



**BOARD OF COUNTY COMMISSIONERS**

**DATE:** August 18, 2015

**AGENDA ITEM NO. 13**

**Consent Agenda** ☐

**Regular Agenda** ☒

**Public Hearing** ☐

 **County Administrator's Signature:**

**Subject:**

Approval of the Co-Applicant Agreement with the Mobile Medical Unit Advisory Council (MMUAC) as required by the U.S. Department of Health & Human Services, Health Resources Services Administration (HRSA).

**Department:**

Human Services

**Staff Member Responsible:**

Lourdes Benedict, Director

**Recommended Action:**

I RECOMMEND THE BOARD OF COUNTY COMMISSIONERS (BOARD) REVIEW AND APPROVE THE CO-APPLICANT AGREEMENT WITH THE MMUAC AS REQUIRED BY HRSA.

**Summary Explanation/Background:**

The co-applicant agreement stipulates the roles, responsibilities and authorities of each party in the oversight and governance of the public center. The co-applicant agreement is a blueprint for how the Board and co-applicant governing board work collaboratively to oversee and manage the health center project.

The Board is a grantee of HRSA for the Health Care for the Homeless, Health Center Program (Program) (Grant #H80CS00024). With federal and local funding, Human Services operates the Program with primary care services contracted through the Florida Department of Health in Pinellas County for the Mobile Medical Unit and Safe Harbor.

During each grant period, HRSA conducts a site visit to review the program requirements. As a result of the most recent site visit, a condition was placed on the grant related to the "Board Authority" requirement. The requirement of the program is that the health center governing board maintains appropriate authority to oversee the operations of the center. (Section 330(k)(3)(h) of the Public Health Services Act and 42 Code of Federal Regulations Part 51c.304). While the Board is the grantee, Human Services established the MMUAC, as required by HRSA, to ensure accurate consumer input on the program's needs. In order to comply with the health center program requirement, HRSA recommends that the Board develop and implement a Co-Applicant Agreement with the MMUAC, so that the MMUAC can jointly serve as the health center governing board.

Upon approval, the MMUAC will serve as the co-applicant of the health center governing board. As set forth in the MMUAC Bylaws, a majority of the members shall be consumers of the Program. No more than one-half of the remaining members may be individuals who derive more than ten percent (10%) of their annual income from the health care industry. The remaining members shall be representatives of the community in which the catchment area is located and shall be selected for their expertise in community affairs, local government, finance, banking, legal affairs, trade unions, and other commercial and industrial concerns, or social services agencies within the community. No Council member shall be an employee of the County or the spouse or child, parent, brother or sister by blood or marriage of such an employee. No more than two (2) MMUAC members may be Board members.

On an annual basis, the MMUAC shall present nominations for each vacant seat for consideration and appointment. The Board shall make appointments from the slate of nominees presented by the MMUAC.

The MMUAC has been meeting monthly for several years in service to the County. This agreement will forge a stronger relationship around the operations of the Program. A schedule of upcoming meetings is included.

**Fiscal Impact/Cost/Revenue Summary:**

The Program is funded by a federal grant and Human Services appropriated budget from Fund 0001, Account 3316201. There is no fiscal impact to the County as a result of this action.

**Exhibits/Attachments Attached:**

Contract Review Transmittal Slip  
Co-Applicant Agreement  
MMUAC Bylaws  
Site Visit Final Report, pages 20-22  
HRSA Policy Information Notice 2014-01  
Schedule of Meetings for 2014-2016

**NON-PURCHASING CONTRACT REVIEW TRANSMITTAL SLIP****PROJECT: Approval of Co-Applicant Agreement with MMUAC for Healthcare for Homeless (MMU)****CONTRACT NO.:** number**ESTIMATED EXPENDITURE / REVENUE:** n/a  
(Circle or underline appropriate choice above.)

In accordance with Contract Administration and its Review Process, the attached documents are submitted for your review and comment. Please complete this Non-Purchasing Contract Review Transmittal Slip below with your assessment, and **forward to the next Review Authority on the list, skipping any authority marked "N/A."** Indicate suggested changes by noting those in "Comments" column, or by revising, in RED, the appropriate section(s) of the document(s) to reflect the exact wording of the desired change(s).

**OTHER SPECIFICS RELATING TO THE CONTRACT:** As a Health Center program grantee, HRSA conducts a site visit to review the health center program requirements. As a result of the most recent site visit, a condition was placed on the grant related to the "Board Authority" requirement. The requirement of the program is that the health center governing board maintains appropriate authority to oversee the operations of the center. (Section 330(k)(3)(h) of the PHS Act and 42 CFR Part 51c.304). While the Board is the grantee, Human Services established the MMUAC to ensure that it receives accurate consumer input on the program's needs. In order to comply with the health center program requirement and therefore lift the condition, HRSA recommends that the Board develop and implement a Co-Applicant Agreement with the MMUAC, so that the MMUAC can jointly serve as the health center governing board. The co-applicant agreement stipulates the roles, responsibilities and the delegation of authorities of each party in the oversight and management of the public center and it details any shared roles and responsibilities in carrying out governance functions. The co-applicant agreement should be viewed as a blueprint for how the public agency and co-applicant governing board work collaboratively to oversee and manage the health center project.

REVIEW SEQUENCE	DATE	INITIAL/ SIGNATURE	COMMENTS (IF ANY)	COMMENTS REVIEWED & ADDRESSED OR INCORPORATED
<b>Originator:</b> Lourdes Benedict	6/24/15 6/22/15 TB	LB		7/22/15 LB
<b>Risk Mgmt:</b> Virginia Holscher	6-29-15	GW	Per LEGAL ADVISORY counsel only - Part of Board No Ins. Req.	
<b>Finance:**</b> Cassandra Williams	7/1/15	CBW		
<b>OMB:**</b> Bill Berger	7/8/15	Z	See attached.	
<b>Legal:</b> Carl Brody	7/16/15	CB	MMUAC part of Co-Applicant Agreement budget or financials → Co App has not signed yet, must come back if any changes	
<b>Assistant County Administrator:</b> Paul Sacco	7/13/15	PS	See question. PS	

Please return to Elisa DeGregorio by June 23, 2015 | All inquiries should be made to ext. 4-8434

## OMB Contract Review

<b>Contract Name</b>	Co-Applicant Agreement Between Mobile Medical Unit Advisory Council (MMUAC) and Pinellas County Board of County Commissioners (BCC)		
<b>CATS#</b>	47477	<b>Contract #</b>	N/A

**Mark all Applicable Boxes:**

Type of Contract									
CIP		Grant		Other	X	Revenue		Project	

**Contract information:**

<b>New Contract (Y/N)</b>	Y	<b>Original Contract Amount</b>	n/a
<b>Fund(s)</b>	0001	<b>Amount of Change</b>	
<b>Cost Center(s)</b>		<b>Contract Amount</b>	
<b>Program(s)</b>	1569	<b>Amount Available</b>	n/a
<b>Account(s)</b>		<b>Included in Applicable Budget? (Y/N)</b>	n/a
<b>Fiscal Year(s)</b>	FY15 and forward		

### Description & Comments

(What is it, any issues found, is there a financial impact to current/next FY, does this contract vary from previous FY, etc.)

This Co-Applicant Agreement is submitted for approval by Human Services in response to a condition placed on the Health Care for the Homeless, Health Center Program grant by the grantor, Federal Health Resources and Services Administration (HRSA). The agreement stipulates roles and responsibilities, delegated authorities of each party, oversight and management of the center, and governance.

