




Pacific Islands Primary Care Association (PIPCA)

FQ CHC Partnerships in the USPIJ

64th PIHOA Board Meeting

September 6, 2018 Honolulu, HI

Clifford Chang, MPH
Executive Director, PIPCA

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Executive Director, Kosrae CHC
PIPCA Vice President

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PIPCA Board members here: the ED/CEO/COO from the Chuuk, Ebeye, Guam, Kosrae, Wa`ab CHCs, and the PBDA President

Mission

To promote and support quality Pacific Islands primary health care for all member islands.

Members

- **American Samoa Community Health Center**, American Samoa
- **Chuuk Community Health Center, Chuuk, FSM**
- **Ebeye Community Health Center**, Republic of the Marshall Islands
- **Kagman Community Health Center**, CNMI
- **Kosrae Community Health Center**, Kosrae, FSM
- **Northern & Southern Regional Community Health Centers**, Guam
- **Palau Community Health Center**, Republic of Palau
- **Pohnpei Community Health Center**, Pohnpei, FSM
- **Wa`ab Community Health Center**, Yap, FSM
- **American Pacific Nursing Leaders' Council (APNLC)**
- **Northern Pacific Environmental Health Association (NPEHA)**
- **Pacific Basin Dental Association (PBDA)**
- **Pacific Basin Medical Association (PBMA)**
- **Pacific Islands Health Officers Association (PIHOA)**
- **Pacific Behavioral Health Collaborating Council (PBHCC)**

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Overview

- Brief review of the HRSA CHC program and public center model, particularly as it effects the USAPIJ
- Expanding federally funded CHCs in the Pacific
- Clarification of some of the activities connected to the PI CHCs organized by PIPCA
- Kosrae CHC Experience

KEY MESSAGE

Critical and essential partnership/ collaboration (effective communication and shared decision-making as appropriate) between Ministries/ Departments of Health and the CHCs whether

- the PI CHCs remain as co-applicant public entity CHCs, or
- Become independent, stand alone non-profit CHCs
  - From the CHC side, many of the current frustrations of the public center model are related to HR and Finance, and not with MOH/DOH
- Any move from the public center to non-profit independent CHC needs to be a collaborative, carefully discussed and planned effort by both co-applicants

The successful delivery and continuum of care in the USAPIJ makes this essential.

Different models of Community Health Centers: Private Non-profit and Public Center

- No more than 5% of all CHC funding goes to public centers (in 2007 [most recent numbers I have], 91 of the over 1,000 federally funded CHCs were public centers)
- Eight of the Pacific Island community health centers are public center CHCs, governed by a community-based Board under a partner/co-applicant agreement with the respective Ministry/Department of Health
- This year one of the PI CHCs has become a private non-profit CHC.
- *The public agency does not qualify for CHC funding by itself – there must be a co-applicant governing board; the CHC program IS different from other federally funded programs.*

History of the Community Health Center (CHC) Program

- Started in the 1960's in the U.S. when millions of Americans living in inner cities & rural areas suffered from poverty and a desperate need for health care.
- President Lyndon Johnson, declared a "War on Poverty" and the first community health center was funded.

History of the Community Health Center (CHC) Program

- The health center model that emerged targeted the roots of poverty by combining the resources of local communities with federal funds to establish neighborhood clinics that were governed by the community.
- The strength of the health center boards lie in their involvement and direction in the health care services unique to their community.

History of the Community Health Center (CHC) Program

- In 1975, Congress permanently authorized the health center program, under Section 330 of the Public Health Service Act, supporting the provision of services to medically underserved populations living in urban and rural underserved communities.
- Since then the health center program has become an integral part of the health care delivery system.

