

Nonprofit Boards

Nonprofit organizations, as providers of community service, have become an integral part of the American way of life. The Internal Revenue Service grants tax-exempt status to nonprofits, most often as 501(c)(3) entities, to operate in the public interest. Nonprofits do not pay dividends or interest to shareholders. While for-profit organizations are driven to make money (profit) for their shareholders, nonprofits must serve people as their bottom line. While it is necessary for community health centers (CHCs) to generate revenue for sustainability, profits must be reinvested into the expansion or improvement of services to protect nonprofit status.

Governance

Volunteer boards, as governing entities, are critical to the existence and advancement of nonprofit organizations. People who commit time and energy to serving on volunteer boards, be it a community group, a religious organization or charity, give substantively to their communities. However, nonprofit boards are now subjected to greater scrutiny because of the scandals that plagued the corporate world at the beginning of this century. In response to corporate scandals, Congress passed the Sarbanes-Oxley Act (SOXA) of 2002 to raise the consciousness of both corporate and nonprofit boards. SOXA is designed to make boards more independent and knowledgeable; emphasize that the governing board has the ultimate authority; give boards greater responsibility for monitoring the actions of management; and discourage board members from having a 'passive' approach to governance. Clearly, boards must equip themselves with the tools necessary to effectively govern. OKPCA's *CHC New Board Member Checklist* includes a listing of specific board roles and responsibilities.

Board members must first learn the standards of conduct expected to fulfill their responsibilities. As public stewards, every member of a nonprofit board should diligently practice the duty of care, loyalty and obedience to the organization and its mission.

- **The Duty of Care** – means that the board member is expected to exercise the same level of judgment that any other competent and prudent person would exercise in a similar situation. This does not mean that board members will never make mistakes – it does mean that each board member should be reasonably careful when making decisions.
- **The Duty of Loyalty** – being faithful to the organization. Information provided to board members should not be used in any form or fashion for personal gain. Specific written policies must be developed regarding how to handle potential conflicts of interest – a conflict between the private interest and public obligations of a person in an official position. If a nonprofit organization engages in business dealings with one of its board members, a full disclosure should be made detailing the board member's involvement and the transaction should always be in the best interest of the organization.
- **The Duty of Obedience** – individual board members must be true to the mission and are not permitted to act in any way inconsistent with the policy or goals of the organization, thereby ensuring that public trust is never compromised.

Linkage with the Community

In addition to the governing responsibilities, nonprofit board members should also link their organization with the community served. The first part of its linkage role is to serve as the voice of the community, representing the community and its needs. The organization was established to meet a specific need. In the case of a community health center, that need is to provide primary care services to the community's medically underserved and vulnerable residents. The board's job is to represent the community in assuring that the center maintains the appropriate management and staff necessary to provide the scope of services needed for that particular community. The second part of the board's linkage role requires board members to promote the center and its mission to the community. The health center must be valued by community members before they will use its services, recommend it as a 'medical home' to others, and actively support advocacy efforts to ensure the continuation of the health center. The organization's public image becomes especially important when additional funding is pursued – be it public dollars, foundation support or community fundraising. Board members should be the 'cheerleaders' - publicly promoting the organization and its services.

Conflict of Interest & Job Description

With the heightened level of scrutiny directed at all governing boards, it is imperative that organizations adopt conflict of interest policy as part of the bylaws. Each board member should also complete a *Conflict of Interest Disclosure Form* (attachment included) to document that the collective governing board is proactively minimizing risk by identifying potential conflicts of interest. The attached *IRS Sample Conflict of Interest Policy* explains purpose, definitions, procedures, violations and includes other related information.

Organizations should develop a written board member *Job Description* (sample attached) to make it clear what is expected from each individual serving on the board. A team cannot succeed if a player does not know the rules of the game. All board members, as part of the team, must understand their role and be willing to learn all they can to better serve the organization. Board members have no authority to act individually on behalf of the board. The entire board must meet formally, at least monthly, to make decisions and set policy.

A board member who is not adhering to the organization's bylaws, ignores policy and seeks personal gain **poses great risk** to other board members. Any hint of this behavior must be addressed immediately by the full board. If a board member is not exercising duty of care, loyalty and obedience, it is up to the remaining board members to take action to remove that individual from the board in accordance with organizational bylaws.