This agreement does not have a fiscal impact separate from the grant award for this ongoing program, but an agreement is required for continued funding.

OMB analyst notes on review of this agreement/agenda item:

- Section 1.4.3 of the agreement pertains to MMUAC having personnel authority related to the program's Project Director (employed by Pinellas County). This, and section 2.1.4 should be vetted with Human Resources, if not done already.
- Sections 1.4.7, 1.4.8, 2.2.2 and 2.2.3, relating to approval of the program budget and amendments, require the OMB Director's review/approval of the specific language.
- 1.4.7 – Who is the "finance department"?
- 1.4.8 – What is "full approval"? Recommend approval of MMUAC before amendment request submission to OMB. Same applies to 2.2.3.
- 1.4.9 – What strategic planning process and plan is being referenced? Same applies to 2.1.5.
- 2.1.2-4 – Why defined if intent is to follow County policies and procedures?
- 2.2.2 – See 1.4.7. What is timeline and how does it align with countywide budget prep timeline?

**Analyst: Veronica Ettel**

*recommend further review, as noted above*



# Mobile Medical Unit Advisory Council & Pinellas County Board of County Commissioners **Co-Applicant Agreement**

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*Approved by Mobile Medical Unit Advisory Council, June 2, 2015*

*The Mobile Medical Unit Advisory Council (MMUAC)(Co-Applicant Board) serves as the patient/community-based governing board to set health center policy for the Healthcare for the Homeless Program on behalf of the Pinellas County Board of County Commissioners. As a public center, the MMUAC includes a representative majority of consumer/patient representatives, meets monthly and fulfills all the required authorities of a governing board. The purpose of the co-applicant arrangement is for the co-applicant board to oversee the implementation of the Section 330 grant and the operation of the Healthcare for the Homeless Program via the Mobile Medical Unit operated by the Pinellas County Human Services Department in accordance with the terms of this Agreement and the Bylaws as adopted by the BCC and MMUAC.*

## **CO-APPLICANT AGREEMENT**

### **BETWEEN**

**Mobile Medical Unit Advisory Council (MMUAC)**

### **AND**

**Pinellas County Board of County Commissioners (BCC)**

This Co-Applicant Agreement (hereinafter referred to as “Agreement”) is entered into this June 2, 2015, by and between the Mobile Medical Unit Advisory Council (MMUAC) and the Pinellas County Board of County Commissioners (BCC), herein represented by MMUAC and BCC, defined below, shall be collectively referred to as the “Parties”).

### **Recitals**

**Whereas**, the MMUAC was established to serve as an advocate for consumers of the Healthcare for the Homeless program and per HRSA governance requirements, to oversee operations of the Healthcare for the Homeless program in Pinellas County; and

**Whereas**, The MMUAC will assist the Pinellas County Human Services (PCHS) department to implement health services for homeless residents of Pinellas County. These services represent a significant effort by the PCHS to assure that homeless residents have access to an organized system of health care; and

**Whereas**, The MMUAC shall review budgets that are included as part of the 330(h) initial and renewal applications; and

**Whereas**, The MMUAC shall participate in the planning of the grant application to the U.S. Department of Health and Community Services (HHS), Health Resources and Services Administration, Bureau of Primary Health Care, under Section 330(h) of the Public Health Services Act for operation of a Federally Qualified Health Center; and

**Whereas**, pursuant to such funding by the HHS, the BCC and the MMUAC must set forth the responsibilities of each party; and

**Whereas**, the BCC wishes to give support to the MMUAC, and recognizes the powers, privileges, and functions of each party as contained herein.

**NOW, THEREFORE**, in consideration of the promises and the mutual covenants set forth in this Agreement, the receipt and adequacy of which are acknowledged by the Parties to this Agreement, MMUAC and the BCC hereby agree as follows:

#### **1. MMUAC’s Role.**

##### **1.1. MMUAC Purpose:**

The MMUAC shall oversee the implementation of the Section 330 grant and the operation of the Healthcare for the Homeless Program operated by the Pinellas County

## CO-APPLICANT AGREEMENT

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Human Services Department in accordance with the terms of this Agreement and the Bylaws as adopted by the BCC and MMUAC. The Bylaws are incorporated herein by reference and attached as Exhibit A. The MMUAC will provide guidance and assist the BCC and the PCHS Department to implement health services for Pinellas County homeless residents. These services shall provide assurance that homeless Pinellas County residents have access to an organized system of health care, and shall assure that County residents have adequate access to categorical public health programs. The MMUAC, BCC and PCHS Department shall be particularly committed to meeting the needs of the homeless population in the county.

### 1.2. Composition of and Appointments to the MMUAC.

The MMUAC shall present nominations for vacancies on the MMUAC to the BCC for consideration and appointment consistent with its bylaws. Both the MMUAC and the BCC shall work to maintain the same ratio of consumer members, provider members and community members as set out in the Board Composition section of the MMUAC Bylaws and required by Section 330 policies and guidelines.

### 1.3. Joint Application

The BCC and MMUAC will take such actions as are required to make application for the Section 330 grant. They shall also take the steps necessary to name Pinellas County and the MMUAC as co-applicants in these actions.

### 1.4. Governance Authorities and Responsibilities for Operation of the Health Center.

The MMUAC shall exercise the following authorities and responsibilities of a co-applicant as set forth in Section 330, its implementing regulations and related BCC policies. These authorities and responsibilities include:

- 1.4.1. Access to Care: To increase the accessibility of primary care services to the homeless population which experiences a shortage of primary care.
- 1.4.2. Program Evaluation: Evaluating the MMU achievements at least annually and utilizing the knowledge gained thereby to revise the MMU goals, objectives, plan and budget as necessary and appropriate, including providing advise regarding the establishment of linkages with other health care providers and/or health care programs.
- 1.4.3. Evaluation of Project Director: The Project Director shall be primarily responsible for the management and operation of the Healthcare for the Homeless Program . The MMUAC shall have the authority to suspend, remove, appoint and/or reappoint a person the position of Project Director in accordance with the Pinellas County personnel rules and other procedures and policies of the Board of County Commissioners. The MMUAC shall participate in the annual performance evaluation of the Project Director, to be conducted in accordance with HHS Health Resources and Services Administration's Bureau of Primary Health Care's Program Requirements and Pinellas County personnel policies.

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1.4.4. Personnel Policies: Personnel policies and procedures of the health center shall be those adopted by the Board of County Commissioners for Pinellas County employees (See Section 2.1.6 below). The MMUAC may make recommendations to the BCC regarding the terms and conditions of those agreements as might benefit the operation of the Healthcare for the Homeless Program.

1.4.5. Compliance: Evaluating itself periodically for efficiency, effectiveness, and compliance with all requirements imposed upon community health centers, as set forth in Section 330 of the Public Health Service Act, 42 U.S.C. § 254b;

In conjunction with Human Services, assuring that the Healthcare for the Homeless Program is operated in compliance with applicable Federal, State and local laws and regulations; and

1.4.6. Subject to Section 2.1 of this Agreement, performing all other authorities and responsibilities that are required by Section 330 and its implementing regulations and policies to be vested in a Section 330-compliant governing Board.

