

Governing Board Handbook

*The People We Serve . . .
The People We are*



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INTRODUCTION

The Governing Board Handbook has been prepared for the Health Resources and Services Administration's Bureau of Primary Health Care (BPHC)-supported health center governing board members. This handbook has been designed as an orientation tool to assist new members to understand the structure and responsibilities of a governing board. It also describes the characteristics of health center governing boards that make them unique. We hope that new and experienced board members will find the Governing Board Handbook a useful tool.

This Handbook is organized into two modules. Module 1 explains the purpose and responsibilities of a governing board. It also explains the three major duties of a member of a governing board. Module II is an overview of how board operations relate to the day-to-day functions of a health center.

These materials can be used by members of any health center governing board, but the focus is the specific characteristics and issues that face federally supported health center governing boards. The generic terms health center or center have been chosen to include any BPHC-funded or -supported health center or health care program. Also, while these terms may be interchangeable, the administrator or executive director will be referred to as the chief executive officer.

Training and technical assistance and consultation for governing board members of BPHC-supported health centers is made available by BPHC through a variety of resources including State/regional primary care associations, national organizations, and Federal staff. The "Resources List" following Module 2 of the handbook lists national, regional, and state-level associations and other resources that may help to address specific issues that concern your health center.

A “History of the Community Health Center Model” is included as an appendix to this Handbook. This appendix has been provided for those who may be interested in additional background information on the community health center movement in the United States.

Our thanks to the Executive Director and board members of Southern Jersey Family Medical Centers, Inc. and John Troidl (trainer) for allowing us to observe first-hand one of the Centers’ governing board training sessions; and Sheila Ray of Ray & Associates, who provided additional writing, review, and expertise. We also thank the following individuals for serving on the advisory committee to provide direction, review, and suggestions during the development of the Governing Board Handbook: Mickey Goodson, chair; John Cafazza and Paula McLellan, members.

module 1.

BUILDING AN EFFECTIVE BOARD

Being a board member is a serious responsibility. At times, board members may feel slightly overwhelmed. But how the board goes about doing its business does not need to be complicated—especially if the board, as a whole, and its individual members, understand their responsibilities and act based on that understanding.

Because the board as a whole has roles, responsibilities, and authority that are unique and different from the roles, responsibilities, and authority of each individual member, we have organized this module to make those differences clear. In the sections that follow, we will briefly discuss why boards are necessary and then present an in-depth discussion of the functions of the nonprofit board, and finally, summarize the roles and responsibilities that are required of each board member.

BOARDS EXIST TO:

- Govern
- Link with the community

WHY HAVE A BOARD?

Your health center (center) has a board to:

- “Govern” the center
- Serve as a link with the community
- Comply with State and Federal laws.

To GOVERN

The board “governs”—it provides leadership and guides the center in doing what it was intended to do. This requires an understanding of the mission, ensuring (preserving and developing) programs and



services to fulfill that mission. It also requires providing a vision—a direction for the organization. Thus, the board governs the present and plans for the future in a way that preserves the mission of the center.

TO LINK WITH THE COMMUNITY

The board also serves a dual role in linking the center and the community. The first part of its linkage role is to serve as the voice of the community, representing the community and its needs to the center. The center has been established to meet a specific need—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 the board to promote the center and its mission to the community.

IT'S REQUIRED

Although the center is a nonprofit organization, it is still a business. It has been incorporated and granted tax-exempt status by the State and the Federal Government to fulfill a need. A nonprofit business has rules regarding how it is managed. One of those rules is that it must establish and maintain a board to make sure that the organization continues to operate and to do what it was set up to do.


WHAT IS A BOARD SUPPOSED TO DO?

How a board goes about governing and ensuring that the organization serves the community involves a variety of activities. Some boards have responsibility for overseeing the operation of large health center networks that provide a full range of medical, dental, nursing, social support services, and training programs to an extensive and diverse population. The operation of these centers is quite complex and involves managing many clinical, administrative, and support staff as well as overseeing considerable assets. Because of the complexity of this type of business, individual board members tend to be more distanced from the daily operation of the health center.

Some boards, on the other hand, may govern a center that has only one site, limited staff, and serves a smaller, more homogeneous client population. Members of these boards may have a closer and more “hands on” knowledge of the operation of the center.

Because of these differences, these boards may vary in their approach to “governing.” But their basic responsibilities (or duties) remain the same. These responsibilities are presented here as a series of six elements that build on and support each other each other:

BASIC RESPONSIBILITIES OF A NONPROFIT BOARD

- 
- Define and Preserve the Mission of the Organization
 - Make Policy
 - Safeguard the Assets of the Center
 - Select, Evaluate, and Support the CEO
 - Monitor and Evaluate Center and Board Performance
 - Plan for the Long-Range Future of the Center





■ 1 DEFINE AND PRESERVE THE MISSION OF THE ORGANIZATION

The mission of Merced Family Health Centers, Inc. is to improve the health status of our patients by providing quality, managed primary health care services to people in the communities we serve regardless of language, financial, or cultural barriers.

*Merced Family Health Centers, Inc.
Merced, CA*

Everyone, including each board member, center staff, chief executive officer (CEO), and the community, should understand *why* the center exists and *what* it hopes to accomplish. This is a cornerstone responsibility of the board—to make sure that everyone associated with the center understands exactly why the center is in existence, and why it is important to ensure that the center continues to operate. In other words, *what is the mission (business) of the center?*

MEASURE ACTIVITIES AGAINST MISSION STATEMENT

Is the board accomplishing the mission? If not, why?

Is the CEO accomplishing the mission? If not, why?

The Mission Statement

A written mission statement is a public declaration of the center's guiding principles or values. It lets everyone know what the center stands for, its purpose, and the community to be served.

The mission statement should:

- Explain why the center was established and whom it serves
- Depict the services provided
- Illustrate what makes the center special or different—why clients should use its services
- Point to a clear direction for future center activities and priorities and form the basis for future planning
- Be “flexible”—provide for changes in the community and the overall health care marketplace
- Be widely distributed and/or visible to center board, staff, and clients
- Be simply worded, brief, and to the point.

The mission statement is the basis for all board responsibilities and activities. It serves as the “Gold Standard”—the measure by which the board constantly assesses how well it and the CEO are doing their jobs.

Understand, Commit to, and Clarify the Mission

Most new members join a board of a health center that has been in operation for a period of time. In these situations, the center will probably already have a mission statement. It is still the board’s responsibility, however, to understand and commit to that mission. The board should also periodically review the mission statement to ensure that its principles are being fulfilled and that it is still appropriate and relevant.

In other words, it is the board’s job to continually clarify (or define) the mission of the center. The board should also understand that all corporate goals and objectives should be based on or “flow out of” the mission statement. Because the health care environment is constantly changing, it is the board’s job to be attuned to those changes and to ensure that the health center’s goals and objectives remain dynamic and sensitive to the marketplace in which it operates.

A Word About Goals and Objectives

There is nothing complicated or mysterious about goals and objectives. Just as in sports, *goals are the ends*—where we want to be or what ultimately we want to achieve—whether that goal is to win a marathon or to improve access to health services for underserved and vulnerable populations. *Objectives are the steps* we take to achieve those goals. For example, to finish and win a marathon, a runner must train to cover the distance within a certain period of time. The runner’s first step (i.e., objective) in

MEASURE THE MISSION STATEMENT AGAINST NEEDS AND GOALS

Are the needs/goals of the owners (i.e., the community) reflected in the mission statement?
If not, why?

Should the mission statement be revised?
If so, why?

ACTIVITIES AND MISSION—

Do current and proposed programs and services help accomplish the center’s mission and purpose?

reaching that goal may be to finish a marathon within 4 hours after 6 months of training. For a health center, the first step (objective) in reaching a program goal of improving access to maternal and child health services may be to obtain \$300,000 in new funds for perinatal screenings by January of the following year.

In each case, the goals are long range, concisely worded, and based on what the individual (in the first example) or the board (in the second example) wants to achieve. Again, think of goals as the “ends” in what needs to be accomplished, and objectives as the “means” in describing how the goals will be met. Goals are accomplished by specific objectives that are measurable, realistic, and consider the resources available to the health center.

■ **To Summarize:** It is the board’s job to ensure that the mission statement is well crafted and relevant, and that its principles are being fulfilled through realistic goals and objectives. If this has been accomplished, then the board’s job of making policy will be much easier.



■ 2 MAKE POLICY

Another primary responsibility of the board is to make and monitor policy. Policies furnish a framework for future decision making—they determine a general course of action to follow in similar or recurring situations. Policies should ensure uniformity and consistency of action throughout the organization. Policies must be consistent with the overall mission, goals, and objectives of the center, with each other, and with applicable laws and regulations.

Consistent with Mission?

Whenever it initiates or changes policy, or takes any kind of action related to the center, the board should first review the mission statement and ask: “Is this policy (or decision) in keeping with the mission statement? If not, why?”

BOARDS MAKE POLICY ABOUT:

- Operations
- Personnel Management
- Fiscal Management
- Clinical Management and Quality Assurance

If the proposed policy or action is *not* in keeping with the stated mission, the board must then decide: “Is this policy or action appropriate or valid?” If the board determines that the policy or action is indeed necessary and appropriate, but outside the existing mission statement, then the mission statement should be *amended* to reflect that change.

■ **Caution:** Boards should not change mission statements too readily. It is often easier to change a mission statement than to change policy, but not always appropriate.

Formulating Policy

It may be helpful to know why and when boards set policy:

- To initiate action to accomplish the center’s mission
- As a response to a changing need from within the community
- As a response to a directive or policy change from a funding agency.

Boards must address policies dealing with *finance* and with *programs*. In setting policy, a good rule of thumb is: Never make financial and programmatic decisions independently of each other! This is often easier said than done, and boards often observe that most of their meetings seem to be spent dealing with issues of finance and fundraising.

The board must constantly reassess and reorder its priorities; interpret and evaluate its policies; and modify, discard, or create new policies to meet the changing needs of the community, of the health center, and of its funding sources.

NEVER

Make financial and programmatic decisions independently of each other!

When governing boards of health centers formulate policy, this action typically falls within one of four categories: operations, personnel, finances, and provision of services/quality assurance.

Operations

“ABC HEALTH CENTER”

Although “ABC Health Center” sees patients five days a week, the number of patients has increased and clients have to wait several weeks for a routine appointment.

BOARD MAKES POLICY

The board of “ABC” sets a policy that clients should have to wait no longer than 72 hours for a nonemergency appointment.

CEO/STAFF IMPLEMENTS

The CEO and staff follow that policy by extending hours of operation on certain weeknights and adding Saturday hours.

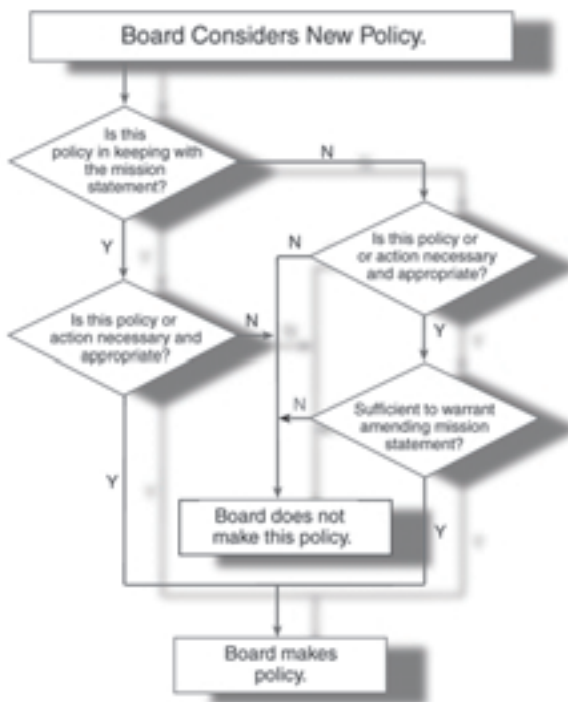
The board is ultimately responsible for efficient, effective, and sound operation of the health center. For example, the board should establish policies that:

- Address the process of selection, review, and dismissal of the CEO
- Provide for an effective organizational structure
- Ensure the availability of equipment, facilities, and personnel necessary to achieve the center’s goals and objectives
- Determine the scope, location(s), and availability of center services
- Establish a process for handling and resolving client grievances
- Ensure that the center is operated in compliance with applicable Federal, State, and local laws and regulations.

Personnel

The board should establish broad personnel policies that will guide the CEO in developing a sound and realistic personnel program that includes:

- Selection and dismissal procedures
- Employee compensation, including wage and salary scales and benefit packages
- Position descriptions and classification
- Performance review and evaluation procedures
- Employee grievance procedures
- Equal opportunity practices.



