigation shall include, as applicable, at least the following:
        i. Interviews of all persons who may have knowledge of the alleged conduct and a review of the applicable laws, regulations and standards to determine whether a violation has occurred.
        ii. Identification and review of relevant documentation, including, where applicable, representative bills or claims submitted to the Medicare/Medicaid Programs, to determine the specific nature and scope of the violation and its frequency, duration and potential financial magnitude.
        iii. Interviews of persons who appeared to play a role in the suspected activity or conduct. The purpose of the interviews is to determine the facts surrounding the conduct and may include, but shall not be limited to:
            - The person's understanding of the applicable laws, rules and standards;
            - Identification of relevant supervisors or managers;
            - Training that the person received; and
            - The extent to which the person may have acted knowingly or with reckless disregard or intentional indifference of applicable laws.
        iv. Preparation of a summary report that:
            - Defines the nature of the alleged misconduct;
            - Summarizes the investigation process;
            - Identifies any person who is believed to have acted deliberately or with reckless disregard or intentional indifference of applicable laws;
            - Assesses the nature and extent of potential civil or criminal liability; and
            - Where applicable, estimates the extent of any resulting overpayment by the government.
    d. For all investigations in which HCHC's legal counsel is not involved, ensure that significant developments are promptly reported so that a determination can be made as to whether HCHC's legal counsel should be contacted.
    e. Establish a due date for the summary report or otherwise ensure that the investigation is

completed in a reasonable and timely fashion and that the appropriate corrective action is taken, if warranted.

C. Organizational Response

In the event the investigation identifies employee misconduct or suspected criminal activity, HCHC will undertake the following steps:

1) HCHC will, as quickly as possible, cease the offending practice. If the conduct involves the improper submission of claims for payment, HCHC will immediately cease all billing potentially affected by the offending practice.
2) HCHC will consult with legal counsel to determine whether voluntary reporting of the identified misconduct to the appropriate governmental authority is warranted.
3) If applicable, HCHC will calculate and repay any duplicate of improper payments made by a Federal or State government program as a result of the misconduct.
4) Initiate appropriate corrective action, which may include, but is not limited to, reprimand, oral warning, written warning, demotion, suspension and/or termination. If the investigation uncovers what appears to be criminal conduct on the part of an Employee or Agent, appropriate corrective action against the Employee/s and/or Agent/s, who authorized, engaged in or otherwise participated in the offending practice will include, at a minimum, removal of the person from any position of oversight and may include, in addition, suspension, demotion and termination.
5) Promptly undertake appropriate training and education to prevent a recurrence of the misconduct.
6) Conduct a review of applicable HCHC policies and procedures to determine whether revisions or the development of new policies and/or procedures are needed to minimize future risk of noncompliance.
7) Conduct, as appropriate, follow-up monitoring and auditing to ensure effective resolution of the offending practice.

D. Enforcement of Compliance Program

It is HCHC's position that all violations, including failure to report the misconduct of others when required, will be viewed as a serious infraction and that corrective action up to and including termination of employment maybe imposed upon Employees and Agents as a result of such findings. If a supervisor or manager, due to negligence or carelessness, contributes to or perpetrates misconduct, HCHC will take appropriate corrective action that is commensurate with the seriousness of the violation in question.

A progressive corrective action approach will be used to address all violations, unless the violation is an offense that may warrant immediate termination. Offenses that may warrant such termination include, but are not limited to:

1. Committing intentional violations of local, state and federal laws or regulations governing coding and billing procedures and practices at HCHC.
2. Taking retaliatory actions against an Employee or Agent for reporting a compliance question, issue or matter to the Compliance Contact; or
3. Presenting false or misleading information or data during the course of an auditor investigation conducted by the Compliance Contact or by a government agency.

HCHC, in determining what corrective action is appropriate, will consider whether the individual

voluntarily reported the issue and fully cooperated in any investigation and review.

E. Records and Non-Retaliation

Records of suspected misconduct and any subsequent investigation shall be confidentially retained by the Compliance Officer for ***at least 5 years.***

No HCHC Employee or Agent who in good faith reports suspected misconduct shall be retaliated against or otherwise disciplined by HCHC or any HCHC Employee. The Compliance Officer may review personnel records and information periodically to ensure that those who report suspected misconduct are not subject to retaliation or other improper conduct.