1.4.7. Financial Plan and Budget: The Project Director, in collaboration with the finance department, shall prepare a budget and financial plan for each fiscal year, in accordance with Pinellas County policies and procedures. The MMUAC shall annually review and approve the budget prepared by PCHS for the operation of the Healthcare for the Homeless Program and recommend this budget to the BCC. The MMUAC and BCC shall jointly approve the annual Section 330 budget submitted to the Bureau of Primary Health Care.

1.4.8. Amendments to the Budget: Pinellas County budget policies and procedures will be utilized for all amendments to the jointly adopted Healthcare for the Homeless Program budget. Amendments requiring full approval of the BCC shall also require approval of the MMUAC. MMUAC approval shall either be obtained prior to the submission of the adjustment to the BCC or the action of the BCC shall be contingent upon the concurrence of the MMUAC.

1.4.9. Strategic Planning: The MMUAC shall participate in the strategic planning process based on (i) an assessment of the health care needs of the community served by the MMU, (ii) the scope and capabilities of other health care providers in the community, (iii) the resources available to the MMU; and (iv) any policy changes that may be required to comply with such strategic plan.

## 2. The BCC's Role.

### 2.1. Governance Authorities and Responsibilities for the Health Center.

The BCC shall exercise certain governance responsibilities and authorities with respect to the MMU. These authorities and responsibilities include:

2.1.1. Access to Care: To arrange for the provision of comprehensive primary care services to the homeless residents of the Medically Underserved Areas (MUAs)/Medically Underserved Populations (MUPs) of Pinellas County.



## CO-APPLICANT AGREEMENT

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- 2.1.2. Financial Management: Developing, adopting, and periodically updating policies for financial management practices, including a system to assure accountability for Health Center resources, and long-range financial planning in conjunction with MMUAC;
- 2.1.3. Internal Controls: Developing, adopting, and periodically updating internal control procedures to ensure sound financial management procedures as well as purchasing policies and standards;
- 2.1.4. Personnel Policies: Developing, adopting, and periodically updating personnel policies and procedures that shall be applicable to all County employees. Policies and procedures shall set forth selection, performance review/evaluations, and dismissal procedures, employee compensation, including wage and salary scales and benefit packages, position descriptions and classification, employee grievance procedures, and which shall meet all Federal and/or State employment requirements including, but not limited to, equal employment opportunity, drug free workplace, and non-discrimination laws;
- 2.1.5. Strategic Planning: In conjunction with the MMUAC, developing and adopting an annual strategic plan; and
- 2.1.6. Compliance: In conjunction with the MMUAC, assuring that the Healthcare for the Homeless Program is operated in compliance with applicable Federal, State and local laws and regulations.

### 2.2. Operational Responsibilities.

The BCC shall fulfill the following obligations with respect to Healthcare for the Homeless Program:

- 2.2.1. Applying for and maintaining all licenses, permits, certifications, and other approvals necessary for the operation of the Healthcare for the Homeless Program.
- 2.2.2. Budget: The Project Director, in collaboration with the finance department, shall prepare a budget and financial plan for each fiscal year, in accordance with Pinellas County policies and procedures. The MMUAC shall annually review the budget prepared by PCHS for the operation of the Healthcare for the Homeless Program. The MMUAC shall review and approve the annual Section 330 grant budget and recommend this budget to the BCC. The MMUAC and BCC shall jointly approve the annual Section 330 budget submitted to the Bureau of Primary Health Care.
- 2.2.3. Amendments to the Budget: Pinellas County budget policies and procedures will be utilized for all amendments to the jointly adopted Healthcare for the Homeless Program budget. Amendments requiring full approval of the BCC shall also require approval of the MMUAC. MMUAC approval shall either be obtained prior to the submission of the adjustment to the BCC or the action of the BCC shall be contingent upon the concurrence of the MMUAC.

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- 2.2.4. In accordance with Federal Section 330 regulations, receiving, managing and disbursing Healthcare for the Homeless Program revenues, if any, consistent with the Healthcare for the Homeless Program budget approved and Federal Program Requirements in accordance with this Agreement. MMUAC shall not be required to disburse funds for any expenditure not authorized by a budget approved in accordance with this Agreement. BCC shall advise in writing to the MMUAC before implementing any material change in the Healthcare for the Homeless Program approved budget.
- 2.2.5. Directly employing or contracting for all Healthcare for the Homeless Program personnel (including the Project Director, other key management, and all clinical, administrative, and support staff) as may be necessary to operate the Healthcare for the Homeless Program and to furnish, or arrange for the provision of, the full range of primary, preventive, and supplemental health care services required by Section 330. Clinicians hired by the Healthcare for the Homeless Program shall meet the credentialing requirements and qualifications established by the BCC.
- 2.2.6. Developing and establishing management and control systems for the Healthcare for the Homeless Program that are in accordance with sound financial management procedures, including:
  - 2.2.6.1. The establishment of billing and collection systems pursuant to which MMU shall make every reasonable effort to bill and collect payment from patients in accordance with the fee schedule and schedule of discounts established in accordance with 42 CFR §51c.303 and other billing and collection policies developed in consultation with the BCC, as well as make reasonable efforts to bill and collect payments without application of any discounts from public and private third party payors; and
- 2.2.7. On behalf of the BCC, PCHS is responsible for preparing monthly financial and operational reports for the MMUAC, and any other reports reasonably requested by the MMUAC in order to enable the MMUAC to fulfill its responsibilities for the Healthcare for the Homeless Program;
- 2.2.8. Under the direction of the HS's Project Director, managing the day-to-day business affairs of the MMU. Such management functions may include, but are not limited to:
  - 2.2.8.1. Developing clinical protocols, medical standards, productivity standards, and quality assurance programs designed to meet the health care policies and procedures established by the MMUAC, as well as standards imposed by appropriate funding sources, government agencies, and certifying agencies; and
  - 2.2.8.2. Providing all necessary management, administrative or financial expertise and personnel as shall be necessary to assure high level technical expertise in areas relevant to the Healthcare for the Homeless Program operations.

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### 3. Mutual Obligations.

- 3.1. The MMUAC Chair (or his/her duly authorized designee), on behalf of Healthcare for the Homeless Program, and the Health Center's Project Director (or his/her duly authorized designee), on behalf of the BCC, shall coordinate the Parties' efforts to meet their respective obligations under this Agreement and shall cooperate to communicate and resolve any issues between the Parties. Each shall be reasonably accessible and available for (i) consultations regarding day-to-day operations of the Healthcare for the Homeless Program; (ii) when requested, meetings of the Parties' respective governing boards; and (iii) otherwise as is reasonably necessary.
- 3.2. The Parties shall collaborate to provide orientation and training to MMUAC members, in conjunction with Healthcare for the Homeless Program staff, in order to educate MMUAC members regarding their legal duties and obligations vis-à-vis the Healthcare for the Homeless Program.
- 3.3. The Parties agree that Section 330 grant funds and grant-related income (including fees, premiums, and third-party reimbursements) and State, local and other operational funds which may be collected, shall be utilized to reimburse the Parties for costs incurred in carrying out each Party's obligations consistent with the approved Healthcare for the Homeless Program's annual budget.
- 3.4. Record Keeping and Reporting.
  - 3.4.1. Each Party shall maintain records so as to enable the Parties to meet all grant-related reporting requirements. Specifically, MMUAC shall assist the BCC, as requested, in the preparation of those portions of the financial report ("FFR"), as well as other reports, which pertain to the operation of the Healthcare for the Homeless Program.
  - 3.4.2. The Parties shall maintain financial records and reports, supporting documents, statistical records, and all other books, documents, papers or other records related and pertinent to this Agreement for a period of four (4) years from the date this Agreement expires or is terminated. If an audit, litigation, or other action involving the records is started before the end of the four (4) year period, the Parties agrees to maintain the records until the end of the four (4) year period or until the audit, litigation, or other action is completed, whichever is later. The Parties shall make available to each other, DHHS and the Comptroller General of the United States, or any of their duly authorized representatives, upon appropriate notice, such financial systems, records, reports, books, documents, and papers as may be necessary for audit, examination, excerpt, transcription, and copy purposes, for as long as such systems, records, reports, books, documents, and papers are retained.
  - 3.4.3. The Parties agree that the BCC shall retain ownership of all medical records established and maintained relating to diagnosis and treatment of patients served by the Healthcare for the Homeless Program.