Finances

The board should establish policies that ensure proper administration of funds and accurate recording of the center's financial activities. For example, the board should:

- Establish the center's financial priorities
- Institute long-range financial planning
- Review and approve the center's annual budget and annual audit.

The board should also ensure the establishment of:

- Internal control procedures
- Purchasing policies and standards
- Protocols for determining eligibility for services, including criteria for partial-payment schedules
- A billing and collection system that:
 - establishes charges based on locally prevailing charges and the health center's costs
 - adjusts or discounts charges based on a person's ability to pay and family size
 - bills and collects from users of services and third-party payers, such as Medicare and Medicaid, insurance companies, or managed care plans
 - incorporates procedures for aging accounts receivable
 - includes procedures for writing off bad debts.

Provision of Services/Quality Assurance

The center's board is obligated to make sure that the CEO and staff make continuing efforts to maintain and improve the quality of care that the center provides. Thus, the board should ensure that:

- The CEO hires a competent, qualified Medical Director who will supervise other clinical staff
- Generally accepted principles of quality health care are developed and followed
- An internal quality assurance program provides for the periodic review of the center's performance in meeting the health needs of the community.

THE BOARD'S RESPONSIBILITY DOESN'T END WITH MAKING POLICY. ONCE FORMULATED, POLICY IMPLEMENTATION MUST BE REVIEWED AND APPROVED BY THE BOARD.

The board's responsibility doesn't end with making policy. Once formulated, policy implementation must be reviewed and approved by the board.

Implementing Policy

The board is responsible for making sure that the center's CEO implements the approved policy—and when that policy is implemented, the board's job is to support the CEO and the staff in their efforts.

For example, in response to a newly enacted law or regulation, the board sets (makes) a policy to ensure that the center conforms to the new regulation. The CEO and staff act on (implement) that policy by purchasing new equipment, adding a capital improvement, or developing new or revised procedures for the center's operations. The board sustains (supports) the policy by approving funds for capital improvements, if required.

The board has the job of *making* policy while the center's CEO and staff have the job of *implementing* policy. However, it is important for the board to be ready to accept ideas for policy change based on program needs put forth by the staff through the CEO.

Note: It is the CEO and the staff who have first-hand knowledge of the daily operation of the center. In fact, it is not uncommon for staff to recognize a particular service need within the community—even before the community representatives on the board are fully aware of such a need.

■ 3 SAFEGUARD THE ASSETS OF THE CENTER

The center’s board is placed in a position of trust by the community and funding sources to protect the center’s assets, ensure that the center’s income is managed properly, and preserve the center’s mission. In other words, board has a *fiduciary* responsibility for management of the center.

External Rules and Regulations

There are various “external” rules that must be followed because the center is a nonprofit business chartered by the State. There are also other external regulations that must be followed because the center is tax exempt and therefore must comply with IRS rules and regulations and most likely receives a combination of Federal, State, and private funding, which carries numerous legal requirements. As part of its fiduciary responsibility, the board is required to understand and follow all of these rules and regulations.

Articles of Incorporation and Bylaws

Every nonprofit business, including a health center, also has “internal” rules and regulations regarding how the center and the board conduct business. These organizational and legal documents—the articles of incorporation and bylaws, are the ground rules that the board is required to follow when it governs (makes policy).

The articles of incorporation (sometimes called the corporate charter) usually contain a statement about why the center was founded, a list of the center’s legal powers and authority, and any limits on that power or authority. It is *very* important that the board understand that once the articles are approved by the State, the center *cannot* undertake any activities that are described in the articles of confederation.



FIDUCIARY

A person who acts as a trustee. A person acts in a fiduciary capacity when the business transacted or the money or property handled is not for that person’s own benefit but for the benefit of another.

SAFEGUARDING FINANCES

- Understand where the money is coming from
- Understand how the money is being spent
- Understand how to plan for needed services and growth

Bylaws are detailed rules about how an organization will be governed. They deal with procedure rather than with guiding principles. They generally include:

- How and when board meetings will be conducted
- How board members and officers will be selected
- Duties of corporate officers
- Committee structure
- Description of the board's relationship with the center's CEO and staff.

(See Module 2 for a detailed discussion of these “internal rules and regulations.”)

Center Finances

As part of its fiduciary responsibility to safeguard the center's assets and resources, the board continually must address issues of finance. The board should be clear about the ground rules and its role in the financial management of the center. The board's job is to:

- Make policies that clearly define
 - sources of revenue and categories of expenditures in the budget
 - the process for adjusting to meet the actual financial situation as the year progresses
- Leave the details to management (as long as those decisions are within the boundaries set by board policy)
- Monitor the status of income and expenditures against the policies made by the board regarding the annual budget
- Compare the actual financial condition of the center against the policies originally set by the board
- Plan for needed revenue sources and plan and budget for capital improvements.

If the board operates within this framework—that is, the board makes policy and the CEO acts on that policy—the board's ability to govern will not become fragmented or disorganized and its ability to protect center assets will be preserved.

The Budget

The board must pay careful attention to the budget. The board must review and approve the annual budget (usually prepared by the center's CEO and staff). Approval of the annual budget is one of the most significant policy decisions that the board will make and it sets in motion a series of programmatic, personnel, and fiscal decisions.

The board should think of the budget as the center's business plan—how it will spend the center's revenues to pay for the services that it provides—and it should regularly compare the *real* state of finances (called *actuals*) to what was *planned* for in the budget when it was first presented and approved (called *projections*). While the audit (see below) may fulfill a legal requirement and help protect against financial mismanagement, it may not reveal problems until a year after they happen.¹ A budget, if monitored regularly (monthly, if possible), will help identify problems as they occur.

Because it is responsible for monitoring the center's finances, a goal for any board should be to assure that at least one board member has financial expertise. It is also important to keep in mind that the board can only truly monitor budget performance if it has understandable, accurate, and timely information. The board, therefore, has the right to receive monthly fiscal status reports that include a comparison of budgeted to actual expenditures, balance sheet, and a forecast of future income and expenditures, which, ideally, should be reviewed by the Finance Committee before presentation to the full board.

¹ Health centers receiving more than \$300,000 in Federal funds are required to undergo an annual audit.

SPOTTING TROUBLE

- Income Sources ▼
- Key Expenditures ▲

The Audit

An audit does more than fulfill a legal requirement. It is probably the best way that the board can protect the center's financial management. That is why the audit must be conducted by an independent CPA or accounting firm (and comply with Federal requirements). A change of CPA firm every few years or, at a minimum, rebidding the audit, is recommended.

It is a good idea that the CEO/CFO meet with the auditors before the audit actually begins. It is also a good idea for a designated committee (typically, the Audit or Finance Committee) to meet with the auditor at least as soon as the audit is completed, but before it is in its final form, to attempt to resolve any audit issues. Finally, it is a good idea for all board members to receive the final report in time to review it before meeting with the firm's representative to discuss the results of the audit.

Danger Signs

Now that we have discussed *what* the board needs to know to make sure that the center's finances are healthy, let's discuss *how* the board should learn to spot trouble.

Income Is ▼: Every nonprofit has certain critical sources of income that it counts on. The most common revenue streams for many health centers are Federal and State grants or contracts, reimbursement from insurers, and collection of patient fees. It is the board's job to pay close attention to *any* changes in the law, policies, or fiscal situation of its funding sources, especially those that will have an obvious impact on the availability or amount of funding.

Some Expenditures Are ▲: Boards also need to carefully watch the effect of increased costs in certain areas—especially in personnel (staff salaries and benefits) and contractual services—these two areas represent the bulk of the center’s expenditures. Another area to watch is increases in miscellaneous expense account spending or past due bills. Again, by regularly monitoring the budget, board members can see if expenditures (actuals) are greater or less than what was budgeted. It is then the board’s responsibility to ask why.

■ **To Summarize:** What we have covered so far (elements 1–3): A health center board is responsible for ensuring preservation of the center’s mission, directing its actions (setting policy), and making sure that the center’s assets are safe and healthy (fiduciary responsibility). Now let’s move on to elements 4–6.





■ 4 **SELECT, EVALUATE, AND SUPPORT THE CEO**

Because the CEO translates board policy into action, the choice of CEO is one of the board's most important responsibilities. In addition to hiring the CEO to manage the day-to-day operations of the health center, the board is also responsible for making sure that the CEO fulfills the requirements of this position.

Selecting the CEO

The CEO will have a significant impact on the center's development and effectiveness. Therefore, recruiting and selecting the CEO is extremely important. Although other individuals may have some input into helping define the requirements for this position, the board is responsible for the actual selection of the CEO. Therefore, the board should establish and conduct a careful search process. Before beginning that process, the board should:

- Make a list of the center's "pluses" and "minuses." (What does the center have to offer? What are its drawbacks?)
- Decide exactly what the board is looking for in a CEO (e.g., the characteristics, skills, and credentials necessary to do the job):
 - as a base from which to develop a set of questions to guide the interview process
 - as a guide against which to measure each candidate.
- Prepare a clear and concise position description with defined roles and responsibilities. Including differences in the job of the board, the CEO, and the staff.
- Provide a competitive compensation package that will attract well-qualified candidates.
- Develop a written list of priorities for the incoming CEO by establishing clear objectives for at least the first year of the CEO's employment.

When these tasks have been completed, the board can begin the search process. The search may be extensive or quite narrow—there may be a suitable candidate from within the center's staff, or

there may be a clear choice from outside. It is important to consider all qualified candidates so that the board can select the best “fit” from candidates with a diverse range of expertise and perspectives. Paying close attention to the list of desired qualifications, the board should make the first cut and then start to schedule interviews.

It is important to support the interview with as much information as possible. After the interview, the board (or search committee) should contact the candidate’s professional references and validate credentials. Information from references should be reviewed and discussed by the *entire* board, as it is the responsibility of the *entire* board to select and hire the CEO.

Evaluating the CEO

The board has placed considerable trust and responsibility in the CEO, and it is up to the board to ensure that the CEO is successfully fulfilling the requirements of the position. Usually this evaluation (performance review) takes place every year, at the time the CEO’s contract is renewed or at the anniversary date of employment. The board should treat the annual evaluation with the same importance as the first time the board hired the CEO.

No one is especially comfortable being evaluated, and most of us are not very comfortable doing the evaluating. It helps to remember that evaluation can be very positive—especially if the CEO and the board agree about the purpose of the performance review and how it will be conducted. Evaluations offer an opportunity to provide the employee with specific guidance on areas for improvement, and to discuss professional growth issues and training needs. The CEO’s performance should be tied directly to his/her position description and overall role and responsibilities, for example:

- **Community relations:** How well the CEO works with the board and other community organizations to ensure that current services are needed and used by the center’s clients.
- **Financial management:** Budgeting and accounting for all revenues and expenditures.

THE ROLE OF THE CEO

To manage, direct, and monitor health center operations and patient care functions. These activities must comply with Federal and State requirements and the policies established by the board.

- **Grants management:** Being accountable to public and private sources for the funds that they provide to the center.
- **Personnel administration:** Creating a spirit of teamwork that is the basis for employees' individual and group efforts.
- **Program development:** Planning, implementing, and evaluating the center's programs in meeting the needs of the community while complying with board policy and the center's mission.

Although the CEO should have a formal performance review formally each year, the board should know how and what the CEO is doing on an ongoing basis. The board should make sure that interim steps are taken to improve upon deficiencies (if any) noted in the evaluation, and the board should identify and deal with problems as they occur. Most importantly, feedback (both positive and negative) should not be stored and delivered *only* during the annual review. Therefore, many boards have found that it is sound business practice to receive a CEO report (written or verbal) at each board meeting.

CEO PERFORMANCE

The center's current operations and future are tied directly to how well the CEO performs!

Supporting the CEO

It is important that open communication be maintained between the board and the CEO—an essential element in a positive working relationship between the two parties.

Once the CEO is hired, the board should support his/her decisions. Therefore, the board should give the CEO clear guidance about policies to be carried out as well as overall expectations. This guidance should be ongoing. But its directives have been made clear, the board should refrain from interfering in the daily operation of the health center and should trust the CEO's ability to manage. If problems arise, the board should follow accepted procedures within the parameters of the center's bylaws.

The board is also responsible for providing the CEO with the resources to carry out policy. For example, if it establishes a policy

that requires capital expenditures for building improvements or equipment purchase, the board should be prepared to allocate the funds necessary to pay for those improvements.

It is important that the board support the CEO to effectively manage the center. Everyone has his/her own strengths, and the CEO is no exception. The CEO may not fulfill all duties and functions of the position equally well. It is the board's responsibility to work *with* the CEO to identify other center staff whose skills complement those of the CEO, and identify areas for skill building.