In addition, the Compliance Officer has the authority to keep confidential the names of HCHC Employees and Agents who report information. The Compliance Officer does not, however, have the authority to unilaterally extend any protection or immunity from corrective action, prosecution or any other sanction to those Employees or Agents who have engaged in misconduct.

Policy Title: HIPPA Privacy Management Policy	**Policy Number:** ADM-17
Department: Clinical	**Policy status:** Active
Regulatory Reference: Title 45 CFR 164.500 – 534(e)	
Date Published: April 2003	
Dates Reviewed: October 2020	
Dates Revised: October 2020	

PURPOSE:

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

POLICY:

1. HCHC's patient privacy process must include procedures for the following:
    a. Assignment of Security Responsibilities
    b. Disclosure of PHI with and without patient consent
    c. HIPAA Documentation requirements
    d. HIPAA privacy safeguards
    e. HIPAA training requirements
    f. A patient's right to access and copy
    g. Handling requests for confidential communication and access restrictions
    h. Handling requests for amendments to records
    i. Safeguarding deceased patient information
    j. Use of Business Associate Agreements
    k. Procedures for reporting violations

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

Approved by Board of Directors on: _____

Approved by:

_____ _____

Policy Title: Security Management Process Policy	**Policy Number:** ADM-18
Department: Administrative	**Policy status:** Active
Regulatory Reference: 45 CFR 164.308(a)(1)(i)	
Date Published: September 2012	
Dates Reviewed: October 2020	
Dates Revised: October 2020	

PURPOSE:

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

POLICY:

1. HCHC's security management process must include procedures for the following:
   a. Assignment of Security Responsibilities
   b. Defining the appropriate access, control and supervision of workforce members
   c. Contingency planning, data backup planning and media controls
   d. Facility and Information Access Controls
   e. Risk Analysis & Management
   f. Policy violation sanction
   g. Security Awareness Training
   h. Security Incident Reporting
   i. Workforce Clearance and Security
   j. Acceptable Use of company-owned workstations

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

Approved by Board of Directors on: _____
Approved by:

_____ _____
Chief Executive Officer, HCHC HCHC Board of Directors

Policy Title: Anti- Discrimination Policy	**Policy Number:** HR-012
Department: Administrative	**Policy status:** Active
Resources:	
Date Published: SEP 2018	
Dates Reviewed: JULY 2019, SEP 2020	
Dates Revised: JULY 2019, SEP 2020	

PURPOSE:

Hilltown Community Health Centers, Inc. is committed to ensuring that anyone who interacts with the health center is valued and does not experience discrimination in employment, volunteering, or the provision of services. HCHC strives for inclusivity and works to create a culture in which each individual is valued as employees, volunteers, patients, and community members. The organization seeks to include individuals from diverse backgrounds and celebrate the contributions they bring to the HCHC community.

POLICY:

Hilltown Community Health Centers, Inc. prohibits any form of discrimination on the basis of race, color, religion, creed, sex, gender, gender identity or gender expression, age, marital status, national origin, mental or physical disability, political belief or affiliation, veteran status, sexual orientation, genetic information, and any other class of individuals protected from discrimination under state or federal law with respect to employment, volunteer participation and the provision of services. Any violations of this policy will result in disciplinary actions as required under federal or state law, other HCHC policies, or as outlined in the HCHC Employee Corporate Compliance Program.

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

Approved by Board of Directors on: _____
Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Policy Title: Code of Conduct Policy	**Policy Number:** HR-02
Department: Administrative	**Policy status:** Active
Resources:	
Date Published: MAR 2018	
Dates Reviewed: JULY 2019, SEP 2020	
Dates Revised: JULY 2019	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for implementing and enforcing a Code of Conduct for all employees.

