NATIONAL ASSOCIATION OF
Community Health Centers®

GOVERNANCE GUIDE

FOR HEALTH CENTER BOARDS

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
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ABOUT NACHC

Established in 1971, the mission of the National Association of Community Health Centers (NACHC) is: *"To promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all."*

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NOTES:

Introduction

Boards of directors play a vital role in the overall success and sustainability of community health centers (health centers) serving high-need medically underserved areas and special populations (migratory and seasonal agricultural workers, homeless, and residents of public housing).

A strong board that understands its role and effective governance practices is better able to help its health center adapt and thrive in the changing and increasingly complex health care environment. This *Governance Guide for Health Center Boards* (*Governance Guide*) is designed as a resource for health center boards and board members. While the board's personnel oversight responsibilities extend only to the Chief Executive Officer (CEO), the CEO often designates staff to assist them in supporting the board; the CEO and such staff may also find this *Governance Guide* to be useful.

The *Governance Guide* addresses major areas of board responsibility and contextualizes them, where appropriate, in the requirements of Section 330 of the Public Health Services Act, and implementing regulations (42 CFR, parts 51c and 56), addressed in the Health Resources and Services Administration (HRSA) Health Center Program Compliance Manual (Compliance Manual) and relevant state and federal laws. In particular, the *Governance Guide* includes hyperlinks to the Compliance Manual, which are best utilized when reading an electronic version of this document.[1] The *Governance Guide* also reflects the latest effective governance practices for nonprofit boards. An Appendix at the end of this document contains key governance terms (Appendix 1).

Health centers may use this *Governance Guide* in a variety of ways:

- Individual board members or staff members may review the *Governance Guide* independently. Each chapter contains questions for reflection by individual learners.
- A board may opt to use this resource as part of its own ongoing board education. For example, a board may assign a chapter as a pre-read and have a conversation about the content at a board meeting or during a board retreat. Each chapter contains questions for reflection by the board.
- It can be used in conjunction with a facilitated board training.

Note: In the workbook the term "**health center**" refers to public or private nonprofit entities that: (1) receive an award under Section 330 of the Public Health Service Act (Section 330), including Sections 330(e), 330(f), 330(g) and 330(h) (collectively "Health Center Program Awardees"); and (2) entities that have been determined by the United States Department of Health and Human Services (DHHS) to meet the requirements to receive funding without actually receiving an award ("**look-alikes**").

[1] Links and citations were accurate at the time this document was written.

Health Center Program Overview

It is important for health center board members to have an understanding of the history of the health center Movement and knowledge of the Health Resources and Services Administration (HRSA) Health Center Program. This short section addresses:

A. A Brief History of Health Centers
B. A Brief Overview of the Health Center Program

A. A Brief History of Health Centers[2]

America's Health Centers owe their existence to a remarkable turn of events in U.S. history, and to a number of determined community health and civil rights activists who fought more than 50 years ago to improve the lives of Americans living in deep poverty and in desperate need of health care.

Among those determined to change these conditions was H. Jack Geiger, then a young doctor and civil rights activist who, while studying in South Africa with British public health experts Sidney and Emily Kark, witnessed how a unique community-based health care model had brought about astonishing health improvements for the poorest citizens of that country.

Moving on the opportunity presented by President Lyndon B. Johnson's major War on Poverty initiatives in the early 1960s, Dr. Geiger and other health care pioneers submitted proposals to the federal Office of Economic Opportunity to establish health centers in medically underserved inner city and rural areas of the country based on the same health care model Geiger had studied in South Africa. Funding for the first two "Neighborhood Health Centers" (as they were then called) – one in Boston, Massachusetts, and the other in Mound Bayou, Mississippi – was approved in 1965, and the Community Health Centers Program was launched. Drs. Count Gibson, John Hatch, and Robert Smith, among many others, played a critical role in the creation of the health center Movement.[3]

The Community Health Center Model was designed to remove barriers and challenges to care such as the lack of transportation, different languages, literacy, and race, by providing services in communities where people would otherwise not have access to doctors, primary care, and other essential health services. Community Health Centers were also among the first to go beyond the four walls of medicine to address the causes of chronic and poor health conditions such as nutrition and food insecurity, homelessness, dangerous environmental conditions, and unemployment.

In 1975, Congress passed legislation that authorized the creation of the nation-wide Health Center Program under Section 330 of the U.S. Public Health Service Act. The law specifically defined how organizations receiving grants under the Health Center Program should function. A unique and distinguishing element of health centers was, and remains, governance by consumer-majority governing boards.

Over 1,400 health centers serve as the primary medical home for more than 28 million people across America. Health centers enjoy longstanding bipartisan support by Administrations and policymakers at all levels, as well as in both the private and public sectors.

[2] This history is primarily from www.nachc.org and NACHC's *Community Health Forum*, America's Community Health Centers 50 Years (Spring 2015).

[3] Extensive additional resources and information on the health center movement's history can be found at https://www.chcchronicles.org/.

B. A Brief Overview of the Health Center Program

Under the Health Center Program, Congress appropriates federal dollars for awards to health centers and tasks the U.S. Department of Health and Human Services (DHHS) to oversee award-supported activities. Within DHHS, the Program is administered by the Health Resources and Services Administration (HRSA) through its Bureau of Primary Health Care (BPHC). Organizations that meet the requirements of the Health Center Program submit an application for funding and, based on availability of funds and an objective review of the application, HRSA may provide an award to help cover the costs of providing health care services in its community.

Health Center Program "look-alikes" are organizations which do not receive an award but are eligible for other benefits available to Health Center Program awardees.[4] The HRSA website notes: "Look-alikes were established to maximize access to care for medically underserved populations and communities by allowing entities that do not receive Health Center Program funding to apply to become part of the Health Center Program;" more information on look-alikes, including the application process, can be found on the HRSA website.[5]

Additional information about the Health Center Program can be found on the HRSA website (https://bphc.hrsa.gov/about/index.html).[6]

Health Center Program Compliance Manual

HRSA is responsible for monitoring awardees and look-alikes to assure that they are in compliance with certain applicable Federal laws, regulations, and policies. These requirements are addressed in HRSA's Health Center Program Compliance Manual (often referred to as the "Compliance Manual").[7] The Compliance Manual supersedes many former Policy Information Notices (PINs) and Program Assistance Letters (PALs), including PIN 2014-01: Health Center Program Governance.

Health Centers should now look to the Compliance Manual for all Health Center Program requirements including governing board-related requirements. Each program requirement-related chapter in the Compliance Manual includes various sections:[8]

- Authority: Lists the applicable statutory and regulatory citations.
- Requirements: States the statutory and regulatory requirements.
- Demonstrating Compliance: Describes how health centers would demonstrate to HRSA their compliance with the requirements.
- Related Considerations: Describes areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing a requirement.

It is important for boards to be familiar with the Compliance Manual in its entirety. In this *Governance Guide*, Chapter 19: Board Authority and Chapter 20: Board Composition of the Compliance Manual are highlighted because they are particularly applicable to boards; both of these chapters also include references to various other chapters that contain additional relevant details for boards.[9] Also of particular note to boards are Chapter 11: Key Management

[4] See Section 1861(aa)(4) of the Social Security Act.
[5] See https://bphc.hrsa.gov/programopportunities/lookalike/index.html for more information on look-alikes.
[6] For more information about the Health Center Program, visit https://bphc.hrsa.gov/about/index.html.
[7] HRSA's Health Center Program Compliance Manual can be accessed at https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html.
[8] Descriptions are from the "Introduction" of the HRSA Health Center Program Compliance Manual available at https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html.
[9] Chapter 19 of the HRSA Health Center Program Compliance Manual can be accessed at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-19.html#titletop and Chapter 20 can be accessed at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#titletop. Chapter 19 includes references to: Chapter 4: Required and Additional Health Services; Chapter 6: Accessible Locations and Hours of Operation; Chapter 9: Sliding Fee Discount Program; Chapter 10: Quality Improvement/Assurance; Chapter 12: Contracts and Subawards; Chapter 15: Financial Management and Accounting

Staff and Chapter 13: Conflict of Interest. Throughout this *Governance Guide,* excerpts from and hyperlinks to the Compliance Manual are included where relevant to board roles and responsibilities.

Operational Site Visit

HRSA conducts periodic site visits of health centers, called Operational Site Visits (OSV), as part of its oversight responsibility under the Health Center Program. HRSA's Health Center Program Site Visit Protocol (SVP) is the tool used to assess compliance with the Health Center Program requirements during such visits; the SVP establishes a standardized methodology for the OSV that aligns with the Compliance Manual.[10] Various governing documents, such as the bylaws and board meeting minutes are assessed during the OSV and board members participate in interview(s).