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### 3.5. Ownership of Property and Equipment Acquired with Grant Funds.

3.5.1. The provisions of 45 C.F.R. § 74.40 et seq. apply to real property and equipment acquired under this Agreement. The Parties agree that the BCC shall be the title holder to all property purchased with grant funds.

### 3.6. Copyrightable Material.

3.6.1. If any copyrightable material is developed under this Agreement, the BCC shall hold all right, title and interest to such material, and BCC shall have a royalty-free, non-exclusive and irrevocable right to reproduce, publish, authorize others or otherwise use such material.

3.7. Survival of Article. Sections 3.3, 3.4, 3.5, and 3.6 of this Article shall survive the termination of this Agreement without regard to the cause for termination.

3.8. Sovereign Immunity. Nothing in this Agreement shall limit, or shall be deemed to limit, the BCC's right to the protections and limitations provided by statutes designed to protect and limit the exposure and liability of the BCC as an instrumentality of the State of Florida.

## 4. Third Party Affiliations.

Neither Party shall execute a merger, consolidation, or comprehensive affiliation with a third party that affects, or may affect, the MMU without the written consent of the other Party, which consent shall not be unreasonably withheld.

## 5. Governing Law.

### 5.1. Applicable Federal Laws, Regulations and Policies.

This Agreement shall be governed and construed in accordance with applicable Federal laws, regulations, and policies, including but not limited to: Section 330, its implementing regulations at 42 C.F.R. Part 51c, applicable BPHC policies (including, but not limited to, BPHC Program Expectations), the Public Health Service Grants Policy Statement in effect as of the date the Agreement is executed, DHHS administrative regulations set forth in 45 C.F.R Part 74, and relevant Office of Management and Budget Circulars.

### 5.2. Compliance with State and Local Law.

This Agreement is governed by the laws of the State of Florida. Each Party covenants to comply with all applicable laws, ordinances and codes of the State of Florida and local governments in the performance of the Agreement, including all licensing standards and applicable accreditation standards.

5.3. New BPHC Directives.

The MMU Division Director shall submit promptly to each Party any additional directives that are received from the BPHC pertinent to the Section 330 grant, and the Parties shall comply with such additional directives, as applicable.

5.4. Non-Discrimination.

Each Party agrees that it and its subcontractors, if any, will not discriminate against any employee or applicant for employment to be employed in the performance of this Agreement with respect to his hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment, because of his or her race, religion, color, sex, disability, national origin or ancestry.

6. **Term.**

This Agreement shall remain in effect during the project period of any Section 330 award the BCC receives with MMUAC as its co-applicant Board, unless terminated at an earlier date in accordance with the terms of Section 7 of this Agreement.

7. **Termination.**

7.1. Immediate Termination.

This Agreement shall terminate immediately upon the effective date of non-renewal or termination of the Section 330 grant, or upon the loss of any license, permit or other authorization required by law or regulation for operation of the Healthcare for the Homeless Program.

7.2. For Cause Termination.

Either Party may terminate this Agreement for cause in the event that the other Party fails to meet any material obligation under this Agreement, subject to Section 7.4 of this Agreement. Such for cause termination shall require sixty (60) days' prior written notice of intent to terminate during which period the Party that has allegedly failed to meet a material obligation may cure such failure or demonstrate that no such failure has occurred. Any dispute between the Parties regarding whether a breach of a material obligation has occurred, or that such a breach has been satisfactorily cured, will be resolved in accordance with Section 8 of this Agreement.

7.3. Termination for Mutual Convenience.

This Agreement may be terminated upon the mutual written consent of the Parties, subject to Section 7.4 of this Agreement.

7.4. Termination Contingent upon Bureau of Primary Health Care (BPHC) Approval.

For cause termination or termination for mutual convenience shall not become effective unless and until BPHC issues its written approval of such termination, if such approval is necessary.

**8. Dispute Resolution.**

The Parties shall first attempt to resolve any dispute arising under this Agreement by informal discussions between the liaison designated by BCC and the liaison designated by the MMUAC. In the event the Parties are unable to resolve the dispute through informal negotiations within a reasonable period of time after commencement of such discussions (not to exceed thirty [30] days), the Parties may pursue formal mediation, if they mutually agree to do so. If, after mediation (or in the absence of mutual consent to mediate), the Parties are still unable to resolve the dispute, either Party may thereafter pursue any remedy available at law.

**9. Proprietary Information and Confidentiality.**

- 9.1. The Parties (and their directors, officers, employees, agents, and contractors) shall maintain the privacy and confidentiality of all information regarding the personal facts and circumstances of the patients receiving care provided by the Healthcare for the Homeless Program, in accordance with all applicable State and Federal laws and regulations and the Parties' policies and procedures regarding the privacy and confidentiality of such information. The Parties (and their directors, officers, employees, agents, and contractors) shall not divulge such information to any third parties without the patient's written consent, except as may be required by law or as may be necessary to provide service to such patient.
- 9.2. Except as is necessary in the performance of this Agreement, or as authorized in writing by a Party or by law, neither Party (nor its directors, officers, employees, agents, and contractors) shall disclose to any person, institution, entity, company, or any other party, any information which is directly or indirectly related to the other Party that it (or its directors, officers, employees, agents, and contractors) receives in any form (including, but not limited to, written, oral, or contained on video tapes, audio tapes or computer diskettes) as a result of performing obligations under this Agreement, or of which it is otherwise aware. The Parties (and their directors, officers, employees, agents, and contractors) also agree not to disclose, except to each other, any proprietary information, professional secrets or other information obtained in any form (including, but not limited to, written, oral, or contained on video tapes, audio tapes or computer diskettes) during the course of carrying out the responsibilities under this Agreement, unless the disclosing Party receives prior written authorization to do so from the other Party or as authorized by law.
- 9.3. Each Party shall retain title and all rights to the confidential and proprietary information which has been disclosed to the other Party. Upon expiration or termination of this Agreement, or upon request of a Party for any reason, each Party agrees to return promptly to the other Party all confidential and proprietary information in any physical form whatsoever (including, but not limited to, writings, audio tapes, video tapes, and computer diskettes). Further, each Party agrees: (i) to turn over promptly to the other Party any memoranda, notes, records, and/or other documents created by it which contain references to such other Party's confidential or proprietary information; and (ii) that it will not retain any copies, extracts or other reproductions, in whole or in part, of such returned confidential or proprietary information or any memoranda, notes, records and/or other documents related to such information.