POLICY:

1. All HCHC employees will, upon hire, be provided with a copy of the HCHC Code of Conduct (see Attachment A), be given the opportunity to read it and ask questions, and then sign it agreeing to be held by its provisions.
2. HCHC will provide training to all employees on the Code of Conduct annually.
3. The Code of Conduct will be enforced through the organizational progressive disciplinary process.
4. As a condition of employment all employees are required to sign and comply with this policy.

Questions regarding this policy or any related procedure should be directed to the Human Resources Coordinator at 413-238-4133.

Approved by Board of Directors on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Policy Title: Credentialing and Privileging Policy	**Policy Number:** HR-03
Department: Administrative	**Policy status:** Active
Regulatory Reference: HCHC Corporate Compliance Plan, Annex 7, Public Health Service Act, Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I), BPHC Health Center Program Compliance Manual c. 5, 258 CMR 12.00, M.G.L. c. 13, § 84 and 258 CMR 8.05, 234 CMR 2.00 and M.G.L. c.112, § 45 and § 80B, 244 CMR 3.05(4) and (5), 246 CMR 3.00: M.G.L. c. 112, § 67.	
Date Published: AUG 2012	
Dates Reviewed: DEC 2019, SEP 2020	
Dates Revised: DEC 2019	

PURPOSE:

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

POLICY:

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

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

Approved by Board of Directors on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE: HCHC Credentialing and Privileging Program

I. Introduction and History

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

II. Authority

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

III. Definitions

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

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

Licensed or Certified Health Care Practitioner: an individual required to be licensed, registered, or certified by the State, commonwealth or territory in which a Health Center is

located. These individuals include, but are not limited to, physicians, dentists, registered nurses, social workers, medical assistants, licensed practical nurses, dental hygienists, nutritionists, and registered dieticians. "Licensed or certified health care practitioners" can be divided into two categories: a) licensed independent practitioners (LIPs) and b) other licensed or certified practitioners. As such, the credentialing and privileging requirements of these two groups may vary.

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

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

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

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

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

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

Resident, Intern, or Shadow:

1. Intern- A Student or trainee who will gain work experience by practicing in that specialty.
2. Shadow- a student or trainee who will observe practices by following a professional in the desired specialty.

Primary Source Verification: Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, telephone verification, internet verification, and reports from credentials verification organizations. The Education Commission for Foreign Medical Graduates (ECFMG®), the American Board of Medical Specialties, the American Osteopathic Association Physician Database, or the American Medical Association (AMA) Master file can be used to verify education and training. The use of credentials verification organizations (CVOs) or hospitals that meet JCAHO's "Principles for CVOs" is also an acceptable method of primary source verification.
Verification for some items must be obtained from primary sources and should be in writing from the primary source, although oral verification can be done. In the unlikely event that only oral verification is obtained, a dated and signed note in the credentialing file stating who at the primary source verified the item, the date of verification, and how it was verified is required.

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

Supervisor/Department Head: Acknowledges that the Credentialing Specialist has completed initial gathering and verification of documents. Assists with gathering of supporting documents for initial credentialing and privileging, as well as renewal credentialing and privileging when needed.

Chief Clinical and Community Services Officer (CCCSO): Conducts the ultimate evaluation of the applicant's Credentialing & Privileging file

- Records her/his actions and comments in the Credentialing Review Sheet, and in the Privileging Request Sheet.
- The Credentialing Review Sheets and the Privileging Request Sheets are signed and dated by the CCCSO.
- Informs the Board of Directors of approval or denial of the provider's application.

- The Board of Directors considers the CCCSO's signature as final approval or denial of the provider's application.

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

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

IV. Credentialing

A. Initial Credentialing Requirements

1. *Primary Source Verification*

a) Initial credentialing of LIPs requires primary source verification of the following:

(1) Current licensure;

(2) Relevant education, training, or experience[1];

(3) Current competence, defined as verification of current competence based on a statement from the applicant regarding disciplinary/other actions, peer recommendations, results of the interview and screening process, and a complete review of the provider's file for inconsistencies, gaps, disciplinary actions, etc.; and

(4) Health fitness, or the ability to perform the requested privileges, will be determined by a completed HCHC Health Attestation Form from the individual, and is confirmed by both the supervisor and HCHC's designated physician.