Public Health Center Governance

Public agencies, such as county or city health departments and universities, among others, may receive grant funding under the Health Center Program. As noted in Chapter 19: Board Authority, footnote 12 of the Health Center Program Compliance Manual: "Public agencies are permitted to utilize a co-applicant governance structure for the purposes of meeting Health Center Program governance requirements. Public centers may be structured in one of two ways to meet the program requirements: 1) the public agency independently meets all the Health Center Program governance requirements based on the existing structure and vested authorities of the public agency's governing board; or 2) together, the public agency and the co-applicant meet all Health Center Program requirements."

To learn more about public health center governance, see the Public Centers Monograph available from NACHC (https://mylearning.nachc.com).

Systems; Chapter 17: Budget; Chapter 18: Program Monitoring and Data Reporting Systems. Chapter 20 includes references to: Chapter 4: Required and Additional Health Services; Chapter 6: Accessible Locations and Hours of Operation; Chapter 9: Sliding Fee Discount Program; Chapter 17: Budget. The full Compliance Manual can be found at https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html.

[10] HRSA's Site Visit Protocol can be accessed at https://bphc.hrsa.gov/programrequirements/svprotocol.html.

Chapter 1:
The Role of the Health Center Board and Board Members

Executive Summary

The majority of health centers are incorporated in their respective states as a non-profit organization and have a board of directors which governs the organization. Governance refers to the legal process carried out by the board as a collective to ensure the efficiency and sustainability of the health center on behalf of the community it serves.

Health center boards must comply with relevant state and federal laws. As a condition of receiving an award under the Health Resources and Services Administration (HRSA) Health Center Program, health center boards must also follow various requirements of that program.[11] The most effective boards are also aware of and implement good governance practices.

This chapter discusses some of the fundamentals of governance. Specific topics include:

A. Health Center Board Roles and Responsibilities
B. Individual Board Member Duties and Roles
C. Governance versus Management
D. Pillars of High-Performing Boards

Tips for Using this Section

Using This Chapter as a Board

If your board is reviewing and discussing this chapter as a group, consider the following discussion questions:

- Is our board fulfilling its roles and responsibilities? What responsibilities do we want to learn more about?
- How are individual board members doing in fulfilling their responsibilities?
- How well do we understand the board's role versus that of the CEO (and staff)? If we tend to overstep and focus on tasks that should be handled by the CEO, how can we identify and address it as a group?
- What pillars of high-performing boards do we currently have in place? What practices of high-performing boards might we want to implement or learn more about?

Using This Chapter as an Individual

If you are reviewing this chapter on your own, consider the following questions:

- What did I learn from this chapter and how will it help me?
- What did I learn from this chapter that may be helpful to the board that I serve on or support?
- How well does the board I serve on or support understand its role versus that of CEO?
- What pillars of high-performing boards does the board I serve on or support not currently have in place that might enhance the board's performance?
- Would additional information be helpful and, if so, on what topics?

[11] For more information, visit https://bphc.hrsa.gov/.

A. Health Center Board Roles and Responsibilities

The vast majority of health centers are nonprofit organizations, which are required by law to have a board of directors that assumes fiduciary responsibility for the well-being of the organization. Governance is unique because authority is placed in the board of directors as a collective and this authority is exercised when the board formally convenes at its board meetings. The board steers the organization and provides oversight. Individual board members have duties and responsibilities (discussed later in this chapter) but alone have no authority for decision-making on behalf of the health center.

In general terms, a health center board's responsibilities fall into the areas below, which will also be discussed in greater detail in other parts of this *Governance Guide*. It is recommended that boards have a description that outlines the collective role of the board (see Appendix 2 for a sample).

- **Strategic Board Composition –** The board is responsible for its own size and strategic composition (ensuring the board meets requirements of the Health Center Program and is composed of members that can help the board govern now and in the future), recruiting and vetting board members, electing members, and ensuring board members are oriented and engaged. The board is also responsible for preparing and ensuring it elects board officers.

- **Strategic Planning and Strategic Thinking –** The board approves the health center's mission, vision, and values; engages in, approves, and provides oversight of the strategic plan; and engages in ongoing strategic thinking in partnership with the CEO.

- **Various Forms of Oversight –** The board provides oversight of various areas including financial, quality, corporate compliance, the Health Center Program, and the CEO. The board also assures plans are in place to manage risks faced by the health center.

- **CEO Oversight and Partnership –** The board hires the CEO, works with the CEO to establish annual performance goals, periodically evaluates the CEO's performance, approves the compensation of the CEO and the CEO's contract, and is responsible for partnering with the CEO to ensure day-to-day management is aligned with board-established priorities and policies.

- **Policies –** The board approves the organization's bylaws and other key policies.

- **Effective Board Functioning –** The board ensures its meetings and committee structure (if it opts to have committees) are effective, and that the board has a healthy culture. It also ensures that it understands and engages in good governance practices.

- **Resources and Partnerships –** The board helps ensure various types of resources for the health center, which may include reputational resources with the community and/or (optionally) financial resources if the organization engages in fundraising.

State and federal law establish parameters for how nonprofit corporation boards should be structured and function. Health center boards must also comply with additional requirements, most notably the HRSA Health Center Program requirements. These requirements are addressed in HRSA's Health Center Program Compliance Manual (often referred to as the "Compliance Manual").[12] It is important for boards to be familiar with the Compliance Manual in

[12] HRSA's Health Center Program Compliance Manual can be accessed at https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html.

its entirety. In the *Governance Guide*, Chapter 19: Board Authority and Chapter 20: Board Composition of the Compliance Manual are highlighted because they are particularly applicable to boards; both of these chapters also include references to various other chapters that contain additional relevant details for boards.[13] Also of particular note to boards are Chapter 11: Key Management Staff and Chapter 13: Conflict of Interest. Throughout this *Governance Guide,* excerpts from and hyperlinks to the Compliance Manual are included where relevant to board roles and responsibilities.

Public Health Center Governance
Public agencies, such as county or city health departments and universities, among others, may receive grant funding under the Health Center Program. As noted in Chapter 19: Board Authority, footnote 12 of the Health Center Program Compliance Manual: "Public agencies are permitted to utilize a co-applicant governance structure for the purposes of meeting Health Center Program governance requirements. Public centers may be structured in one of two ways to meet the program requirements: 1) the public agency independently meets all the Health Center Program governance requirements based on the existing structure and vested authorities of the public agency's governing board; or 2) together, the public agency and the co-applicant meet all Health Center Program requirements."

To learn more about public health center governance, see the Public Centers Monograph available from NACHC (https://mylearning.nachc.com).

B. Individual Board Member Duties and Roles

In nonprofit corporation law, individual board members each have legal responsibilities, commonly described as the:

- Duty of Care
- Duty of Loyalty
- Duty of Obedience

Carrying out these duties creates trust among board members, staff, and the community. Each may be applied in a court of law or by the Internal Revenue Service to determine if an individual board member acted properly. From a legal standpoint, a board member who does not abide by these duties could be considered negligent and personally liable for actions or inactions. More detail on each duty follows:

- **Duty of Care –** When engaging in health center business, board members must use good judgment and a level of care that an "ordinary prudent person" would exercise in a similar situation under like circumstances. Board members are not expected to know everything about a topic they are asked to consider and may rely on the advice of management and of outside advisors. But board members are legally expected to be aware of what is going on and to make reasonable inquiry so they can act in a manner that they reasonably believe is in the best interests of the health center.

[13] Chapter 19 of the HRSA Health Center Program Compliance Manual can be accessed at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-19.html#titletop and Chapter 20 can be accessed at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#titletop. Chapter 19 includes references to: Chapter 4: Required and Additional Health Services; Chapter 6: Accessible Locations and Hours of Operation; Chapter 9: Sliding Fee Discount Program; Chapter 10: Quality Improvement/Assurance; Chapter 12: Contracts and Subawards; Chapter 15: Financial Management and Accounting Systems; Chapter 17: Budget; Chapter 18: Program Monitoring and Data Reporting Systems. Chapter 20 includes references to: Chapter 4: Required and Additional Health Services; Chapter 6: Accessible Locations and Hours of Operation; Chapter 9: Sliding Fee Discount Program; Chapter 17: Budget. The full Compliance Manual can be found at https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html.

Examples of how a board member fulfills the Duty of Care include:
- Attend board and committee meetings.
- Be prepared for meetings. Read meeting packets completely before attending meetings.
- Think independently. Ask for training where particular skill sets are needed to thoughtfully review particular analyses and reports.
- Get all relevant data and information before making a decision or voting to take a specific action.
- Review health center finances, programs, and quality results on a regular basis.

- **Duty of Loyalty –** This duty prohibits board members from using their board positions to benefit themselves, their immediate family members, or their businesses. It requires that board members place the health center's needs and interests above all else when making decisions on behalf of the health center. This is demonstrated by being objective and unbiased when making decisions, being free of any conflict of interest when discussing issues or making decisions, and maintaining confidentiality when dealing with health center matters.

