

Transcript
Informational Call
Program Information Notice (PIN) 2014-01: Health Center Program Governance
February 12, 2014
3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn your meeting over to Mr. (Jim Macrae). You may begin.

(Jim Macrae): Great. Thank you and welcome everybody. Thanks to all the folks that are on the call today. For the folks who are in the Washington, DC area I know many folks are preparing for a big snow event so thank you for making the time to be part of today's call. Hopefully it won't be too bad although I know a lot of children would be happy if they missed some more school although I guess they have to make it up in the summer.

And for those out west and east and other places, thank you for joining us today. We're really excited about being able to talk to you about our governance (PIN). This is something that's been in the making for quite a period of time. I think it's taken us almost eight years. I'm looking at (Beth

Rosenfeld) across the table - almost eight years to be able to get to this place where we've been able to release our (PIN).

And while it took a while, I think part of the reason was because what governance is is really the core of our program. And so getting it right took us a while in terms of just dealing with all of the different comments and feedback that we got. But I think we really did make I think some powerful statements about governance.

And in particular I think most of you are well aware but governance is what makes this program unique. It really is what is different about the health center program than any other program that deals with health in this country. And in particular the idea that patients should be involved in their own health and the health of their communities is a powerful statement to make. As you all know it's also not always the easiest thing to do and to be engaged in but we really do think it's unique and what makes the program what it is today.

So we are - like I said - very excited to be able to share this guidance. I think it is powerful in the sense of reinforcing the idea that individuals and board members really do need to take some responsibility. We do try to also balance that to make sure they take the right responsibilities in terms of what is their role and responsibility versus what is the role and responsibility of the CEO and hopefully we struck the right balance.

So on today's call we're going to share some information but I think even more importantly answer any questions that you all may have. Just a couple of just overarching points that I wanted to make beyond just the (PIN) itself getting out.

First and foremost this new (PIN) actually clarifies existing policy and pulls all of our health center governance policies into one document which I think is extremely beneficial both hopefully to us as staff here but also to grantees. It also I think provides some key clarifications for all health centers including what is the definition of a patient board member. I know that's been something that's been confusing for a lot of folks for a number of years and to be able to provide some specificity on that I think is really important.

At the same time it also recognizes that those who are non-patient board members don't have to be a one for one match in terms of some of the responsibilities that are laid out in our statutes and in our regs. It shares what needs to be required in terms of the bylaws. It also talks about what exercises or what responsibilities must be exercised by the board as opposed to the executive committee and in particular the executive committee can't supersede the full board and I know we've run into that in certain situations.

It also makes clear that the day to day direction and management responsibility must rest with the health center staff with the board playing their more overall responsibility and direction. It also which I think will be one of the most beneficial things helps clarify the whole issue for public centers and governance and in particular around the co-applicant governance structure including what fiscal and personnel policies may be retained by the public agency and which ones may not and in particular it provides information about what the co-applicant agreement must have.

It also reinforces something that I know we've had to address in a couple of different circumstances especially recently around affiliation agreements where those affiliation agreements and contracts cannot as part of those actually compromise or limit in any way the governing board's required authorities.

And then finally I think with special populations it makes it clear that while we still would prefer to have folks that are actual members of that particular population whether it's a homeless individual or a migrant seasonal farmworker, advocates can also be representative and take that place in terms of providing that kind of input.

In addition which I think is probably the biggest change is that there is no longer a potential to waive the monthly meeting requirement. As we've shared on a couple of different calls already, the responsibilities of managing these organizations has become much greater over time and in addition technology has made it much easier for people to get together whether they do it in person or virtually. So I think requiring now monthly meetings I think is really important in terms of making sure that there's appropriate oversight and accountability for what it is that we are doing.

In addition the last piece is that we do recognize that there are going to be some health centers that are going to be impacted by different parts of this (PIN) in different ways and so there will need to be time to basically work with these centers in terms of what their current structures are, what if anything they need to do to address or change their structures to come into compliance and that we want to provide support to you in particular as you're dealing with these grantees one on one but also to our policy staff to provide support with any kind of general questions.

So we're -- like I said - very excited about this. To me I'm really excited because it gives me an opportunity to stress both internally and I hope externally the importance of governance and why it's so important and, you know, how with this (PIN) we're rolling out different aspects of what is it that really governance is and is not. And I think it's a great opportunity for all of

us really going back to what I think is an incredible social experiment in terms of having people be in charge of their own health and their own healthcare.