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

2. *Secondary Source Verification*

a) Credentialing of LIPs and other licensed or certified health care practitioners also requires secondary source verification of the following:

(1) Government issued picture identification;

(2) Drug Enforcement Administration registration (as applicable);

(3) Hospital admitting privileges (as applicable);

(4) Immunization and PPD status; and

(5) Life support training (as applicable)

3. *National Practitioner Data Bank*

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

4. *Release of Liability*

a) All clinical staff must sign and agree to the Release of Liability document prior to initial credentialing.

5. *Attestation Agreement*

a) All clinical staff must sign and return the Attestation Agreement prior to initial credentialing.

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[1] The Massachusetts Board of Registration in Medicine conducts primary source verification of education and training as a requirement of the licensure process, and therefore HCHC is not be required to duplicate primary source verification when completing the credentialing process, and can take an up-to-date Massachusetts medical license as proof of education and training. See https://www.mass.gov/service-details/primary-source-verification-statement for more information.

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

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

6. Advanced Practice Clinician Supervision Agreements

Advanced Practice Clinicians and physicians must have a signed Advanced Practice Clinician Supervision Agreement that complies with applicable laws and regulations. HCHC will maintain an agreement for all Nurse Practitioners and Physician Assistants, and will renew every three years, or if there is a change in supervising physician.

7. Credentialing Requirements for Medical Residents

In addition to the requirements for an "Other Licensed or Certified Health Care Practitioner," medical residents must also provide the following:

a. Proof of Professional Liability insurance in the amount $1M/$3M required
b. Signed contract with the school or other training facility permitting students to train at the health center
c. CORI check completed with no findings
d. Letter from the student stating ability to perform requested privileges
e. Name of HCHC's supervising provider
f. Release of Liability
g. Attestation Agreement

8. Credentialing Requirements for Interns and Shadows

a. Proof of Professional Liability insurance in the amount $1M/$3M, if applicable
b. Signed contract with the school or other training facility permitting students or trainees to train at the health center, if applicable
c. CORI check completed with no findings
d. Letter from the student stating ability to perform requested privileges, if applicable
e. Government issued Photo I.D.
f. Proof of Immunizations/Titers as described in the Personnel Handbook
g. Name of HCHC's supervising provider
h. Release of Liability
i. Attestation Agreement

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

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

[2] Refer to current employee handbook for required immunizations.

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

B. **Types of Verification**

1. Primary Source Verification

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

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

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

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

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

2. Secondary Source Verification

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

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

3. Other Verification

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

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

education/training to perform requested procedures.

4. Database Queries

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

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

C. Credentialing Process

The determination that all clinical staff, including practitioners, meet the credentialing requirements must be stated in writing by the Health Center's CCCSO. A list of newly credentialed and/or privileged staff will be presented to the Board for informational purposes.

Credentialing of all clinical staff must be completed prior to the individual being allowed to provide patient care services and will follow the same procedure as that outlined for Independent Practitioners.

The Credentialing process will proceed as follows:

1. The Credentialing Specialist will request and collect all the necessary documentation.
2. Once all the necessary documents have been received and the file is completed, a Credentialing Review Sheet will be placed on top of the provider's application.
3. The Credentialing Specialist will sign off that a satisfactory review has been conducted
4. The supervisor or his/her designee will review all applications and sign off on the Review Sheet.
5. The Credentialing Specialist will present the provider's application to the CCCSO, who will review all items in the application and sign off on the Review Sheet if approved
6. In some cases, the supervisor and the Credentialing Specialist may agree to submit an incomplete application to the CCCSO for approval on a Pending status, noting the reason for this action in the blank section of the Credentialing Review Form. The CCCSO may approve the pending application with the requirement that the application be completed within 30 days.

After the review by the CCCSO, the following action is made:

7. Approved File**:** A letter of approval is signed by the CCCSO and sent to the provider by the Credentialing Specialist.
8. Denied File: A letter of denial is signed by the CCCSO and sent to the provider by the Credentialing Specialist.
9. File Approved, Pending Completion: The Credentialing Specialist will obtain additional information requested so that the file can be completed within 30 days.