  Examples of how a board member fulfills the Duty of Loyalty include:
  - Review conflict of interest policies annually.
  - Require disclosure from candidates for board membership and annually for sitting board members to identify key affiliations, including immediate family members and employers.
  - Include a policy that when a conflict arises, any individual discloses the conflict and recuses themself from deliberation as well as the vote.
  - Avoid use of any board opportunities for personal gain or benefit.
  - Maintain confidentiality about patient and health center business matters at all times.

- **Duty of Obedience –** This duty requires board members to be faithful to the health center's mission; to follow all state, federal, and local laws; and to abide by board bylaws when representing the interests of the health center. This duty is demonstrated when board members protect limited resources to ensure the maximum benefit to meet the community's needs.

  Examples of how a board member fulfills the Duty of Obedience include:
  - Participate in a comprehensive orientation and understand all documents that pertain to board governance such as bylaws.
  - Understand the health center's mission and how it is being achieved by the health center.
  - Always act in a manner consistent with the health center's mission, goals, and objectives, as well as the decisions of the board (even if you disagree).
  - Advance the mission when representing the health center within the community (as authorized).

  In today's context, it is important to acknowledge that the term "obedience" can have many negative connotations and on its surface this term may be confusing when used in relation to board member responsibilities. What is most important to underscore about the intent of this duty is that board members must ensure the organization follows its own mission, policies, priorities, as well as applicable laws.

Each board member must keep the three "duties" front of mind in every interaction. These three duties apply to all decision making, to every action, and to strategic planning. Board members are responsible even if they do not attend meetings regularly or participate in the discussions.

Many boards will also have a list of individual board member responsibilities that it expects members to fulfill (see Appendix 3 for a sample). It is not uncommon for such tools to include elements that reflect the various legal duties of board members (e.g., attend board meetings); for a health center board, this document also often sets expectations on how members can share the unique perspective that both consumer board members and

community board members bring to the boardroom. Some boards ask members to annually review the list of Individual Board Member Responsibilities and sign an agreement indicating that they will fulfill them.

C. Governance versus Management

It has been said that "effective boards understand the difference between governing and managing."[14] It is important that boards and board members understand the board governs while the CEO is responsible for the overall management of the health center. The CEO is the only employee hired by and overseen by the board and the board delegates the day-to-day operational responsibilities to the CEO. Staff – led by the CEO – manage and implement the priorities and policies set by the board.

The following table illustrates some specific examples of the board's role versus that of the CEO.[15]

	Board /Governance	CEO/Management
Strategic Board Composition	• Ensures its own strategic composition • Ensures composition complies with requirements of the Health Center Program	• Supports board in ensuring its strategic composition, has voice in recruitment
Strategic Planning and Strategic Thinking	• Participates in establishing the strategic plan • Approves strategic plan • Monitors progress of strategic plan • Engages in ongoing strategic thinking	• Engages board and staff, as well as other stakeholders, in developing strategic plan • Implements strategic plan with staff • Works with board chair to include strategic issues on board agendas
Financial Oversight	• Approves budget • Monitors financials • Oversees audit • Approves certain policies	• Prepares and proposes budget to board along with key financial staff • Manages health center in alignment with financial policies and budget guidelines
Quality Oversight	• Approves and revises quality assurance (QA) and quality improvement (QI) policies • Ensures follow-up taken regarding quality, patient grievances, etc.	• Ensures staff manage the quality program
CEO & Staff	• Hires, provides oversight of CEO • Establishes CEO compensation • Approves certain personnel policies	• Hires, manages rest of staff • Coaches staff
Policy	• Approves bylaws and certain policies	• Makes recommendations to board regarding policy • Implements policies
Effective Board Functioning	• Ensures own functioning via effective meetings, committees, board culture • Demonstrates a commitment to effective governance practices	• Supports board in accomplishing work by helping focus on important issues, advising on trends and compliance, providing information, etc.
Ensuring Resources and Partnerships	• Supports positive reputation • Approves major partnerships	• Hires and oversees staff that handle communications • Manages partnerships

[14] Barry S. Bader, "Distinguishing Governance from Management," *Great Boards* (Fall 2008).

[15] This table originally appeared in a NACHC Community Health Institute & Expo session titled, "Building and Maintaining an Effective Board-CEO Partnership" (2018).

It is also important to note that there are areas of shared responsibility between a board and CEO. Both are participants in the governance process and steward resources, guide health center strategy, and ensure effective board functioning.

At times, it is possible for well-meaning board members to get "into the weeds" of operational details (sometimes called "micromanagement") creating frustration for the CEO and leaving "big picture" work unattended. It is important to remember that effective boards do not meddle or "micromanage."

Micromanagement can be caused by a variety of factors such as a lack of understanding of the board's role, a lack of board orientation to reinforce the board's role, and board member "interest" in operational issues. It is important for a board to have conversations about how it will manage such instances so it can employ agreed-upon techniques when or if micromanagement happens. Some boards rely on the board chair to point it out and redirect conversation while others empower all board members to identify this. Ongoing micromanagement can have significant adverse consequences and can result in CEO and board turnover as well as ineffective governance, so boards are encouraged to identify and address it when it does occur.[16]

D. Pillars of High-Performing Boards

In addition to fulfilling baseline board roles and responsibilities and complying with state, federal, and local laws, as well as the Health Center Program requirements, high-performing boards embrace effective governance practices. Some commonly agreed upon practices of high-performing boards include:[17]

- Board-CEO Partnership – The board and CEO understand that an effective partnership supports good governance and a strong health center. Key elements of a strong partnership include role clarity, mutual goals and accountability, open communication, trust, respect, and an ability to navigate difficult situations.

- Accountable to the Mission and a Focus on Organizational Sustainability – An effective board understands it has a fiduciary responsibility to make decisions in the best interest of the health center's stakeholders. The board reviews relevant data, considers various sides of an issue, and makes decisions that are both in alignment with the mission and focused on organizational sustainability.

- Strategic and Diverse Board Composition – A good board dedicates significant time and energy to recruiting the members it needs to govern the health center now and into the future. The ongoing work involved is delegated to a Governance Committee (or equivalent committee). Diversity is embraced and the board prioritizes inclusion among its members. Robust orientation and ongoing education ensure all members feel comfortable contributing to board oversight and strategic deliberations.

- Intentional Board Practices – An effective board is intentional about the structure of its meetings – ensuring that there is enough time for the board to carry out its duties and provide meaningful opportunities for board members to participate. The board is also intentional about designing a committee structure (if it opts to utilize committees) that supports the work of the board.

- Healthy Board Culture – An effective board is deliberate about defining its culture – which are the practices and norms the board will follow in carrying out its governance role.

[16] Melanie Lockwood Herman and Erin Gloeckner, "Let's Work Together: The Sweet Sounds of a Board-CEO Partnership" (available at www.nonprofitrisk.org).

[17] Based on and adapted from AHA Trustee Services, "Top Ten Principles and Practices of Great Boards" and BoardSource, *The Source: Twelve Principles of Governance That Power Exceptional Boards*.

- Ongoing Learning – A strong board undertakes a periodic self-assessment to reflect on how it can enhance its own performance. It dedicates time and resources to learning as a group and ensures members are informed about the health care environment in which the center is operating.

- Strategic Focus – An effective board spends significant time looking forward. It allocates time on board meeting agendas and at retreats to address strategic challenges and opportunities.

Chapter 2: Strategic Board Composition, Recruitment, Orientation, and Engagement

Executive Summary

A high-performing board consists of members who collectively have the competencies, values, and commitment required to govern the health center. The goal is to have a board that is diverse and independent that brings a broad range of perspectives to health center governance. Ideally, the board continually assesses its composition needs especially in the context of current and upcoming gaps, as well as in relation to the Health Resources and Services Administration (HRSA) Health Center Program and its requirements, and approaches member recruitment as an ongoing activity.

It is recommended that a board have a robust orientation that prepares members to immediately contribute to the board and a focus on ongoing board education. Additionally, it is important that a board consider how it will handle rotation and the inclusion of new voices and perspectives on the board. Finally, it is good practice to prepare and elect members to serve as board officers and committee chairs. While an overall board responsibility, this work is often delegated to the Governance Committee (sometimes called a Board Development Committee) that reports to the board.