■ 5 MONITOR AND EVALUATE CENTER AND BOARD PERFORMANCE

It is important that the board periodically review both the Center's performance and its own performance. The purpose of evaluating and monitoring performance is to decide if that performance is appropriate and, if not, to take corrective action.

Evaluating the Center's Performance

Remember that the center was established to achieve something: an end, a result, a mission. It follows, then, that the board cannot evaluate its own performance or the performance of the CEO without assessing how well the center is doing what it was set up to do. This leads us back to that all important mission statement. The best way to see if the center is succeeding is to see how it measures up against the current mission statement.

Determine *how well* that mission is being achieved. Certainly, *some* things are getting done; *some* programs are delivering primary health care services to the community. But how effective are those programs? Are they reaching everyone they were set up to reach? What is the quality of those programs and services? What is the cost of those programs and services? Would the needs of the community be better served by revising, replacing, or even discarding some of these programs or services?



HEALTH CENTER PERFORMANCE STANDARDS

- Mission/goals/objectives
- Budget, financial plan, business plan
- U.S. DHHS *Program Expectations for Community and Migrant Health Centers*
- Various clinical measures (e.g., decrease in infant mortality rate)
- Past performance
- Patient satisfaction surveys
- Client focus groups (i.e., small groups of 8 to 10 patients gathered to discuss—or focus on—key issues)

These are not easy questions to answer. Governing a health center is not an exact science—it's okay that some of these answers are more subjective than objective. There are, however, some standards against which the center's performance can be measured. Some of these standards are "internal," such as how well the center has achieved its goals and objectives. Others are "external"—they have been developed by outside funding sources, such as the State or Federal Government, as qualitative measures of performance.

Whatever the source, these standards all ask the same two basic questions: "Is the health center achieving its mission?" and "Is the health center providing appropriate and feasible services?" Moreover, these standards all have one objective—to benefit the users of the health center's services.

It is also important to keep in mind that without evaluating the center's performance the board would have little basis for assessing the performance of the CEO. Furthermore, it would be extremely difficult to plan realistically—either for the short- or long-term future of the center. There would be no basis for making program decisions, and the board would find it difficult to ensure its own credibility within the community. It is the latter issue that we address next when we discuss the board's responsibility to review its own performance.

Evaluating the Board

It's a good idea to have a written policy that the board will evaluate itself at least once a year. The evaluation should focus on the board's strengths and weaknesses. It should be written and retained so that board members can review it as part of the next year's evaluation.

How the board measures its own performance does not need to be a lengthy or complicated process. In addition to comments from individual board members (as well as the CEO and other center staff), the board should take a thorough look at:

- **How well the board meets its responsibilities**

Are board responsibilities and goals and objectives reviewed at least annually? Do the goals and objectives reflect the center's mission? Are they realistic? Do the board's decisions have a positive impact on the community? Does the board maintain linkages with the community? Are fundraising activities successful?

- **Meeting minutes for the year**

The minutes, written records of board meetings, are a useful tool for helping the board evaluate itself. Minutes will provide records of discussions and details on decisions made by the board. The minutes will also answer certain questions that speak directly to board operations: Does the board meet monthly in accordance with regulations? Is there a quorum at each meeting? Are appropriate committee reports and CEO reports regularly provided?

- **The board's interaction with the CEO**

Has it been positive? Has it been effective? Have there been problems? What were they? What caused those problems? How were they resolved?

- **The dynamics of board members' interaction with each other**

Do one or two members dominate meetings? If so, why? Is there tension between certain members? If so, why? How is it resolved? Do members understand and follow basic parliamentary procedures? Does the board chairperson effectively keep discussion on track?

SEVERAL RESOURCES ARE AVAILABLE TO PROVIDE GENERIC AS WELL AS SPECIFIC TRAINING TO BOARDS. THESE INCLUDE:

- State and regional primary care associations
- National technical assistance contracts available through the Federal funding agency
- Local resources such as community colleges, universities, hospitals
- Organizations such as the National Center for Nonprofit Boards

■ **Time set aside for skill building and training**

Do new board members receive initial orientation and training? Does the board receive training and skill building in areas of weakness identified through the evaluation? An active board will attempt to stay current by taking advantage of training opportunities provided at national and State conferences such as those conducted by State and regional primary care associations, the National Association of Community Health Centers, and the National Rural Health Association.

■ **How well the board sets goals for the upcoming year**

Are the goals realistic? Do they reflect the center's mission? Are goals and objectives formally developed as part of a 3- to 5-year strategic plan?

Don't confuse board goals with organization goals. Board goals deal with how the board operates (e.g., to increase attendance at meetings or to secure specific expertise needed on the board). These kinds of goals are internal—they deal with how the board functions. Organizational goals, on the other hand, are much broader (e.g., to provide certain services). They are included in the center's long-range strategic plan. And that moves us forward to the next, and final, element in our discussion of the board's responsibilities.

■ 6 PLAN FOR THE LONG-RANGE FUTURE OF THE CENTER



By this point, the board has defined a clear mission; set policies consistent with that mission; ensured that center assets are safeguarded, available, and being appropriately spent; hired a capable

“Would you tell me, please, which way I ought to go from here?”

“That depends a good deal on where you want to get to,”
said the cat.

“I don’t much care where—,”
said Alice.

“Then it doesn’t matter which way you go,”
said the cat.

Alice in Wonderland
—Lewis Carroll

CEO to oversee the daily operations of the center; and established procedures to monitor and evaluate the board’s and the center’s performance. The board can now turn its attention to planning.

Although opinions differ as to how planning should be defined and interpreted or designed and executed, a general consensus exists that there is a need for both long-term or strategic planning as

well as short-range planning. It is useful to differentiate between long-term (strategic) planning and short-term planning. A long-term or strategic plan is a *dynamic* process, one that continually guides the board and center management toward meeting specific goals that are tied to the center’s overall mission. The short-range (or annual) plan is derived from the strategic plan.

Strategic Planning Defined

Strategic planning, broad-based and conceptual in nature, deals with the future in terms of long-term objectives and integrated programs for accomplishing these objectives. The future can be defined as a period of time from 3 to 5 years.

PLANNING IS:

- A “change agent” that establishes the need for change when merited and the parameters by which change will occur
- The process whereby you figure out where the center is, where you want it to go, and how you intend to get it there
- Hard work, which requires careful organization, specific activities, and schedules
- Feedback that tells employees how well they are doing and how they can do better
- An opportunity to eliminate less productive activities and undertake new ones
- A valid management function

The strategic plan also addresses critical issues facing the organization for the future and is often seen as planning in the face of obstacles or competition. Strategic planning requires setting clear goals and objectives and reaching these objectives within specific timeframes.

This approach to planning emphasizes the process itself, which is characterized by self-examination, setting direction and priorities, making difficult choices, implementing, monitoring, and evaluating.

Why Is Planning Important?

The center’s board operates in an economic, social, and political environment. As such, planning is critical. Through planning, the board can give the center the means to establish and sustain its mission, determine policies and procedures, highlight the need for—and ways to obtain—funding, market the center’s services, deal with changes in leadership, and make timely responses to legal and political mandates.

Getting the Commitment for Planning

The first and most critical aspect of planning is getting commitment from the board, the center’s CEO, and the staff to engage in the planning process. It is vital to the center’s success that all who are responsible for both long-term and short-term planning are identified and their commitment to the planning process is obtained.

Who Should Plan?

Planning is an on going process. Boards, administrators, and senior staff must participate. When we talk about strategic planning, we are talking about a 3- to 5-year vision for the center. That's the board's responsibility. But it is imperative to include the CEO and other members of the center's management team. Collectively, these senior staff usually possess the expertise and information needed to develop a reasonable course of action for the center and an implementation plan to manage it. Planning is a team effort, and all members of the team must "buy into" that plan.

The Planning Process

The planning process consists of six, sequential stages:

Stage 1: Mission Formulation

Stage 2: Organizational Assessment

Stage 3: Developing Objectives

Stage 4: Developing Action Plans

Stage 5: Implementation

Stage 6: Evaluation

Each of these stages is essential to the center's ability to accomplish its mission.

Stage I: Mission Formulation

The center's mission statement is the starting point for the plan. As we discussed earlier, the mission statement forms the foundation for all other strategic elements. As mentioned earlier, the mission statement should describe the values or beliefs that will shape the center's operations. While developing the mission statement may be a difficult and time-consuming task, it is critical because the mission statement will chart the center's future direction and establish the basis for decision-making.

PLANNING IS NOT:

- Magic; it involves hard work and careful direction—it does not just happen
- A search for obvious or convenient answers
- Simply a written plan that is relegated to a dusty bookshelf
- Something incomprehensible or to be feared
- Merely jumping through a hoop every few years to satisfy a regulatory agency or funding agent

Values. Values are the beliefs that shape the center and behavior of the board, CEO, and staff. Typically, an organization's values are organized and codified into a "philosophy of doing business." These organizational values explain how the center approaches its work, how it is managed internally, and how it relates to the community. Thus, values play an important role by influencing administrative decisions as well as employee actions.

Purpose of the Center. A clear mission statement:

- Defines the purpose of the center
- Allows the board, CEO, and staff to see themselves as part of a worthwhile enterprise
- Enables the board, CEO, and staff to see how they can improve the community through the work of the center

The success of the center will, to a large extent, depend on the clarity of the purpose statement.

Stage 2: Organizational Assessment

An important question facing the board is whether the center has the ability to accomplish its mission effectively. Therefore, during the organizational assessment stage of the planning process, special attention should be paid to collecting the following data that will influence the center's capabilities:

Critical Issues. The organizational assessment should include information about critical issues both inside and outside the center that might impact the strategic plan. A critical issue is defined as a difficulty that has significant influence on the way the center functions or on its ability to achieve its goals. Thus, a critical issue can be almost anything— funding, current Federal/State statutes and regulations, the center's policies and procedures, new technologies, politics, or community acceptance. The planning team needs to develop an issues agenda and prioritize any issues that the planning team believes will have the most impact on the center over the next 3 to 5 years.

Strengths, Weaknesses, Opportunities, and Threats.

The planning team should identify and rank the center's strengths and weaknesses, as well as its future opportunities and threats. Thus, the planning team should be able to identify strengths that can be utilized in accomplishing the center's mission, as well as isolate weaknesses that need to be avoided or managed. New opportunities and impending threats should be examined because the board is likely to find that much of the center's future may be dictated by forces outside its own structure. Therefore, no plans should be developed without studying these external forces.

Stage 3: Developing Objectives

At this stage, the planning team should ask, "What do we want the center to accomplish, and how do we measure our success or failure?" When developing objectives, the planning team should examine what is expected of the center from its users of services. The planning team should then compare those objectives with the information gathered about critical issues and the strengths, weaknesses, opportunities, and threats facing the center. The team should attempt to develop specific actions to manage critical issues by building on strengths, overcoming weaknesses, taking advantage of opportunities, and blocking threats.

If there is substantial discrepancy between the center's objectives and the capacity to achieve them, the planning team should re-evaluate these objectives and rework the plan, until the gap between the objectives and the capacity to achieve them is minimized. The center's board, CEO, and staff also may want to revisit any discrepancies during annual planning sessions (short-term planning).

Stage 4: Developing Action Plans

After objectives have been established, the planning team should identify the proposed ways in which *each* objective might be met. This effort should include analyzing the cost benefit of each objective and selecting specific strategies that are most likely to achieve the objective.

OBJECTIVES

What do we want the center to accomplish, and how do we measure our success or failure?

The action planning phase could be delegated to various members of the center’s board, CEO, or staff. Delegating these tasks also will help reinforce commitment to the plan and allow staff to “buy into” the planning process. The action plans should then be reviewed by the board, who then can identify any gaps in the various plans, determine how any gaps can be closed, and decide what impact, if any, the gaps might have on implementation of the strategic plan.

Stage 5: Implementation

During this stage, the plan is handed to the CEO and center staff to implement to achieve the required results. The true test of the overall action plan’s implementation and effectiveness is whether center staff use it in everyday decision-making.

By this time, the board has been involved in every stage of the strategic planning process. It is now important for the board to voice its commitment to the center’s strategic plan and demonstrate this commitment by dedicating the resources necessary to make the strategic plan a success.

During the implementation stage, the center’s CEO should submit periodic reports to the board about the center’s progress in achieving strategic objectives. The implementation stage also requires evaluating the action plan and making necessary changes to specific strategies to ensure that objectives are being met and the center’s mission is accomplished.

Stage 6: Evaluation

The decision to engage in the planning process and to develop and implement specific objective for the center involves substantial time and resources. The board, CEO, center staff, and the community have a right to know how well the center is working. They also need to know how to improve center operations and services to the community. Therefore, the evaluation stage should not be overlooked.