History of the Community Health Center (CHC) Program

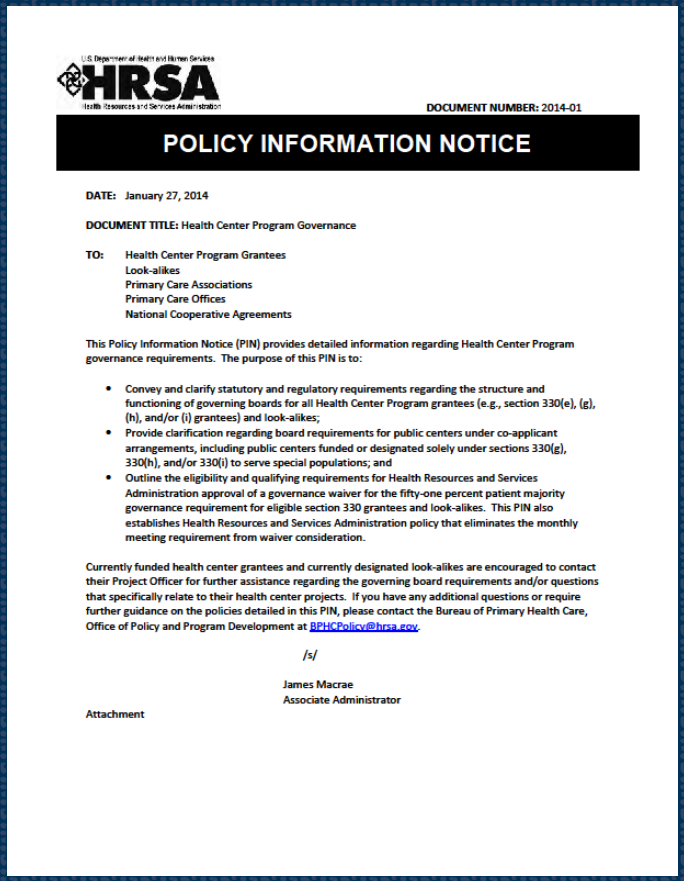
- It is the only health care system that is controlled in partnership with patients.
- Through the community controlled boards, patient do not just pay for their health care, they also "have a say" in how their health care is delivered.

Different models of Community Health Centers

Private non-profit versus Public Center

- "Public center" is defined as a health center funded through a section 330 grant to a public agency.
- Public agencies (e.g., state, county, or local health departments) must comply with all health center requirements and regulations except as specifically allowed through the co-applicant structural exception (described further later on).

Reference: Governance and Public Centers



U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

DOCUMENT NUMBER: 2014-01

POLICY INFORMATION NOTICE

DATE: January 27, 2014

DOCUMENT TITLE: Health Center Program Governance

TO: Health Center Program Grantees
Look-alikes
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

This Policy Information Notice (PIN) provides detailed information regarding Health Center Program governance requirements. The purpose of this PIN is to:

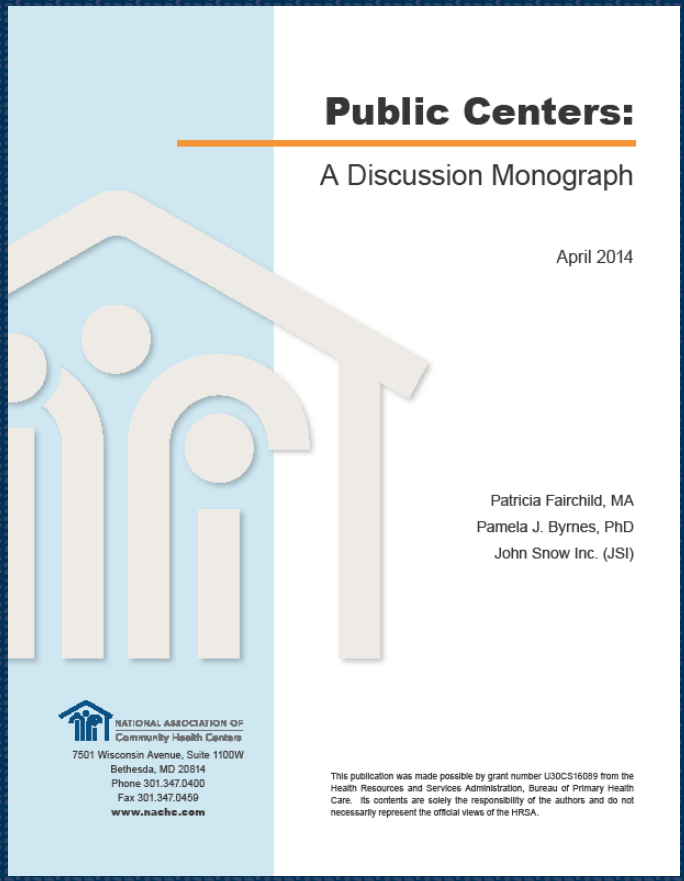
- Convey and clarify statutory and regulatory requirements regarding the structure and functioning of governing boards for all Health Center Program grantees (e.g., section 330(e), (g), (h), and/or (i) grantees) and look-alikes;
- Provide clarification regarding board requirements for public centers under co-applicant arrangements, including public centers funded or designated solely under sections 330(g), 330(h), and/or 330(i) to serve special populations; and
- Outline the eligibility and qualifying requirements for Health Resources and Services Administration approval of a governance waiver for the fifty-one percent patient majority governance requirement for eligible section 330 grantees and look-alikes. This PIN also establishes Health Resources and Services Administration policy that eliminates the monthly meeting requirement from waiver consideration.

