Health Choice Network
Board Member Orientation

Staying on the Right Path:
A Governance Discussion

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AGENDA

I. Current Events and Updates

II. Roles and Responsibilities of Health Center Board Members

III. Governance High Risks and “Hot Topics”

IV. Best Practices for Governing Boards

I. Current Events and Updates

OIG ENFORCEMENT: RETURN ON INVESTMENT

	FY 2013	FY 2014	FY 2015	FY 2016
Individuals and entities excluded from Federal health care programs	3,214	4,017	4,112	3,635
Total health care fraud judgments and settlements	$2.6 billion	$2.3 billion	$1.9 billion	$2.5 billion
Total OIG expected recoveries (including investigations and audits)	$5.8 billion	$4.9 billion	$3.3 billion	$5.6 billion
Return on investment from various HCFAC activities	**$8 to $1**	**$7.7 to $1**	**$8 to $1**	**$8 to $1**

Sources: OIG Budget Requests to Congress (FY 2014, FY 2015, FY 2016; FY 2017); Health Care Fraud and Abuse Control Program Annual Report (FY 2013, FY 2014, FY 2015, FY 2016)

340B DRUG DISCOUNT PROGRAM: AUDITS ON THE RISE

FY	TOTAL AUDITS	FQHC AUDITS	FQHCs WITH FINDINGS
2013	94	10 (11%)	7 (70%)
2014	99	14 (14%)	8 (57%)
2015	200	23 (12%)	19 (83%)
2016	197	36 (18%)	24 (66%)
2017 (as of 5/1/2017)	6	1 (16%)	0 (0%)
Total	**596**	**80 (14%)**	**54 (68%)**

Source: https://www.hrsa.gov/opa/programintegrity/index.htm (last updated 5/1/2017)

HOT ISSUES IN 340B AUDITS

- Diversion
  - Contract pharmacy dispenses 340B drugs to non-patients
  - Prescription written by ineligible provider
  - No patient record documenting prescription
  - Delivery site not registered on OPA database
- Contract Pharmacies
  - No written contract
  - Actual delivery sites do not match OPA database
- Duplicate Discounts
  - Inaccurate record on OPA Medicaid Exclusion File
    - Billing Medicaid contrary to data on file
    - No NPI or Medicaid billing number registered
  - Using contract pharmacy to dispense to Medicaid fee-for service beneficiaries without method to prevent duplicate discounts
- Administrative
  - Registration of new health center sites with OPA
  - Wrong authorizing official or contact person
  - No, or inadequate, written policies and procedures for 340B program

HIPAA ENFORCEMENT: COMMON THEMES

- Common themes emerging from HIPAA enforcement cases:
  - Lost or stolen backup tapes, laptops, and thumb drives
  - Unencrypted storage of ePHI or otherwise inadequately protected PHI (*e.g.*, hospital network accessible by a default password on a wireless router)
  - No Business Associate Agreement or an outdated agreement
  - No risk assessment or an inadequate risk assessment conducted
  - Significant delay in implementing measures to address any vulnerabilities discovered in a risk assessment or after an actual breach
  - Failure to develop and implement appropriate policies and procedures to safeguard PHI (prior to or after a breach)
  - Lack of appropriate authorizations to use/disclose PHI

2017 HIPAA ENFORCEMENT HIGHLIGHTS

- Memorial Hermann Health System (MHHS) **($2.4 million):** In response to an incident where an individual presented an allegedly fraudulent ID card to staff, MHHS published a press release. MHHS impermissibly disclosed PHI when it included the patient's name in the title of that press release, but MHHS also failed to timely document the sanctioning of its workforce members for impermissibly disclosing the patient's information.

- CardioNet **($2.5 million):** a company laptop containing the ePHI of 1,391 individuals was stolen from a parked vehicle outside of an employee's home. OCR's investigation revealed insufficient risk analysis and risk management processes in place at the time of the theft. Additionally, CardioNet's policies and procedures implementing the standards of the HIPAA Security Rule, including safeguards for ePHI on mobile devices, were in draft form and had not been implemented or finalized.

- Center for Children's Digestive Health (CCDH) (**$31,000)**: the HHS Office for Civil Rights (OCR) initiated a compliance review of CCDH following an investigation of CCDH's business associate, FileFax, Inc., which stored records containing protected health information (PHI) for CCDH. Neither party could produce a signed Business Associate Agreement (BAA).

- Metro Community Provider Network (MCPN) **($400,000)**: due to a lack of a security management processes, a hacker was able to access employee email accounts and obtain electronic protected health information (ePHI) for 3,200 individuals through a phishing incident. MCPN's subsequent risk analysis was insufficient and did not meet the requirements of the Security Rule.

