



# Governance

## Public Housing

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Hudson River HealthCare, Inc.

## History: *Our Enduring Legacy*

HRHCare  
COMMUNITY HEALTH

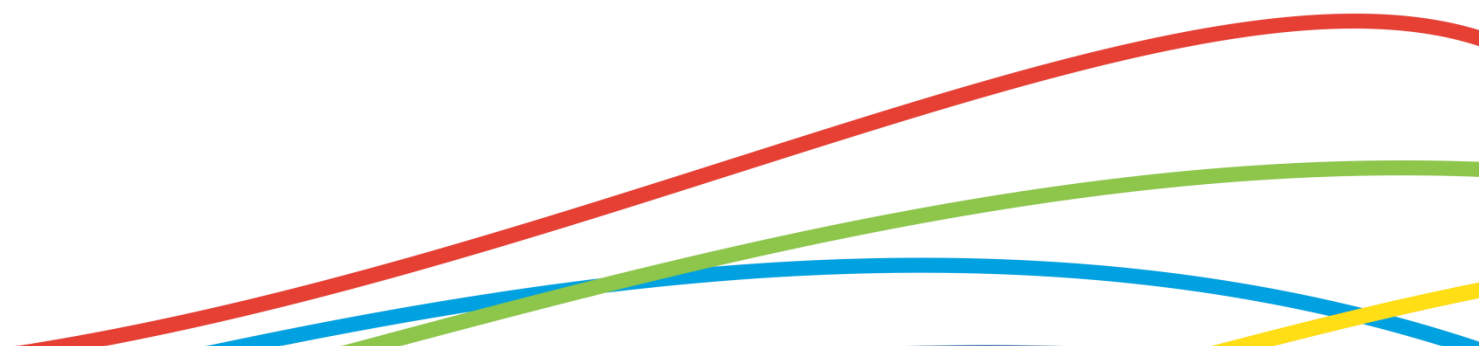


In the early 1970's a group of local residents and religious leaders addressed the lack of appropriate health services in their community. In particular, a group of four women, fondly referred to as our founding mothers, spearheaded the efforts and have remained committed to the organization since its inception. Our CEO completes this picture having served in her position since 1977.