While an outside, independent evaluation may be preferable, much can be gained from self-evaluation. Even a very simple evaluation strategy can help ensure that the center continues to meet the community's needs and that it is responsive to changes both within the organization and in the external environment. Evaluation should be ongoing throughout the implementation of the plan. The evaluation strategy should include five major components:

- Defining the center's goals and objectives
- Detailing the center's history
- Defining the center's services
- Describing the impact and outcomes of the center's accomplishments and services
- Summarizing the center's accomplishments and providing recommendations for change

The evaluation will serve to identify successful strategies, as well as strategies, that many need to be modified to ensure that all objectives are met.

Short-Term Planning

Today, most boards participate in annual planning sessions or retreats. These retreats, which usually last from 1 to 2 days, are opportunities for the board and senior management staff to celebrate their accomplishments over the past year, reassess goals and objectives, and determine if any redirection is necessary.

WHY EVALUATE?

Even a very simple evaluation strategy can help ensure that the center continues to meet the community's needs.

**PLANNING HELPS BUILD
CONSENSUS, BUT**

Not everybody involved in planning will agree on what should be done.

This may be the first time that the board and management staff have come together to discuss and agree about what is most important to do and what can't be done. Not everybody involved in planning will agree on what should be done. Some participants, for instance, will want to aim the center in one direction while others will want to aim it in another. Even if participants agree on a direction, they may not agree on how to get there. Some may plead for a wide variety of services, while others may argue to provide fewer services, but in more depth. Don't be discouraged. This is typical. To move things along and come to closure—not necessarily unanimous agreement—you may want to utilize the services of a trained facilitator who will help move the planning process along.

Everyone should come out of the planning meeting with a sense of belonging to a team. And everyone should know where they want the center to go and be determined to get it there. This will keep the board from getting “side-tracked” in the upcoming year.

■ CONCLUSION

Planning can be exciting, challenging, and also one of the most rewarding parts of board membership. Planning is also a continuous process; it is important to realize that both strategic and short-term planning are required throughout the life of the center. Often, participants in the planning processes get bogged down and lose sight of planning's purpose. Keeping planning simple and consistent, with reasonable expectations, will ensure success. Special emphasis should be placed on reminding all of those involved in the planning process that both strategic and short-term plans are meant to serve as a framework for action in creating the center's future direction.



WHAT IS THE JOB OF A MEMBER OF A HEALTH CENTER BOARD?

At this point, you may be thinking: “Finally! Isn’t this the whole purpose of this Handbook—to be sure that I understand what my responsibilities are as a health center board member?” Yes, you are correct. But far too often, health center boards (and ultimately the health center’s entire future) run into trouble if the roles and responsibilities of the board as a whole and of individual board members aren’t clearly spelled out. It is potentially disastrous to jump into a discussion of what is expected of a board member without dealing with the very real distinction between what the board *can* and *should* do and what the individual board member *can* and *should* do.

The responsibilities of the individual board member and those of the board as a whole should complement each other. Sometimes, they may even seem to overlap. But they are fundamentally different. Board members *as individuals* have no special privileges or authority; the board must meet formally to make decisions or set policy. Individual board members, however, are expected to meet standards of personal conduct that are higher than those usually expected of other types of volunteers.

It is a good idea for the center to have a clear statement of what it expects from its board members, such as a written position description for board members. (See the sample job description for a health center board member.)

Board member responsibilities should relate directly to the center’s organizational needs and circumstances. A board member position description can help greatly in recruiting—it makes it clear what is expected before the new member accepts the position. It can also assist the board or nominating committee as it reviews the performance of individuals who are eligible for reappointment.

EVERY MEMBER OF A NONPROFIT BOARD OWES:

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

Job Description of a Health Center Board Member

DUTIES AND RESPONSIBILITIES OF INDIVIDUAL BOARD MEMBERS

- To put the interest of the health center above any personal or other business interest
- To maintain the confidentiality of board information
- To attend board meetings regularly and participate actively
- To serve on at least one committee
- To review information and data provided to the board and make informed decisions
- To exercise reasonable business judgment in the conduct of board business
- To participate actively in board issues by critiquing reports and providing innovative resolutions to problems
- To assure that the needs and interest of the community are represented in plans and decisions regarding services to be offered by the health center

REQUIRED KNOWLEDGE AND SKILLS OF INDIVIDUAL BOARD MEMBERS

- Understanding of the concept and operation of a health center
- Ability to read and understand standard financial statements
- Ability to work with others on the board and in a community setting
- Training and/or experience in one or more of the following areas is desirable:
 - management
 - community affairs
 - marketing/public relations
 - personnel management
 - health care delivery
 - financial management
 - employee relations
 - law

As is the case with discussing the role of a nonprofit board as a whole, a discussion of the role of the individual board member can be as detailed as we want it to be. But there are three “givens” that form the basis for board member responsibilities.

Every member of a nonprofit board owes:

- The Duty of Care
- The Duty of Loyalty
- The Duty of Obedience.

These are traditional terms that continue to be used to describe the standards of conduct and attention a board member must meet in carrying out his/her responsibilities to the organization. If the board member fully understands and carries out these duties, he/she will fulfill the responsibilities as a board member as well as act as a positive and energizing influence on the board as a whole.

THE DUTY OF CARE

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. No one expects the board member to *never* make mistakes or to *never* take risks. What *is* expected is that the board member should be *reasonably* careful when making decisions. This is sometimes called the “business judgment rule.” It is the board member’s responsibility to seek any needed training (e.g., regarding regulations, program expectations, and “good management” practices in the area of governance) so that each member is equipped with the knowledge needed for such decision making.

THE DUTY OF LOYALTY

This is the fundamental duty to be faithful to the organization. It means that the board member owes undivided allegiance to the center when making decisions affecting the center. In other words, the board member can *never* use information obtained in his/her position as a board member for personal gain. Trouble usually occurs when a board member uses center property for personal use or when a board member takes advantage of an opportunity available to the center. Board members *can* have business dealings with the center. But expect that those dealings

CONFLICT OF INTEREST

A conflict between the private interest and public obligations of a person in an official position.

will be subjected to close scrutiny. There should always be full disclosure of the board member's involvement in the business, and the transaction should always be in the best interest of the center.

Any discussion of duty of loyalty needs to include the subject of *conflict of interest*. The center must develop a specific written policy regarding how to handle a potential conflict of interest. That policy will be based on the various funding sources' rules and regulations. These regulations may be quite specific. For example, federally funded centers are clearly prohibited from hiring relatives of board members. Regulations may also prohibit the center from doing business with any member of the board or with relatives of board members. The written policy should be reviewed and approved by the board and reflected in its bylaws, as well as in the corporate policy manual.

Most States and the Federal Government have explicit regulations regarding conflict of interest. In such cases, it is important that the conflict be disclosed by the board member and that the member refrain from voting on the issue. The meeting minutes should reflect such noted conflict and the member's abstention from the vote.

THE DUTY OF OBEDIENCE

The board member is expected to be faithful to the center's mission. Board members also have a legal obligation to voice their own opinions about how the board should accomplish the center's mission and ensure that any objections to a board action are recorded in the board minutes.² However, once the board makes a decision or sets policy, the individual board member is not permitted to act in any way that is inconsistent with that policy or the goals of the center. It is important to keep in mind that a nonprofit health center relies heavily on the public trust. The public has a right to expect that each board member will never compromise or violate that trust.

² As a board member, if you fail to record your objection to a board action in the board minutes, you could be held liable for the consequences of board actions with which you disagreed.

OBEDIENCE MEANS:

Once the board makes a decision or sets policy, the individual board member is not permitted to act in any way that is inconsistent with that policy or the goals of the center.

The list in the following box provides examples from each of the three categories of duty. This is an extensive list of do's and don'ts. But it is important to remember that if you are careful, loyal, and obedient, the do's and don'ts will take care of themselves.

HEALTH CENTER BOARD MEMBERS DO'S

- Do know the center's mission, purpose, and goals as well as its programs and services
- Do get to know the center's strengths and weaknesses
- Do pitch in enthusiastically and willingly
- Do make sure you have all the information before expressing an opinion or a 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 even if you disagree
- Do support the CEO and staff, and understand that they are operating with limited resources
- Do avoid any possible conflict 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

Even when your term on the board ends, you can continue to lend your by being an effective ambassador for the center.

We are now at the point where we are ready to go on to explore some issues that deal with how the board operates and how it relates to the community.

module 2.

COME ON BOARD!

Let's review what has been covered so far. In Module 1, we examined the reasons for having a board, your role as a board member, and the responsibilities of the board as a whole. In this module, we focus on “nuts and bolts” issues: how the board is organized and how it actually operates internally, as a major factor in overall functioning of the health center, and externally, in relation to the community and to sources of funding.

INTERNAL RELATIONSHIPS AND FUNCTIONS

Running a health center can be a complex endeavor. Like any business, if the health center is operating efficiently, it will be able to provide the type and quality of services that its users expect. As a result, users are likely to be satisfied and continue to rely on the center for health care. Providing efficient, effective quality services is also critical to meeting the performance expectations of the center's funders.

It is important to remember that the health center's effectiveness is directly tied to how well the board operates. That does not mean that the board should be involved in the day-to-day operation of the center. What we do mean is that if the board is well organized and operating efficiently, it will be able to do its job successfully—that is, make policies that will ensure that the center can continue to meet the needs of the community it serves.

Time spent learning and applying the information presented in this module can increase board teamwork and effectiveness. These basic operational issues are important. Once the board understands these issues establishes procedures to deal with them, the board can then get on with one of its biggest jobs—planning (see Block 6 of Module 1).

There are many details involved in governing a health center in particular, board meetings and the mechanics of board work. New board members should be quickly oriented to these activities so that each board member is comfortable about participating in the board’s work and has the knowledge to carry out his/her legal and fiduciary responsibilities.

In the next section, we address the board’s internal rules and regulations—the ABCs of how the board is organized and does its work. All board members are legally responsible for knowing these rules and regulations and for abiding by them. The board is not expected to guess at what these rules are—most of the issues that we discuss likely are included in the center’s bylaws. In fact, each new board member should receive a copy of the bylaws as soon as he/she comes on board. Also, the Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC) may provide additional documents that cover many of these issues. Other useful documents and assistance may be available from the organizations included on the Resources List following this module.

BOARD ORGANIZATION

When we talk about board organization, we mean how the board is put together. We will look at key structural elements of any health center board and answer some basic questions such as:

- What determines the size of the board?
- Are there rules about who can be a member?
- How long should members serve?
- What are the typical responsibilities of “officers”?

Every board may operate a little differently, but all have to address certain basic issues. For health centers that receive Federal support, some of these issues, (e.g., “Who is on the board?” and “How large is the board?”) are mandated by specific rules and regulations.

Other issues, such as terms of office, are not regulated. However, good management practice requires that procedures be established and followed for each of these areas.

Board Size—Are We Too Big or Too Small?

When a board is determining its size, it should make sure that it is large enough to do its job but small enough to be manageable. The board should have at least enough members to:

- Represent all segments of the community
- Represent all areas of expertise required
- Complete the work needed without overloading some or all of the board members.

Keep in mind that it is easier to discuss issues and make decisions with a small group of people, but it is equally important to be sure that the board has the kinds of expertise it will need. Balance in terms of size and composition must be constantly reviewed. When boards get too large, it may be difficult to gain consensus on important issues. A board that is too small may not be able to carry out all of its required functions.

Board Eligibility—Who Can Become a Board Member?

Once internal rules (i.e., bylaws) establish the size of the board, the next step is to decide who should be on the board. Composition of the board must reflect the community and comply with any applicable regulations.

Just as funders may have rules about board size, it is likely that they will want to ensure that the board represents all segments of the community. Federal regulations are intended to ensure support by the user community—the people for whom the health center was originally founded.

WHEN A BOARD IS DETERMINING ITS SIZE, IT SHOULD MAKE SURE THAT IT IS LARGE ENOUGH TO BE ABLE TO DO ITS JOB BUT SMALL ENOUGH TO BE MANAGEABLE. THE BOARD SHOULD HAVE AT LEAST ENOUGH MEMBERS TO:

- Represent all segments of the community.
- Complete the work needed without overloading some or all of the board members.

COMPOSITION OF THE BOARD MUST REFLECT THE COMMUNITY.

In the following box, we have summarized requirements about size and composition of boards of community health centers that receive Federal funds. These requirements are meant to safeguard the founding principles of a federally supported center, and are provided as an example of how any health center might ensure it has a board that represents the community it serves. They are not meant to impose quotas of any kind.