- Memorial Healthcare System (MHS) **($5.5 million)**: a former employee's log-in credentials were used by other staff members to improperly access patient PHI on a *daily basis* for at least one year without detection primarily because MHS failed to implement procedures with respect to reviewing, modifying and/or terminating users' right of access.

FEDERAL TORT CLAIMS ACT (FTCA) SITE VISITS

- HRSA may conduct a FTCA site visit during the deeming application process and/or as part oversight responsibilities to ensure appropriate implementation of FTCA requirements
  - HRSA states that site visit results will not affect current deeming status; however, should respond to findings prior to next deeming cycle
  - Common Findings:
    - Credentialing & Privileging
      - Lack of Board involvement/oversight in privileging/credentialing
      - Failure to follow peer review policy as part of credentialing and privileging

FTCA SITE VISITS: COMMON FINDINGS

- Quality Improvement & Assurance Systems
  - Failure to have QI/QA Plan with specific clinical/business plan measures
  - Failure to have QI Committee meeting minutes reflect specific information to PDSA processes and projects or other process improvement
  - Board minutes do not reflect discussion of QI activities
  - Failure to conduct peer review appropriately
- Risk Management
  - QI Committee does not review claims
  - Failure to inform Board of claims (both pending and settled)
  - Issues with diagnostic tracking policy
  - Issues with hospitalization tracking policy
  - No system to analyze claims to identify training needs
  - No tracking to demonstrate provider attendance at risk management training
  - Failure to notify patients about FTCA deemed status
  - Limited number of staff review claims for standard of care
  - No process for clinical review of claims

IMMIGRATION ENFORCEMENT

- Recently there has been a sharp rise in federal activity involving immigration, including:
  - A significant expansion of U.S. Immigration and Customs Enforcement (ICE) enforcement actions
  - Issuance of three Executive Orders ("EOs"):
    - *Border Security and Immigration Enforcement Improvements* (1/27/2017) orders the construction of a wall on the U.S. southern border
    - *Enhancing Public Safety in the Interior of the United States* (1/25/2017) provides for potential sanctions on "sanctuary jurisdictions," adds 10,000 immigration officers, gives state and local agencies the authority to perform the functions of immigration officers and expands whom the government considers a priority for deportation
      - NOTE: Potential sanctions on "sanctuary jurisdictions," if applied at all, would only apply to **public-entity** health center grantees and would not directly affect non-public entity health centers
      - The US District Court for the Northern District of California held in favor of the City of San Francisco and County of Santa Clara by enjoining the key provision of the EO on sanctuary jurisdictions. Specifically, the Court enjoined enforcement of paragraph 9(a) of the EO which states: "jurisdictions that willfully refuse to comply with 8 U.S.C. § 1373 (sanctuary jurisdictions) are not eligible to receive Federal grants, except as deemed necessary for law enforcement purposes by the Attorney General or the Secretary [of Homeland Security]."
    - *Protecting the Nation from Foreign Terrorist Entry into the US* (1/25/2017; revised 3/6/2017) suspends entry in the U.S. from six countries for 90 days – ON HOLD: nation-wide temporary restraining order issued 3/15/2017 (HI) and a preliminary injunction upheld by the 4th Circuit (5/25/2017)
    - The EOs do not directly impact immigrants' ability to receive care at health centers; however, news coverage has created a great deal of fear and apprehension among immigrant communities that may negatively impact immigrants' willingness to seek services

IMMIGRATION ENFORCEMENT

- Health centers are not required to verify the citizenship or immigration status of patients and can treat any person regardless of their immigration status
- According to a 2011 Department of Homeland Security memo, immigration enforcement actions are generally not to occur in certain **"sensitive locations"** including medical treatment and health care facilities, such as doctors' offices, accredited health clinics, and emergent or urgent care facilities
  - As of February 27, 2017, the "sensitive locations" policy remains in effect, but how it is implemented is determined by the Administration and it can be changed at any time without congressional approval or a public notice-and-comment process
- With a valid court order, warrant, subpoena, or summons, any governmental entity, including ICE, can require a health center to provide protected health information
  - If a health center maintains information regarding the immigration status of patients along with other PHI and receives a request for PHI that complies with HIPAA, the health center should supply its files as maintained in the normal course of business
  - In responding to law enforcement requests for PHI, health centers should comply with HIPAA's privacy rules as well as any state laws related to confidentiality and privacy
    - For a valid court order signed by a judge, a health center should disclose only the information expressly described and requested
    - If a subpoena is issued by someone other than a judge *(e.g.*, a court clerk or attorney) a health center may disclose PHI only if there is evidence of reasonable efforts to notify the person who is the subject of the information so that the person has an opportunity to object or seek a protect order