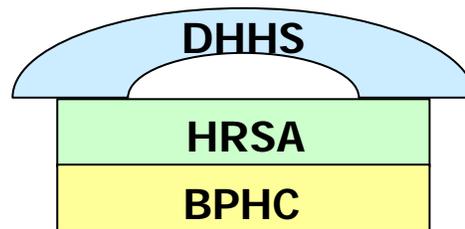
Ultimate Responsibility

Nonprofit organizations exist to address a social need identified by community members. Your job as a board member is to protect the good work done by volunteers who came before you, govern current operations to the best of your ability and plan for the future in a way that preserves the mission of the center. To do that, you must be ready to work and willing to make tough decisions. The proverbial 'buck' does stop with the board as it has ultimate responsibility for the organization. Boards whose organizations receive federal funding should be ever mindful that they are under the scrutiny of the Office of Inspector General (OIG). The OIG is the enforcer that makes certain federal dollars are spent in accordance with the law.

Section 330 Community Health Centers

History

Community health centers (CHCs) began as part of President Lyndon B. Johnson's *Great Society Program* in 1966 and were first known as 'neighborhood' health centers. The Consolidated Health Centers program, of which CHCs are the cornerstone, was established over 40 years ago to provide access to affordable, high quality preventive and primary care in medically underserved communities, including service to millions of Americans without health insurance. Communities may seek federal funding from the Department of Health and Human Services' (DHHS) Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) through a competitive grant process under Section 330 of the Public Health Service (PHS) Act.



The 330 CHC program allows a community to design an effective health care delivery system unique to its service area and target population. The grant funds are not 'seed money'; CHCs receive on-going support based on their productivity. Health centers have long served as a prototype for effective public-private partnerships, demonstrating their ability to meet pressing local health needs while being held accountable to national performance standards. Section 330 CHCs are also commonly referred to as Federally Qualified Health Centers (FQHCs) because they meet rigorous federal standards related to high quality of care and services, as well as cost, and they are qualified to receive cost-based reimbursement under Medicaid and Medicare law. The Health Center program was permanently authorized under the Patient Protection and Affordable Care Act signed into law March 2010.

330 Core Tenets

For over 40 years, community health centers have delivered comprehensive health and social support services to people who would otherwise face major financial, social, cultural and language barriers to obtaining high quality, affordable health care. CHCs succeed because of several core elements found in Section 330 of the PHS Act, including requirements that (1) federal resources be targeted to communities with the most significant health care access needs, (2) services be made available to all residents regardless of ability to pay based on a sliding fee scale tied to income and number in household, (3) services include preventive and primary health care, enabling (transportation and translation) and health education, (4) health centers must be directed by a governing board of which 51% are patients of the center to ensure they be responsive to the needs in their communities, and 5) performance and accountability measures regarding administrative, clinical and financial operations are met. With the above elements in place, community residents have access to a 'medical home' that offers affordable health care. Health centers provide much more than just treatment for illness or episodic conditions. By having a 'medical home', people can access timely, cost-effective preventive care.

America's Health Centers

Your organization is one of 1,200 community, migrant and homeless center grantees that serve 7,500 urban and rural communities in every state and territory. Health centers serve as the medical home and family physician to over 20 million people nationally. Half of the health center patients reside in rural areas with many of the other half living in economically depressed inner city communities. Health centers serve one in five low-income, uninsured people and 71% of health center patients have family incomes at or below poverty. Nearly 38% of health center patients are uninsured and another 36% depend on Medicaid. CHCs save the national health care system approximately \$24 billion annually by reducing inappropriate emergency room use, hospital and specialty care and providing medical homes for people so preventive care may be accessed. (Source: NACHC publications posted at www.nachc.com).

Oklahoma CHC Presence

For over thirty years, state leadership was not supportive of CHC development. Oklahoma, a state having 68,667 square miles with over 650,000 uninsured, had only four CHC grantees prior to 2001 while comparable states had numerous health center sites (New Mexico - 115 and Arkansas - 46). The CHC program grew very little during the 1980s and 1990s. That changed in 2001 with the *Presidential Five-Year Initiative to Expand Health Centers* – a window of opportunity for Oklahoma communities to secure funding for new CHC development. Since 2001, the number of Section 330 grantees in Oklahoma has increased dramatically - from four to eighteen as of 2012 with the total number of delivery sites increasing from six to over fifty (including two homeless health centers). A complete listing of Oklahoma's health centers with a map showing locations is attached.

330 Funding Requirements and Opportunities

Grantees are required to submit annual applications for continued funding. For each year within the grantee's specified project period, a **Budget Period Progress Report (BPR)** must be submitted to HRSA by the stated deadline – referred to as the non-competing continuation of funding. Several months before the project period ends, grantees must prepare a **Service Area Competition (SAC) application**. Grantees should put every effort into completing a stellar SAC as it is a competing continuation and open to all eligible entities. If other organizations apply for an existing grantee's service area, grant submissions are scored by external reviewers and awarded to the best applicant. A competitive SAC requires strong organizational capacity.