## CO-APPLICANT AGREEMENT

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- 9.4. The Parties agree that their obligations and representations regarding all confidential and proprietary information shall be in effect during the term of this Agreement and shall survive the expiration or termination (regardless of the cause of termination) of this Agreement.
- 9.5. The Parties shall ensure that their respective directors, officers, employees, agents, and contractors are aware of and shall comply with the aforementioned obligations.

### **10. Notices.**

All notices permitted or required by this Agreement shall be deemed given when in writing and delivered personally or deposited in the United States Mail, postage prepaid, Certified and Return Receipt Requested, addressed to the other Party at the address set forth below, or such other address as the Party may designate in writing:

For MMUAC: Mobile Medical Unit Advisory Council  
Attn: Chairman  
Care of: Pinellas County Human Services Director  
440 Court Street, 2<sup>nd</sup> Floor  
Clearwater, FL 33756

For BCC: Pinellas County Human Services Department  
Attn. Director, Human Services  
440 Court Street, 2<sup>nd</sup> Floor  
Clearwater, FL 33756

The foregoing addresses may be changed and/or additional persons may be added thereto by notifying the other Party hereto in writing and in the manner hereinafter set forth. All notices shall be effective upon receipt.

### **11. Assignment.**

This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective transferees, successors and assigns; provided that neither Party shall have the right to assign, delegate or transfer this Agreement, or its rights and obligations hereunder, without the express prior written consent of the other Party provided prior to such action.

### **12. Non-Severability.**

The provisions of this Agreement are not severable. In the event that any one or more provisions of this Agreement are deemed null, void, illegal or unenforceable, or should any part of this Agreement, as determined by DHHS or any other governmental authority, cause BCC and the MMUAC (as co-applicants) not to comply with Section 330, the Parties agree to attempt to amend this Agreement as shall reasonably necessary to achieve compliance. In the event that the Parties reach such an agreement, this Agreement shall be construed in all respects as if such invalid or unenforceable provisions have been omitted. In the event that no such amendments or agreements for amendments can reasonably be made, this Agreement shall immediately terminate.

**13. Amendments.**

Any amendment to this Agreement shall be in writing and signed by both Parties. Except for the specific provision of this Agreement which thereby may be amended, this Agreement shall remain in full force and effect after such amendment.

**14. Descriptive Headings.**

The descriptive headings in this Agreement are for convenience only, and shall be of no force or effect in construing the interpreting any of the provisions of this Agreement.

**15. Waiver.**

No provision of this Agreement shall be waived by any act, omission or knowledge of a Party or its agents or employees except by an instrument in writing expressly waiving such provision and signed by a duly authorized officer of the waiving Party.

**16. Agency.**

Neither Party is, nor shall be deemed to be, an employee, agent, co-venturer or legal representative of the other Party for any purpose. Neither Party shall be entitled to enter into any contracts in the name of, or on behalf of the other Party, nor shall either Party be entitled to pledge the credit of the other Party in any way or hold itself out as having the authority to do so.

**17. Third-Party Beneficiaries.**

None of the provisions of this Agreement shall be for the benefit of or enforceable by any third party, including, without limitation, any creditor of either Party. No third party shall obtain any right under any provision of this Agreement or shall by reason of any provisions make any claim relating to any debt, liability, and obligation or otherwise against any Party to this Agreement.

**18. Entire Agreement.**

This Agreement constitutes the entire agreement of the Parties with respect to the Parties' joint operation of the MMU as a public health center receiving funds pursuant to Section 330 of the Public Health Service Act, and supersedes all prior oral and unsigned agreements.



CO-APPLICANT AGREEMENT

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives.

ATTEST:  
Ken Burke  
Clerk of the Circuit Court

PINELLAS COUNTY, FLORIDA  
Acting by and through its Board of County  
Commissioners

By: \_\_\_\_\_  
Deputy Clerk


By: \_\_\_\_\_  
Chairman

Date: \_\_\_\_\_

APPROVED AS TO FORM  
OFFICE OF COUNTY ATTORNEY

By:  \_\_\_\_\_  
Assistant County Attorney

MOBILE MEDICAL UNIT ADVISORY  
COUNCIL

By:  \_\_\_\_\_  
Chairman

Date: 7/2/15



# Mobile Medical Unit Advisory Council BYLAWS

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*Approved June 2, 2015*

*The Mobile Medical Unit Advisory Council (MMUAC)(Co-Applicant Board) serves as the patient/community-based governing board to set health center policy for the Healthcare for the Homeless Program on behalf of the Pinellas County Board of County Commissioners. As a public center, the MMUAC includes a representative majority of consumer/patient representatives, meets monthly and fulfills all the required authorities of a governing board. The purpose of the co-applicant arrangement is for the co-applicant board to oversee the implementation of the Section 330 grant and the operation of the Healthcare for the Homeless Program via the Mobile Medical Unit operated by the Pinellas County Human Services Department in accordance with the terms of this Agreement and the Bylaws as adopted by the BCC and MMUAC.*

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## **BYLAWS**

### **ARTICLE I – NAME**

This organization shall be known as the Mobile Medical Unit (MMU) Advisory Council.

### **ARTICLE II – MISSION**

To bring community services and resources together to provide the best care possible for those in need.

### **ARTICLE III – GOALS**

1. The MMU Advisory Council will assist the Pinellas County Human Services (PCHS) department to implement health services for residents of Pinellas County. These services represent a significant effort by the PCHS to assure that low-income residents have access to an organized system of health care. The MMU Advisory Council and PCHS shall be particularly committed to meeting the health care needs of at-risk indigent populations.
2. The MMU Advisory Council shall review budgets that are included as part of the 330(h) initial and review application.
3. The MMU Advisory Council will serve as an advocate for consumers of the MMU.
4. The MMU Advisory Council will strive to improve communication between the MMU Advisory Council and other service providers.
5. The MMU Advisory Council shall participate in the planning of the grant application to the U.S. Department of Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, under Section 330(h) of the Public Health Services Act for operation of a Federally Qualified Health Center.

### **ARTICLE IV – OBJECTIVES**

1. To increase the accessibility of primary care services to uninsured/underinsured population groups which experience a shortage of primary care.
2. To assure that the MMU provides high quality primary care services.

### **ARTICLE V – SIZE AND COMPOSITION**

#### **A. Size**

The MMU Advisory Council shall consist of not less than nine (9) and not more than 25 members.

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## **B. Composition**

1. A majority (at least 51%) of the MMU Advisory Council members shall be individuals who are a currently registered patient and must have accessed the health center in the past 24 months to receive at least one or more in-scope services that generated a health center visit. As a group, represent the individuals being serviced or to be served in terms of demographic factors, such as race, ethnicity and gender.
2. No more than one-half of the remaining members of the MMU Advisory Council may be individuals who derive more than ten percent (10%) of their annual income from the health care industry.
3. The remaining MMU Advisory Council members shall be representatives of the community, in which the catchment area is located and shall be selected for their expertise in community affairs, local government, finance, and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social services agencies within the community.
4. No Council member shall be an employee of the Pinellas County or the spouse or child, parent, brother or sister by blood or marriage of such an employee.
5. No more than two (2) MMU Advisory Council members may be Pinellas County Board of County Commission members.
6. Conflicts of interest, as defined by FLORIDA law, or the appearance of conflicts of interest, shall be prohibited.
7. PCHS shall provide logistical and managerial assistance to the MMU Advisory Council.