IMMIGRATION ENFORCEMENT

- Health centers are permitted to educate patients about their rights; HOWEVER, we recommend health centers not use Section 330 grant funds for these purposes, unless such activities have been included in the health center's HRSA-approved scope of project (*e.g.*, a medical-legal partnership)
  - Permissible activities can include posting information about rights, distributing information about rights, and holding educational sessions about rights

HYDE AMENDMENT RESTRICTIONS

- **Consolidated Appropriations Act**, 2017:
  - "SEC. 506. (a) "None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion."
  - Sec. 507. (a) "The limitations established in the preceding section shall not apply to an abortion—
    - (1) if the pregnancy is the result of an act of rape or incest; or
    - (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."

HYDE AMENDMENT RESTRICTIONS

- In 1978, HHS promulgated regulations to implement the Hyde Amendment
  - Generally applicable to grant programs and projects supported in whole or in part by federal funds (whether by grant or by contract), which are appropriated to HHS and administered by the Public Health Service
  - Prohibits the use of federal funds "for the performance of an abortion in programs or projects to which this subpart applies" with certain exceptions, consistent with those found in the Hyde Amendment (*i.e.*, the life of the mother is endangered by carrying the fetus to term or in the case of rape or incest) (42 C.F.R. § 50.303)
  - Permits federal financial participation in expenditures for medical procedures performed upon a victim of rape or incest if the program or project has received signed documentation from a law enforcement agency or public health service stating:
    - (a) That the person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest;
    - (b) The date on which the incident occurred;
    - (c) The date on which the report was made, which must have been within 60 days of the date on which the incident occurred;
    - (d) The name and address of the victim and the name and address of the person making the report (if different from the victim); and
    - (e) That the report included the signature of the person who reported the incident." (42 C.F.R. § 50.306)
- Note: these documentation requirements are not required if the life of the rape or incest victim would be endangered by carrying the pregnancy to term, as certified by a physician

HYDE AMENDMENT RESTRICTIONS

- Section 330 requires that health centers provide, either directly or through an established arrangement, a broad range of primary health care services
- Required primary health services include:
  - Services related to reproductive health, including "health services related to…obstetrics, or gynecology…" (42 U.S.C. § 254b(b)(1)(A)(i)(I))
  - "Preventive health services, including…prenatal and perinatal services…appropriate cancer screening … voluntary family planning services" (42 U.S.C. § 254b(b)(1)(A)(i)(III))
  - "Referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (included substance abuse and mental health services)." (42 U.S.C. § 254b(b)(1)(A)(ii))
- "Voluntary family planning services" are defined in the Health Resources and Services Administration ("HRSA") Service Descriptor Guide as the following:
  - "Voluntary family planning services are *appropriate counseling* on *available reproductive options* consistent with Federal, state, local laws and regulations. These services may include management/treatment and procedures for a patient's chosen method (e.g., vasectomy, subdermal contraceptive placement, IUD placement, tubal ligation)." (The Service Descriptor Guide at p. 10)
  - Neither "appropriate counseling" nor "available reproductive options" is defined in Section 330, the implementing regulations, or HRSA guidance

MEDICAL MARIJUANA

- Under the **Federal Controlled Substances Act ("CSA")**, marijuana is classified as a Schedule I drug
  - 21 U.S.C. § 812, 21 C.F.R. § 1308.11(d) "Schedule I. –
    - (A) the drug or other substance has a high potential for abuse.
    - (B) the drug or other substance has no currently accepted medical use in treatment in the United States.
    - (C) There is a lack of accepted safety for use of the drug or substance under medical supervision."
  - The possession, manufacturing or distribution of marijuana, even for medical purposes, is illegal as a matter of Federal law.
- **Drug-Free Workplace Act of 1988**, 41 U.S.C. § 702
  - Federal grant recipients are required to publish "a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violations of such prohibition…"