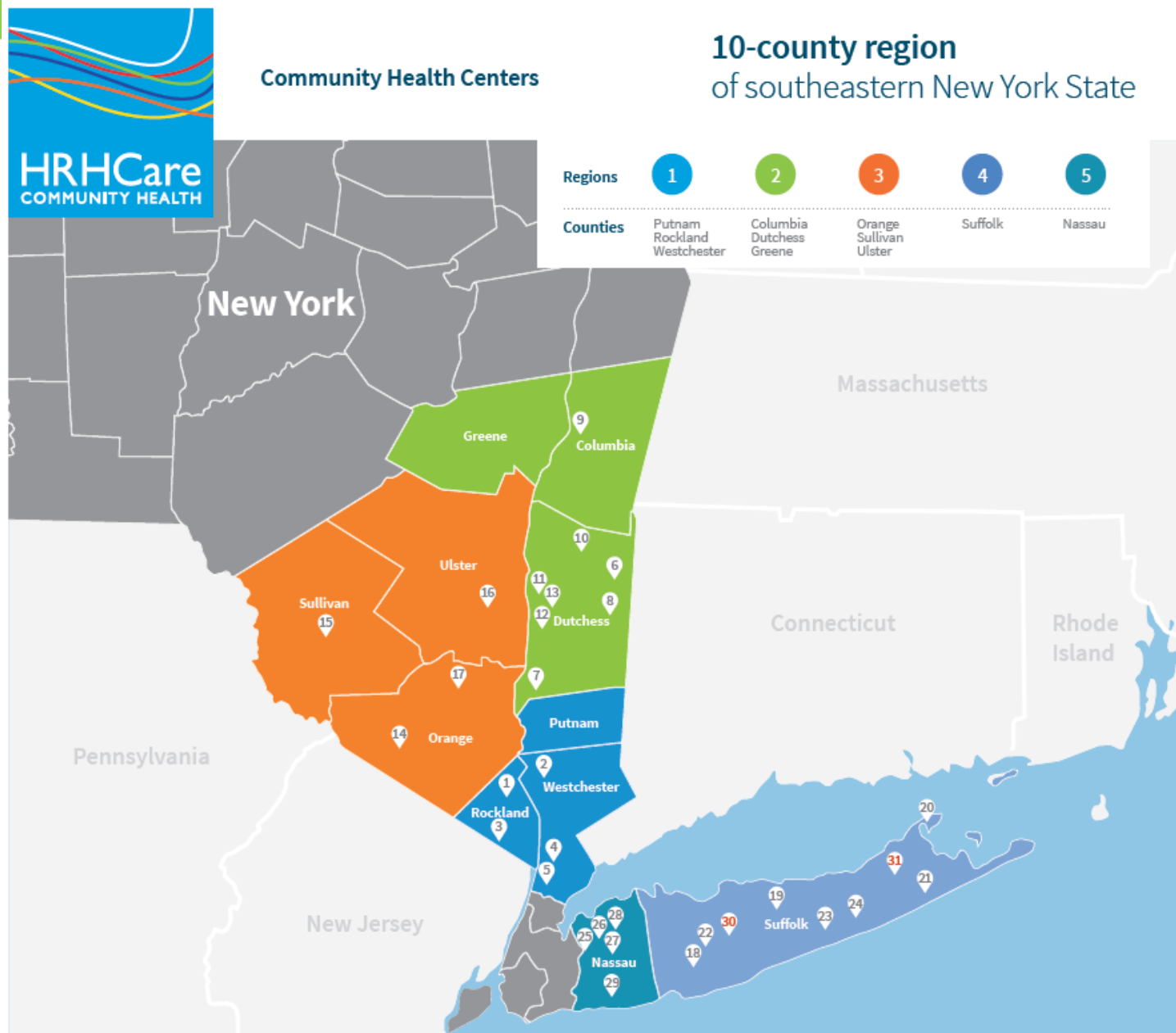


# Mission

To increase access to comprehensive primary and preventive health care and to improve the health status of our community, especially for the underserved and vulnerable.

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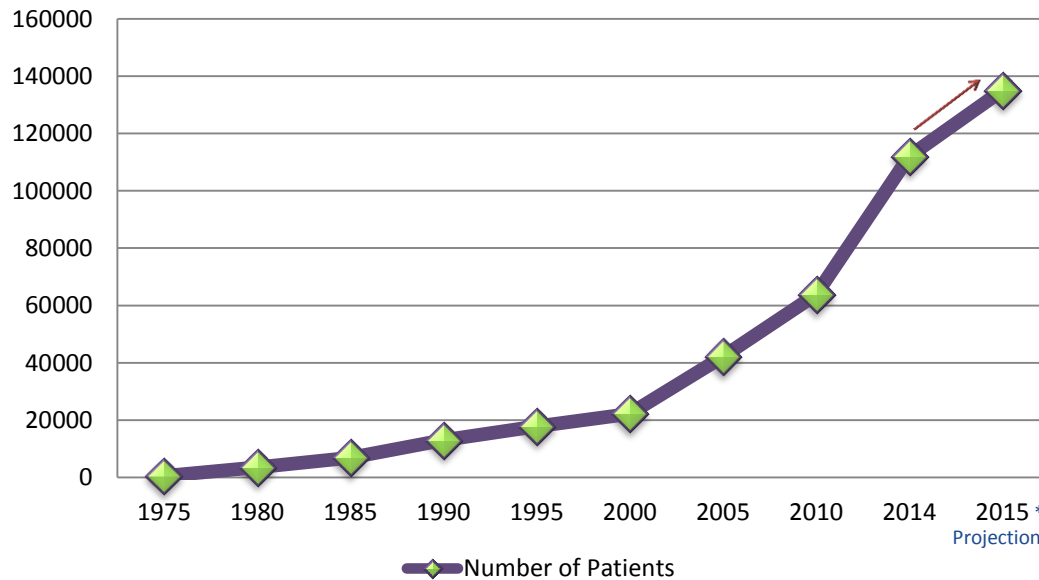
# HRHCare Service Area – Access is the Answer



# Commitment to Access: Patients Served



## Number of Patients



<b>1975</b>	500
<b>1980</b>	3,500
<b>1985</b>	7,000
<b>1990</b>	13,000
<b>1995</b>	18,000
<b>2000</b>	22,000
<b>2005</b>	42,000
<b>2010</b>	64,000
<b>2014</b>	112,000
<b>2015 Projection</b>	<b>135,000</b>