This section covers the following topics:

A. Roles and Responsibilities Related to Board Composition
B. The Health Center Program and Board Composition
C. Identifying Board Composition Needs
D. Building a Pipeline & Recruiting and Vetting Board Candidates
E. Orientation and Mentorship
F. Ongoing Education and Engagement
G. Rotation and Term Limits
H. Officer Roles, Selection, and Succession

Tips for Using this Section

Using This Chapter as a Board

If your board is reviewing and discussing this chapter as a group, consider the following discussion questions:

- Does our board have a Governance Committee (or similar committee) that leads ongoing work related to strategic board composition, recruitment, orientation, education, and board rotation? If not, do we want to establish such a committee or expand the focus of an existing committee?
- Does our board take a strategic look at its future board composition needs when considering new members? What additional considerations might we focus on?
- How do we recruit new members? What is working? Are there any new practices we may wish to try?
- How effective is the board's current orientation? What is working? Are there any new practices we may wish to try?
- Does our board have a mechanism for board member rotation? Does the board have term limits? Why has it opted to adopt or forego this practice?

- Do we have a system in place to prepare future officers? What is our philosophy related to board officer succession?
- What additional topics would the board like to learn about?

Using This Chapter as an Individual
If you are reviewing this chapter on your own, consider the following questions:

- What did I learn from this chapter?
- What practices addressed in this chapter may be helpful to the board I serve on or support?
- Would additional information be helpful and, if so, on what topics?

A. Roles and Responsibilities Related to Board Composition

Subject to the Health Center Program requirements, discussed in the next section of this chapter, the board is responsible for its own composition. It is recommended that a board ensure it has proactive efforts to: assess and identify future board composition needs; build a pipeline of candidates; vet and prepare candidates for the board; train and engage members once on board; and ensure rotation to provide a mechanism to bring new ideas and perspectives to the board.

It is recommended the focus on board composition, recruitment, orientation, and rotation no longer be episodic work but rather an area of ongoing focus. If a board makes use of standing committees (discussed in greater detail in Chapter 9 of the *Governance Guide*), it is widely considered to be a good governance practice for a board to form a Governance Committee (sometimes called a Board Development Committee) that is responsible for identifying future board composition needs and building a pipeline of candidates.[18] This committee also often leads efforts essential for member onboarding and retention, including board member orientation, the board self-assessment process, board member mentoring programs, and educational programs aimed at strengthening the work of the board. For years, boards had Nominating Committees tasked with episodic recruitment and nominations of new board members. While not required, a board may wish to consider forming a Governance Committee or transitioning a Nominating Committee into a Governance Committee (or equivalent).

The following table outlines good practices for the role of the board, board members, Governance Committee (or equivalent), and CEO related to board composition and succession.

Role	Responsibilities
Board	• Ensure that board composition and succession is an ongoing focus • Consider establishing a committee to lead the work • Vote on slate of candidates (often recommended by the Governance Committee or an equivalent committee) • Decide on the board's approach to rotation and renewal
Board Members	• Serve on the Governance Committee based on interest and committee assignments • Recommend board members (note: It is important to be sure members understand that they may recommend candidates but not extend an invitation to serve; the authority for selecting members rests with the board)
Governance Committee	• Assess board composition needs with board input • Identify, recruit, and vet possible members • Organize board member orientation and board mentoring programs

[18] BoardSource, *Leading with Intent: 2017 National Index of Nonprofit Board Practices* and BoardSource, "Recommended Governance Practices" available on www.boardsource.org.

Role	Responsibilities
(or equivalent; this type of committee is recommended, but not required)	• Facilitate the board self-assessment process • Collaborate with the CEO and board chair on ongoing board education aimed at strengthening the work of the board • Focus on developing a pipeline of board officers and committee chairs • Present a slate of new members and board officers to the board for vote when needed and required by the bylaws
CEO[19]	• Partner with the board in providing critical input and support throughout the board recruitment, orientation, and succession processes • Provide input on board recruitment • Participate in conversations with prospective members • Play key role in new member orientation • Assign other staff leaders to work closely with the Governance Committee • Serves as an ex-officio non-voting member of the board

B. The Health Center Program and Board Composition

The HRSA Health Center Program Compliance Manual (Compliance Manual) sets forth a number of requirements that health center boards must comply with related to board composition in Chapter 20: Board Composition. An excerpt from the Compliance Manual that discusses how a health center would demonstrate compliance with these requirements is included below for ease of reference.[20]

Excerpt from HRSA Health Center Program Compliance Manual, Chapter 20: Board Composition. Please note the footnotes in this excerpt are from and link directly to the Compliance Manual.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center has bylaws or other relevant documents that specify the process for ongoing selection and removal of board members. This board member selection and removal process does not permit any other entity, committee or individual (other than the board) to select either the board chair or the majority of health center board members,[7] including a majority of the non-patient board members.[8]
b. The health center has bylaws or other relevant documents that require the board to be composed as follows:
    - Board size is at least 9 and no more than 25 members,[9] with either a specific number or a range of board members prescribed;
    - At least 51% of board members are patients served by the health center. For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved scope of project;
    - Patient members of the board, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender;
    - Non-patient members are representative of the community served by the health center or the health center's service area;
    - Non-patient members are selected to provide relevant expertise and skills such as:

[19] BoardSource, "CEO "Do's and Don'ts" https://boardsource.org/wp-content/uploads/2017/01/CEO_Dos_Donts.pdf.

[20] For more information see the HRSA Health Center Program Compliance Manual, Chapter 20 at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#titletop.

        - Community affairs;
        - Local government;
        - Finance and banking;
        - Legal affairs;
        - Trade unions and other commercial and industrial concerns; and
        - Social services;
    - No more than one-half of non-patient board members derive more than 10% of their annual income from the health care industry; and
    - Health center employees,[10] [11] and immediate family members (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage) of employees may not be health center board members.

c. The health center has documentation that the board is composed of:
    - At least 9 and no more than 25 members;
    - A patient[12] majority (at least 51%);
    - Patient board members, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender, consistent with the demographics reported in the health center's Uniform Data System (UDS) report;[13]
    - Representative(s) from or for each of the special population(s)[14] for those health centers that receive any award/designation under one or more of the special populations section 330 subparts, 330(g), (h), and/or (i); and
    - As applicable, non-patient board members:
        - Who are representative of the community in which the health center is located, either by living or working in the community, or by having a demonstrable connection to the community;
        - With relevant skills and expertise in areas such as community affairs, local government, finance and banking, legal affairs, trade unions, other commercial and industrial concerns, or social services within the community; and
        - Of whom no more than 50% earn more than 10% of their annual income from the health care industry.[15]

d. The health center verifies periodically (for example, annually or during the selection or renewal of board member terms) that the governing board does not include members who are current employees of the health center, or immediate family members of current health center employees (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage).

e. In cases where a health center receives an award/designation under section 330(g), 330(h)and/or 330(i), does not receive an award/designation under section 330(e), and requests a waiver of the patient majority board composition requirements, the health center presents to HRSA for review and approval:
    - "Good cause" that justifies the need for the waiver by documenting:
        - The unique characteristics of the population (homeless, migratory or seasonal agricultural worker, and/or public housing patient population) or service area that create an undue hardship in recruiting a patient majority; and
        - Its attempt(s) to recruit a majority of special population board members within the past three years; and
    - Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following elements:
        - Collection and documentation of input from the special population(s);

- Communication of special population input directly to the health center governing board; and
- Incorporation of special population input into key areas, including but not limited to: selecting health center services;[16] setting hours of operation of health center sites;[17] defining budget priorities;[18] evaluating the organization's progress in meeting goals, including patient satisfaction;[19] and assessing the effectiveness of the sliding fee discount program.[20]

f. For health centers with approved waivers, the health center has board minutes or other documentation that demonstrates how special population patient input is utilized in making governing board decisions in key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization's progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the sliding fee discount program.

Special Population Input
The excerpt of the Health Center Compliance Manual (above) addresses various requirements related to special population representation on boards of health centers that receive funding or designation under sections 330(g), (h), or (i) of the PHS Act. In cases where a health center receives a waiver related to special population representation on its board, it is required that other mechanisms be utilized to gain input from the special population on health center strategy and policy. The health center has discretion over ways to surface this input; some opt to use an advisory council or hold focus groups with representatives of the special population.

C. Identifying Board Composition Needs

There are various items a board must consider related to composition – including board size, demographics, and the personal and professional competencies needed by the board.

Thinking Strategically About Board Size

As noted above, Chapter 20: Board Composition of the Compliance Manual specifies: "Board size is at least 9 and no more than 25 members" and goes on to note the board may either select "a specific number or a range of board members."[21]

The following considerations may be helpful when considering or reflecting on board size:

- *Specifying a Range of Members versus a Number of Board Members* – Including a range of board members (e.g., 9-13, 11-15) in the bylaws provides a board with more opportunity to be flexible in case of unanticipated board member departures and/or in case the board wants to strategically size up or down.

[21] For more information see the HRSA Health Center Program Compliance Manual, Chapter 20 available at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#titletop.