MEDICAL MARIJUANA

- Florida passed the Compassionate Medical Cannabis Act of 2014 ("Act"), Fla. Stat. § 381.986), which became effective on January 1, 2015
  - The Act authorizes doctors licensed under Chapter 458 and Chapter 459 of Florida Statutes to order low-THC cannabis for qualified patients, but has significant limitations
  - In November 2016, Florida voters passed a constitutional amendment to expand the law and legalize the use of marijuana for medical purposes. The new amendment will allow those who suffer chronic pain related to one of 10 qualifying conditions to receive either low-THC cannabis or full strength medical marijuana.
  - In January 2017, the Florida Department of Health released proposed rules to regulate the medical marijuana program. As of June 6, the Florida State Legislature has not approved a different set of rules and, unless the Legislature convenes in a special session, DHS will implement its rules by July 3, 2017
- **But,** health centers must carefully consider the risks of conduct that may be construed as violating Federal law:
  - Federal law prohibits a health center from prescribing or dispensing medical marijuana
  - Verifying a patient's eligibility for medical marijuana may violate the CSA: it is an unsettled area of law as to whether completing a written certification constitutes a prescription and, therefore, risks prosecution for aiding and abetting distribution
  - While the DOJ has offered some guidance about its enforcement priorities, it has made clear that nothing precludes the Federal government from prosecuting in circumstances deemed to be of particular Federal interest

MEDICAL MARIJUANA

- Participating in state medical marijuana programs may result in severe consequences for a provider and/or the health center:
  - Violations of the CSA may result in debarment from participating in Federal health programs
  - The DOJ may refuse to defend a claim under FTCA if the claim is based on a patient obtaining medical marijuana pursuant to a health center provider's certification or prescription
  - Violations of the Drug-Free Workplace Act may result in termination of Section 330 grant funding and a ban on future Federal contracts for up to five years
  - Additional legal exposure may include termination of CMS agreements (and the ability to bill Medicare and Medicaid), False Claims Act violations; or withdrawal of the health center's Federal tax-exempt status