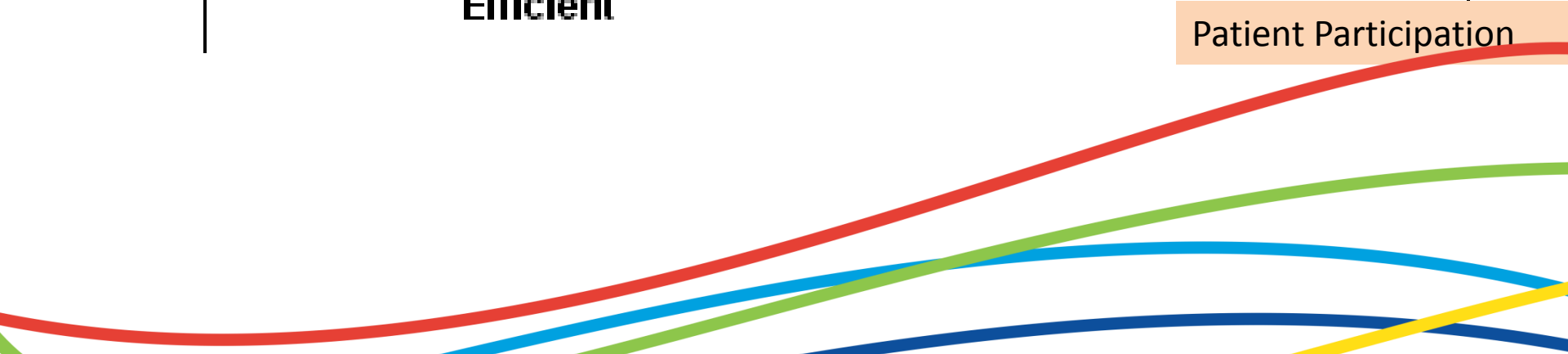
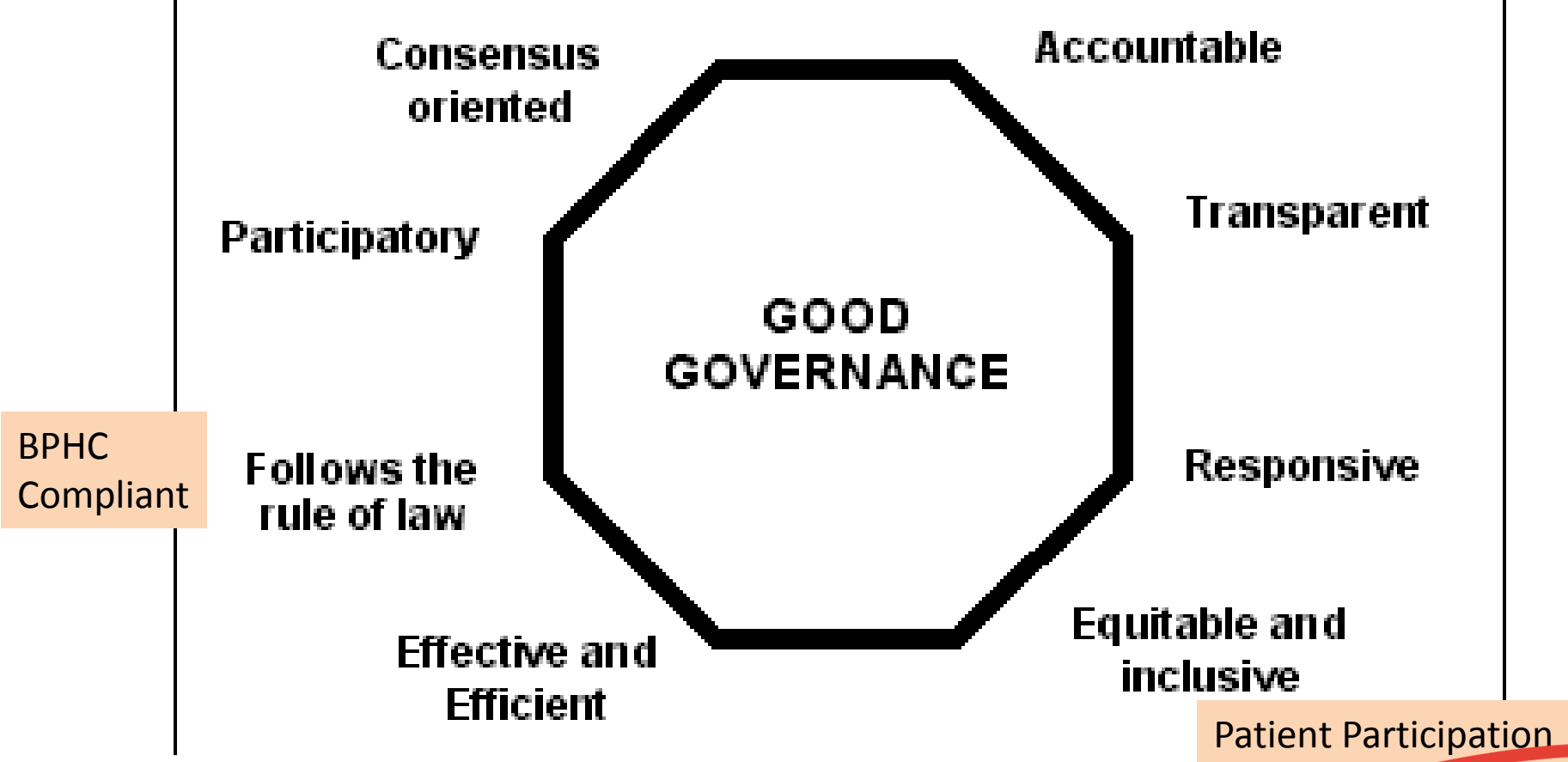
## Special Populations at HRHCare

- Public Housing
- Homeless
- Migrant and Seasonal Farmworkers
- Ryan White
- Veterans