## **ARTICLE VI – MEMBERSHIP AND TERMS OF OFFICE**

### **A. Recruitment/Appointment**

On an annual or as needed basis, the MMU Advisory Council shall nominate between one (1) and three (3) individuals to the MMU Advisory Council for each vacant council seat for consideration and appointment. The MMU Advisory Council may solicit nominations from the community, current or former consumers of the MMU, persons who are currently or formerly homeless, and other interested individuals who are committed and interested in the delivery of services of the Mobile Medical Unit. The Board of County Commissioners shall make appointments from the slate of nominees presented by the MMU Advisory Council. The MMU Advisory Council and the Board of County Commissioners will use their best efforts to maintain the same ratio of consumer members, provider members and consumers-at-large as set out in Article V above.

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## **B. Terms of Office**

Members shall be appointed for terms of two (2) years and shall serve until his/her successor is appointed and qualified. Members may serve no more than three (3) consecutive full terms of office.

## **C. Removal**

Any member of the Council may be removed for unexcused absences, inappropriate behavior or unfavorable representation of the MMU Advisory Council, contingent upon a 2/3 vote of the Council, after notice and an opportunity to be heard. An unexcused absence is defined as an absence of which the chair and/or staff coordinator was not notified in advance for the meeting. Not more than three consecutive unexcused absences from board meetings or failure to attend 75% of the meetings in any calendar year will be allowed.

## **D. Vacancies and Resignations**

On an annual basis, vacancies occurring on the Council shall be filled in the same manner as previous appointments were made, following the guidance in Section A. In the process of filling vacancies, the Advisory Council shall extend their best efforts to maintain the Council's composition of consumer members, provider members and consumers-at-large. Any Council member appointed to fill a vacancy shall be appointed for the unexpired term of her/his predecessor in office.

All resignations must be in writing and submitted to the MMU Advisory Council Chairperson thirty (30) days prior to effective date.

The MMU Advisory Council Chairperson shall nominate an interim appointment to fill the remainder of the term of members removed pursuant to Sections C and D. A member appointed by the Chairperson shall serve as a full member of the Advisory Council pending confirmation by the Board of County Commissioners. The Chairperson in making interim appointments shall use best efforts to maintain the same ratio of consumer members, provider members and consumers-at-large as set out in Article V above.

## **E. Compensation**

Members of the Council shall serve without compensation. However, members may be reimbursed for reasonable expenses actually incurred related to their service on the MMU Advisory Council.

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## **ARTICLE VII – MEETINGS AND VOTING**

### **A. Annual Meeting**

The MMU Advisory Council shall hold an annual meeting during the second quarter of each year. The date and time are to be decided by the Council members.

### **B. Regular and Special Meetings**

Regular meetings of the MMU Advisory Council shall be monthly at a time and place to be decided by the Council. The agenda of each meeting will be distributed to the membership not later than two (2) business days prior to each meeting. Notices of meetings will be included on the Mobile Medical Unit monthly calendar. The agenda may be modified by a majority vote of the members present. All meetings of the Mobile Medical Unit Advisory Council shall be open to the public.

Where geography or other circumstances make monthly, in person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

Special meetings may be called by the Council Chairperson or by four (4) members of the MMU Advisory Council, at such time and place as may be deemed necessary.

### **C. Notice of Special Meetings**

Council members shall be notified of the time, place and purpose of all special meetings of the MMU Advisory Council at least two (2) days prior by email, facsimile, correspondence, or hand delivery in person. Notices of special meetings of the MMU Advisory Council shall specify the business to be transacted at the special meeting and no other business except that specified shall be considered at the special meeting.

### **D. Quorum**

A majority of the MMU Advisory Council members appointed and serving shall constitute a quorum for the transaction of business. Council officers can act in absence of quorum.

### **E. Voting**

All members shall be deemed as equal members and a simple vote is all that is required. A minimum of three members must be present to solidify a vote, except as may be provided by statute or these bylaws.

### **F. Recording, Distribution and Storage of Minutes**

The MMUAC shall keep a record of its proceedings and shall be custodian of all books, documents, and papers filed with it. All meetings of the MMUAC, as well as all records, books, documents, and papers, shall be open and available to the public in accordance with F.S. § 286.011.

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## **ARTICLE VIII -- OFFICERS AND STAFF ASSISTANCE**

### **A. Officers**

The officers of the Council shall be the Chairperson, Vice-Chairperson, and Secretary.

### **B. Election and Terms of Office**

The officers shall be elected by the Council during the annual meeting and shall take office immediately thereafter. Terms of office shall be for two (2) years or until their successors are elected. Officers shall be elected at the first meeting of the MMU Advisory Council and shall serve until the second annual meeting thereafter.

### **C. Removal**

Any officer elected by the Council may be removed by two-thirds majority vote after notice and an opportunity to be heard.

### **D. Vacancy**

The unexpired term of an officer not completing his or her term shall be filled by a majority vote of the MMU Advisory Council at the next regular meeting after the vacancy or at a special meeting called for that purpose. A majority vote of the total MMU Advisory Council membership shall be necessary to elect an officer.

### **E. Chairperson**

The Chairperson shall be elected by a majority of the MMU Advisory Council membership and shall preside at all meetings of the MMU Advisory Council. The Chairperson shall make appointments to Councils, with approval of a majority of MMU Advisory Council members. The Chairperson shall arbitrate disputes between these Councils. The Chairperson shall be kept advised of the affairs of PCHS and ensure that all directives and policies are carried into effect. The Chairperson shall fill unexpired terms of Advisory Council members. The Chairperson shall perform other duties as may be assigned by the Council.

### **F. Vice-Chairperson**

The Vice-Chairperson shall perform the duties of the Chairperson in the absence of the Chairperson and shall perform such other duties as from time to time may be assigned by the MMU Advisory Council.

### **G. Secretary**

The Secretary shall keep the minutes of all meetings of the MMU Advisory Council. The Secretary shall give notices of all meetings of the MMU Advisory Council in accordance with the provisions of these bylaws or as required by statute or resolution. The Secretary shall perform other duties as assigned by the MMU Advisory Council.

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## **H. Staff Assistance**

PCHS STAFF shall ensure that secretarial and/or stenographic assistance and staff assistance, if appropriate, is provided to the MMU Advisory Council meetings and to the Chairperson in the performance of his/her MMU authorized duties, as may be reasonably requested.

## **ARTICLE IX – COUNCIL(S)**

### **A. Ad-hoc Committees**

The Council may establish ad-hoc Committees as it deems necessary to carry out the purpose and objectives of the MMU. The Chairperson, with the consent of a majority of MMU Advisory Council members, may appoint MMU members to these Committees. Ad-hoc Committees shall be advisory in nature.

### **B. Standing Committees**

The Chairperson of the MMU Advisory Council shall, from among Council members, appoint with the concurrence of a majority of MMU Advisory Council members, the following standing Committees:

1. A Planning and Development Committee composed of four to five (4 -5) Advisory Council members shall be responsible for developing the goals and objectives of the MMU for monitoring and evaluating their implementation and progress, and for reviewing the MMU's by-laws. Additionally, this Committee will monitor local, state, and federal issues regularly informing the Board of these issues.
2. A Clinical Operations Committee composed of four to five (4 -5) council members shall work with PCHS on establishing all policies and procedures, except for personnel and fiscal policies and procedures (retained by Pinellas County Board of County Commissioners). This Council recommends the approval of the annual quality assurance/quality improvement plan to the full council, monitors the plan's implementation and results. This Council will meet at least quarterly.