D. Other

1. Right to Review Credentialing File

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

2. Orientation

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

E. HCHC Re-Verification Process

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

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

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

V. Privileging

A. Privileging Requirements

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

1. The initial granting of privileges to LIPs is performed by the health center. Ultimate approval authority is vested in the CCCSO, who may review recommendations from the Department Head.
2. For other licensed or certified health care practitioners, privileging is completed prior to the start of employment

B. Privileging of Licensed Independent Practitioners

Due to the wide range of clinical services provided by HCHC, privileging requirements will be necessarily be slightly different based on clinical specialty and position. Approval will be granted by the Department Head, in conjunction with the CCCSO for up to three years and must be renewed at that time.

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

1. ***Medical Practitioners***

a) Family Practice Physicians

Initial privileging for the following procedures does not require additional documentation of proficiency beyond residency training and applies to patients of all ages, newborns to seniors:

Clinical Competencies for Family Practice Physicians			
Core medical	**Skin procedures**	**Gynecology**	**Orthopedic procedures**
Complete medical history	Punch biopsy	IUD insertion and removal	Injection of knee
Physical examination	Shave biopsy	Endometrial biopsy	Injection of shoulder
Clinical application of cognitive skills	Excisional biopsy		Injection of hip
Delivering preventive counseling	Cryotherapy		Other joint injection
Ordering of diagnostic studies	Suturing		
Interpretation of laboratory data	Incision and drainage		
Prescribing of therapies	Toenail removal		
	Cyst removal		

Clinical Competencies for Internal Medicine and Pediatric Physicians			
Core medical competencies	**Skin procedures**	**Gynecology**	**Orthopedic**
Complete medical history	Cryotherapy		
Physical examination	Suturing		

Clinical application of cognitive	Incision and drainage		
Delivering preventive counseling			
Ordering of diagnostic studies			
Interpretation of laboratory data			
Prescribing of therapies			

b) Medicine/Pediatrics, Internal Medicine and Pediatric Physicians

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

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

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

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

c) Nurse Practitioners and Physician Assistants:

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

Clinical Competencies for Internal Medicine and Pediatric Physicians			
Core medical competencies privileges	**Skin procedures**	**Gynecology procedures**	**Orthopedic procedures**
Complete medical history			
Physical examination			
Clinical application of cognitive			
Delivering preventive counseling			
Ordering of diagnostic studies			
Interpretation of laboratory data			
Prescribing of therapies			

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

Clinical Competencies for Nurse Practitioners, Physician Assistants	
Skin procedures	**Orthopedic procedures**
Punch biopsy	Injection of knee

Shave biopsy	Injection of shoulder
Excisional biopsy	Injection of hip
Cryotherapy	Other joint injection
Suturing	
Incision and drainage	
Toenail removal	
Cyst removal	

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

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

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

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

The following services require proof of additional training:

- Eye Movement Desensitization and Reprocessing (EMDR)
- Dialectical Behavior Therapy (DBT)
- Internal Family Systems (IFS)
- Eating Disorder Treatment
- Hypnotherapy
- HRV Biofeedback
- Animal Assisted Therapy

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

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

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

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

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

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

The minimum training requirements for privileging for Optometrists consist of

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

Clinical Competencies for Optometrists		
Photo-documentation	Medical laboratory studies	Ocular imaging studies
General Optometric exam/diagnosis/optical therapy	Diagnostic pharmaceutical agents	Extended posterior segment evaluation
Visual fields testing/evaluation	Low vision management	Contact lens management
Oculomotor/perceptual/pupillary problems	Non-invasive management of lid conditions	Non-invasive care of external eye injuries/burns
Epilation of lashes	Conjunctivitis therapy with topical medications	Non-invasive lacrimal function evaluation

Corneal abrasion care	Non-perforating foreign substance removal	Management of keratitis- sicca and other epithelial keratitis (non-microbial)
Gonsioscopy	OTC oral medications for ocular disease	Emergency treatment of life/sight/threatening condition prior to referral
Ultrasound measurement/ evaluation	Punctum dilation/plugs/irrigation	Anterior uveitis care
Medical hyphema management	Co-manage open angle glaucoma	Co-manage acute glaucoma
Lids and periorbital skin	Keratitis	Episcleritis
Post-surgical eye care		