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# FQHC Perspective



# Governance Pin #2014-01



- Issued on January 27, 2014
- Draft circulated in 2009
- Replaces PIN #98-12
- Consolidates key policy guidance into a single PIN
- New PIN serves as the primary, but not sole source of information on governance



# Governing Boards at FQHC

- Assumes full authority and oversight responsibility for the health center
- 19 Standards for FQHCs - #17 Board Authority
  - Hire & evaluate CEO;
  - Approve sites, services, hours;
  - Meet monthly
  - Approve grant submission
  - Approve annual budget and audit
  - Approve the sliding fee scale policy
  - Approve organizational policies
  - Represent the voice of the patient
  - Monitor organizational performance
  - Develop strategic plan



# Governing Boards at FQHC



- #18 Board Composition
- #19 Conflict of Interest
- Other Key Areas of Input for Patient Board Members
  - Needs assessment – sufficient focus on special populations and unique barriers
  - Scope of service – appropriate for special population, unique programmatic needs that should be considered
  - Collaborative relationships – opportunities for partnership to meet unique needs
  - Hours and locations

# Appropriate Representations



- “As a group, patient members of the board must reasonably represent the individuals who are served by the health center in terms of race, ethnicity and sex. Health Centers are also encouraged to consider patient members’ representation in terms of other factors such as socioeconomic status, age and other relevant demographic factors.”

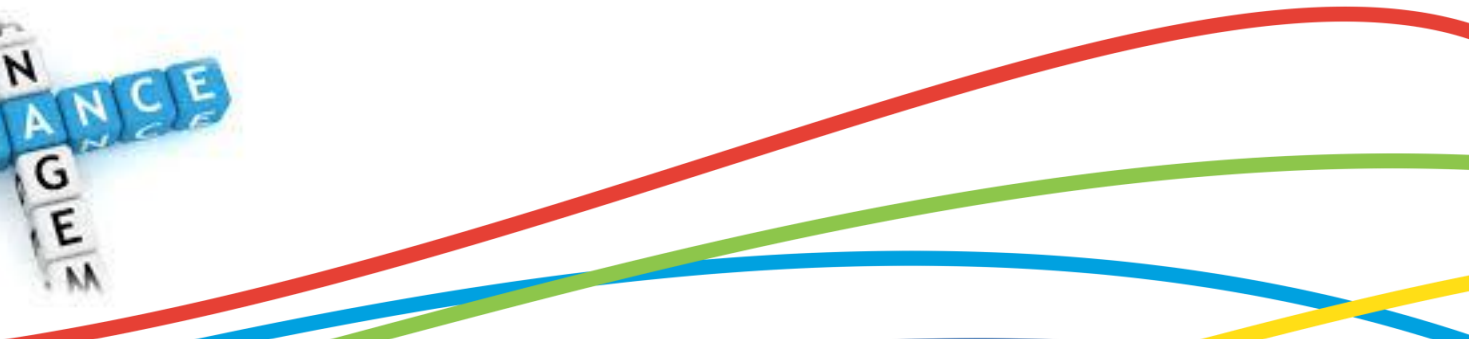
# Appropriate Representations



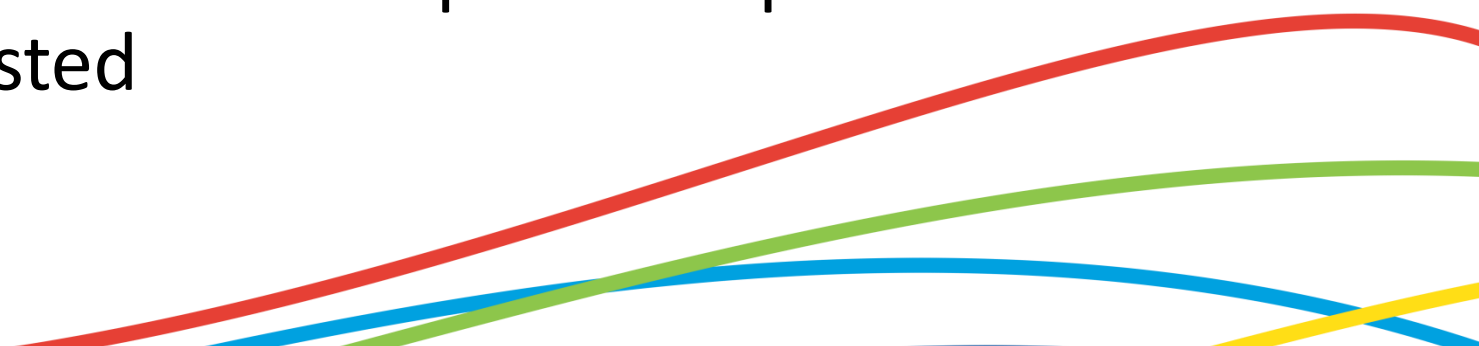
- Note change in language from “community member of the board” to “patient member of the board”.
- Board Membership itself need not reflect the community where the health center is, but rather its patient population.
- Special populations – at a minimum, there must be at least one board member that is representative of each of the special populations for which the health centers receives section 330 funding