The *Presidential Five-Year Initiative to Expand Health Centers*, effective FY 2002-2006 and back by strong bipartisan support from Congress, facilitated unsurpassed 330 CHC funding opportunities for existing grantees. While the *Presidential Initiatives* under the Bush Administration have been completed, opportunities for continued CHC growth are available. In 2009, President Obama continued CHC growth with the American Recovery and Reinvestment Act (ARRA). The Affordable Care Act (ACA) of 2010 continued CHC growth opportunities. Existing 330 grantees are routinely offered opportunities to secure additional funding to serve more people and increase services – including enhancement of oral, behavioral health and pharmacy services plus outreach. New Access Point (NAP) funding is offered as federal appropriations allow for existing grantees wishing to develop an expansion health center site (new service area and target population) or communities applying as a 'new start' organization. NAP funding opportunities are awarded through a highly competitive grant process. Boards should carefully consider the pros and cons of new projects before pursuing grant funding (see *OKPCA Board Bulletin*, Volume 2, Number 9, September 2004).

Section 330 Community Health Center Boards

Expectation

One of the core tenets of the Section 330 Community Health Center (CHC) program is the consumer governance provision. Who can better address the needs of the people served than a consumer board made up of at least 51% health center patients? HRSA's Health Center Site Visit Guide (found at <http://bphc.hrsa.gov/policiesregulations/centerguide.html>) outlines Key Section 330 Health Center Program Requirements. To better understand specific board expectations, review Section IV: Governance, which includes the Program Requirements 17-19 that respectively focus on Board Authority, Board Composition, Conflict of Interest Policy.

Leadership

The health center board provides leadership and guides the center in doing what it was intended to do. The mission of the health center provides direction, just as a compass point, for the organization. Each board member must understand the mission to appropriately develop and preserve programs and services to fulfill that mission. The governing board provides vision - the inspiration for the future destination of the organization. The vision should be ambitious, inspiring enthusiasm and commitment by all stakeholders, especially board members. To fulfill the expectation of linkage with the community, health center board members should be able to take the mission and vision to the community. Board members should also be the voice of the people served in making sure that specific community needs are being met by the health center.

Board Composition

In accordance with the 330 statute, Program Requirement 18 outlines board composition. At least 51% of the CHC board must be consumers – health center patients. No more than half of the non-consumer board members may receive more than 10% of their income from the health care industry. That means that if you have a fifteen-member board of which eight (51%) are consumer board members, only three non-consumer board members can receive more than 10% of their income from the health care industry. CHC boards must have at least 9 and no more than 25 board members with the consumer majority mirroring the community served – with consideration given to gender, race/ethnicity, age and socioeconomic status when fulfilling this requirement. Health center employees, their spouses, children, parents, brothers or sisters (blood or marriage) cannot be members of the board.

Governing Board Responsibilities

Established health center bylaws should be reviewed and modified to remain current. All board members should be familiar with their organization's bylaws which should address the mission; board membership; officers; committees; meeting schedule; quorum and acceptable meeting venues; meeting minutes; and provisions regarding conflict of interest, executive session and dissolution. Each board member should have a copy of your CHC's bylaws. CHC boards are responsible for establishing and preserving the mission; setting policy; selecting and evaluating the health center executive officer; safeguarding CHC assets; strategic planning; monitoring and evaluating CHC operation and performance; and engaging in ongoing board development. CHC boards are required to meet at least monthly with minutes recorded to document board action. There should be a committee structure that facilitates effective governance by the entire board as described further next section.

Board Organization

Size and Eligibility

Section 330 Community Health Center (CHC) boards are federally required to have at least 9 and no more than 25 members. Each health center must decide how many members, within those requirements, are needed to represent the community and yet be small enough to be manageable. Boards should also consider how many members are needed to avoid overloading some or all of the board members. Boards should recruit members who bring expertise in finance, legal affairs, business, health, managed care, social services, labor relations and government while being careful to follow eligibility guidelines in the bylaws and CHC-specific requirements.

Officers

CHC Board officers play a vital role in guiding board operations, and a position as a board officer involves a significant commitment of time and effort as well as knowledge and leadership ability. CHC bylaws specify officers and typically include:

- **Chairperson** - the team builder, liaison between board and CEO, planner - from large-scale issues to agendas, facilitator, delegator. The chairperson keeps the group organized, prods the group to move ahead, sets rules for internal discipline, and tries to help the group make sound decisions.
- **Vice-chairperson** - backup chairperson and logical successor to chair, leads committees and heads up special assignments. The vice-chair must be prepared to take over for chairperson when necessary.
- **Secretary** - responsible for minutes, which are the legal documents of the meeting; they are a record of actions, attendance, and decisions made at the meeting. The secretary does not have to physically record the minutes but is responsible for their accuracy and completeness and must review and sign the minutes before they are forwarded to the entire board.
- **Treasurer** - responsible for making sure adequate financial records are kept, that accurate and timely financial reports are delivered to the board, and that the center's finances are audited annually. However, this does not mean that the treasurer is responsible for managing the center's finances - that is the job for salaried staff.