So with that I will turn it over to (Amanda) to share some of the details of the (PIN) and then most importantly answer any questions that you all may have. (Amanda).

(Amanda): Okay like Jim was saying, the purpose of this particular call is to review and highlight the contents of this particular - this (PIN) which we're very excited about -- as the single source for health center program policy on governance.

There are slides accompanying this call. They're on the BPHC website in the TA section. If you haven't found the link, I'm going to read it out. It's <http://bphc.hrsa.gov/technicalassistance> -- all one word -- /trainings/index.html.

[\[http://bphc.hrsa.gov/technicalassistance/tranings/index.html\]](http://bphc.hrsa.gov/technicalassistance/tranings/index.html) So one more time - again if you're just navigating to the BPHC website if you click on the specific TA link up on the info bar you'll see it right there - a link right there you can click on there or I'll read the address again. It's <http://bphc.hrsa.gov/technicalassistance> -- all one word -- /trainings/index.html.

[\[http://bphc.hrsa.gov/technicalassistance/tranings/index.html\]](http://bphc.hrsa.gov/technicalassistance/tranings/index.html)

After reviewing the sections of the (PIN) via the slide presentation we'll be sharing frequently asked questions and responses that we've gotten through a variety of mechanisms already. Additional technical assistance and QA sessions may be scheduled based on your guys' feedback and if we decide to schedule those sessions, we'll announce those in the Primary Care Digest which I hope everyone is subscribed to and if you aren't then a link to how to subscribe to that is also on the BPHC homepage sort of on the bottom right.

The slides themselves are set up basically to have one slide per section of the (PIN) which is really not enough space to go into over every detail so that's why we really encourage everyone to read the entire (PIN). Your specific question may be addressed in a detail that won't be covered in these slides and can't be covered in this session.

If you have specific questions related to your - to how - anything in the (PIN) relates to your specific health center and your specific case, we encourage you to talk to your project officer who's going to know much more about both aspects and can help you out with that.

The first section of the (PIN) is the purpose section. It basically tells readers again the purpose of the (PIN) which we've emphasized several times but this is going to be the primary policy document on governance. It is a list of the PINs and specific - a brief list of specific PINs and PALs that this (PIN) supersedes along with a blanket statement that this (PIN) will supersede any other previous policy document that's inconsistent with this (PIN).

So what does that mean? I mean hypothetically so you're rooting around your archives. You find some dusty regional memorandum from who knows when and you're wondering I wonder if this is still in effect. Wonder no longer, you know. You just go to this (PIN), read that and that's where you go for all your governance questions.

The next section is on applicability and basically this section applies to all health centers - lookalikes and program - health center program grantees so all health centers. The only exception to this are tribal health centers or health centers operated by an urban Indian organization - they're required to have

some sort of governance structure but it doesn't necessarily need to comply with all the requirements outlined in this (PIN).

The next section is really sort of - is labeled section three governance requirements and this is really where you get to the meat of the (PIN). Summing up if I had to put in a nutshell this section - it's that the governing board needs to function well, represent the target population and the community and must retain all their required authorities' responsibilities and functions. And you'll see this as sort of a theme throughout this section of the (PIN) and through the rest of the (PIN).

Note that the (PIN) typically provides a floor rather than a ceiling when it comes to specific requirements. So health centers have discretion to establish additional elements to support the intent I gave before as long as those elements don't violate any other requirements. More specifically about this particular section it talks about board composition requirements including - as (Jim) mentioned - that really great definition of what a patient board member is.

Just to read it out, a patient board member is defined as someone who at a minimum is a current registered patient and has used an in scope service in the past 24 months that has generated a health center visit. From HRSA's perspective that is the minimum definition of who can count towards that patient majority requirement.

It also gives a little more information on non-patient board members. They have to be representative of the community being served and must have a broad range of expertise. The (PIN) gives an example list of areas of expertise but there doesn't need to be - it clarifies that there doesn't need to be a one to

one correlation between those areas of expertise and the non-patient board member.

So it doesn't necessarily mean that you need to have for example one non-patient board member who does finance, one non-patient board member who does legal affairs. We really - the (PIN) really clarifies that we're looking for this broad range of expertise.

As (Jim) mentioned before for health centers that receive special - that receive 330(e) general CHC funds and special population funding - they need to have some sort of representation from the special population they receive funding for on that board. But that representation can consist of an advocate for the special population. There's a little bit more detail on what it means to be an advocate in the (PIN) but as an important side note, that advocate wouldn't count towards the patient majority unless that person also happened to be a patient.