# Appropriate Representations

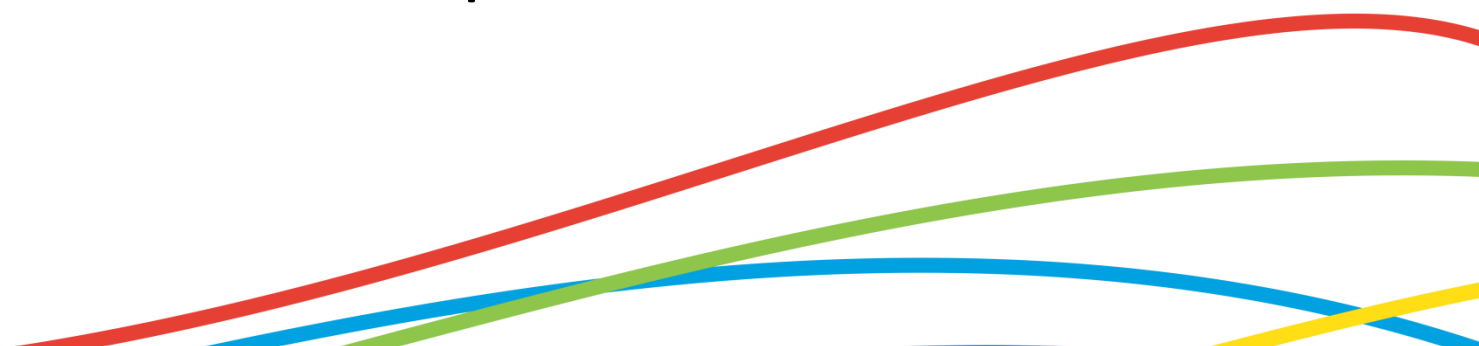
- Patient representation of special populations “is best achieved through patients who are members of the special population”
- However – advocates who have personally experienced being a member of the population would meet criteria



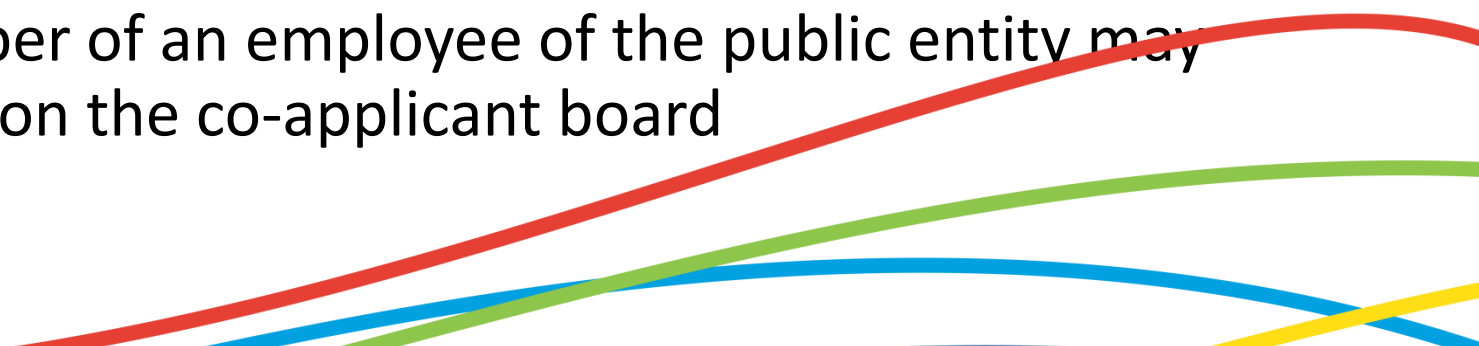
# Key Clarifications

- Definition of a patient
    - Current patient with an in-scope visit within last 24 months (billable visit)
    - Legal guardian of a dependent child or adult who is a patient
  - Clarified that non patient board members to not have to reflect specific expertise in all areas listed
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# Key Clarifications

- Eliminates the ability to waive the monthly meeting requirement
  - Continues to allow waiver of 51% consumer requirement, but clarifies that HRSA will provide stricter scrutiny
  - Continues the limited involvement of third parties in board composition and decision making
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# Key Clarifications