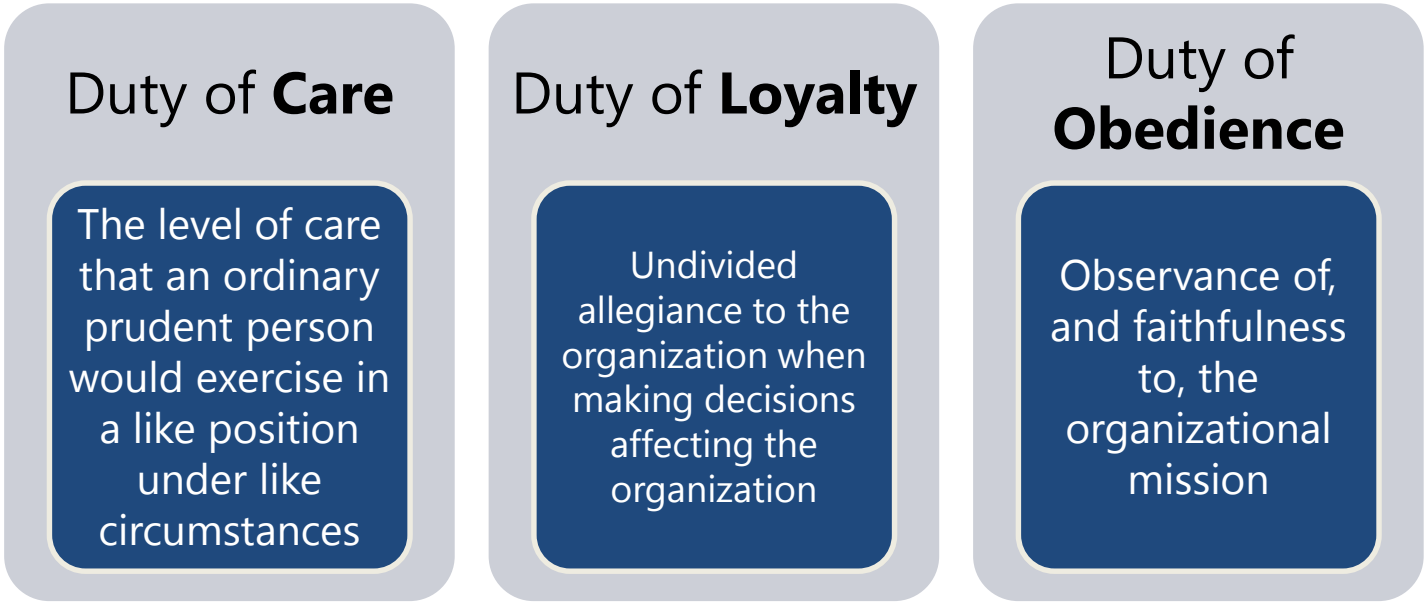
ASSISTED SUICIDE

- **Federal Assisted Suicide Funding Restriction Act of 1997** (42 U.S.C. § 14401 *et seq*.):
  - 42 U.S.C. § 14402 - "no funds appropriated by Congress for the purpose of paying (directly or indirectly) for the provision of health care services may be used ---
    - (a)(1) "to provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing;…"
    - (a)(2) "to pay (directly, through payment of Federal financial participation or other matching payment, or otherwise) for such an item or service, including payment of expenses relating to such an item or service; or…"
    - (a)(3) "to pay (in whole or in part) for health benefit coverage that includes any coverage of such an item or service of any expenses relating to such an item or service."
- **Public Health Service Act**, 42 U.S.C. § 238o:
  - "Appropriations for carrying out the purposes of this chapter shall not be used in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 *et seq*.]"
- Even if health centers do not engage in assisted suicide activities, staff should receive training regarding:
  - The prohibition on participating in such activities within the Section 330-supported health center program
  - Limitations on participating in such activities outside of the Section 330-supported health center project, such as the prohibition on furnishing health care items or services for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide activities

II. Roles and Responsibilities of Health Center Board Members

BOARD'S FIDUCIARY DUTIES

- Board owes Fiduciary duties to the health center:



WHERE DO THE FEDERAL GOVERNING BOARD RULES COME FROM?

- By accepting a federal grant, each health center has agreed to abide by the terms and conditions of that grant award, which are found in:
  - Section 330 of the Public Health Service Act (42 U.S.C. § 254b)
  - Health Center program regulations (42 C.F.R. Part 51c)
  - Interpretative Material: *e.g.* PINs and PALs
  - Specific Award Conditions

SPECIFIC RESPONSIBILITIES OF THE HEALTH CENTER BOARD

- Meet monthly
- Establish appropriate committees
- Hire, annually evaluate, and if necessary dismiss the CEO
- Determine scope, location, and availability of services
- Development, adoption, and periodic updating of general policies and procedures of the health center:
  - Financial management practices: annual operating and capital budgets, schedule of charges and discounts, and collections policies
  - Personnel policies: selection and dismissal procedures, salary and benefit scale, and employee grievance procedures
  - Establish quality of care audit policies and quality assurance/improvement plan
  - Compliance program policies and procedures
- Approve the annual health center budget and audit

RESPONSIBILITIES OF THE BOARD CONT'D

- Provide regular Board training on appropriate exercise of authorities (including not overstepping roles)
- Evaluate Board procedures and performance periodically for efficiency and effectiveness
- Evaluate health center activities including services utilization patterns, productivity, patient satisfaction, achievement of the project objectives
- Conduct long-term strategic planning, including regular updating of the health center's mission, goals, and plans,
- Evaluate the health center's progress in meeting its annual and long-term goals
- Oversee Compliance Program implementation

DISTINGUISHING BOARD ROLES FROM MANAGEMENT ROLES

Board of Directors

- Determines mission and vision, goals and strategy
- Chooses direction, sets priorities, and makes policy
- Selects and oversees CEO
- Engages in strategic planning
- Establishes measures of accountability
- Evaluates health center performance
- Supports the CEO

Management

- Determines how to *accomplish* goals and strategy
- Implements procedures and necessary operational processes
- Selects and oversees health center employees
- Oversees and monitors daily operations
- Collects data regarding health center services and patients
- Provides Board with information and requests guidance

FOSTERING A RESPECTFUL BOARD-MANAGEMENT RELATIONSHIP

- The Board and the Management Team should:
  - Build trust and respect one another
  - Recognize their respective roles and limitations, and not "cross the line" or usurp each other's roles
    - Management should trust the Board to establish strategic priorities, make broad policy decisions, and approve key health center actions
    - Board should participate in reviewing and approving key actions of the health center, but delegate comprehensive day-to-day operational responsibilities to CEO and the management team

EFFECTIVE BOARD-MANAGEMENT COMMUNICATION

- Board and Management should always maintain coordination – work together with one voice and one intention
- Regular, effective, two-way communication is a "must"
- Work together to promote the health center by developing a clear and consistent message for the community, media, *etc*.
- Board should avoid the temptation to be an outlet for employees who want to "end run" the established processes

III. Hottest Compliance Topics

HIGH RISK AREAS

- "Rogue" conduct – Board members should not
  - Individually speak for or act in an official capacity on behalf of the health center unless specifically authorized to do so
  - Publicly disagree with decisions made or actions taken by the full Board and/or management
  - Usurp the CEO's authority or intervene in day-to-day administration of health center
  - Communicate with health center staff directly except as authorized
- Avoid "preferential" treatment
  - Scheduling patient appointments
  - Contracting with health center to provide goods/services
  - 340B
  - Other