- *Board Size* – Research demonstrates that the average size of a nonprofit board is 15 members[22] and one study suggested that the average health center board was 12 to 13 members.[23] Ideally a board identifies a size range that allows it to effectively exercise its various oversight and strategic duties, ensure critical diversity and expertise on the board, enable each member to actively contribute, and is manageable such that the board can ensure robust dialogue in the boardroom.

Health center boards will want to be cautious about having 9 board members; if a member leaves for any reason, the board will immediately be out of compliance with the Health Center Program requirement related to board size.

Considering the Composition Needs of the Board

All board members – whether they are community or patient members – are multi-dimensional individuals that bring their own experiences, personal and professional backgrounds, and connections to contribute to the success of the board.

Often, the Governance Committee (or equivalent committee) takes a strategic approach when identifying future board composition needs. The Governance Committee may want to periodically – meaning at least annually – assess the board's current composition, consider planned rotation, and anticipate the future needs of the board based on such factors as:

- Health Center Program Requirements – Are we meeting the board composition requirements? Has the center's scope of service changed? Are we serving a new special population (e.g., homeless people, migrant and seasonal farm workers, or people living in public housing) that impacts the type of representation we need on the board?

- Planned and/or Anticipated Rotation – What members are slated to rotate off the board? What gaps might this create on the board?

- Health Center Strategic Plan – What types of new or different expertise or connections in the community may be helpful to have on the board given items in the health center's strategic plan?

- Changing Community Needs – What changes or shifts are occurring in the community? What new or different types of community perspectives may be helpful to the board?

- Other Demographics and Diversity – In addition to considering race, ethnicity, and gender when selecting its board members, the health center board can determine other relevant demographic or geographic factors to consider when selecting patient or non-patient board members. What other forms of diversity are important to the board and why? Some boards, for example, are committed to focusing on age diversity and the next generation of board leaders.

- Health Care Landscape – The health care landscape is constantly evolving. What type of expertise might be helpful to the board (keeping in mind the limitations on the percentage of community board members who can earn a portion of their personal income from the "health care industry")?

- Needed Expertise – Many boards find certain types of experience helpful to have on the board so members can provide a particular perspective in board discussions. For example, many boards opt to have at least some members with deep financial knowledge. Is any particular expertise needed or is the board anticipating a member to rotate off who brings important expertise?

[22] BoardSource, Leading with Intent: 2017 National Index of Nonprofit Board Practices available at www.boardsource.org.

[23] Brad Wright, "Who Governs Federally Qualified Health Centers," *Journal of Health Politics, Policy and Law* (October 10, 2012).

- Needed "Soft Skills" – Increasingly, boards are looking for members who can think strategically and, in the health care sector, members who are comfortable with ambiguity and making decisions at times with incomplete information given the pace of change in the sector.

Board Matrix

Many boards utilize a grid – often called a matrix – that helps them keep track of current members, member terms, member type (e.g., patient or community member), the professional backgrounds of members, patient demographics or other demographics desired by the board, connections members may have, along with leadership skills needed on the board (see Appendix 4 for a sample).

Looking at current composition, anticipated rotation, and considering future needs helps define board recruitment priorities. However, it is important that the matrix not become a static document but rather that the Governance Committee (or equivalent committee) – with board input – periodically update this tool based on the changing healthcare environment and changes in the community, as well as the health center's strategic plan.

D. Building a Pipeline & Recruiting and Vetting Board Candidates

Identifying the types of members that a board needs helps the Governance Committee build a pipeline of candidates. Reaching out to multiple networks and finding members from various sources is important during this phase.

Patient Members

Training health center staff on the importance of patient board members, what the board currently needs related to consumer members, and training staff on how to start a conversation with a patient who may be a good fit for the board are helpful techniques to employ.

One health center uses various techniques to build a pipeline of possible patient board members.[24] The health center leverages an internal recruitment orientation to ensure health center staff are routinely informed about future board composition needs. If a clinician, for example, recognizes a patient that could potentially be an ideal candidate for the board, they may discuss this possibility of such an opportunity with the patient and convey any interest to senior staff who in turn can inform the board. This health center also has strong existing partnerships with organizations in its service area that support agricultural workers; it turns to these partners for recommended candidates to be approached and considered as a representative of this special population on the board.

Community Members

Various channels may be used to find non-consumer board members from the community that meet the needs of the board; a committee may:

- Ask current board members, committee members, and staff for suggested candidates but do not stop there
- Reach out to organizational partners and social service organizations to solicit recommendations of candidates with needed backgrounds or skills
- Contact the state Primary Care Association for suggestions
- Reach out to local associations or community organizations for suggestions
- Talk with businesses or other related organizations in the community that may encourage staff members to serve on boards in the community
- Leverage relationships with those in the health care sector

Having non-board members serve on board committees, when permitted by state law, can also be a good way to engage and vet possible future board members.

[24] For more information, see NACHC, "Governing Board Succession Planning: A Case Study on Cherry Health" (2018) available on http://mylearning.nachc.com.

Once identified, invite candidates to submit a background information form or resume developed by your health center (see Appendix 5 for an example).

It is ideal to have several conversations about board service as part of the recruitment and candidate vetting process. CEO involvement and getting the CEO's input during this phase is crucial. Asking candidates a core set of questions can help the Governance Committee (or its equivalent) compare prospective members (see Appendix 6 for sample questions). The following tips may be helpful to consider:

- Talk candidly about board responsibilities and be sure the candidate is able to fulfill them
- Explore the candidate's interest and motivations for serving on the board
- Take time to answer questions they may have

Some boards also utilize a ratings form to capture information on conversations with candidates and to use when the Governance Committee formulates a slate of board members to present for the board's vote and approval. [25]

Board Member Background Checks
While it may be an uncomfortable topic, it is a good practice for the board to have a policy in place that addresses background checks for board members. These can be conducted prior to inviting an individual to formally join the board and periodically throughout a member's service.

As part of this policy, it is important a board require checking members against the Office of the Inspector General's exclusion list – which lists individuals and entities excluded from Federally funded health care programs for various reasons such as a conviction for Medicaid or Medicare fraud – so as not to put the center's federal award at risk.

It is important to seek permission of potential and current board members prior to undertaking such checks. It is also suggested that a health center consult with qualified legal counsel about any requirements or restrictions on this process in the state in which the health center is based.

E. Orientation and Mentorship

Once elected to the board, it is important to orient new board members. It is good practice to have a multi-faceted approach that might include:

- Providing the board's handbook – The handbook may include items such as:[26]
  - Mission, vision, and values statements
  - Organizational chart
  - A copy of the health center's articles of incorporation and bylaws
  - A copy of the board of director role description
  - A copy of the health center's expectations of individual board members
  - Board roster (list of all members and contact information)
  - Committee descriptions, chairs and co-chairs/vice chairs, and committee assignments

[25] BoardSource has a "Candidate Rating Form" as publicly available resource on its website at https://boardsource.org/wp-content/uploads/2016/10/board-candidate-rating-form-new.pdf.

[26] List adapted and updated from NACHC resource, "Developing and Maintaining Effective Health Center Boards of Directors," written for NACHC by Marcie H. Zakheim, Esq. with Feldesman Tucker Leifer Fidell.

- Current board and committee meeting calendars
- Copy of the strategic plan
- A copy of the health center's conflict of interest policy and annual disclosure form
- Copies of relevant statutes, regulations and guidance from the U.S. Department of Health and Human Services and key state agencies – such as, Section 330, Health Center Program Compliance Manual
- A copy of minutes from the board meetings from the last six months to one year
- A copy of the budgets
- A copy of the most recently submitted Section 330 Service Area Competition application or look-alike designation application (as applicable), as well as other relevant submissions to HRSA since submission of the last full application
- A copy of the last set of audited financial statements
- A copy of the current Quality Assurance / Quality Improvement plan and sample Quality Dashboards (if relevant)
- Information on the health center's corporate compliance program and risk management plans
- As applicable, a copy of the current board work plan and/or a board culture statement
- Any other information that the board feels is appropriate

- Having in-person orientation session(s) with the board chair, CEO, and others as relevant – In-person orientation – which may be one long session or several shorter sessions – can review and underscore information in the board handbook but can also go a step further to equip board members with the knowledge and skills needed to begin contributing immediately during board meetings. Topics to address may include:
  - the requirements the board and health center must fulfill based on receiving federal funding,
  - how to read financial reports and quality data,
  - the board's culture and nuances about serving on a board – including that it is a group of equals where everyone has one vote,
  - health center issues and trends,
  - health care industry issues and trends,
  - particular opportunities and challenges facing the health center so that the member feels comfortable contributing immediately to any dialogue or discussion.

  Some boards invite all members to attend in case individuals may find the additional education to be helpful.