HEALTH CENTER BOARDS—FEDERAL REQUIREMENTS

- The board must have at least 9, but no more than 25 members.
- At least 51 percent of the board's members must be users of the health center.
- Half of the remaining members of the board (49 percent or less) cannot earn more than 10 percent of their income from the health care industry. (Example: if the board has 10 members, then no more than 4 members may be considered "nonusers" of the center's services. Of those four, only two members may earn more than 10 percent of their income from the health care industry.)
- The remaining members of the board (49 percent or less) must represent the area served by the center and have expertise in community affairs; Federal, State, and local government; accounting; health administration; health professions; business; finance; banking; legal affairs; trade unions; insurance; and personnel management as well as social services such as religion, education, and welfare.
- Board members must reasonably represent the individuals served by the health center in terms of demographic factors:
 - ethnicity
 - race
 - sex
 - migrant/seasonal farmworker (if the center receives Federal migrant health grant funds)*.
- Employees of the center and their spouses, children, parents, or brothers or sisters (blood or marriage) cannot be members of the board.

* Please refer to the current edition of
Program Expectations for Community and Migrant Health Centers.

In addition to understanding the needs and viewpoints of the community, the center’s board will need members with a variety of skills and expertise. Though difficult to achieve for many boards, an ideal to aim for is to have at least one member who understands finance (although that person should never be solely responsible for preparing, reviewing, or making decisions about budgets), someone who has links to funding sources, someone who can help interpret legal issues, and someone who has experience in marketing or public relations. As was the case for size, the center’s bylaws should clearly state the rules about board composition.

To help explain some of the rules about board composition, we have included the following sample board composition evaluation tool, using “ABC Health Center”, a center serving migrant farmworkers located in an area that is approximately 20 percent African American, 30 percent Hispanic, with mixed income. Using this composition tool, the board can see that the ideal nominee for the next vacancy would be a female Hispanic migrant farmworker (the center receives Federal migrant health grant funding) who is between the ages of 50–59 and who earns below the poverty level.

Clearly it is unrealistic to expect to find a candidate that fits that description. However, these qualifications should be considered when it is time to fill the next board vacancy. Subsequent nominees to the “ABC Health Center” board should have experience in as many as possible of the following areas: government, health administration/professions, human resources, law, and marketing/public relations.

Board Selection—What Determines How We Choose Board Members?

In today’s environment, the skills required of health center boards are complex and comprehensive, selection of appropriate board members is extremely important. When the board selects new members, all of the factors we discussed must be considered.

HEALTH CENTER BOARD SELECTION CRITERIA

- The health center board member must represent some group characteristic of the community being served—namely, ethnicity, race, gender, age, economic status, and migrant/seasonal farmworker status.
- The health center board member should possess some type of expertise that is especially needed by the center.

**“ABC HEALTH CENTER”
SAMPLE BOARD COMPOSITION EVALUATION TOOL**

Categories	Current Composition	Ideal Composition	Req'd to Meet Ideal
Age			
70 and over	1	1	–
60–69	2	1	(1)
50–59	–	2	2
40–49	2	2	–
30–39	2	2	–
Under 30	3	2	(1)
Sex			
Female	3	6	3
Male	7	4	(3)
Race			
African American (if 20%)	2	2	–
Asian or Pacific Islander (if < 1%)	–	0–1	–
Hispanic (if 30%)	2	3	1
Native American or Alaska Native (if 4%)	1	0–1	–
White (if 50%)	5	3–5	–
Economic Status			
High	2	0–3	0
Moderate	7	4–6	(1)
Low	1	3–4	2–3
Areas of Expertise			
Acctg/Finance/ Banking	3	3	–
Business	2	2	–

The center’s bylaws should specify how to replace a board member who resigns before completing his/her term. Many boards will ask their nominating committees and the CEO for nominations and then hold a special vote of the full board to choose a successor to complete the term of the resigning member.

SAMPLE BOARD COMPOSITION EVALUATION TOOL (CONT'D)

Categories	Current Composition	Ideal Composition	Req'd to Meet Ideal
Areas of Expertise (cont'd)			
Community Affairs	5	5	–
Education	2	2	–
Fed./State/Local Gov't	1	2	1
Health Administration*	2	3	1
Health Professions*	3	4–6	1-3
Human Resources	1	1	–
Insurance	3	2	(1)
Law	1	2	1
Marketing/P. R.	1	3	2
Religious Orgs.	–	1	1
Union	3	3	–
Other	–	–	–
Length of Service			
Over 20 years	–	0–2	–
10–20 years	1	0–2	–
5–10 years	2	2–4	–
2–5 years	5	3–8	–
less than 2 years	2	3–4	1
Clinic Users (>50%)**	4	6 or more	2
Migrant Farmworker***	2	1 or more	–
Total Board Members	10	10	–

* Federal requirements mandate that fewer than half of the non-clinic users earn more than 10 percent of their income from the health care field.

** A majority of the board members must be individuals who are or will be served by the health center.

*** Representation mandated by Federal requirements for migrant health centers that receive HRSA funds.

CHOOSING NEW BOARD MEMBERS

Every time a new member is needed, rules regarding board composition continue to apply.

Board members should always be thinking about community residents who would make good board members. It may be a good idea to develop a “Board Member Position Description.” This can be a one-page summary of board member responsibilities, including estimates of time required by various committees, board meet-

ings, and other center activities. This document and the board composition evaluation tool will be of considerable help for the nominating committee when it comes time to fill a board vacancy.

Terms—How Long Should Board Members Serve?

Terms refer to the length of time that board members serve. Boards must develop their own rules about this issue. The center's bylaws should specify the length of a board term, and how many terms can be served consecutively.

Many boards have found that 3 years is a reasonable term of office. In the first year, the board member learns about the center and becomes familiar with board operations before moving into the next stage of active participation. During the second year, the board member should be ready to assume a leadership position as an officer or a committee chair. In the third year, while continuing to actively participate in board business, the outgoing board member also helps new board members “learn the ropes.”

Except in the case of a newly established health center, it would be impractical and potentially chaotic to have a board with all new members at the same time. That is why most boards stagger terms (i.e., alternate the number or percentage of board members who may be elected each year).

It is important that the center's bylaws deal with turnover among board members. The rate of turnover should provide sufficient continuity so there is familiarity with issues and effective participation (in other words, “institutional memory”)—usually by having staggered terms. Except at startup, there should never be a board composed of entirely new members.

One way to determine how many board members will be elected each year is to divide the number of board members by the length of a standard term. For example, if your center's board has 3-year terms, you would elect one-third of the board each year. By using this formula, there is provision for a balance of new board members and experienced board members.

TERMS SHOULD BE STAGGERED

Except at startup, there should never be a board composed of entirely new members

Another way that boards try to maintain balance is by limiting the number of terms that an individual may serve. Term limits have both positive and negative aspects. By limiting terms, more members of the community have an opportunity to serve on the board. Limiting terms also helps keep an individual board member or a small group from becoming too entrenched in doing “business as usual” or from gaining too much power. Term limits encourage new expertise, new energy, and new and different perspectives and ways of doing things. On the other hand, there is a risk of losing truly dedicated members or members with much-needed skills and talents. When deciding whether to adopt term limits, carefully consider board needs as well as the dynamics of the community.

Sometimes boards create special positions for ex-board members who are interested in continuing to serve in some capacity or who have a particular area of expertise. The board may allow for “ex-officio” members, or it may create an advisory committee of former board members. Through these special positions, an ex-board member may continue to support the center by, for example, serving as a “special liaison” with another community-based organization or helping raise funds. Through this assistance, former members can apply their knowledge about the center in dealing with ongoing, everyday issues so that current board members can deal with more pressing issues or crises without taking time away from strategic planning.

Boards need to encourage regular attendance at meetings and ensure active participation by all board members. Many health centers bylaws specify guidelines for terminating a board member if that person misses a predetermined number of meetings each year. Of course, there are always reasonable exceptions, such as serious illness or injury. These situations can be dealt with on a case-by-case basis. However, if a member consistently misses meetings, the board does not benefit from that member’s expertise.

EVERY TIME A NEW MEMBER IS NEEDED, RULES REGARDING BOARD COMPOSITION CONTINUE TO APPLY.

ALTHOUGH IT MAY BE FLATTERING TO BE INVITED TO BE A BOARD OFFICER, BEFORE ACCEPTING BE SURE YOU CAN DEVOTE THE TIME AND EFFORT NECESSARY TO DOING THE JOB.

Officers of the Board—Who Are They and What Do They Do?

Board officers, especially the chairperson, must be respected by other board members, have strong leadership skills, and be willing to commit the time to carry out the extra duties of being a board officer.

Selecting Board Officers

As is the case for board members, the rules for how and when board officers are selected and term of office should be part of the center’s bylaws. There are no set rules about selection or terms of office, but officers are usually elected at the first or last meeting of each year. It is important to select individuals who are leaders and who have the skills and experience necessary to do the job required.

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.

Although it may be flattering to be invited to be a board officer, before accepting be sure you can devote the time and effort necessary to doing the job.

Typically, board officers are the chairperson, the vice-chairperson, the secretary, and the treasurer. In the next section we discuss the responsibilities of these four positions.

Chairperson

Very early in life we learn that leaders tend to emerge in various group settings. These individuals keep the group organized, prod the group to move ahead, set rules for internal discipline, and try to help the group make sound decisions. The same holds for the center’s board. Somebody has to lead the board and maintain order. That person is the board chairperson (sometimes referred to as the “chair”).

The chairperson's job is usually defined in the center's bylaws. Chairpersons of nonprofit boards tend to have certain roles and responsibilities:

- **Team Builder:** It is the chairperson's job to make sure that the board functions as more than just a group of people. The board should work as a team, and it is the chairperson's responsibility to keep the team together to reach consensus (i.e., agreement), which may involve resolving conflicts.
- **Liaison:** The chairperson is the link between the board and the CEO. The chairperson's job is to convey board concerns and needs to the CEO as well as convey CEO concerns and staff needs back to the board. The chairperson often serves as a sort of advisor or "sounding board" for the CEO.
- **Planner:** The board chairperson generally takes a lead role in working with the health center's CEO to plan. The chairperson may provide input on approaches to large-scale issues and relatively minor planning tasks, such as the agenda for a board meeting.
- **Facilitator:** The chairperson makes sure that all board members have a chance to participate in discussions, attempts to ensure that all sides of an issue are addressed fairly, and encourages the board to take action. The chairperson makes sure that meetings begin and end on time and that all agenda items are discussed.
- **Delegator:** Depending on the bylaws, the chairperson may be responsible for assigning tasks to the board members most appropriate to carry out these roles. Therefore, the board chairperson is responsible for learning about each member's experience, skills, and interests. The chairperson is also responsible for making sure that committees perform their jobs.

ALL BOARD MEMBERS, INCLUDING THE CHAIRPERSON, SHOULD VIEW THEIR ROLE AS ONE OF FACILITATOR RATHER THAN CONTROLLER.

WHEN CONSIDERING
TERMINATING A BOARD
MEMBER, THE BOARD
MUST DO WHAT IS
BEST FOR THE
CENTER IN THE
“LONG RUN.”

Vice-Chairperson

The board vice-chairperson is the backup for the chairperson, and is often considered the logical successor when the chairperson’s term expires. The vice-chairperson frequently receives certain special assignments, such as leading a committee or taking charge of special activities. The vice-chairperson should work closely with the chairperson to stay abreast of all current issues and board operations and be prepared to take over for the chairperson, if necessary.

Secretary

The secretary is responsible for the notes (or minutes) of each board meeting. This is an important job—minutes are legal documents; they are a record of actions, attendance, and decisions made at the meeting.

Because all members of the board need to participate in discussing issues and setting policy, the board secretary may not be able to actually take the minutes of the meeting. That task may be assigned to a staff member who, in addition to taking the minutes, safeguards them for future reference and prepares all formal board correspondence. However, because the secretary is responsible for the accuracy and completeness of the minutes, the secretary should review and sign the minutes before they are forwarded to the full board. Thus, while the secretary continues to be responsible for maintaining the center’s historical and legal documents, other traditional tasks may be performed by a center staff person.

Treasurer

The treasurer is responsible for making sure that 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. This does not mean that the treasurer is responsible for managing the center’s finances. That is the job of salaried staff—the CEO, chief financial officer, business manager, or finance director.

It is appropriate for the treasurer to serve as the chair of the finance committee and help the committee review the annual and quarterly budgets before submitting them to the full board. The treasurer should also assist in interpreting financial reports for the board.

Now we are ready to talk about how a board actually operates—in other words, committees and meetings.

Board Operations

When we talk about board operations, we mean how the board does its work. Much of that work is done by committees, but meetings with all members participating are at the heart of board operations. Committees can conduct research and make recommendations, but a vote by the full board is needed to set policy.

Committees

A health center board deals with many complex and pressing issues. One way to resolve these issues efficiently so that the board can make informed decisions is to divide up the work—usually by assigning certain issues to board committees and center staff. By working together committees and staff study and develop recommendations to present to the full board for discussion and followup action.