HIGH RISK AREAS: CEO COMPENSATION PACKAGES & WAGE AND BENEFIT SCALES FOR OTHER PERSONNEL

- Health centers may pay reasonable compensation
- Comply with IRS requirements and the grant-related cost principles, as well as the HHS salary cap (applicable to expenditure of Federal grant funds)
  - Documentation of comparability
  - Include all compensation, including fringe benefits, incentives, *etc.*
  - No conflicts of interest
- Remember, ALL compensation must be considered, including: fringe benefits, insurance, car allowances, incentives, *etc.*

DISTINGUISHING BETWEEN LOBBYING AND POLITICAL ACTIVITY

- **Lobbying**: written or oral communication that is an attempt to influence (for or against) specific legislation, including referenda, initiatives, or similar ballot measures
    - Tax law: Health centers may lobby, within certain limits
    - Federal cost principles: federal grant funds may not be used to support the cost of lobbying activities
    - Education is not lobbying!
- **Political activity**: Health centers may not intervene in any election for public office or attempt to influence the outcome of any federal, state or local election
    - Board members can support or oppose candidates and engage in political process as individuals, **PROVIDED THAT** they do not act on behalf of the health center or use any health center resources

SECTION 330
GOVERNANCE HIGH RISK AREAS

Services

- #16: Scope of Project
- #2: Required & Additional Services

Management and Finance

- #7: Sliding Fee Discounts
- #10 & #11: Collaborations & Affiliations
- #12: Financial Management and Control Policies
- #14: Budget

Governance

- #17: Board Authority
- #18: Board Composition
- #19: Conflict of Interest Policy

SECTION 330 HIGH RISK AREAS

- **Scope of Project**
  - Maintain accurate and up to date Scope of Project
  - Ensure Board review and approval of: needs assessment findings; service area and target population; health center sites, services, and locations; and new grant application(s)
- **Required and Additional Services**
  - Ensure mix and level of services is consistent with needs assessment / strategic plan
  - Determine most effective mode of delivery for each in-scope service; can vary by site
  - Ensure contracted service arrangements, hospitalization and other referral arrangements are formalized and compliant

SECTION 330 HIGH RISK AREAS

- **Sliding Fee Discount Program**
  - Schedule of Charges should be consistent with locally prevailing charges and designed to cover the health center's costs
  - Evaluate Schedule of Discounts annually to ensure discount levels and/or nominal fee amounts do not create a barrier to care
    - No discounts for patients with annual income above 200% FPL
    - No more than a nominal fee for patients at or below 100% FPL
    - Fully charge all third-party payors
  - Ensure discounts offered by in-scope referral providers or pay the difference
  - Establish and/or review policies and procedures regarding:
    - Eligibility / income verification documentation
    - Waiver or reduction of fees for individuals who do not otherwise qualify for discounts
    - Partial payment / discount schedules and policies
    - Bad debt write offs and collection from self-pay patients

SECTION 330 HIGH RISK AREAS

- **Sliding Fee Discount Program (cont'd)**
  - Main goal is to improve access by minimizing financial barriers to care (*i.e.*, neither the fees nor the operational procedures should present obstacles) – BUT also have to maximize revenue – balance is key!
  - Patients must be made aware of the SFDP:
    - Use multiple methods to inform patients, including signage and registration process
    - Provide information in appropriate languages and literacy levels
  - **PIN 2014-02** provides guidance on the statutory and regulatory requirements to:
    - Establish and implement fee schedule and sliding fee discount schedule (SFDS)
    - Bill and collect payments from third party payors and patients
    - Ensure no denial of services due to inability to pay
    - PIN does not supersede:
      - Billing requirements under Medicaid, Medicare or other programs
      - Requirements specified in applicable Funding Opportunity Announcements or Notices of Awards

SECTION 330 HIGH RISK AREAS

- **Collaborations & Affiliations**
  - Structure affiliations / collaborations in compliance with all Section 330-related requirements and, as appropriate, procurement rules
  - Address concerns regarding potential service area overlap with other health centers

SECTION 330 HIGH RISK AREAS

- **Financial Management and Control Policies**
  - Ensure financial policies and procedures safeguard health center resources and prevent fraud, waste, and abuse
  - Maintain up-to-date grants management practices
    - Federal dollars and non-federal resources should be tracked separately and allocated appropriately
    - Procurements with federal dollars must be consistent with 45 C.F.R. Part 75
- **Budget**
  - Actively monitor health center budget and expenditures
    - Review monthly reports detailing cash/investments, assets, and liabilities
    - Follow up to ensure that any known issues have been resolved
    - Routinely evaluate whether the Board-approved budget supports the approved scope, locations, and schedule of services