The function of the standing Committees is advisory in nature. Any action or decision must be approved by the FULL MMU Advisory Council. No Council or individual member may decide any matter or action without specific Council approval. The PCHS Project Director shall be a non-voting member of all Committees.

### **C. General Committee Procedures**

1. Term: Each standing Committee, except the Nominating Committee, shall be appointed at the annual meeting of the Advisory Council and shall serve for the ensuing year. Council chairpersons shall also serve for the ensuing year.



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2. Meeting Procedure: Every meeting of a standing Committee of the Advisory Council shall be called by its chairperson or by a majority of Council members. At the first meeting of a standing Council, a meeting schedule shall be determined. In the event that a special meeting is necessary, Council members shall be notified of the time, place and purpose of the special Council meeting at least two (2) business days prior by facsimile, correspondence, or hand delivery in person. A quorum for the conduct of Council business shall require the presence of a majority of the Council members.
  3. Membership: Only Council members may be appointed to standing Committees of the MMU Advisory Council. The Council may request that non-Council members attend MMU Advisory Council meetings to provide assistance or information.
  4. Voting: When a Council meets and votes on an issue, only members of that Council may vote. Advisory Council members who are present and who are not members of the Council may not vote. MMU Advisory Council is advisory in nature and all actions shall be forwarded for review and action/inaction to the full Board of County Commissioners.

## **ARTICLE X -- RESPONSIBILITIES OF THE COUNCIL**

### **A. Personnel Policies and Procedures**

The MMU Advisory Council, through its Cooperative Agreement, shall be bound by the Pinellas County personnel policies and procedures. These agreements and policies include selection and dismissal procedures, performance appraisal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity and non-discrimination practices as established by the Pinellas County Board of County Commissioners.

### **B. Financial Management**

The MMU Advisory Council shall annually review the budget prepared by the PCHS Department for the operation of the MMU. The MMU Advisory Council shall advise the Pinellas County Board of County Commissioners regarding this budget. The MMU Advisory Council shall review and approve the annual Section 330 grant budget and recommend this budget to the Board of County Commissioners. The MMU Advisory Council and Board of County Commissioners shall jointly approve the annual Section 330 budget submitted to the Bureau of Primary Health Care.

The MMU Advisory Council shall review management reports to support the PCHS and the Board of County Commissioners in the operation of the MMU. The MMU Advisory Council shall provide assurance to the Federal Bureau of Primary Care that the MMU shall operate within the adopted budget. The MMU Advisory Council shall set a fee schedule for the services provided through the MMU and shall recommend to the Board of County Commissioners policies for discounting fees (i.e. sliding fee scale) based on patient/family size and income.

Audits, as required by law for the 300 Grant Agreement shall be performed by an independent auditor. The audits may be performed in conjunction with other Pinellas County audits.

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### **C. Evaluate Health Center Activities**

The Council shall evaluate utilization patterns, productivity, patient satisfaction, and achievement of project objectives of the MMU, and shall develop and implement a process for hearing and resolving patient grievances.

The Council shall evaluate the MMU achievements at least annually and utilizing the knowledge gained thereby to revise the MMU goals, objectives, plan and budget as necessary and appropriate, including providing advice regarding the establishment of linkages with other health care providers and/or health care programs.

The Council shall evaluate itself periodically for efficiency, effectiveness, and compliance with all requirements imposed upon community health centers, as set forth in Section 330 of the Public Health Service Act, 42 U.S.C. § 254b.

### **D. Compliance with Laws**

The Council shall assure that the MMU is operated in compliance with applicable Federal, State and local laws and regulations.

### **E. Health Care Policies**

The Council shall work with the MMU clinical staff to establish policies for health care delivery, including those dealing with the scope, availability and types of services, location and hours of services, and quality of care audit procedures.

### **F. Grants**

The Advisory Council shall work with the PCHS to identify and make application for grant opportunities.

### **G. Administrative Assistance**

The PCHS shall provide the administrative assistance necessary to fulfill the Council's responsibilities.

### **H. Conflict of Interest**

No employee, officer or agent shall participate in the selection, award or administration of a contract supported by Federal funds if a real or apparent conflict of interest would be involved. Such a conflict would arise when the employee, officer, or agent, or any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award. The officers, employees and agents of the recipient shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors, or parties to sub-agreements. However, recipients may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value. The standards of conduct shall provide for disciplinary actions to be applied for violations of such standards by officers, employers or agents of the recipients.

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## **ARTICLE XI -- FISCAL YEAR**

The fiscal year of the Council shall be November 1 through October 31.

## **ARTICLE XII -- ORDER OF BUSINESS**

The order of business of the Council at its regular and annual meetings, unless changed by a majority vote of its members, shall be as follows:

### **Regular Meeting**

1. Welcome and Call to Order
2. Approval of Minutes
3. Guest Speaker, if applicable
4. Community Input (limited to 3 minutes unless extended by the Chairperson)
5. Staff Reports (Governance, Fiscal, Clinical)
6. Committee Reports, if any
7. Other
8. Adjournment

### **Annual Meeting**

1. Welcome, and Call to Order
2. Approval of Minutes
3. Community Input (limited to 3 minutes unless extended by the Chairperson)
4. Chairperson's Annual Report
5. Election of Board Officers
6. Unfinished Business
7. New Business
8. Board Announcements
9. Adjournment

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### **ARTICLE XIII—AMENDMENTS**

These bylaws may be amended at a regular meeting of the Council by a two-thirds vote of the entire membership of the MMU Advisory Council, only after the proposed change has been presented and discussed at a previous regular meeting. Amendments to the bylaws do not become effective until voted and approved by the Board of County Commissioners.

### **ARTICLE XIV -- PROXY**

An absent MMU Advisory Council member shall not be allowed to vote by proxy.

### **ARTICLE XV -- PARLIAMENTARY AUTHORITY**

The Parliamentary Authority of the Council shall be Robert's Rules of Order.

### **CONCLUSION**

To the extent that any of the MMU Advisory Council By-laws are contrary to statutory requirements or the PCHS' authorization, they shall be of no force or effect.

### ***ADOPTED -***

Approved by MMU Advisory Council 11/04/2014  
Updated Draft as of 4/10/2015 per feedback from HRSA on 3/30/2015  
Provided to MMU Advisory Council for review on 5/5/2015  
Approved by MMU Advisory Council 06/02/2015

**Compliance Review Findings:**

PCBCC's Scope of Project appears to be accurate in terms of services and sites observed on site compared to the approved Scope of Project documented by the grantee on its current Form 5A and 5B. The program utilizes a Medical Mobile Unit to provide services at several locations rotated daily and the Mobile Medical Unit and administrative site are appropriately reflected.

However, PCBCC projected that by the end of the project period, October 31, 2015 it would have 3,129 medical users and 4,116 medical encounters. The grantee reported only 1,247 medical users and 3,405 non-nursing medical encounters for CY2013. The 1,247 users represent only 40% of what PCBCC projected while the 3,405 encounters are 83% of projected.

**If Not Met - Steps/Actions Recommended for Compliance:**

The grantee must develop a strategy to ensure that the number of medical patients it serves aligns with the projections in Form 1, Part A of the Competing Continuation Application for the project period ending October 31, 2015.