Other things included in this really meaty and great section is a clear and comprehensive list of all the required bylaw elements, a really clear list of the authority of functions and responsibilities that need to be retained by the governing board including clear language again sort of going back to what I think as sort of the moral of this section that no other body including an executive committee or an advisory council or anyone can supersede the full board and those authorities, functions, and responsibilities.

Sort of balancing that out - there's an explicit statement in there that day to day direction and management of the health center lies with the CEO and the health center staff and not with the health center board. So there is that balance in there that needs to be struck.

The next section of the (PIN) is about public centers. It really pulls together formally all in one place all these governance requirements related to public centers which we know that there's a lot of questions on. First off it does, you know, reemphasize public agencies are allowed to be health centers and they have to - but they have to also follow all the health center program requirements with the one exception that they can meet governance requirements through a co-applicant structure and public agencies are the only organizations that can meet governance requirements through a co-applicant structure.

Public agencies can meet governance requirements on their own or through this co-applicant model that we were discussing before. It reinforces the public agency is really who HRSA has the legal relationship with however for programmatic purposes we consider the co-applicant and the public agency to collectively be the health center. So there's sort of this balance between these two thoughts.

It talks about the co-applicant model governing requirements and if there is sort of a new piece in here it's that the - it really specifies that it's a very limited set of general policies - general fiscal and personnel policies that can be retained by the health centers. Quite a limited set and that's contained within the (PIN). For fiscal policies, It's internal control procedures to assure sound financial management procedures, purchasing policies and standards.

For personnel policies, it's employee selection performance review, evaluations and dismissals procedures, employee compensation including wage and salary scales and benefit packages, position descriptions and classification, employee grievance procedures and equal opportunity practices. And that's it. Those are the only authorities that the public agency

can retain over those responsibilities that need to be retained by the co-applicant board.

Everything else needs to be - everything I've sort of talked about in section three - some of the other section needs to be retained by that co-applicant board.

It also describes a co-applicant agreement which is basically an agreement on how these two parties relate to each other and it also sort of reinforces that we understand that there may be sort of shared responsibilities between the public agency and the co-applicant and that's really what's going to be discussed in this co-applicant agreement. So it really sort of underlines that relationship balance that has to be - that's part of being a public agency with a co-applicant.

The next section is on waivers. It explains in detail the waiver authority including that special pop, so health care for the homeless, public housing and migrant health center only and also sparsely populated health centers are eligible to request a governance waiver and they're the only ones eligible to request a governance waiver.

And this is the new piece that the only request that we will consider waiving is this patient majority governance waiver. No other waivers will be granted. This means that there are no more monthly meeting waivers.

A piece that we don't want to get lost in here is that HRSA gives a lot more clarity on what is meant by good cause. You know, in order to get a waiver you have to demonstrate that you have good cause to get whatever - to get the requirement waived - to get that patient majority governance requirement waived. So that good cause is based on some characteristic of the special

population of the service area that creates a significant barrier to meeting the patient majority.

It also gives some clarification on what documentation the health center has to demonstrate they have good cause to waive out of the requirement meaning not just some sort of characteristic of the special population that they're serving but also that the health center has made attempts to meet the patient majority and why those attempts have not been successful.

There's also a description of what elements need to be described and implemented in an acceptable mechanism for meeting the patient majority requirements like how that mechanism will get patient input, what types of patient input will be gathered, how that input will make it to the governing board and actually used by the governing board and then there's also a list of example alternative mechanisms.

And there's a side note that again harkening back to section three that advisory councils cannot substitute in any way for the governing board. But one of the pieces I'd like to emphasize here is sort of an area of discretion that as long as a health center can come up with an alternative mechanism that meets the elements outlined in the section, there's no reason why they can't have any combination of alternative mechanisms or if they even come up with something we haven't thought of before. That's fine as long as it meets the elements as described in the (PIN).

The last section is mostly for health centers that have affiliation agreements with some outside organization or some sort of relationship. And again, you know, and I know there's a lot of themes like I was saying before that this is a theme that runs throughout the (PIN) that the nutshell description of the section is that no outside organization or body can compromise or limit the

governing board's required authorities nor can these authorities be delegated in any way.

There's a minimum list of the types of agreements that HRSA would review from this particular programmatic perspective and I want to say that we reviewed them from that particular programmatic perspective and not from any other perspective.

As an additional note, the section - also the same sorts of concerns about an outside organization compromising the governing board's required authority in this (PIN). The section of the (PIN) also extends those concerns to compromise - potential compromises to the executive committee since in many cases the executive committee can temporarily act for the full board.