5. Applicable to all Medical LIPs

For each procedure, the practitioner should submit a summary of the training they have received, the approximate time they first began doing the procedure, the approximate number of procedures they have done, and a statement as to their competency to perform the procedure. The QI Director for Medicine will be responsible for reviewing a sample of charts for visits in which the procedure was performed, and making a recommendation to the CCCSO. Following initial privileging, each clinician is responsible for:

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

C. Other Licensed or Certified Practitioners

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

Initial evaluation will be conducted during their orientation period. Validation of competence shall be documented on a new hire 90-day performance evaluation.

1. ***Medical Practitioners***

   a) Medical Auxiliaries

      (1) Registered Nurses

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

1. the application of nursing theory to the development, implementation, evaluation and modification of plans of nursing care for individuals, families and communities;
2. coordination and management of resources for care delivery,

3. management, direction and supervision of the practice of nursing, including the delegation of selected activities to unlicensed assistive personnel.

(2) Licensed Practical Nurses

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

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

(3) Medical Assistants

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

2. *Behavioral Health Practitioners*

a) Licensed Clinical Social Workers

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

3. Dental/Oral Health Practitioners

a) Dental Auxiliaries

Dental auxiliaries include the following positions:

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

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

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

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

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

Clinical Competencies for Hygienists and Dental Assistants				
Delegated Procedure	Appropriate Supervision			
	RDH	**CDA**	**FTA**	**OJT**
Give oral health instruction	G	G	G	G
Perform dietary analysis for dental disease control	G	G	G	G
Take and record vital signs	G	G	G	G
Chart dental restorations and record lesions	G	D	D	D
Take intra-oral photographs	G	G	G	G
Retract lips, cheek, tongue and other oral tissue parts	G	G	G	G
Place temporary restorations	G	D	D	I
Irrigate and aspirate the oral cavity	G	D	D	D
Isolate the operative field	G	G	G	D
Take impressions for study casts, athletic mouth guards, custom trays	G	G	G	I
Take wax bite registrations for identification purposes	G	G	G	D
Apply topical anesthetic agents	G	I	I	I
Take oral cytologic smears	D			
Remove sutures	G	G	G	D
Place and remove periodontal dressings	G	G	G	D
D Place and remove rubber dam	G	G	G	D
Irrigate and dry root canals	I	I	I	
Expose radiographs	G	G	D	D
Remove gingival retraction cord	D	D	D	D
Apply cavity varnish	I	I	I	I
Remove temporary restorations with hand instruments	G	I	I	N/A
Place and remove wedges	G	D	D	I
Place and remove matrix bands	G	D	D	I
Place gingival retraction cord	D	D	D	D
Cement and remove temporary crowns and bridges	G	G	G	I
Insert and/or perform minor adjustment of athletic mouth guards and custom fluoride trays	G	G	G	I
Polish teeth after dentist or dental hygienist has determined that teeth are free of calculus	G	G	G	N/A
Apply anti-cariogenic agents	G	G	G	D
Remove surgical dressings	G	G	G	N/A
Apply dental sealants	G	I	I	N/A
Place surgical dressings	G	G	G	N/A

Perform pulp testing	D	N/A	N/A	N/A
Select and try stainless steel crowns or other pre- formed crown for insertion by dentist	I	I	I	I
Perform periodontal charting	G			
Conduct dental screenings	G			
Perform preliminary examination to determine needed dental hygiene services	G			
Perform sub-gingival and supra-gingival scaling	G			
Perform root planing and curettage	G			
Polish amalgam restorations	G			
Apply identification microdisks	G			
Perform minor emergency denture adjustments to eliminate pain and discomfort in nursing homes and other long term care facilities	G			

Table obtained from 234 CMR-2.04

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

D. Privileging Revision or Renewal Requirements

The revision or renewal of all clinical staff privileges must occur at least every three years and will include primary source verification of expiring or expired credentials, a synopsis of peer review results and/or any relevant performance improvement information. Similar to the initial granting of privileges, approval of subsequent privileges is vested with the CCCSO.