Currently funded health center grantees and currently designated look-alikes are encouraged to contact their Project Officer for further assistance regarding the governing board requirements and/or questions that specifically relate to their health center projects. If you have any additional questions or require further guidance on the policies detailed in this PIN, please contact the Bureau of Primary Health Care, Office of Policy and Program Development at BPHCPolicy@hrsa.gov.

/s/

James Macrae
Associate Administrator

Attachment



Public Centers:

A Discussion Monograph

April 2014

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Public Center CHCs

- In the public center arrangement, a separate "co-applicant" must be established whose governing board meets section 330 governance requirements.
- The public agency receives the section 330 grant and the co-applicant serves as the "health center board" with the two collectively considered as the "health center" or "public center".
- Without the co-applicant governing board, the public agency does not qualify for CHC funding.

Public Center CHCs

- The objective of the co-applicant arrangement is for the co-applicant board as the patient/ community-based governing board to set health center policy.
- The co-applicant's governing board must meet all the size, member selection, and composition requirements.
- The co-applicant arrangement may not allow the public agency to override or overrule the final approvals and required decision-making authorities of the co-applicant board.
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Why Have a Co-Applicant Board?

- It represents the people that use the CHC services
- It promotes the center and the mission of the program.
- Provides leadership and guides the center in doing what it is intended to do.
- Serves as the link and voice of the community being served.

Typical Public Center and Co-Applicant Arrangement

HRSA Section 330 Grant Funds

Public Agency

-Establishes general financial management & control systems

-Establishes personnel policies

-Employ management team/staff, including CEO.

Co-Applicant Agreement (needs to be formalized in writing)

Co-Applicant Governing Board

-Complies with all Section 330 board composition and selection requirements

-Maintains key authorities and approvals regarding the 330 project.

-[May employ management team/staff, including CEO.]

NOTE: The Health Center is considered as both the Public Center and the Co-Applicant Governing Board

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Public Center CHCs "Co-applicant Structural Exception"

- The co-applicant provision recognizes that public agencies may be constrained by law in the delegation of certain government functions to private entities, and thus permits the public agency to retain authority over general policies for the public center.
- Therefore, a public center with an approved co-applicant board arrangement does not need further justification for the public agency to retain authority for the establishment of the following types of general policy:

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Examples of General Policies Retained by the Public Agency

- **FISCAL POLICIES**
  - Internal control procedures to ensure financial management procedures.
  - Purchasing policies and standards.
- **PERSONNEL POLICIES**
  - Employee selection, performance review/evaluations and dismissal procedures.
  - Employee compensation, including wage and salary scales and benefit packages.
  - Position descriptions and classification.
  - Employee grievance procedures.
  - Equal opportunity practices.

Co-Applicant Agreements General Guidelines

Grantees must have a formal co-applicant agreement that clearly states:

- Roles, responsibilities and the delegation of authorities.
- Any shared roles and responsibilities of each party in carrying out the governance functions.
- For independent CHCs, how the continuity of care between the CHC and the government hospital and government-provided priman

Critical/Essential Partnerships

- Critical and essential partnership/ collaboration between Ministries/ Departments of Health and the CHCs, whether a public center or a non-profit stand-alone organization

- If a public center, equally important is the partnership with Ministries/ Departments of Finance and Personnel

  - The number 1 issue PIPCA responds to from the PI CHCs is related to the lack of good communication/conflict/frustration/ misunderstanding between the co-applicants – the CHC management staff and Board, and the Government partners

Critical/Essential Partnerships

- From PIPCA's perspective, the public center co-applicant CHC structure makes sense may be fraught with potential problems and conflicts…but provides a tremendous opportunity for success.

It's kind of like an arranged marriage: neither "side" necessarily has selected the other, but working together is critical for success.

Critical/Essential Partnerships

- Key issues:
  - It is critical the Ministers/Directors of Health understand why the CHC program is different from all other federally funded programs, and why a Governing Board is both a requirement and essential.
  - The MOA/U between the M/DoH and the CHC Governing Board needs to be reviewed, updated and signed on a very regular basis.

Critical/Essential Partnerships

- Key issues:
  - It is critical the CHC Governing Board and senior management understand why active, regular and ongoing communication with the Ministers/Directors of Health is essential.

Expanding federally funded CHCs in the Pacific

- There may be NAP funding for additional CHCs in FY2019, but this has not been confirmed.
- If the new locations will be connected to the Ministry/Department of Health, it must be connected to the existing CHC governance structure.