The last section of this is the effective date. Basically this (PIN) was made effective upon issuance and HRSA will work within the progressive action policy and process described in PAL 2010-01 - existing waivers beyond the 51% majority have now technically expired. However like (Jim) was mentioning, we recognize that there could be cases where health centers may be able to justify the need for additional time to alter their structures or documents.

So we want health centers to really be deliberate about reading the (PIN) and looking at where there may be gaps between their organization and what's illustrated in the (PIN). And HRSA may allow health centers up to two years to demonstrate compliance with the (PIN). We really want to work with health centers to meet the standards in this (PIN).

And this is where it becomes extremely case specific on your structure and your challenges and what you may be facing so we really strongly encourage

health centers to, you know, again read the (PIN), think about their organizations and contact their project officer with any particular questions. And I know some of you have already started talking to your project officers. In some cases project officers have already been reaching out to you so we really encourage that dialogue to continue and grow.

If there's any additional questions again direct questions related to individual circumstances should be directed to the BPHC project officer. If there are general policy questions, they can be directed to BPHCpolicy@hrsa.gov. That email address is also given in the (PIN). I will say that you'll probably get better case specific information from your PO - from your project officer because again they're going to know your case a little bit better but that avenue is also open to you.

So that's all for going over the (PIN). I'd like to turn it over to (Beth Rosenfeld) who will talk a little bit about some of the frequently asked questions we've received.

(Beth Rosenfeld): Hi. Good afternoon everyone. At this time we're ready to move into the question and answer part of today's presentation and we hope that you have found the summary of the (PIN)'s highlights to be helpful so far. So - excuse me - in order to best utilize our limited time together today the policy staff has pulled together a number of questions that have come to us via the mailbox that was referred to in that last slide and for project officers in direct conversations with you so far. And we believe the following questions include a wide variety of subject areas that are touched in the (PIN) and were selected based on their broad applicability to this audience.

So we'll move into that session right now.

(Lisa): Okay so our first question is about board composition. And the question is I receive general community health center or 330(e) funding and special populations funding so 330(g), (h), or (i). What are my board composition requirements?

(Susan): Okay. In that situation the health center must meet all board composition requirements and must have at least one board member who is representative of each special population funding source that the health center receives. The special populations representative can be a patient from the special population such as homeless, public housing resident, migratory and or seasonal farm worker or be an advocate for that population but it should be noted that this representative or advocate would not count towards the patient majority unless he or she also happens to be a patient of the health center.

(Lisa): Great, thank you. So our next two questions are about bylaws. The first one is can my governing board bylaws contain more elements than what is listed in the (PIN) - specifically can my governing board have additional authorities, functions and responsibilities beyond those listed in the (PIN)?

(Beth Rosenfeld): The (PIN) provides what's considered a minimum list of required bylaw elements and authorities, functions and responsibilities, however each health center has discretion in going beyond those lists as long as no other health center program requirements are compromised, such as conflict of interest for instance, and as long as the day to day direction and management responsibility for the health center rests with the staff under the direction of the CEO or the executive director.

(Lisa): Okay. And we've also been asked will HRSA be issuing any template bylaws that will be assured of receiving HRSA's okay?

(Susan): Well of course every health center is unique and as we say, you've seen one health center, you've seen one health center. And this applies in this instance too. Bylaws in addition to meeting HRSA requirements must be designed to meet the needs and unique circumstances of each health center. In addition there may be specific state or local requirements that the health center must meet. Therefore HRSA/bureau does not provide templates or model agreements.

Health centers are encouraged to consult with their state primary care associations and or any appropriate bureau of primary healthcare national cooperative agreement partners for assistance in developing bylaws. Health centers may also wish to confer with their own legal counsel when developing their bylaws. In addition BPHC also hosts an online samples and templates resource center that may contain - that contains many valuable templates and documents. However it should be noted these documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

And of course if you have any specific questions on the application of the governance requirements to your health center, please contact your project officer.

(Lisa): Great. Our next question relates to public centers. For public centers how can the co-applicant governing board functionally retain all of its required authorities if the public agency is the legal entity held accountable to HRSA.

(Beth Rosenfeld): So the public agency co-applicant relationship is very specific to the individual public agency and the related co-applicant board. While the co-applicant board must retain all required authorities aside from the limited set that may be retained by the public agency that (Amanda) went over just a little

while ago and these are laid out on Page 10 of the (PIN) for a reference. It may be appropriate to establish shared roles and responsibilities for carrying out the governance functions of the health center.