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

2. When a Department Head makes an adverse decision on a practitioner's re-privileging, clinical staff are afforded an opportunity for a fair hearing and appellate review by the CCCSO in accordance with the appeal provisions outlined in the Grievance Policy of the Employee Handbook.

3. For Nurse Practitioners and Physician Assistants, Advanced Practice Clinician Supervision Agreement is to be reviewed and signed by all required parties every three years or if there is a change in supervising physician.

4. Re-Verification of PPD and flu will occur annually as described in the Immunization Against Influenza Policy and the Communicable Diseases Policy.

E. Revision of Privileges at mid-cycle.

Clinical privileges may be added, amended or terminated at any point in time by the CCCSO, in conjunction with the Department Head.

Re-Verification of Privileging Activity			
	Licensed or Certified Practitioner		Non-licensed/Certified/Registered Clinical Staff
Renewal or Revision of Privileges	**Verification Method**		
Current licensure or registration (MCSR)	Primary source	Primary source	Not applicable
Current certification or registration (DEA, CPR, AAMA etc…)[1]	Secondary source	Secondary source	Not applicable
New (additional) privileges according to Health Center scope	Secondary source	Secondary source	Not applicable
Current clinician competence	Primary source (peer review, supervisory performance review)	Primary source (peer review, supervisory performance review)	Primary source (peer review, supervisory performance review)
National Practitioner Data Bank (NPDB) query	Secondary source	Secondary source	Secondary source
Fitness for Duty (Health Attestation)	Verified by Supervisor and HCHC Designated Physician	Verified by Supervisor and HCHC Designated Physician	Verified by Supervisor and HCHC Designated Physician
Government issued photo ID	Secondary source	Secondary source	Secondary source
Frequency	Ongoing basis- at least every three years	Ongoing basis- at least every three years	Ongoing basis- at least every three years

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

Policy Title: Immunization Against Communicable Disease Policy	**Policy Number:** HR-061~~1~~
Department: All departments	**Policy status:** New
Date Published: JULY 2019	
Dates Reviewed: SEP 2020	
Dates Revised: SEP 2020	

PURPOSE:

Hilltown Community Health Centers have established this policy to ensure its workforce is appropriately immunized against communicable disease.

POLICY

All employees of HCHC shall be required to be immunized against communicable disease in order to ensure the safety of the staff members and HCHC patients. Employees shall provide proof of immunization upon hire, or when asked by the HR Coordinator, if employment predates required immunization. If documentation of immunization status or immunity is not available, employees shall either be offered the required immunization or complete antibody testing to establish immunity status.

In the case of an individual who cannot be appropriately immunized (e.g. they are pregnant or had an adverse reaction to one dose of vaccine and were never able to receive the rest of the series), HCHC would consider those on an individual basis. HCHC would consider the case of a current employee or the hire of a prospective employee if it were possible to develop a plan to ensure the safety of the prospective staff member and HCHC patients. Current employees who can be appropriately immunized but still refuse immunizations will be disciplined through the progressive disciplinary process.

If at any time during a person's employment it is suspected that (s)he may have a communicable disease that may constitute a risk for other staff or patients, the medical director or assistant medical director, in her/his absence, should be notified immediately.

Approved by Board of Directors on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC ~~President~~ HCHC Board of Directors

Procedure

HCHC employees are required to adhere to the following immunization standards:

1. Tuberculosis:
    a. New employees, are required to have a Tuberculosis test (PPD) prior to their start date. This requirement also applies to students, volunteers, and interns.
    b. Proof of having had a PPD test within three (3) months of hire may be presented in lieu of testing.
    ~~c. Annually thereafter, an employee, student, volunteer or intern must complete a PPD test.~~
2. Measles (rubeola), Mumps, Rubella (MMR), Hepatitis B, and Pertussis.
    a. A prospective employee must provide proof of immunization or immunity to measles (rubeola), mumps, rubella, and Hepatitis B. The individual can either bring old vaccination records or lab results showing positive antibodies to measles (rubeola), mumps, rubella, and hepatitis B surface antibody. A prospective employee must provide proof of immunization for pertussis.
    b. If they have vaccination records, it should show:
        i. MMR: two doses, at least one month apart if given as an adult, or two doses given in childhood;
        ii. Hepatitis B: three doses, with the last dose no less than 6 months after the first;
        iii. Tdap: one dose given after age 25, or if the individual is age <25, evidence of prior childhood vaccination. If the individual is pregnant, Tdap should be given during pregnancy (and at all subsequent pregnancies).
    c. If the individual has neither proof of vaccination nor proof of immunity to any one of these diseases, then they should be offered vaccination (MMR at 0 and 1 months; Hepatitis B at 0,1 and 6 months; varicella at 0 and 1 month; Tdap once).
    d. If the individual refuses vaccination, but agrees to antibody testing, HCHC can offer this testing. Antibody testing would be ordered the Medical Director, and paid for by HCHC. No antibody testing should be done unless the individual agrees to vaccination if they prove not to have immunity.
3. Varicella:
    a. A prospective employee must provide proof of immunization or immunity to Varicella. The individual can either bring old medical records showing documented provider diagnosis of chicken pox, vaccination records, or lab results showing positive antibodies to varicella.
        i. If they have vaccination records, it should show two doses at least one month apart if given after age 13, or at least 3 months apart if given at a younger age.

Policy Title: Sexual Harassment Policy	**Policy Number:** HR-14
Department: Administrative	**Policy status:** Active
Resources:	
Date Published: APR 2016	
Dates Reviewed: JULY 2019	
Dates Revised: JULY 2019	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to maintain an environment where all employees may work free from sexual harassment. Sexual harassment in the workplace is unlawful.

POLICY:

HCHC strives to maintain an environment where all employees may work free from sexual harassment. Sexual harassment in the workplace is unlawful. Sexual harassment means sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature when:

- ❖ Submission to or rejection of such advances, requests or conduct is made either explicitly or implicitly a term or condition of employment or as a basis for employment decisions;

- ❖ Such advances, requests or conduct have the purpose or effect of unreasonable interference with an employee's work performance by creating an intimidating, hostile, humiliating or sexually offensive work environment.

Examples of sexual harassment may include, but are not limited to: explicit or implicit demands for sexual favors in exchange for job benefits; unwelcome letters, telephone calls or displays of materials of a sexual nature; physical assaults of a sexual nature; unwelcome and deliberate touching, leaning over, cornering or pinching; unwelcome sexually suggestive looks or gestures; unwelcome pressure for sexual favors; unwelcome pressure for dates; unwelcome teasing, jokes or questions of a sexual nature; and sexually explicit voice mails, e-mails, graphics, downloading materials or websites.

Questions regarding this policy or any related procedure should be directed to the Human Resources Manager at 413-238-4133.

Approved by Board of Directors on: _____
Approved by:

_____ _____
Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

a.) An employee who feels that he or she has been sexually harassed or has witnessed sexual harassment, has the right and obligation to report such conduct. Each employee, supervisor or manager who is aware of an incident of potential sexual harassment must report such conduct. Reports of sexual harassment should be made to Human Resource or to any level manager.

b.) A thorough, impartial investigation of the alleged harassment will be conducted immediately, and if warranted, immediate appropriate action will be taken against the person responsible, up to and including termination of employment. Confidentiality will be maintained to the extent possible by the person conducting the investigation. Employees not satisfied with the results of the investigation may file a written complaint with the Chief Executive Officer of HCHC. There will be no reprisal or retaliation against anyone who reports such a complaint of sexual harassment: it is unlawful to retaliate against an employee for filing a complaint of sexual harassment or for cooperating in an investigation of a sexual harassment complaint.

c.) An employee may report a claim of sexual harassment to: The Massachusetts Commission Against Discrimination, 436 Dwight St., Springfield, MA, telephone 413-739-2145 or the Equal Employment Opportunity Commission, John F. Kennedy Federal Building, 475 Government Center, Boston, MA 02203, telephone 800-669-4000. Any questions about this policy or its applications should be directed to the Chief Financial Officer or the Chief Executive Officer of HCHC.