Activities connected to the PI CHCs organized by PIPCA

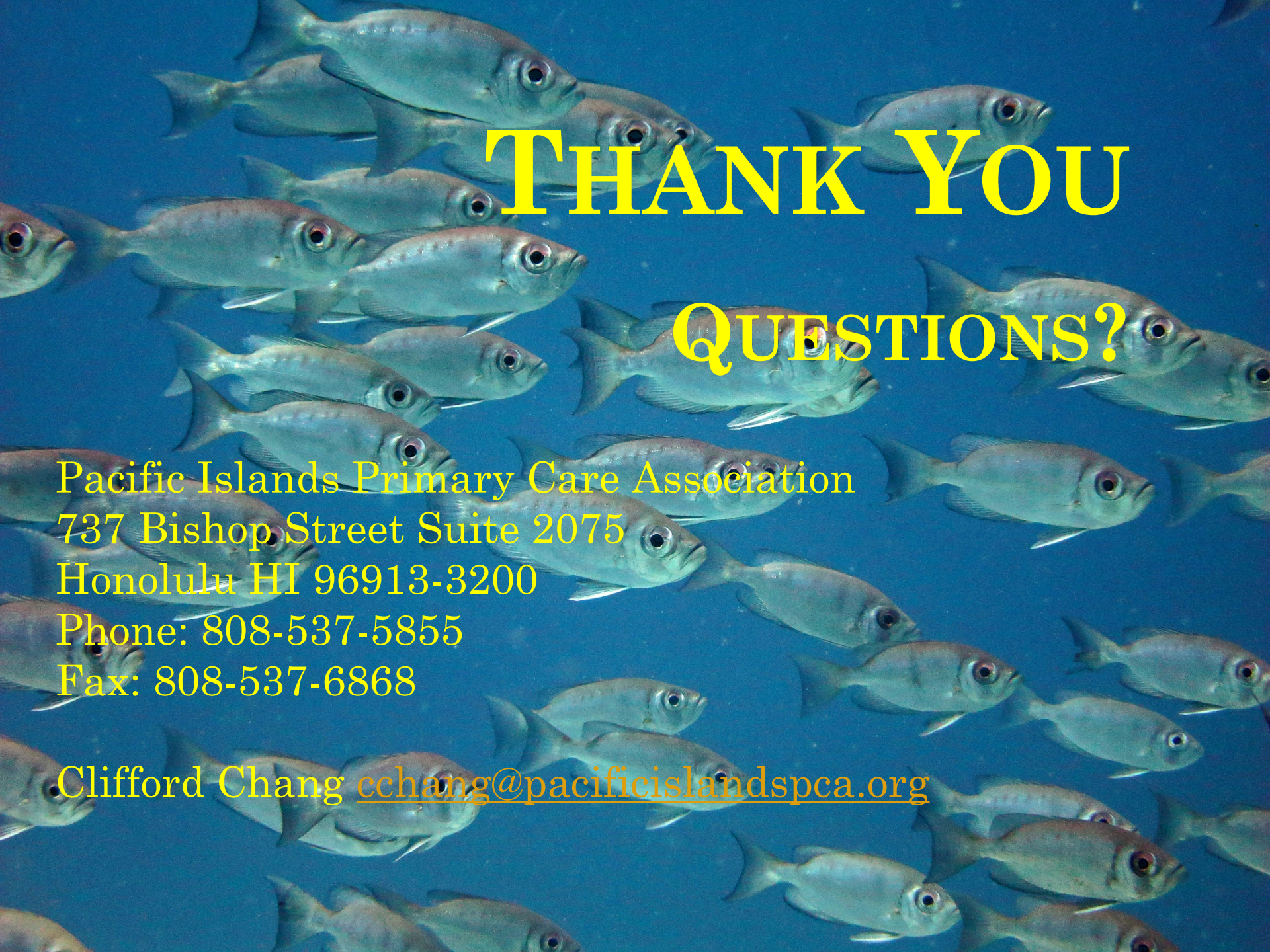
- PIPCA Board Annual Meeting (paid for by PIPCA)
- Annual Expanded UDS Training (paid for by the CHC)
- Annual NACHC Policy and Issues Forum held in March in Washington DC (paid for by the CHC)

Annual NACHC Policy and Issues Forum

- 4 day meeting held in Washington DC in March each year
- PIPCA encourages attendance at this meeting as it is one opportunity the PI CHCs can meet in person with HRSA leadership and staff
- Each CHCs decides whether to attend and who attends
  - Because the Forum focuses on policy, NACHC (and PIPCA) encourages CHC senior management staff and Board representatives to attend

Annual NACHC Policy and Issues Forum

- Each year PIPCA has organized a meeting with Senior BPHC staff to highlight key PI issues, and with the Project Officers and Grants Management Specialist to discuss issues specific to each PI CHC
  - This has evolved into a one day visit to the HRSA Headquarters for meetings with HRSA staff and HRSA-organized TA opportunities



Thank You

Questions?

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