- Supporting a mentor or board buddy program – Assigning new board members a mentor or buddy who has served on the board for a period of time can be a tool for helping new members become comfortable in their board role. Often the mentor/buddy will call the new member in advance of their first meeting to answer questions and sit next to them during the new member's first few meetings so they can ask questions or provide additional information. Having an informal "sounding board" can be helpful to a new member especially for individuals who have never served on a board or who are new to health centers. Below are a few considerations:[27]

  - Mentor Role – A mentor can help a new board member learn about the board and how it operates. They can help provide some of the overarching context for board discussions, provide support, and help the mentee set expectations.

  - Mentee Role – A mentee is ideally committed to learning more about their role on the board, respects the mentor's suggestions, and appreciates the mentorship relationship.

[27] Considerations are adapted from a presentation at NACHC's CHI 2017 on "Using Mentors to Engage Consumer Board Members" by Kimberly McNally, McNally & Associates.

– Determine parameters for the relationship – It can be helpful to determine the goals of the relationship, how often to meet (e.g., once a month), how meetings will be scheduled, and create a process for checking in on the relationship.

F. Ongoing Education and Engagement

Allocating time for ongoing board education is critical for a few reasons. First, effective governance takes work and periodically talking about different facets of governance is good practice for any board. Additionally, the complexity of the health care and regulatory environments in which health centers operate mean there is continuous need to share information with boards.

Topics for board education may be identified based on:

- Board Self-Assessment Results: A board's self-assessment may reveal areas in which a board rates its performance low and/or identify areas of training that may be helpful. See Chapter 10 of the *Governance Guide* for a discussion of Board Self-Assessments.
- Future decisions: What decisions does the board need to make in six to twelve months that require up-front education? Is the health center, for example, considering joining an Accountable Care Organization?
- Changing health care landscape: What changes in the community, health care sector, and/or regulatory landscape does the board need to know about?

Some boards allocate time before or during board meetings or during board retreats for such education. Appendix 8 includes a list of Board Member Competencies which can be referenced for skills/knowledge board members may need and can serve as a resource for providing ideas on board education topics.

G. Rotation and Term Limits

Every board can decide how it will approach rotation and renewal on the board, including whether it will adopt term limits. While term limits are a good practice, they are not a required practice and each board will want to consider whether or not to adopt them if it has not done so already.

Adopting Term Limits

It is worth noting that "term limits have become the norm" among U.S.-based nonprofit organizations with 72% of boards adopting this practice and term limits are generally a recommended governance practice.[28] Term limits provide a mechanism to bring new ideas and new perspectives to the board and its decision-making; they also create the opportunity to adjust the board's membership to align with the organization's changing needs.

Of those boards that have term limits, the most common configuration is two, three-year terms.[29] Some boards opt for three, three-year terms and still others have an initial year-long term followed by two or three longer terms with the rationale that an initial year-long commitment allows both the member and organization time to try out the fit.

Once the term allotment is complete, some boards require members come fully off the board for at least a year but, allow former members to be considered for membership again once that period has passed. In order to realize the benefits of rotation, however, it is important to use this option sparingly and for the truly exceptional board members whose background and skills meet the future needs of the board.

At times, boards and board members resist term limits; for example, boards may fear losing a valued member and board members rotating off may fear losing a connection to members staying on and/or no longer being of service

[28] BoardSource, *Leading with Intent: 2017 National Index of Nonprofit Board Practices* and BoardSource, "Recommended Governance Practices" available at www.boardsource.org.

[29] BoardSource, *Leading with Intent: 2017 National Index of Nonprofit Board Practices* available at www.boardsource.org.

to the health center. However, there are many ways that former board members can stay connected to the health center. For example:

- Committees – Former members may serve on board committees if service by non-board members is permitted by state law and the health center's bylaws.
- Foundation Board – If the health center has a connected Foundation, former health center board members may be a good fit for that board.
- Fundraising and Advocacy – Board members are often some of a health center's best ambassadors. Engaging former members in fundraising and/or allowable advocacy efforts can be a great way to continue to utilize this critical skill set.

A board instituting term limits for the first time will want to divide the board into groups so that all members do not have terms that expire at once. For example, the board may be divided into three groups that are slated to rotate off in different years (e.g., group 1 has terms that expire in 1 year, group 2 has terms that expire in 2 years, group 3 has terms that expire in 3 years).

Opting Not to Adopt Term Limits

Some boards opt not to adopt term limits – often because the board values the institutional memory of longer-serving members. One board that does not have term limits ensures that its board culture emphasizes active and engaged participation, ensures a robust vetting process is in place so that it brings on members who will actively participate, and has various mechanisms for removing members who are not meeting expectations and/or attending meetings.

Generally, a board without term limits will want to pay attention to signs that it may need to revisit the issue. If the board is experiencing stagnation, power is concentrated with a few members, or new members are not welcome or do not stay, revisiting this issue can help. The purpose is not term limits for the sake of rotation but rather to build systems and structures that allow the health center to thrive now and in the future.

Removing Board Members

Regardless of whether or not a board adopts term limits, the health center bylaws or other relevant documents must specify a process for the removal of board members. The following excerpt is from the Health Center Compliance Manual, Chapter 20: Board Composition, Demonstrating Compliance, a:

> "The health center has bylaws or other relevant documents that specify the process for ongoing selection and removal of board members. This board member selection and removal process does not permit any other entity, committee or individual (other than the board) to select either the board chair or the majority of health center board members, including a majority of the non-patient board members."

A health center can define the criteria for removal and it is considered good practice to include a provision that allows board members to be removed if they are not fulfilling their duties. For example, a board may wish to specify that members that miss a certain number (e.g., four) consecutive board meetings without providing notice shall be deemed to have resigned.

No automatic re-election

Some boards establish culture of "no automatic re-election" – meaning that before a member can be re-elected to another term (if eligible) there is some assessment of whether the board member wants to continue serving, is fulfilling board member responsibilities, and is the right fit for the board's needs. The individual board member assessment (discussed in Chapter 10 of the *Governance Guide*) can be a tool for informing such discussions and decisions.

Starting a Conversation about Term Limits

If your board has not previously adopted term limits and has members who have served for 10 or more years, the thought of discussing term limits may be too uncomfortable to raise. However, it is a board's responsibility to address important issues regardless of level of difficulty. These conversations can be broached in a way that still honors and respects the many contributions of long-serving members.

The following questions may help:

- What have our long-serving members brought to the health center? What would it mean for the board if long-serving members were to rotate off of the board and serve the health center in other ways? What might we lose?
- What might we gain from instituting rotation and making room for new members?
- What might we have missed out on by not creating space for new members?
- How can we continue to engage members that rotate off?

H. Officer Roles, Selection, and Succession

Board officers play an important role in leading the board and ensuring it is governing effectively.

Officer Roles

Boards typically have officers who provide leadership to the board. Common roles include:

- Chair – The chair leads board meetings and provides overall leadership of the board. The chair partners with the CEO to design board meeting agendas and takes the leadership in building a strong partnership with the CEO. Appendix 9 lists key board chair competencies.
- Vice Chair – The vice chair supports the chair and fills in when the chair is unable to carry out duties.
- Secretary – The secretary ensures board actions are recorded – which may involve taking minutes or, more likely, reviewing minutes taken by staff, among other duties.
- Treasurer – The treasurer chairs the Finance Committee and provides board leadership related to financial oversight.

Often, officers are assigned to chair particular committees (e.g., the Treasurer chairs the Finance Committee). Additional members of the board may serve as committee chairs as well and these individuals also play a critical role in the overall efficacy of the board's committees.

Officer Selection

Typically, the formal process of identifying officers is guided by the Governance Committee (or equivalent committee) which presents a roster for board approval.

Officer Succession[30]

Many boards implement term limits for officers which is also considered a good governance practice. Terms vary and are selected by each individual board; for example, a board may implement limits of two consecutive two-year terms. This does not preclude a member from serving in the role again after stepping away for a period of time; in particular, a former board chair may be nominated to serve in the role again during challenging times such as in cases of emergency or crisis for the organization (e.g., unplanned CEO transition).

[30] Information in this section related to officer succession is adapted from a NACHC Webinar titled, "Board Chair Succession" completed by Kimberly McNally, McNally & Associates (2018) available on http://mylearning.nachc.com/.

Just as a board plans for rotation among its members and takes action to plan for CEO succession (discussed in Chapter 7 of the *Governance Guide*), proactively addressing officer succession helps assure leadership continuity, promotes strength through diversity, provides leadership stability, and illustrates the importance of this practice throughout the organization.

Ideally the board will make a commitment to identify and develop potential new board officers ahead of vacancies. This process may entail:

- Ensuring roles are clearly defined and role descriptions are written down.
- Identifying board members who are potential successors to the chair and other officers; this entails both helping those interested in such roles develop skills as well as encouraging members who may not naturally consider such a role to consider them.
- Recognizing gaps between current sets of competencies and competencies required to credibly step up to chair position, and actively investing in opportunities to develop necessary perspectives and skills to assume future leadership positions.
- Focusing on future potential board leadership as the board recruits.