Board members should expect to serve on at least one committee—perhaps two or three if the board has a limited number of members. Therefore, it is important that board members understand the types and purposes of the committees that are common to most health centers.

Working on a committee benefits the individual board member, the board as a whole, and the center. The member learns more about a particular aspect of the center's operations. The committee and the center gain from the individual member's expertise.

Usually, committees also present a brief review of the options considered to the full board and explain why they were not recommended. Sometimes, the committee chair will make a brief presentation and provide more detailed information in a written report.

COMMITTEE ISSUES

EXAMPLE 1

The board has to make a decision about whether to authorize purchase of a new furnace. The board designates an ad hoc committee to research other options, such as the feasibility and cost implications of repairing the furnace, and report back to the board.

EXAMPLE 2

A certain board member's term will expire at the end of the current year. The Nominating Committee reviews the board's composition requirements and also determines gaps in expertise. The Committee then begins to identify community members who might fill these gaps, and then presents its recommendations to the board.

This process documents that the committee has considered all facts and options. The board is then able to reach an informed decision faster. Committees should keep written records of their proceedings and report to the full board on a regular basis.

Committee Membership

There are no set rules about number, size, or type of committees, although the center's bylaws should include some guidelines about committee structure. Well-functioning committees are often a sign of a healthy board, but it is important to have only the number of committees needed. When the board creates a committee, it is advisable to have a "Committee Description"—a clear, written charge of the committee's responsibility, timeframe to complete the charge (i.e., assignment), and level of authority to act on the board's behalf—not unlike the "Board Member Position Description" we talked about earlier.

Types of Committees

Although there could be as many committees as there are issues, it is a good idea to keep the number of committees manageable. In the case of boards with a limited number of members, it may be helpful to have "committee overlap." For example, the Executive Committee could also serve as the Marketing Committee; or the Finance Committee could also serve as the Planning Committee.

Committees tend to fall into three basic categories. Because these committees probably already function within your center, it is important that you understand their similarities and differences.

- **Standing (or Permanent) Committees:** These committees function on a year-round, long-term basis. They should be described in your center's bylaws. They include: executive, finance, personnel, planning, and quality assurance. Even though these committees are considered permanent, the board should conduct an annual review of each standing committee to make sure that it continues to perform a necessary function.

- **The Executive Committee:** This is a special type of standing committee—typically it is made up of board officers, the CEO (usually an ex-officio, non-voting member), and sometimes chairpersons of the other standing committees. The board chairperson often chairs the executive committee.

The Executive Committee may meet to conduct critical business that cannot wait until the next board meeting, and it may have limited powers to act for the full board in emergency situations. However, all Executive Committee actions must be reviewed and approved by the full board. Like the board chairperson, the Executive Committee often functions as a “sounding board” for the CEO, providing feedback and guidance as needed between meetings of the entire board. However, the board should ensure that the Executive Committee never takes on more responsibility than what was originally given to it by the bylaws or by the full board.

- **Ad Hoc (or Temporary) Committees:** These committees are appointed by the board to study important issues as they arise. Ad hoc committees have a time-limited function, and they are disbanded when they complete their charge. Examples of ad hoc committees include audit, CEO search, CEO evaluation, and grievance (if the latter is not considered a responsibility of the Personnel Committee). Non-board members may be brought on to assist ad hoc committees.

Now let’s talk about what committees *can* and *cannot* do.

Committees Report to the Board

Each committee reports to the full board. Committee reports should summarize what the committee has learned and list recommendations for resolving specific issues.

COMMITTEES CAN:

- Investigate/research
- Report
- Make recommendations

COMMITTEES CANNOT:

- Set policy
- Act on their own
- Interfere with the daily operation of the center

COMMITTEES, IN AND OF THEMSELVES, HAVE NO POWER OR AUTHORITY EXCEPT WHAT IS VESTED IN THEM BY THE BOARD.

Although a board member may question a committee member about an issue, the board should remember that the point of having committees is to save time and streamline effort. If the full board engages in lengthy and repetitious discussions of committee work, time is wasted rather than saved. On the other hand, it is the board's responsibility to make policy decisions. Thus, the board should feel free to debate committee recommendations sufficiently to ensure that it has satisfied its obligations to the center. In short, the board should neither re-do committee work nor "rubber stamp" committee recommendations.

Committees Have No Power or Authority

The most important thing to keep in mind is that committees, except perhaps the Executive Committee, in and of themselves, have no power or authority. Their purpose is to make board operation more efficient and comprehensive. Committees are always responsible to the full board, which sets policy based on committee findings and recommendations.

Because committees sometimes take on work that should be carried out by the center's staff, board members need to understand the boundaries of committee relationships. Just like the full board, committee members should not interfere in the daily operation of the health center. The committee cannot cross the line between establishing policy and managing the center's operations. For example, the Personnel Committee may discuss and make recommendations concerning staff grievances, but it is the staff's responsibility to take action. The committee (or individual board member, for that matter) should never discuss any grievances with a staff member outside the formal hearing process.

Now let's talk about board meeting requirements and how to get the most out of these meetings without wasting time.

Board Meetings—Where the Action Is!

The meeting is the heart of board operations. It is during meetings that the board sets policy and keeps abreast of operational issues. It listens to reports from committee chairpersons and the CEO, CFO, medical director, and occasionally other senior staff, who summarize problems or issues encountered since the last meeting as well as anticipated issues or problems.

How well board meetings are conducted is a direct reflection of how well the board is operating. Effective board meetings are more than a gathering of members to discuss the latest topics of interest to the health center and the community. These meetings are formal events where decisions are made and recorded.

There are no set rules about the structure of board meetings. If your center receives Federal funds, however, the board is required to meet at least once a month and to maintain minutes. In some States, nonprofit organizations are required to hold their meetings in public. It is important that your board check with its legal advisor about your State's laws regarding meetings.

It is also important to point out that courts have ruled that you may violate your responsibility as a board member by failing to attend meetings. Even if you are not in attendance, you are liable for the decisions made at all board meetings.

Getting Ready

The board chairperson is responsible for running the meetings and guiding the board to make informed decisions. Each board member is responsible not only for attending the meeting, but for being prepared.

Board meetings require careful planning; they work best when an agenda is prepared and distributed in advance. It is helpful if the agenda includes time allocations for each item of business that will be discussed. Because each item may require a different type of action, it is also helpful if the item is labeled to indicate what action is expected, as shown in the following sample agenda.

**SAMPLE AGENDA
HEALTH CENTER BOARD MEETING**

Time	Presenter	Issue	Action Required
7:00 pm	Treasurer	Annual audit	Selection of CPA firm
7:15 pm	Treasurer and Chair Finance Committee	Monthly financial report	Board acceptance
7:25 pm	Chair, Building Committee	Building site update	Pending

RULES ARE IMPORTANT

Rules ensure that every board member has the right to discuss an issue and to agree/disagree with the discussion.

Following the Rules

Board meetings are a formal process; the board should establish a set of rules that determine how each meeting will be conducted. Traditionally, board meetings follow *Robert’s Rules of Order* or some other standard parliamentary procedures. Whether or not your bylaws specify that meetings must be conducted according to strict parliamentary format or in a less formal manner, those 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. No matter what rules you follow, remember that they are there to ensure the rights of every board member to discuss an issue and to agree and/or disagree with the discussion.

It is a good idea for each board member to have a basic understanding of parliamentary procedures so that you can help meeting discussions move forward. In fact, some boards provide an annual review of parliamentary procedures.

**MOTIONS—
THE BASIC PROCESS**

- Move (the motion)
- Second the motion (the support—needed to consider the motion)
- Restate (the chairperson)
- Discuss, clarify, debate
- Vote

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. The member making the motion simply addresses the chairperson or board officer presiding at the meeting and states, “I move that...” and then states the action the member wants the board to take. For example, “I move that we establish an ad hoc committee to study our center’s compliance with the current guidelines regarding Americans with Disabilities Act regulations.”

Most motions require that another board member agree with the motion by stating that they “second” the motion. Once the motion is seconded, it is restated by the presiding officer. The board may discuss the motion, although some motions do not require discussion. Although enough time should be allotted to discuss the motion fully, the presiding officer and other board members should try to keep the discussion focused and move it toward a decision—in other words, a vote.

The basic process is:

- Move (the motion)
- Second the motion (the support—needed to consider the motion)
- Restate (the chairperson)
- Discuss, clarify, debate
- Vote

Once the motion has been discussed, the chairperson or another board member will “call the question”—that is, ask that the board vote on the motion. Board members may be asked to vote by saying “aye” or “nay” (a voice vote), or they may vote by a show of hands. The minutes then indicate that the motion passed,

VOTING CHOICES

- Yes
- No
- Abstain (prefers not to vote)

SOME BASIC MOTIONS

- | | |
|--|---|
| ■ Amend a motion | ■ Choose methods of voting |
| ■ Withdraw a motion or second | ■ Vote |
| ■ Limit, extend, or end debate | ■ Confirm a vote |
| ■ Avoid considering an improper matter | ■ Suspend the rules temporarily |
| ■ Raise objections | ■ Reconsider or repeal a vote |
| ■ Question facts presented | ■ Reconsider a defeated vote |
| ■ Postpone to a set time to interrupt | ■ Request speaker’s consent |
| ■ Postpone indefinitely | ■ Refer to committee |
| ■ Table (“kill”) a motion | ■ Fix an adjournment time |
| ■ Question a quorum (enough members present) | ■ Accept or adopt reports of committees |
| ■ Take it from the table | |

whether the motion passed unanimously, or that the motion failed to pass. Members can also vote individually—using either the “roll call” method of calling each individual’s name and recording each vote in the minutes or the “ballot” method of using a confidential ballot. When the vote has been recorded, the chairperson will announce that the motion either passed or failed and will then move on to the next item on the agenda. If passed, the vote then becomes policy, which involves implementation by the center staff, or it may require some sort of followup action, either by the designated committee or the full board.

Formal rules exist to conduct meetings; but less formal use of the above basic motions can help expedite meeting business.

If you wish to have on record how you voted on a motion, ask that your vote (yea, nay, or abstain) 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.

In the following section, we discuss how the board operates externally—its relationships with the “outside world.”

**THE BOARD’S ROLES CAN BE
DEFINED IN TERMS OF ITS
RELATIONSHIPS WITH:**

- The community
- Health center staff
- Funding agencies

THE BOARD AND THE OUTSIDE WORLD

While most work will take place in meetings and committees, the health center board also plays several important roles outside the board room. These roles can be defined in terms of the board’s relationships with:

- The community
- Health center staff
- Funding agencies.

Understanding what is involved in each of these relationships is critical for positive and productive board operations—in fact, the future success and even existence of the health center may depend on how well the board understands its role in fostering and supporting these relationships.

THE COMMUNITY CONNECTION

This relationship is the most important relationship required by the center’s board. When we speak of the health center “community” we really mean two things:

- The actual “user” population of the health center
- Other health and social service organizations and providers within the same general geographic area or neighboring areas.

The Community of Users

In the first part of Module 1, we pointed out that the reason for having a board is to make sure that the health center provides services to meet the needs of its users. To do this, the board must actively communicate with the community and respond to the needs of the community with health center programs.

The board has another role as well. It represents the health center to the community. So, while the board has a responsibility to maintain its link with the community to understand needs and gather information, it also has a responsibility to serve as an advocate for the health center and promote center programs and services within the community. In other words, the board serves as a public relations arm of the center, and each board member is an unofficial, or sometimes official, spokesperson for the health center. The role of spokesperson is closely tied to the duty of loyalty discussed in Module 1.

Public Relations

Public relations does not have to be complicated, or even very time consuming. It can mean speaking to civic groups; talking informally with members of the community about the health center’s programs and services; or using the media to promote the health center through news releases, articles, and letters to the editor. In other words, the board is using public relations to “reaffirm” the health center’s mission to the public and to hear back from the community if that mission is not in keeping with current community needs.

THE ROLE OF
SPOKESPERSON IS
CLOSELY TIED TO THE
DUTY OF LOYALTY.

Community Fundraising

Another part of the board's relationship with the community is to act as fundraiser for the center. Like the rest of us, most board members find it uncomfortable to ask for money. It is important to remember, though, that when its income begins to dwindle, the center has two options—cut programs or raise money. It should be clear which is the preferred option. Cutting programs can jeopardize the center. Finding funds will not only maintain the center, these funds can help ensure its position in a changing environment.

It is also logical to expect that board members should be the center's fundraisers. The board is viewed as a group of volunteers truly dedicated to the center. Some board members begin their fundraising efforts close to home—they may be able to contribute personal funds to the center, as well as their time. Other board members may not be in a financial position to contribute. Regardless, board members have a responsibility to actively support the center's fundraising efforts such as:

- Annual campaigns, such as direct mail, telephone calls, and personal contacts
- Special events, such as dinners or open houses
- Capital campaigns for specially designated purchases or projects, such as an addition to a clinic site
- Planned gifts, such as bequests or endowments.