So the specifics involved in these shared roles and responsibilities must be described in the mutually agreed upon co-applicant agreement.

(Lisa): The next question that's come into us is can health centers have a sole corporate member?

(Susan): Health centers must demonstrate that they meet all governance requirements described in the (PIN) including the governing board's retention of all required authorities, functions, and responsibilities. This is generally a difficult bar for sole corporate membership structures to meet. Furthermore lookalikes - FQHC lookalikes must meet an additional statutory requirement that they may not be owned, controlled or operated by another entity. So to sum, it is very difficult for a sole corporate membership structure to meet all of the health center program governance requirements.

(Lisa): Great. We have received a number of questions also about patient majority and about the definition of a patient. And so the first question about this is the parent of a minor child has always been considered a patient for board membership purposes. Are there other family members or caregivers of patients who could be considered patient board members?

(Beth Rosenfeld): The (PIN) clarifies that the legal guardian of a patient who is a dependent child or adult would meet the criteria to be considered a patient board member however this does not mean that those who are not formal legal guardians of patients cannot serve as board members. Simply put it means that these particular members would not count towards the patient majority. In addition

it might be helpful to point out that health centers have significant discretion in determining how members of the community and health center patients in particular may assist the board in its decision making outside of serving as board members.

(Lisa): And sticking with patient majority we've been asked can a board member who has only visited the health center for a couple of dental exams in the past 24 months count toward the board's patient majority?

(Susan): In order to be considered a patient board member, the board member must be a current registered patient of the health center who accessed an in scope health center service at the health center in the past 24 months which in turn generated a health center visit. As long as a dental service provided is in the scope of the project and the service generated a health center visit, HRSA would consider the board member as meeting the patient definition. Please note though that the intent of the patient majority requirement is to insure patient participation in the organization, direction and ongoing governance of the health center.

Health centers do have discretion in establishing additional definitions to support this such as requiring patient board members to have a primary medical visit within the past 24 months, the past year or other such further defining terms.

(Lisa): And the next question is about waivers of the patient majority requirement. So I currently have a governance waiver of the 51% patient majority. When do I have to demonstrate that I have good cause for a waiver that meets the criteria in the (PIN)?

(Beth Rosenfeld): Health centers would formally demonstrate good cause to HRSA at the time of the next service area competition application. And in the case of a lookalike that would be for renewal of designation.

Health centers that currently have waivers are in fact encouraged to review section five of the (PIN) and analyze whether they meet the good cause criteria as well as the criteria for an acceptable alternative mechanism. Certainly if you have questions or concerns about your ability to meet the standard criteria that's laid out in the (PIN), please contact your project officer for more specific guidance related to your case.

(Lisa): Our next question is about monthly meeting waivers. I am a nonprofit special pops only health center that received the monthly meeting waiver. Can I now meet the requirement for monthly meetings by establishing a co-applicant board that meets monthly?

(Susan): Only public centers such as public agency health centers are permitted to have a co-applicant governance structure. As a nonprofit health center you are not permitted to establish a co-applicant board. If you encounter challenges in transitioning to meeting monthly, please contact your project officer to talk through your situation. The Bureau of Primary Healthcare is working with our technical assistance partners to provide support and additional TA resources as needed to assist health centers in meeting identified challenges.

(Lisa): Thank you. So our final question is about sub recipient arrangements. I am a health center with healthcare for the homeless funding and I have established sub recipient arrangements with several other organizations to assist in carrying out the grant project for which I am funded. Do these organizations have to meet the governance requirements as spelled out in the (PIN)?

(Beth Rosenfeld): To answer simply, yes. Recipients of section 330 funding via a sub recipient agreement must comply with all health center program requirements including those that are spelled out in this (PIN). For reference please see footnote 22 that you'll find on Page 15 of the (PIN) for a formal definition of a sub recipient organization.

In closing this completes today's informational call on in 2014-01 on health center program governance. We certainly thank you for your participation today and hope that you found the additional guidance provided in the session to be useful. If you have not had the opportunity, we really encourage you to review the (PIN) and to use it as a resource for governance policy.

As a quick reminder as (Amanda) mentioned when you have case specific questions or concerns, please health center grantees and lookalikes should contact their project officers to discuss next steps. And as a reminder general policy questions should be directed to the email box bphcpolicy@hrsa.gov. Thank you and we appreciate you joining us.

Coordinator: Thank you. This does conclude the conference call. You may disconnect at this time.

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