The goal is not to identify a single leader, but rather to have several board members in leadership "pipeline" at all times. Appendix 10 contains a sample board officer succession plan.

Addressing Board Chair Succession

If your board has a dedicated and long serving board chair, it may have some difficulty in broaching officer succession. Some common challenges include:

- Other board members may wonder how they could ever fill the capable shoes of the current chair. In such instances, a candidate for board chair can shadow the current chair for a year – participating in meetings with the CEO, helping to plan agendas, and even facilitating board meetings. Some boards use a "chair-elect" designation to denote this approach.
- Boards may be hesitant to raise the issue with a beloved, long-serving, and strong chair. In such circumstances, it may help to consider questions such as: What risks do we face if we don't have this conversation? Don't we want to model effective succession planning for the CEO?

Talking about rotation and succession does not in any way diminish the significant and meaningful contributions of long-serving leaders.

Source: Information in this section related to officer succession is adapted from a NACHC Webinar titled, "Board Chair Succession" completed by Kimberly McNally, McNally & Associates (2018) available on http://mylearning.nachc.com/.

Chapter 3: Financial Oversight

Executive Summary

The board has a fiduciary responsibility for the health center – it oversees the ongoing sustainability of the organization so that the health center can continue to fulfill its mission. Accordingly, the board should ensure that health center activities are conducted in a manner that achieves operating results (operating income and cash flow) sufficient to sustain the organization financially. Collectively, the board approves and monitors the budget, regularly reviews financial status, ensures financial controls are in place, reviews the results of the audit to ensure appropriate follow-up actions are taken and approves the audit, and approves important financial policies. All board members must be able to understand basic financial terminology, review and understand financial statements, monitor financial performance, and to ask questions in order participate in making informed decisions that will benefit the organization.

This section covers the following topics:

A. Financial Roles and Responsibilities
B. The Health Center Program and Financial Oversight
C. Approval of the Budgets
D. Monitoring Financial Performance & Financial Status
E. Accounting and Internal Control Systems
F. Approving Policies
G. Audit
H. IRS Form 990
I. Strategic Financial Planning

Tips for Using this Section

Using This Chapter as a Board

If your board is reviewing and discussing this chapter as a group, consider the following discussion questions:

- Is the board fulfilling all of its duties related to financial oversight?
- Would additional information be helpful and, if so, on what topics?

Using This Chapter as an Individual

If you are reviewing this chapter on your own, consider the following questions:

- What did I learn from this chapter?
- What did I learn from this chapter that may be helpful to the board I serve on or support?
- Would additional information be helpful and, if so, on what topics?

A. Financial Roles and Responsibilities

Board members are stewards of the health center's finances and must act with care to avoid harm to the health center and the investment of public dollars in the organization. Sometimes board members assume that ensuring financial health is the responsibility of the CEO and the CFO and/or the treasurer and Finance Committee. However,

that assumption is not correct. A board is not fulfilling its fiduciary or strategic responsibilities when it passively accepts finance reports or defers to management or a subset of the board to solely monitor finances.

By learning the basics of health center finance, board members are able to provide proper oversight to ensure the health center's future. All board members must be able to understand basic financial terminology, review and understand financial statements, monitor financial performance, and above all, to ask questions in order to judge financial soundness and ultimately make informed decisions that will benefit the organization.

It is critical that both board and staff act as good stewards of the health center's financial and other resources and that such resources – whether they come from public funds, private donations, or other sources of income – are used efficiently and in support of the health center's mission.

The following table outlines good practices for the role of the board, board members, Finance Committee, Audit Committee (if the board has this committee), Treasurer, and staff related to the health center's financials.[36] It is important to check laws in the state in which the health center operates to see if a separate Audit Committee is required; it is also considered a good governance practice to separate the Finance and Audit Committees if the organization conducts outside audits.[37]

Role	Responsibilities

Board	• Approve budget and monitor budget
	• Review financial status of the health center through regular review of:
	  • Income statement
	  • Balance sheet
	  • Cash flow statement
	• Ensure financial controls are in place
	• Review audit, meet in executive session with the auditor
	• Approve policies and update policies that support financial management and accounting systems

Board Members	• Understand financial terminology • Review and understand financial statements • Ask questions to inform decisions
Finance Committee (common committee)	• Revise budget and make recommendations • Meet regularly to review financial information reported by health center staff • Review accounting and control policies and make recommendations • Oversee audit engagement (if no separate Audit Committee)
Audit Committee (if the board has this committee)	• Oversee the independent audit process
Treasurer	• Head of the Finance Committee • Provide financial reports at board meetings in collaboration with center staff • Answer questions from board members
Staff	• Prepare the budget and present it to the finance committee and board • Monitor the finances on daily basis, prepare accurate and timely financial reports • Implement financial policies • Provide information and offer recommendations to the Finance Committee

[36] Information adapted from National Council of Nonprofits, "Board's Role & Audit Committees," NACHC presentation on Financial Responsibilities, and BoardSource, "Finance Committee Fundamentals."

[37] BoardSource, "Recommended Governance Practices" available at www.boardsource.org.

Role	Responsibilities
	• Monitor efficient management of cash flow • Interact with outside agencies • Comply with regulatory requirements and center policies

B. The Health Center Program and Financial Oversight

The Health Resources and Services Administration (HRSA) Health Center Program Compliance Manual (Compliance Manual) sets forth a number of requirements that relate to financial oversight in Chapter 19: Board Authority. An excerpt from the Compliance Manual that discusses how a health center would demonstrate compliance with these requirements is included below for ease of reference.[38] It is important to note that Chapter 19: Board Authority also links to several additional chapters, including Chapter 9: Sliding Fee Discount Program, Chapter 16: Billing and Collections, and Chapter 17: Budget which contain additional information on various requirements.

Excerpt from Health Center Program Compliance Manual, Chapter 19: Board Authority. Please note the footnotes in this excerpt are from and link directly to the Compliance Manual.

The most relevant parts of this excerpt related to the board's financial oversight role are bolded below; this emphasis was added by NACHC.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center's organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the health center governing board maintains the authority for oversight of the Health Center Program project, specifically:
   - The organizational structure and documents do not allow for any other individual, entity or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions;[11]
   - In cases where a health center collaborates with other entities in fulfilling the health center's HRSA-approved scope of project, such collaboration or agreements with the other entities do not restrict or infringe upon the health center board's required authorities and functions; and
   - For public agencies with a co-applicant board;[12] the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.

b. The health center's articles of incorporation, bylaws, or other relevant documents outline the following required authorities and responsibilities of the governing board:
   - Holding monthly meetings;
   - Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO;
   - **Approving the annual Health Center Program project budget and applications;**

[38] See Chapter 19: Board Authority of the HRSA Health Center Program Compliance Manual at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-19.html#titletop for additional information on these requirements. Chapter 19 also includes cross-references to applicable sections of Chapters 9: Sliding Fee Discount Program, 16: Billing and Collections, and 17: Budget. Note: In the financial realm, compliance with Medicare, Medicaid, and federal grant requirements is essential.

- **Approving health center services and the location and hours of operation of health center sites;**
- **Evaluating the performance of the health center;**
- **Establishing or adopting policy[13] related to the operations of the health center; and**
- **Assuring the health center operates in compliance with applicable Federal, State, and local laws and regulations.**

c. The health center's board minutes and other relevant documents confirm that the board exercises, without restriction, the following authorities and functions:
   - Holding monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions;
   - Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO from the Health Center Program project;
   - **Approving applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue;**
   - Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the health center's services;
   - **Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken;**
   - **Conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs**; and
   - Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management,[14] and ensuring appropriate follow-up actions are taken regarding:
     - Achievement of project objectives;
     - Service utilization patterns;
     - Quality of care;
     - Efficiency and effectiveness of the center; and
     - Patient satisfaction, including addressing any patient grievances.

d. **The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies in the following areas: Sliding Fee Discount Program**, Quality Improvement/Assurance**, and Billing and Collections**.[15]

e. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies that support financial management and accounting systems and personnel policies. However, in cases where a public agency is the recipient of the Health Center Program Federal award or designation and has established a co-applicant structure, the public agency may establish and retain the authority to adopt and approve policies that support financial management and accounting systems and personnel policies.

C. Approval of the Budgets

The board is responsible for reviewing and approving the annual organizational operating budget, which is the health center's financial plan for achieving its health service program and financial goals.

It is important that the budget aligns with the overall priorities and strategic plan for the center. In reviewing and approving the budget, a board considers items such as the current year's expected results, anticipated changes in funding, changes in expenses, as well as provider vacancies and anticipated changes in patient volumes. The health

center's operating budget must be approved by the board; it should also be reviewed throughout the year and adjusted, as necessary, by the center's management and the board.