No matter what the fundraising activity, the board members may be asked to provide lists of personal friends, corporate contacts, professional associates, and organizations to solicit. The board also should offer to make solicitation calls on behalf of the center. A team effort spells successful fundraising. Coordinate fundraising with the full board and the CEO.

The “Other Provider” Community

The center's success in providing relevant services, especially in an era of limited resources and complex health and social problems, depends on its success in developing and maintaining linkages with other service providers in the same catchment area.

Since health care needs in communities served by health centers are extensive and cannot be addressed by any one provider, it is imperative that your health center be an active participant in your community's overall health system by collaborating with other providers to identify and address health care needs. To ensure that the health center is an integral and active part of your community's health care and human service delivery system, the center must foster linkages and participate in consortia and task forces dealing with health care issues in the current marketplace.

The board has an obligation to foster and support these linkages. For example, before the board sets a policy that the center will provide primary health care services to persons with HIV infection, it must work with the CEO to find out what types of services are being offered by other providers, such as the United Way, community religious organizations, and the area health department. Once these other services are identified, the board can decide to help the CEO establish contacts with those agencies. For instance, a board member may also sit on the board of the local United Way, have a colleague who is affiliated with the health department, or be a member of a local religious group that provides home visits and meals to persons with HIV infection.

These types of relationships provide a basis for collaboration and capacity-sharing within a community. While it is the CEO's responsibility to "formalize" these networks, the board is often the critical link to other community service providers.

Collaboration is pivotal to the health center's success, especially in today's marketplace. It is clear that in a managed care environment, the center's users are likely to have more options available to them as other health care entities establish themselves in areas that have traditionally "belonged" to health centers.

THINGS TO KEEP IN MIND

- Fully understand the board's position on important issues so that you are able to explain and support that position.
- You speak only for yourself—not for the full board, unless you have been authorized to do so.
- Make no promises. You have no power as an individual; therefore, you cannot promise that the board will take a specific action on an issue.
- Know the board's policy about communicating with the media.
- Listen to what the community has to say and be sure to channel any complaints or compliments through the board to the CEO—do not deal directly with staff.

HEALTH CENTER LINKAGE OPPORTUNITIES

“HORIZONTAL” LINKAGES

- Other health centers
- Programs for special populations
 - perinatal
 - homeless
 - public housing primary care
 - HIV primary care
 - healthy schools/ healthy communities
- Public health departments
- Child welfare agencies
- Community mental health centers
- Adult and child day care centers
- Head Start programs
- Migrant legal services

“VERTICAL” LINKAGES

- Hospitals
- Private specialty practice groups
- Long-term care facilities
- Teaching universities
- HMOs
- Other managed care organizations, such as PPOs or IPAs

Today’s competitive environment underscores the need for stronger, more enlightened boards. Boards must fully understand that a health center’s success depends on its ability to develop both “horizontal” (provide primary care services parallel to the center’s) and “vertical” (complementary services such as inpatient, specialty, and subspecialty care) linkages.

These are challenging times; they also are exciting times for health centers and for their boards. The board’s challenge lies in maintaining the integrity of the center’s mission. The board also has an exciting opportunity to broaden and enhance the range of services that the center currently provides.

Relationships with Health Center Staff

There is no doubt that an open and collegial working relationship between the board and the CEO is key to the health center’s success. As we have stressed throughout this Handbook, it is impor-

CHARACTERISTICS OF A HEALTHY BOARD/CEO RELATIONSHIP

- **High level of trust:** The board trusts that the CEO openly discloses information. The board trusts that there is balance between the CEO and the Executive Committee—that the Executive Committee and the CEO do not make decisions to the exclusion of the full board.
- **Confidence in the CEO:** Even when working with a relatively untrained board, the CEO consults the board before making any programmatic or operational decisions.

tant that the board understand and fulfill its role in making policy while the CEO maintains control over the daily operation of the center. In the first section of this module we discussed that this relationship is often fostered by an even closer working collaboration between the Executive Committee, especially the chairperson, and the CEO.

The CEO also serves as the primary communication link between the center’s

board and staff. Through the CEO, health center staff are assured that their input will be incorporated into business discussions about the need for new or revised programs and services, billing and

collections, site development, and training. As we discussed earlier, the board should expect a report from the CEO and the medical director at each board meeting. Occasionally, other senior staff will report to the board as well.

Various staff members, including administrative and clinical staff, may be asked to participate in special board meetings such as strategic planning sessions. Their input, as well as their participation, can be the key to success.

We are now ready to discuss the third type of relationship that involves health center boards, namely, the interaction of the board with various funding agencies.

Relationships with Health Center Funders

To support the delivery of primary care services and its various programs, the health center relies on support from various groups or organizations. Some of that support may come from Federal, State, or municipal agencies. Other funders may be national or local private philanthropic or charitable organizations. Most health centers receive funding from a combination of these sources.

While the board is not expected to know all the details of these funding arrangements, the board is responsible for knowing:

- Who those funders are
- The basic “rules” established by various funders
- Potential impact of changes in funding
- How to educate and inform health center funders.

Funders and Their Rules

The Federal Government continues to be a primary source of funds for health centers. These funds are usually in the form of grants. In most cases, the major funding partner is the Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS). A BPHC-supported center’s primary relationship will be with a Government Project Officer located in a regional

THE BOARD MUST DEVELOP STRATEGIES TO IDENTIFY POTENTIAL FUNDERS AND ESTABLISH LINKS WITH OTHER HEALTH SERVICE PROVIDERS.

office or with staff in the BPHC central office in Bethesda, Maryland. The Project Officer assigned to the grantee (i.e., health center) assists the center in complying with requirements and reporting procedures in order to continue to qualify for BPHC-supported program funds.

Other DHHS agencies may also fund health center programs. For example, the Centers for Disease Control and Prevention may provide funds to the center for immunizations for infants and children.

It is likely that the health center supports its operations through fee-for-service programs or capitated arrangements. For example, a significant percentage of health center costs may be defrayed through Medicaid reimbursements—a State-administered program jointly funded by the State and Federal Governments. Medicaid reimburses health care providers for services to eligible low-income individuals. In most cases, Medicaid payments account for approximately one-third of a health center’s yearly revenues.¹ If the center serves older adults, it is also likely receiving Medicare reimbursements—a federally subsidized program administered by DHHS’s Health Care Financing Administration.

Other public, corporate, or philanthropic funders have varying expectations and accountability requirements as part of their grants. It is the board’s responsibility to ensure that those reporting requirements are met.

The board is also responsible for understanding how changes in the political and social environment can impact changes in Federal and State funding policies. The board must develop strategies to identify potential funders and establish links with other health

¹*America’s Essential Providers: The Foundation of Our Nation’s Health System.* Gage, L.S., et al., 1995, National Association of Public Hospitals.

service providers. The board must also be prepared to make the views of health center constituents known to current and potential funders. In other words, the board serves as the health center's advocate.

Educating/Informing Public Policymakers

All nonprofit boards, including health center boards, rely on the support of policymakers. This requires keeping them aware of the continued need for various grant and entitlement programs. This can be as simple as accompanying the CEO when the CEO visits a funding source, or more complex such as presenting the board's position on an issue before a legislative committee or delegation. Educating and informing policymakers can also involve writing letters to the editor of a local newspaper, taking a position for or against certain proposed legislation, or organizing other members of the community to work on behalf of the center. Another effective strategy is to invite a legislator or policymaker to visit your center.

■ **Caution:** While educating and informing policymakers is an activity important to the center, it also presents a minefield of potential problems. There can be a fine line between educating/informing and lobbying. And, there are specific Federal laws precluding lobbying with Federal funds. Before embarking on educational/informational activities on behalf of the center, understand the distinction between educating/informing and lobbying and ensure your activities fall into the former category. Check with the center's legal counsel.

THERE CAN BE A FINE LINE
BETWEEN EDUCATING/
INFORMING AND LOBBYING.

DON'T GUESS—CHECK
WITH THE CENTER'S LEGAL
COUNSEL.

EXTERNAL ADVISORS

In addition to individual members of the board and the center's CEO, there are external advisors and resources available to health center boards. Some Federal advisors include the BPHC Project Officer mentioned previously. In addition, assistance is provided through State and regional primary care associations and national organizations that are supported by BPHC.

Other resources are available to provide information, training, and support. Some of these organizations include State primary care associations, the National Association of Community Health Centers, and the National Rural Health Association, each of which sponsors regional and national conferences with sessions specifically designed to train and orient new board members. Most health center boards also utilize the services of special advisors or consultants, including attorneys, accountants, and other as-needed resources such as architects, engineers, and contractors. A listing of some national resources follows this section.

If you are beginning to feel that being a member of a health center board is more than you bargained for, and you are expected to know too much, don't be discouraged. While it is true that being a member of a health center board involves your commitment of time and attention, it can be a very rewarding and positive experience. Remember that you were asked to serve on the board because other board members recognized your skills and expertise. You are not expected to know everything—being on the board is a learning experience.

REMINDER

Utilize available resources

APPENDIX A

RESOURCE LIST

The following organizations can be a source of information about community board operations:

- National Charities Information Bureau
19 Union Square West, 6th Floor
New York, NY 10003-3395
(212) 929-6300
(212) 463-7083 (fax)
www.ncib.org/

- Philanthropic Advisory Service of the Council of Better Business Bureaus
4200 Wilson Boulevard, Suite 800
Arlington, VA 22203
(703) 276-0100
(703) 525-8277 (fax)
www.bbb.org/

- National Center for Nonprofit Boards
1800 L Street, NW, Suite 900
Washington, DC 20036
(202) 452-6262
(202) 452-6299 (fax)
www.ncnb.org/

- National Assembly of National Voluntary Health and Social Welfare Organizations
1319 F Street, NW, Suite 601
Washington, DC 20004
(202) 347-2080
(202) 393-4517 (fax)
www.nassembly.org/

The following HRSA/BPHC-supported organizations provide resource materials to health centers, health planners, policymakers, researchers, information centers, and others. In some cases training and/or technical assistance is also available through these sources.

- Association of State and Territorial Health Officials
1275 K Street, NW, Suite 800
Washington, DC 20005-4006
(202) 371-9090
(202) 371-9797 (fax)
www.astho.org/

- HRSA Information Center
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182
(888) ASK-HRSA
(703) 821-2098 (fax)
www.ask.hrsa.gov/

- National Association of Community Health Centers, Inc.
Suite 122
1330 New Hampshire Avenue, NW
Washington, DC 20036
(202) 659-8008
(202) 659-8519 (fax)
www.nachc.org/

- National Association of County and City Health Officials
1100 17th Street , NW, 2nd Floor
Washington, DC 20036
(202) 783-5550
(202) 783-1583 (fax)
www.naccho.org/

- National Center for Farmworker Health, Inc.
1770 FM 967
Buda, TX 78610
(512) 312-2700
(512) 312-2600 (fax)
www.ncfh.org/

- National Rural Health Association
1 West Armour Boulevard
Kansas City, MO 64111
(816) 756-3140
(816) 756-3144 (fax)
www.nrharural.org/

Your health center's CEO and BPHC Central and Regional Office staff can also provide information about resources available through State/Regional Primary Care Associations, State Cooperative Agreements, State Offices of Rural Health, and national technical assistance contracts.

APPENDIX B

HISTORY OF THE HEALTH CENTER MODEL

This country's current system of health care delivery, including nonprofit health centers, did not evolve in a vacuum. Rather, the roots of this system, as well as the crisis surrounding the system, are firmly grounded in the sociology, philosophy, politics, and economics of the latter half of the 19th and the early part of the 20th century. To successfully understand the current system of health care delivery and the problems of access, quality, and cost that confront this country today, it may be helpful for you, as new members of a health center board, to look back to the roots of those issues and problems. Therefore, together with a discussion about the issues surrounding operating and governing a health center in today's complex and constantly changing business environment, we have included this brief review of the history of the health center model as it has evolved into its present form.

Much of the information included in this overview focuses on the role of the Federal Government in the development of that model. But not every health center depends on Federal funds; and most rely on funds from sources in addition to the Federal Government, including other third-party payers and patient fees. In fact, today it is more common that the Federal Government serves as the "national partner" in a multi-tiered business arrangement of various funding agencies, all with different criteria and reporting requirements.

Health Centers in Retrospect

The beginnings of the current model of health centers can be traced back to the health center movement, which began in this country between 1910 and 1920 as a reaction from public health officials to the split or overlap of services provided to schoolchildren; mothers and infants; and patients with venereal disease, tuberculosis, and other conditions. According to Paul Starr in *The Social Transformation of American Medicine*,¹ the concept of a

health center enjoyed wide popularity until the 1930's, when it faded. It was not until the 1960's that the health center model was revived, and then in a much-altered form.