SECTION 330 HIGH RISK AREAS

- **Board Authority**
  - Ensure bylaws are up to date with required provisions (see PIN 2014-01 and the Site Visit Guide)
  - Hold monthly meetings (no more waivers)
  - Determine which policies must be Board-approved, determining method and frequency for review and update, and **document** approval
- **Board Composition**
  - Ensure compliance with Section 330 composition requirements:
    - 51% consumers , demographically representative of patients served by the health center (see PIN 2014-01 definition)
    - Representation of special populations (*e.g.*, health care for the homeless)
    - No more than 50% of the non-consumer board members may derive more than 10% of their annual income from the health care industry
  - No Boardmember may be an employee or immediate family member of an employee of the health center

SECTION 330 HIGH RISK AREAS

- **Conflict of Interest Policy (or "Standards of Conduct")**
  - Adopt policies that define "conflict of interest"
  - Establish prohibitions regarding: gifts and gratuities, nepotism, and bribery
  - Establish procedures to disclose and manage potential or actual conflicts of interest and include a clear description of the consequences for violating the policies
  - Specifically consider the following risks:
    - Board members or immediate family members providing services to the health center
    - Confidentiality

IV. Best Practices for Governing Boards

EFFECTIVE RECRUITMENT

- Full Board should regularly review selection procedures:
  - Ensure procedures allow for a self-perpetuating Board, including periodic rotation in membership and leadership
  - Term limits?
  - Keep Section 330 composition requirements in mind
- Consider using a Board Development or Nominating Committee to oversee recruitment:
  - Identifying specific skill sets that new members should bring, considering strategic plan, Board self-evaluation, Section 330 requirements
  - Brainstorming possible sources of qualified candidates
  - Evaluating the qualifications of potential candidates
  - Nominating qualified candidates for selection

CONFLICT OF INTEREST DISCLOSURES

- Require written disclosure of a candidate's various affiliations (and those of immediate family members) so as to identify potential conflicts before (s)he is elected to serve on the Board
- Include a clear description of the consequences for violating the Policy
- As a Board, consider:
  - When should a conflict preclude nomination?
  - If proceed with nomination, what precautions should be taken to manage conflicts of interest?

INTERVIEWING PROSPECTIVE CANDIDATES

- Develop a formal Board member job description to share with prospective candidates:
  - Describe policies and expectations for Board members
  - Specify roles and responsibilities
  - Clarify distinctions between Board and management
  - Explain estimated time commitment:
    - Stress the importance of attending all monthly meetings in-person and reviewing reports provided ahead of time
    - Describe the time and effort involved in committee work
- Consider inviting prospective candidates to attend a Board meeting
- Even if they do not join the Board, non-Board members may add valuable expertise by serving on certain committees (provided bylaws permit)

BOARD MEMBER ORIENTATION AND EDUCATION

- Hold orientation session for new Board members:
  - Explain:
    - Board member roles and responsibilities
    - HRSA program requirements
    - Health center compliance program
    - Health center strategic plan
  - Consider who can best provide the orientation
  - Develop a Board member orientation manual
- Match new and seasoned Board members in a mentoring program
- Offer continuing education for all Board members to review:
  - Section 330 governance requirements and “high risk” areas
  - Financial policies and reports, quality assurance policies and reports, others

ENSURING A WELL-INFORMED BOARD

- Provide the right information at the right time:
  - Distribute materials well in advance of meetings to allow Board members adequate time to review:
    - Draft of previous meeting minutes
    - Updated financial statements (including budget-to-actual expenditures presentation)
    - Other materials relevant to specific agenda items
  - Be careful not to overwhelm with voluminous resources; separate required reading from optional reading

DEVELOP AN ANNUAL BOARD WORK PLAN

- Use an annual Board work plan:
  - Ensure work plan aligns with Board authorities outlined in the HRSA 19 Program Requirements
  - Distribute Board responsibilities evenly throughout the year
  - Include both short-term deadlines as well as guideposts for long-range goals
  - Allow for mid-course corrections: prepare to be nimble and respond to emergent issues and crises, as necessary
  - Conduct annual Board self-assessment

SOLICITING PATIENT FEEDBACK

- Institute formal processes to elicit patient input on a routine basis, including grievance process
- Document Board's receipt of input and application of input in Board's decisions regarding:
  - Selecting health center services
  - Changing and/or expanding operating hours
  - Opening a new site(s) or closing a site(s)
  - Quality improvement strategies

  Note: Board should not handle specific grievances, but should be advised of any patterns of complaints.