- Public Entity
    - Roles and responsibility clarification
    - Public entity may not override the final approvals and decision making authorities of the co-application board
    - Requires co-applicant agreement and co-applicant board Bylaws to be two separate documents that are presented to HRSA
    - Clarifies that no employee or immediate family member of an employee of the public entity may serve on the co-applicant board
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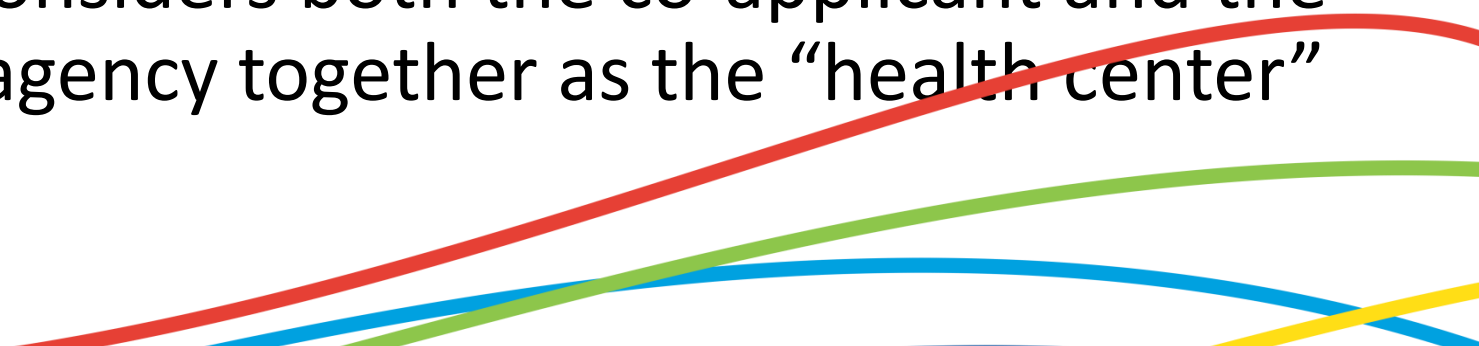


# Co-Applicant Board Requirements



- Defined as a health center funded through a 330 grant to a public agency
- Must comply with all health center requirements and regulations
- Public Centers – 2 options
  - Public agency independently meets all governance requirements
  - Co-applicant and public agency together meet all health center program requirements

# Co-Applicant Board Requirements

- Objective: “For co-applicant board as the patient/community based governing board to set health center policy”
  - May not allow the public agency to overrule the final approvals of the board, but allows public agency to retain authority over general policies for the public center
  - HRSA considers both the co-applicant and the public agency together as the “health center”
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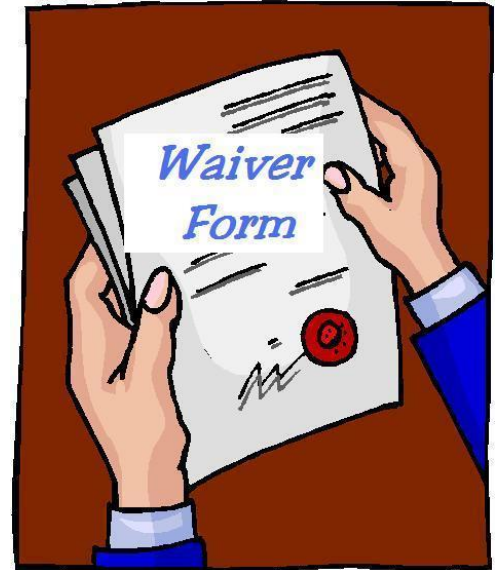
# Co-Applicant Additional



- Strongly encourages health center co-applicant to be formally incorporated
- HRSA requires execution and submission of a formal co-applicant agreement; co-applicant governing board bylaws and articles of incorporation
- Must include delegation of authority and defined roles and authorities of each

# Waivers of Governance

- Eligible for waiver
  - CHC or look-alike serving a sparsely populated rural area
  - Special pops grantees without Section 330e funding
- Only for project period
- Must show good cause – unique/innate characteristics of CHC patients or service area impose an undue hardship and significant barriers to CHC establishing a 51% consumer board