The Early Years: Private and State Involvement

The early health centers were established to coordinate health department programs and the efforts of local voluntary agencies within a particular neighborhood. Starr quotes health reformer Michael Davis' 1927 definition of a health center as an "organization which provides, promotes, and coordinates medical services and related social services for a specified district."²

As Starr points out, "health center" was a rather loose term, applied to child welfare stations, settlement houses, hospital outpatient departments, and tuberculosis and venereal diseases clinics. In contrast to the current model, these early health centers did have one thing in common—they were always meant to serve as an addition to rather than a replacement for the private practitioner.³ In general, these centers were supported largely by local health departments and private philanthropies as well as by various church and business groups. At this time, Federal involvement was virtually nonexistent.

At the end of the First World War, the New York State Commissioner of Health suggested organizing a network of health centers to meet the medical needs of the State's rural counties with a declining availability of physicians. He envisioned health centers consisting of a hospital, outpatient clinic, laboratory, and facilities for public health programs. Although proposed as a way to complement rather than replace the individual physician, this plan drew widespread opposition from the medical community. The bill that was finally passed authorizing State aid to counties for public health facilities failed to provide for health centers.⁴

The few health centers that did develop provided only diagnostic services and referred the patient to private physicians for treatment. According to Starr, this "artificial" separation of diagnosis from treatment laid the groundwork for what would be later

termed the “fragmentation” of this country’s medical care delivery system.⁵ This so-called fragmentation of services would surface again in the 1960’s—becoming a source of heated debate and controversy among health care reformers.

Federal Involvement: The Neighborhood Health Center

In 1965, the first neighborhood health centers (NHCs) were funded as demonstration projects by the Office of Economic Opportunity (OEO) as part of the War on Poverty. Although health care had not been identified as a priority in the original War on Poverty, it soon became apparent that poor health and lack of access to medical care were major obstacles to the success of OEO’s community-based educational and job training programs.^{6,7}

It was at this time that two New England physicians submitted a proposal to OEO for an NHC. Through their efforts and the support of OEO staff, a new model of health care delivery was established. The first two NHCs were opened—one in a Boston housing project in 1965 and a second in rural Mississippi in 1967. In 1966, the Economic Opportunity Act was amended and authorized \$50 million to “develop ‘comprehensive health services programs’ in rural and urban low-income communities.”

Although NHCs were initially met with skepticism and suspicion by bureaucrats and the mainstream medical community, the basic concepts underlying their formation spread very quickly. Based on the belief that consumers and patients of all socioeconomic levels have the right to exercise control over their own affairs within the community where they live, the NHC model had four major components—(1.) comprehensiveness, (2.) training and employment of community residents, (3.) community participation in the governance of the center, and (4.) delivery of cost-effective family-oriented primary care services.⁸ Aside from the training component, these values have survived and still form the underlying requirements driving the establishment and operation of today’s health centers.

According to Larry Patton in his report *Community Health Centers: The Early Years of the Movement*, at this point, NHCs were still virtually unnoticed by national organizations such as the American Medical Association and the American Hospital Association. Local physicians and hospitals did notice, and tended to react negatively. Patton relates that it was not unusual for some hospitals to refuse admitting privileges to NHC physicians. Some private practitioners refused to transfer patient records and some health departments were particularly hostile to the possible intrusion of the Federal Government into local health care delivery.⁹ There are still areas of the country where this is true.

This resistance from local practitioners led to the passage in 1967 of an amendment requiring NHCs to target their services to those below the poverty level. NHC services would be provided based on income rather than residence. There was now a clear demarcation between Government medicine for the poor and private medicine for the rest of the community¹⁰—direct reversal of the initial concept of the NHC serving anyone who lived within the service area. Besides greatly adding to the administrative costs of the NHCs, the concept of “ineligibility” was now firmly established.

By 1968, a total of 32 centers were in operation, and another 16 had been funded and were in various phases of planning. Within 5 years, 150 health centers had been established. Three of every four centers were located in urban areas, and it was estimated that these NHCs could provide services to 1 million individuals when fully operational.^{11,12}

In the late 1960’s, several types of grant programs were consolidated. Funds were no longer automatically allocated to the States, and awards were made at the discretion of the Federal program. The focus shifted from the State to the community level and innovation in the delivery of health care was encouraged.

The 1970's: The Emergence of the Community Health Center Model

During the early 1960's, the Nixon administration dismantled OEO and transferred its programs to the U.S. Department of Health, Education and Welfare (DHEW), which was later re-named the Department of Health and Human Services (DHHS). The policies of DHEW at that time reflected the Nixon and later the Ford administrations' determination to control Federal spending by returning power for many programs to the State and local levels. In 1972, the Bureau of Community Health Services (BCHS), later to become the Bureau of Health Care Delivery and Assistance (BHCA) and then the Bureau of Primary Health Care (BPHC) in DHHS, was created. Bureau staff were almost immediately confronted with a real challenge. As a response to concern in Congress about the efficiency of management and cost effectiveness of individual health centers, some Government policymakers wanted to phase out the entire health center program. The administration was determined at least to reduce funds for health centers and terminate certain types of health programs.¹³ If the health center program were to survive, BCHS would have to demonstrate to Congress that health centers were not only effective, but also necessary. Bureau staff capitalized on the situation described in the next section to gather critical congressional support to ensure further participation of the Federal Government in the health center program.

The Rural Health and Urban Health Initiatives

As early as 1973, it became apparent that approximately half of this country's medically underserved people resided in rural areas. However, as much as 85 percent of health center grant dollars went to cities. Through the development of the Rural Health Initiative (RHI), resources were concentrated in areas perceived to have the greatest need, and BCHS demonstrated the ability to deliver more cost-effective services more efficiently. But this program did much—it gained political support from rural Congressmen who had previously viewed the health center program as an “urban ghetto program”¹⁴ thus, preserving the federally based health centers program.

To further demonstrate that the health center program was efficient and productive, “measures of productivity” were established to evaluate individual health centers. However, it was not until the late 1970’s that program monitoring, efficiency, and “capacity-building” became central themes with BCHS.¹⁵

In 1975 BCHS awarded 35 new grants for “urban health initiatives” (UHIs), which were to be modeled after the rural programs, thus solidifying political support from key urban Congressmen. It is important to point out basic differences between the UHI and NHC models:

- The focus of the UHI was to coordinate and maximize existing resources and use available providers to reach previously unserved populations, in contrast to the NHC which was envisioned as a major new resource for job training and community development.
- UHIs were established to deliver basic medical care rather than the more comprehensive health services in the NHC model.

Self-sufficiency Tied to Reimbursement

From its beginnings in the 1960’s, the intent of the NHC program was to foster self-sufficiency and negate the need for continued grant funds. It soon became evident that to achieve that goal, health centers would have to recover the maximum allowable from Medicaid and Medicare as well as reimbursements from other third-party payers. Beginning in 1973, there was a movement among health centers to develop the more sophisticated accounting systems needed to process Medicare reimbursement requests. Although required by the Federal Government to reimburse for outpatient hospital care in a hospital clinic, Medicaid reimbursement for services obtained at an ambulatory care center was not a well-established procedure. Reimbursement for care at health centers was considered optional under Medicaid reimbursement guidelines.¹⁶

The Emergence of the Primary Care Center

In an attempt to facilitate Medicaid reimbursements, in 1980 the Carter administration recommended that reimbursement for clinic services become mandatory under Medicaid and that “organized primary care providers,” including community and migrant health centers, be designated as “clinics.” However, the measure was never enacted.¹⁷

According to a noted historian of the CHC model, the Reagan administration, when it came into office in 1981, had a goal of “reversing the growth of the Federal Government and turning the administration of social programs over to the States and local governments.” The administration used the mechanism of budget reconciliation to force “massive cuts in spending” and reinstated block grants to the States.¹⁸

Within this environment, the health center and family planning programs became extremely controversial. By 1982, a total of 186 CHCs had been defunded. Defunding was based on five criteria:

- Relative need of the service area
- Administrative efficiency
- Review of billing and collection procedures
- Results of the most recent audit
- Comments from Governors, State health departments, and State medical societies.¹⁹

Not only do these criteria still exist today, they form the basis for the roles and responsibilities of health center board members.

Ronald Reagan’s second term was characterized by a continued commitment to reduce the Federal role while increasing State involvement in providing health care to the underserved. For the most part, President Bush followed the same agenda. However, the Bush administration soon found itself having to deal with two major public concerns: (1.) the growing Federal deficit and (2.) the issues of access, quality, and control of the cost of health care.

The Current Health Care Environment

Most Americans understand that we are dealing with a crisis in our health care system. The delivery of health care in this country has become big business, and we are still trying to solve the same problem of access and quality that faced health care reformers in the early part of this century.

There is widespread concern about the impact of increased health expenditures on the Federal deficit. “Managed competition” has become a catch phrase among health policymakers; and there is support for implementing “managed competition,” possibly within the current framework of health maintenance organizations (HMOs). In one observer’s opinion, “...the current health policy environment has become increasingly structured for competition.” Health center administrators and governing boards are expected to organize their centers to compete with, or team with, other health service organizations in providing cost-efficient, “managed” health care.²⁰ It is clear that most health care reformers, including physicians, agree that the traditional “fee-for-service” system cannot survive in its present form. It is less clear, however, that any significant reform will be able to successfully navigate the turbulent political environment created by economic issues and vested interests.

One possibility is that health centers will continue to be encouraged to contract with HMOs, Integrated Service Networks, primary care associations, or other public and private organizations to provide outpatient services as well as to practice strategic management and market their organizations to consumers and clinicians while maintaining their community-based boards. The new environment requires that the health center be strong enough to compete for new markets of private, non-grant dollars within the current health center model while continuing to deliver comprehensive primary care to low-income populations.

The directive for governance to health center boards promises to be more, not less complicated. More than ever, board members

have to understand their roles and responsibilities, and they must adjust to a constantly changing and complex business environment. Board members are now expected to practice creative strategic planning to meet the challenge of how to deliver much-needed quality services to their community.

Access to health care services—both economic and geographic—has challenged government and community leaders for more than a century. Health centers have evolved out of a history of maternal and child health, rural and urban health, and epidemic prevention programs to improve access to care, reduce needs for more costly hospital services, and support people to maintain healthy and productive lives. Health centers have established a role—as health providers and employers. They have become a key link in the primary health care system, and are part of the solution to the problems of access for people in communities throughout the Nation.

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16. *Ibid.* p. 128–129.
17. *Ibid.* p. 132.
18. *Ibid.* p. 165.
19. *Ibid.* p. 182.
20. *Ibid.* p. 192

APPENDIX C

CHRONOLOGY OF THE COMMUNITY HEALTH CENTER MOVEMENT

- 1910–1920’s Beginning of the health center movement; centers were basically established to coordinate health department programs and efforts of volunteer neighborhood agencies; “health center” term applied loosely to child welfare stations, settlement houses, hospital outpatient departments, and tuberculosis and venereal disease clinics.
- 1930’s Health center concept faded.
- 1965 Federal involvement began as part of the War on Poverty and health centers were funded as demonstration projects by the Office of Economic Opportunity (OEO). There were four major components to this health care model: (1.) comprehensiveness, (2.) training and employment of community residents, (3.) community participation in governance of the center, and (4.) delivery of cost-effective family-oriented primary care services.
- 1966 Economic Opportunity Act amended, authorizing \$50 million to develop comprehensive health service programs in low-income rural and urban communities.
- 1967 Economic Opportunity Act amended; health centers required to target those below the poverty level.
- 1968–73 150 health centers had been established; 3 of every 4 centers were in urban areas.

- Early 1970's OEO dismantled; programs transferred to DHEW (now DHHS); Nixon and Ford administrations attempt to control Federal spending by returning power for a number of programs to the State and local levels and reduce health center funding; Congressional concern regarding level of productivity and management of health centers. CHC model developed.
- 1980 Carter administration fails in attempt to make health center services mandatory under Medicaid.
- 1981 Omnibus Budget Reconciliation ACT (OBRA) enacted as part of the Reagan administration goal of reversing growth of Federal Government and turning governance of social programs over to State and local agencies.
- 1982 Under OBRA, 186 health centers are defunded; 5 criteria for defunding: (1.) relative need of the service area, (2.) administrative efficiency, (3.) review of billing and collection procedures, (4.) results of the most recent audit, and (5.) comments from Governors, State health departments, and State medical societies.
- 1995 There is widespread concern about the impact of increased health expenditures on the Federal deficit. The current health care structure is increasingly competitive. Governing boards will be expected to build linkages and provide cost-effective managed care to compete.