MAKING THE MOST OF BOARD MEETINGS

- Set a clear agenda and stick to it, but allow room on agenda for unanticipated new business, as necessary
- Record minutes, ensure Board reviews minutes at the next meeting
- Determine which issues need full Board discussion and which should be sent to committees
- Chair's role as facilitator:
  - Manage meeting and ensure that all agenda items are addressed
  - Encourage active participation by all Board members
  - No rubber-stamping; allow time for thorough discussion
- In exceptional circumstances where a full, in-person Board meeting is not feasible, if bylaws and state laws permit, meeting by conference call can substitute
- Move into **Executive Session** to discuss litigation, personnel, or other sensitive issues
- Emphasize confidentiality

USE COMMITTEES EFFECTIVELY

- Scope of Authority: except for the Executive Committee, HRSA expects that other committees will be authorized only to make recommendations to the full Board
  - Bylaws should authorize **Executive Committee** to conduct business that cannot be delayed until the next Board meeting
  - Periodically consider whether the standing and ad hoc committees are the right committees to support the Board's work and update the committee charges regularly
- Consider allowing non-Board members to serve on certain committees in the minority where that might add valuable expertise (not recommended for Executive or Compliance Committees)

ONGOING PROGRAM EVALUATION

- Measure and evaluate the health center's activities, including:
  - Service utilization patterns
  - Productivity
  - Patient satisfaction
  - Achievement of project objectives
- Evaluate Board procedures and performance periodically for efficiency and effectiveness

BOARD SELF-EVALUATION

- HRSA expects that the Board will conduct a self-evaluation to determine to what extent the Board fulfills all of its obligations
  - Create a realistic timeline for planning the process
  - Develop and review measurements and goals for Board self-evaluation
  - Evaluate Board against the job descriptions (individually) and the work plan (as a whole), internal goals
  - Analyze and share results with the full Board
  - Determine follow-up actions and/or a plan for improvement

EVALUATION OF THE CEO

- Health Center Program Requirement #17 explicitly requires performance evaluations of the CEO by the Board
- Hold CEO accountable for his/her duties and overall health center performance
  - Implementation of Board-approved policies
  - Day-to-day management of health center and staff
  - Overall operation of the health center (*e.g.*, daily functions, meeting the community's needs, and achieving organizational goals)
- Evaluation provides an opportunity to communicate:
  - Board's satisfaction (or dissatisfaction) with the CEO's performance and provide feedback necessary for improvement
  - CEO's management priorities and/or concerns

ANNUAL PLANNING FOR THE HEALTH CENTER

- Meaningful involvement of the Board in annual needs assessment and oversight of resulting action plans
- Evaluation of patient utilization and satisfaction
- Consider holding stakeholder meetings, focus groups, community forums

STRATEGIC PLANNING (EVERY 2-3 YEARS)

- Define/update health center mission and vision
- Set priorities and goals that support and further the mission
- Allocate resources accordingly

UPDATE HEALTH CENTER GOALS

- Set direction, priorities, goals and objectives to support and further the mission:
  - Measure and evaluate goals and objectives
  - Conduct ongoing review of health center mission and bylaws
  - Evaluate patient satisfaction
  - Monitor health center performance
- Ensure that priorities and goals are beneficial to the community being served:
  - What are the prominent issues confronting the community or special populations served?
  - Consider holding stakeholder meetings, focus groups, community forums

REPRESENTING THE HEALTH CENTER IN THE COMMUNITY

- The Board should
  - Approve and participate in appropriate lobbying activities to advance health center priorities
  - Act as advocates for the health center within the community, as authorized
  - Be involved in fundraising activities (but delineate Board-CEO roles)
  - Serve as the "public relations" arm of the center by reaffirming the mission to the public and getting input
  - BUT individual Board members should not speak for or act in an official capacity on behalf of the health center unless specifically authorized to do so
- The CEO should
  - Interact with the community, providers, and payors on a daily basis
  - Respond to business (and other) opportunities and plan for future events within the community
  - Keep the Board informed about what's going on and, as necessary, request direction and guidance

REPRESENTING THE HEALTH CENTER IN THE COMMUNITY

- Health centers are expected to play a broad role in the community:
  - Communicating with the public about personal health behaviors, health risks and consequences
  - Educating the public on available services
  - Seeking community advice on unmet needs in the service area
  - Identifying and meeting any special needs of the community (e.g., cultural, language, *etc.*)
- Together, the Board and the Management Team should:
  - Work to develop a clear and consistent message for the community, media, *etc.* that promotes the health center
  - Reaffirm, promote, and support the health center's mission and vision to the public

QUESTIONS?

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