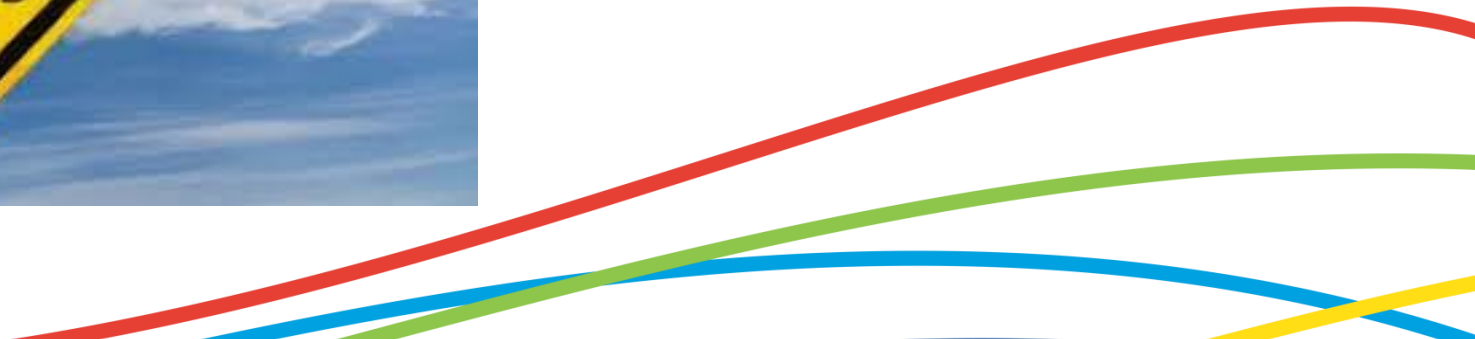


# Waivers of Governance

- Alternative mechanisms plan for complying with intent via alternative mechanism
- Must ensure patient input and participation
- Advisory councils; type of patient input; process for community input to board; how input will be used
- Options
  - Substantial, but not majority on board
  - Advisory councils
  - Advocate board members
  - Focus groups

# Challenges

- Meaningful roles for board members
- Geographic distribution impacting participation
- Redefining public housing – vouchers, UDS,