Committees

Much of the board work is done by committees. However, a vote by the full board is needed to set policy. Your CHC bylaws should specify committees and may include the following:

- **Standing** (or Permanent) - Executive, Finance, Personnel, Planning and Quality Assurance
- The **Executive Committee** - may meet to conduct critical business that cannot wait until the next board meeting; however, all Executive Committee actions must be reviewed and approved by the full board.
- **Ad Hoc** (Temporary) - appointed by the board to study important issues as they arise (e.g., audit, CEO search, CEO evaluation, and grievance). Non-board members may be brought on to assist ad hoc committees.

Committees Can:

- Investigate/research
- Report
- Make recommendations

Committees Cannot:

- Set Policy
- Act on their own or on behalf of the full board
- Interfere with the daily operation of the center

Effective Board Meetings

Board meeting effectiveness is a direct reflection of board effectiveness and center operational effectiveness. While there are no set rules regarding board meeting structure, CHC boards should know the following:

- CHCs receiving federal funds are required to meet at least monthly.
- Maintain minutes - documentation of approval/disapproval of all board policies and procedures is required.
- Adhere to Oklahoma law regarding nonprofit organizations and open meetings (required under Oklahoma Senate Bill 708).
- Courts have ruled that you may violate your responsibility as a board member by failing to attend meetings. Absence is neglect and will not excuse you from potential litigation.

Preparation

Board meetings work best when an agenda is prepared and distributed in advance. It is helpful to include presenter, time allocations and expected action for each agenda item. Traditionally, board meetings follow *Robert's Rules of Order* or some other standard parliamentary procedures. Whether or not your organization's bylaws specify parliamentary conduct, rules should clearly set the tone for businesslike and courteous meetings that allow for participation by all board members without letting a discussion get out of control. Every board member should have the right to discuss an issue and to agree or disagree with the discussion. Having an established plan for meeting conduct will prevent any individual, board member or community attendee, from disrupting the meeting or hindering effective governance. It is up to the chairperson (or acting chair) to learn parliamentary procedure and enforce established meeting rules. As Plato wisely said, "People are freest when the rules are clear."

Making Motions and Voting

A specific issue is brought before the board when a member makes a "motion" - a formal request or proposal for the board to take action. Although enough time should be allotted to discuss the motion fully, the presiding officer and other board members should keep discussion focused and move it toward a decision -- a vote. The basic process for making a motion is as follows:

- Move (state the motion)
- Second the motion (the support - needed to consider the motion)
- Restate (done by the chairperson for clarification)
- Discuss, clarify, debate
- Vote - either Yes, No, or Abstain (you must abstain (not vote), if there is a conflict of interest issue).

The minutes must then document motion activity. If you wish to have on record how you voted on a motion, ask that your vote be recorded in the meeting minutes. The record of your vote may be important if someone later attempts to hold you personally liable for the board's actions or inactions.

Board documentation of the decision-making process is critical to meeting Key Health Center Program Requirements. HRSA site visit teams will review board minutes and decision tracking tools to determine if your board is in compliance with program requirements. Token boards are not acceptable. All board members must remember that absence from a meeting does not remove responsibility accompanying collective board decisions.

Health Center Board Members Do's

- Do know the center's mission, purpose, and goals as well as its programs and services
- Do learn the center's strengths and weaknesses
- Do pitch in enthusiastically and willingly
- Do make sure you have all of the information before expressing an opinion or judgment
- Do get acquainted with the other board members and the Center's CEO and staff
- Do come to meetings – and come prepared to participate
- Do ask questions
- Do support the majority once a decision has been reached, even if you disagree
- Do support the CEO and staff, and understand that they are operating with limited resources
- Do avoid all possible conflicts of interest
- Do maintain a sense of fairness, ethics, and personal integrity
- Do understand the Center's financial statement and help the board plan for future revenue and expenses

Health Center Board Members Don'ts

- Don't lose your sense of humor
- Don't speak for the board, unless authorized to do so
- Don't ask the CEO or staff for special favors
- Don't forget that as a board member you have only one employee: the CEO

Primary Source: HRSA/BPHC Governing Board Handbook, page 35