Health centers submit an annual grant application that includes a budget, also called a "total budget," to HRSA that reflects the revenues and costs needed to support the health center's proposed or HRSA-approved scope of project. The total budget must show projected costs supported by the Section 330 award and projected costs supported by non-award revenues including payments generated from the delivery of services; other state, local, or Federal awards such as Ryan White HIV/AIDS or Head Start; and private operational support generated from fundraising or contributions.

Questions a board can ask include:

- Is the goal of this year's budget to achieve break-even operating results or better?
- What are the key assumptions in the budget and are they reasonable given known conditions and circumstances? For example, is there a realistic expectation of increasing numbers of patients?
- Are expenses listed in the budget consistent with the health center's mission, goals, and objectives?
- How does the center's current year-to-date "bottom line" or net income compare to the current year budget?
- What current year expenses are exceeding budget or last year's levels? Why?

D. Monitoring Financial Performance & Financial Status

The board is responsible for ongoing monitoring of the center's financial status through regular review of the balance sheet, income statement, and cash flow statement, as well as assessment of other financial performance measures. Boards review this information together to get an overall "picture" of the center's financial position.

Not every board member is a financial expert, however, it is important that every board member be able to understand financial statements in order to assess their reliability and to recognize warning signs that might indicate a change in the financial condition of the organization. Common statements include:

- **Balance Sheet** (also called Statement of Financial Position) – The Balance Sheet lists the assets (what the health center owns -- usually cash, grants receivables, patient accounts receivables, equipment and property owned by the health center) and liabilities (what the center owes or debts such as a line of credit or a building mortgage). It provides a snapshot of the health center's financial health at a particular point in time.

- **Income Statement** (also called Statement of Activities or Statement of Operations) – The Income Statement identifies revenue and expenses over a period of time. The report should include comparison to budgets amounts and to actual results for the same time period in the previous year. If income is higher than expenses, there is a profit; if less, there is a loss. While not required, it may be helpful to have information by site and/or service line to aid in decision-making.

- **Cash Flow Statement** – The Cash Flow Statement records the amounts of cash entering such as payment for services (shown as a positive number) and cash leaving the health center such as payment for salaries (shown as a negative number). If the bottom line is positive, the organization has on-hand cash or liquid assets, meaning it can quickly sell assets to get cash. This measure is useful in determining short-term viability, for example, the center's ability to pay its bills.

The board of directors can use financial statements to monitor the financial status of the health center, and if necessary, to change the center's financial goals and objectives. There are many ways to assess financial performance, but for board member review, there are several measures that are commonly used to provide a general picture of the health center's financial well-being.

Financial Ratios

A ratio is a way to express the relationship between one measure to another. When looked at over a period of time, financial ratios are useful to assess an organization's financial situation – whether the financial picture is getting better or worse. Ratios are also useful to compare financial measures at your health center to those of other similar organizations and to industry standards.

Financial Viability/Costs measures required by HRSA/BPHC are:[39]

Measure Name	What it measures	Target/desired direction
Total cost per patient	Measures the dollar value of services provided to a patient	Decrease is desired
Medical cost per medical visit	Measures medical cost efficiency	Decrease is desired
Health Center Program grant costs per patient	Measures Federal grant dollar efficiency	Decrease is desired

HRSA requires that health centers submit clinical and financial performance measures in the center's Budget Period Progress Report (BPR) and in applications that respond to HRSA Service Area Competition (SAC) funding opportunities.

Other Key Financial Measures

Other key financial measures include:

Measure Name	What it measures	Target/desired direction
Operating Margin	Measures the performance of the health center over a period of time, and is calculated by dividing operating income by total revenues.	2 to 4%, over 5% if possible
Days Cash on Hand	Measures how many days a health center can pay its expenses if income were to cease.	45 to 60 days minimum; best practice 90-120 days
Unrestricted Net Assets	Total unrestricted net assets less net investment in fixed assets	Measure should be positive and not decrease over time
Current Ratio	Current assets divided by current liabilities	Minimum 1.5, ideally 2.0
Days in Accounts Receivable	Measures how long it takes for a health center to collect its patient accounts receivable.	Less than 45 days (lower number is better)
Days in Accounts Payable	Measures the days that a health center takes to pay its vendors.	30-45 days or less than 45 days
Net Revenue By Payer[40]	Measures revenue by payer (self-pay, Medicaid, Medicare, Private Insurance) after contractual	Higher is better.

[39] For more information, see https://bphc.hrsa.gov/qualityimprovement/performancemeasures/financialviability.html.

[40] This is anticipated to change. See https://www.fasb.org/cs/Satellite?c=Page&cid=1176169257359&d=Touch&pagename=FASB%2FPage%2FImageBridgePage#section_7 for more information.

Measure Name	What it measures	Target/desired direction
	adjustments and bad debt allowance.	

Monitoring Performance with Dashboards

Dashboards are visual tools for monitoring an organization's performance. A dashboard can highlight what the board needs to know to fulfill its oversight responsibilities so that at a glance, members can see what is on track and what is not. Dashboards can translate the organization's goals – quality, financial strength, patient experience – into activities and processes that can be measured and monitored.

Some common financial indicators that you might see on a dashboard include number of patient visits, payer mix, days cash on hand, days in account receivable, actual revenue in relation to budgeted revenue, and operating expenses in relation to budgeted expenses.

Questions that boards can ask include:

- Have the sources of our health center's income changed?
- Is the center running a gain or loss when comparing income to expenses?
- What is our patient account receivables balance? What percent are we likely to collect?
- Is our cash flow projected to be adequate? How many days can we operate if revenue were to cease (due to Federal award restrictions or a natural disaster)?
- Do we have financial reserves available to support future health center needs (both planned strategic investment needs and unplanned potential emergency needs)?

E. Accounting and Internal Control Systems

Health centers must have in place systems for collecting income, paying bills, determining eligibility for sliding fee discounts, and providing accurate and timely reports. These systems are expected to reflect "Generally Accepted Accounting Principles (GAAP)," which is a standard way for organizations to record and report accounting information.

Internal controls are functions established by the health center to provide checks and balances to ensure reliable financial reporting, effective operations, and compliance with applicable laws and regulations, as well as to prevent fraud. Internal control activities at a health center include segregating duties among staff so that, for example, a person who collects patient payments is not the same person who deposits cash in the bank.

Checking your health center's internal controls.

- Do the accounting systems reflect GAAP?
- What are the center's checks and balances to prevent errors, fraud, and abuse?

F. Approving Policies

It is important for boards to approve various financial policies, which may include policies on reserves, investments, gift acceptance, the audit, among others.

Under the Health Center Program, health center boards must approve various financial policies. Health center boards will want to review Chapter 19: Board Authority, as well as Chapter 9: Sliding Fee Discount Program and Chapter 16: Billing and Collections for discussion of relevant requirements.[41]

G. Audit

Health centers are required to engage an audit firm to perform an annual, independent audit in accordance with federal audit requirements. The audit is an essential step to validate information found in the center's financial statements. The board's role in the audit is to: select the auditor, who must perform the audit in compliance with Federal requirements; review the audit; ask questions of the auditor; and approve the audit. If there are findings or material weakness, the board is responsible for ensuring that the CEO and staff develop and implement a corrective action plan.

H. IRS Form 990

The Internal Revenue Services (IRS) requires that most federally tax-exempt organizations annually file the IRS Form 990. Form 990 provides information that allows the IRS to determine whether or not an organization continues to fill the requirements for its tax-exempt status. The form inquires about the independence of board members, the community benefit of the organization, and the reasonableness of executive compensation. In addition to filing the Form 990 with the IRS, some non-profit organizations must also provide the Form to state taxing authorities, and possibly the state's attorney general, for additional review. Specific oversight of the completion of Form 990 is generally the responsibility of the board's finance committee or audit committee, however the Form includes questions related to the entire governing board. The board typically reviews the Form 990 prior to it being filed by the health center.

For more information about Form 990, see "Governance, Management, Disclosure," on the Form 990 Return of Organization Exempt Form Income Tax at http://www.irs.gov/.

I. Strategic Fiscal Planning

In order to ensure fiscal soundness, it is important to have an overall financial plan that is linked to the strategic plan. The board is key in working with management to develop fiscal goals and ensuring that strategic and operational decisions are guided by those established goals. These financial goals should be evaluated through the review and evaluation of the monthly financial statements and key financial measures.

Questions a board can ask include:

- What are the financial goals in our strategic plan?
- Is our current financial position consistent with those goals?

[41] For more information and guidance, see Chapter 9: Sliding Fee Discount Program in the HRSA Health Center Program Compliance Manual at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html#titletop and Chapter 16: Billing and Collections at https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-16.html#titletop.