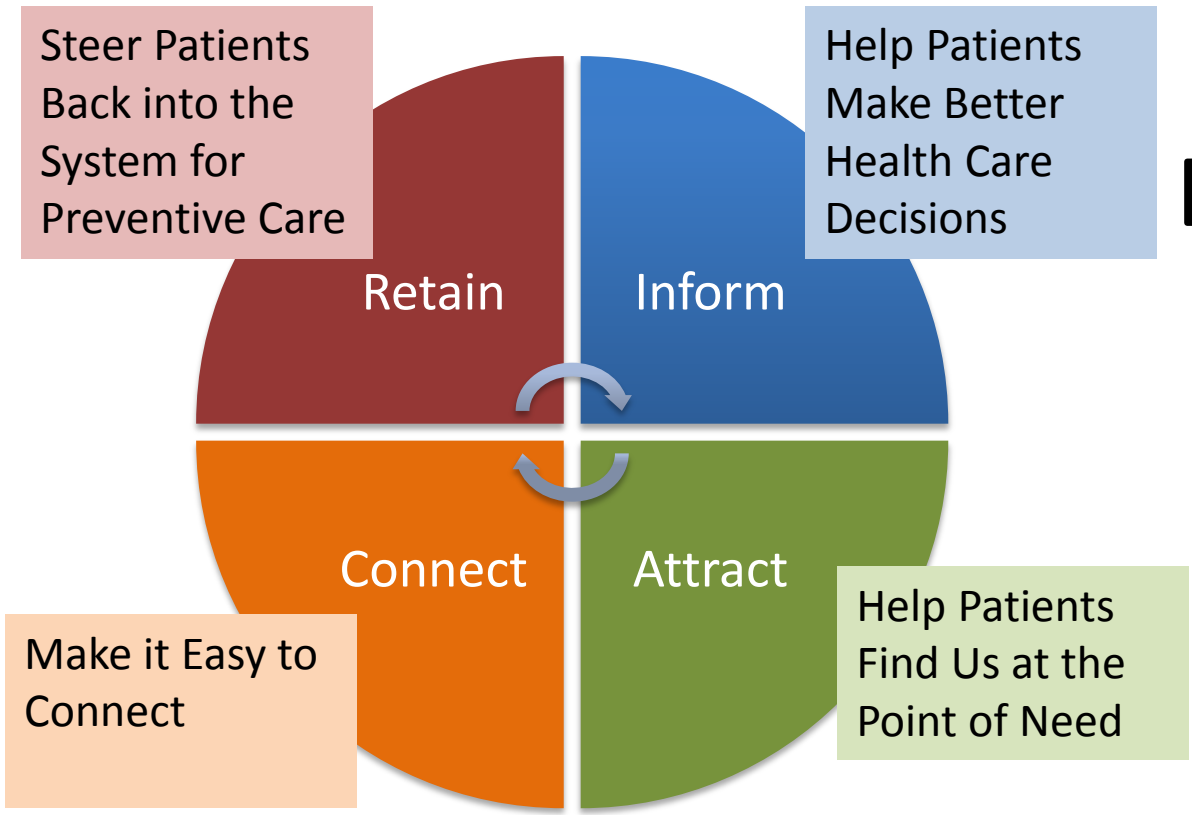


# Role for Consumer Board Member



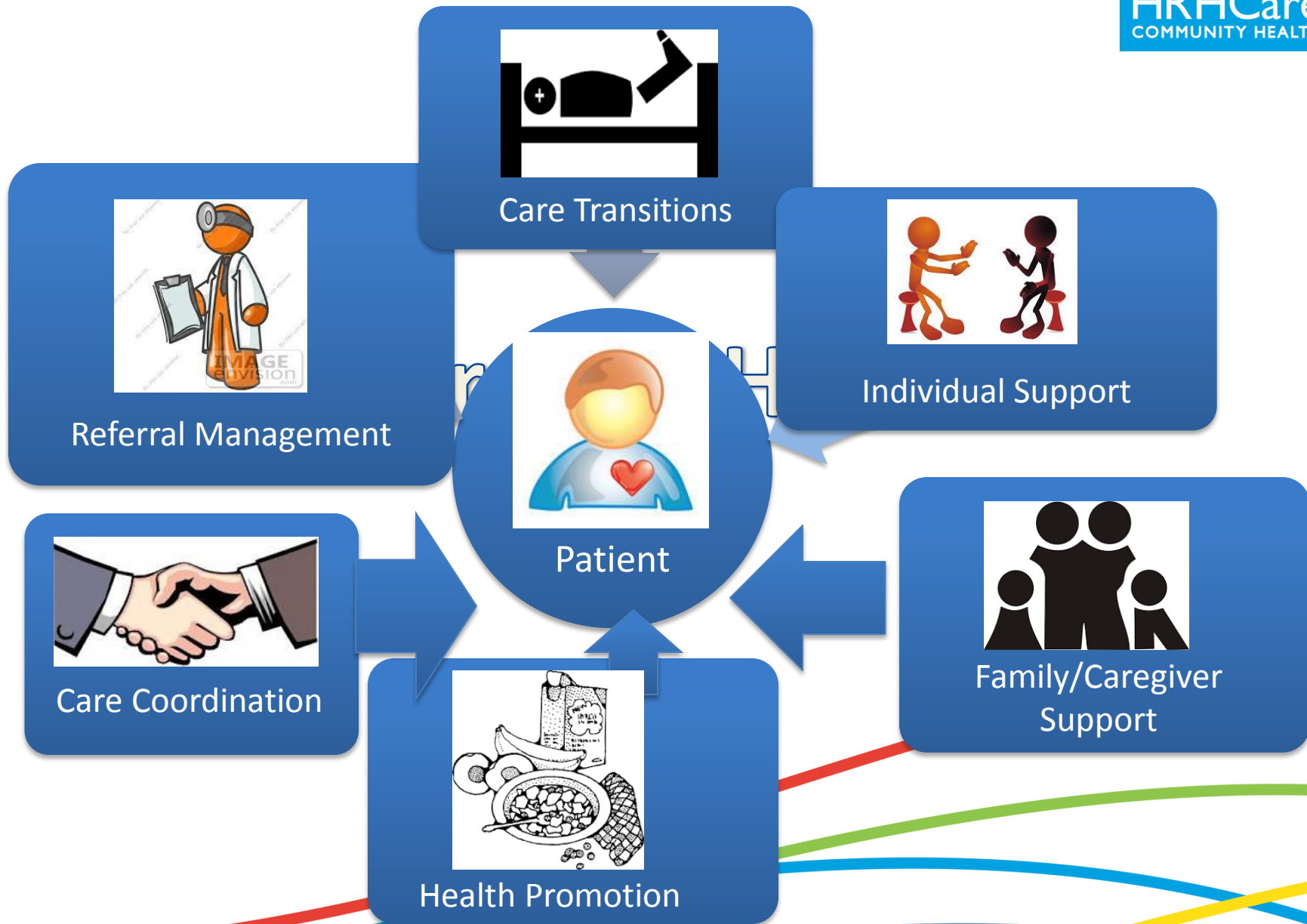
- Patient Engagement
- Community Liaison
- Facilitate Advisory Council
- Health Promoter/ Patient Advocate
- Focus Group Facilitation
- Resident Council Liaison
- Faith based community connections

# Community Engagement & Population Management





# Care Management



WE ARE THE  
PATIENT  
EXPERIENCE!



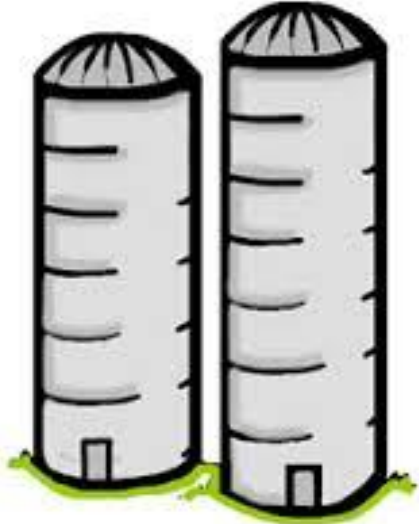
**The Patient Experience Paradigm**



# Behavioral Health & Primary Care

*Historic*

## Silos of Care



Primary Care

Behavioral  
Health

*Current*

## Coordinated



Co-Location

*Future*

## Fully Integrated Pieces of a Whole



Moving Toward Integration

# Board Member Projects



- Health Living
  - Biggest Loser
  - Walking Clubs
- HUGs – Health Unites Generations
  - Culture Club
  - Senior Prom
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