**Section 4. Governance - Program Requirement #17****Program Requirement #17 - Board Authority**

Health center governing Board maintains appropriate authority to oversee the operations of the center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

**Compliance Status: Not Met.****Documents reviewed onsite or in advance:**

Organizational/corporate bylaws

Minutes of recent Board meetings

Health center policies and procedures

List of Board committees

Other: Mobile Medical Unit Advisory Committee Bylaws, the Charter of Incorporation of the Pinellas Board of County Commissioners

**Compliance Review Findings:**

The Pinellas County Board of County Commissioners (BCC) was awarded a grant under its current governance structure to provide medical services to its homeless communities throughout the county. The county's Department of Health and Human Community Services has a targeted population of over 20,000 individuals who are either near homelessness or classified as homeless. This is a unique grantee in that it is a public entity without a co-applicant agreement with another community group to oversee the authority of the grant and its conditions. The

*This report has been prepared for the exclusive use of the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC) to assist in providing guidance and oversight of the HRSA/BPHC grantee. Information provided in this report is restricted to HRSA/BPHC use and cannot be distributed, copied, shared, and/or transmitted without written permission from HRSA/BPHC and the Review Team.*

program has always requested a waiver for Program Requirement #18 - Board Composition, which requires 51% consumer participation. It currently maintains that waiver. While the Pinellas County's BCC is the grantee, it has established an Advisory Committee to ensure that it receives accurate consumer input on the program's needs.

While the BCC does meet monthly (sometimes even more) in its oversight of the county's programs, the requirements as outlined for the expectations of a Board that holds the authority and oversight of the grant dollars for the operation of this program are not all in place.

- The Board meets monthly; however, it does not always have the Mobile Medical Unit (MMU) on its agenda. Its monthly meetings include the MMU in an overview reporting of all ambulatory services of the county.
- The meeting schedules, terms, and officers are based on the selection/election of the County Commissioners as per the laws of Pinellas County and the Florida State Statutes for Counties.
- There is no co-applicant agreement. Therefore, the Board must fulfill all of the responsibilities as outlined in the PHS Statute/Regulations and Grant Requirements.
- Minutes are recorded of each BCC meeting; however, very little if any information focuses on the MMU, nor do the minutes directly reflect approval of grant applications or other HRSA applications.
- The budget is approved as a part of the ambulatory medical services budget for the county.
- The Board does evaluate the Executive Director through the County Executive.
- All approvals of services, hours of operation and mode of service delivery are approved by the Executive Director for the Pinellas County Department of HHS and presented to the BCC for acceptance.
- Evaluation of the program's progress and long-term Strategic Plan is conducted and approved by the office of the Executive Director. There is a Program Director of this project who is hired by the Executive Director of the Pinellas County Department of HHS.
- There are bylaws for the Advisory Committee (one page), which has no real authority for program oversight.
- The bylaws of the BCC are the Charter that follows all of the county's and Florida state statutes/laws. Selection of membership to the BCC is an electoral process.
- Minutes are those of the BCC and are public record, recording little or no specific activities of the MMU for the homeless program.

#### **If Not Met - Steps/Actions Recommended for Compliance:**

This is a public entity and does not operate as an independent organization. As indicated in the aforementioned Findings, the MMU operates under the authority of the Pinellas County's Board of County Commissioners (BCC). In order to comply with the Health Center Program Requirements as a Homeless Program, the Grantee must immediately complete the following:

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- Develop and Implement a Co-Applicant Agreement with the Advisory Board that will assist in meeting the Program Requirements for MMU;
- Initiate monthly meetings to address the MMU operations as a co-applicant board;
- Record Meeting Minutes on a monthly basis that captures the discussions/activities of the Board's oversight of the MMU program;
- Develop and implement Bylaws that coincide with the Co-Applicant Agreement. This agreement should delineate the BCC and Advisory Board's responsibility to carry out its role in the oversight of the MMU program in accordance to the Health Center Program Requirements;
- Develop and implement a Board Recruitment Policy for Advisory Board members;
- There must be evidence that the Budget and Health Center Applications have been approved by the Board of the Health Center specifically and not as a part of the ambulatory budget for the county;
- There must be evidence that the BCC and/or Advisory Board have the authority to hire and evaluate the Project Director of the MMU Program.
- The minutes of monthly meetings must indicate a review and approval of policies and procedures, services offered, hours of operation for the MMU Program;
- There must be documentation that the MMU program is being evaluated on a consistent basis by its board on its long and short term strategic plans.

Note: This grantee has expressed planning efforts to eventually become a PHS CHC 330 Program (e) as well as maintain its (h) status. If the organization intends to move forward in this manner, the BCC must achieve compliance in this area by developing a co-applicant agreement that would include sharing authority and giving the co-applicant the authority to exercise oversight in agreed upon areas of program authority. The grantee must review PIN 2014-01 "Health Center Program Governance". A change in this structure may also impact compliance in other program requirement areas.

## **Section 4. Governance - Program Requirement #18**

### **Program Requirement #18 - Board Composition**

The health center governing Board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. (Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p), and 45 CFR Part 74.25(c)(2)-(3))

**Compliance Status: Met.**

**Documents reviewed onsite or in advance:**

Composition of Board of Directors/most recent Form 6A: Board Composition  
Organizational/corporate bylaws

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## 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](mailto:BPHCPolicy@hrsa.gov).

/s/

James Macrae  
Associate Administrator

Attachment



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## I. PURPOSE

The purpose of this Policy Information Notice (PIN) is to convey and clarify statutory and regulatory governance requirements for all look-alikes and Health Center Program grantees (e.g., health centers funded under section 330(e), (g), (h), and/or (i) of the Public Health Service (PHS) Act, as amended). The Health Resources and Services Administration's (HRSA) intent is to clarify and convey policies related to Health Center Program governance requirements that are relevant and flexible enough to assist health centers<sup>1</sup> as they continue to develop and expand, while preserving the community-based and patient-directed intent of the Health Center Program. In addition, the PIN:

- Recognizes and accommodates the unique governance needs of section 330(g), 330(h), and/or 330(i) health centers that are funded/designated solely to serve special populations and health centers serving an entirely sparsely populated rural area;
- Provides clarification regarding co-applicant board requirements for public centers, including public centers funded/designated solely under sections 330(g), 330(h), and 330(i) to serve special populations; and
- Outlines the requirements for HRSA approval of waivers for the fifty-one percent patient majority governance requirement for eligible health centers. This PIN also eliminates the monthly meeting requirement from waiver consideration.

PIN 2014-01 supersedes PIN 1998-12, "Implementation of the Section 330 Governance Requirements." Where provisions of this PIN conflict with requirements specified in previous PINs listed below, the provisions in this PIN supersede those in the previous PINs and other program guidance documents:

- PIN 1998-23, "Health Center Program Expectations"
- PIN 1997-27, "Affiliation Agreements of Community and Migrant Health Centers"
- PIN 1998-24, "Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers"
- PIN 1999-09, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities"
- PIN 1999-10, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities"
- Regional Program Guidance Memorandum 1989-10, "Community and Migrant Health Networks" and subsequent clarification dated March 11, 1991

In addition, this Governance PIN (2014-01) is the **primary** HRSA policy source for information on Health Center Program governance. Therefore, any other previous program guidance provided on this subject, that is inconsistent with the policy contained in this document is also superseded by this PIN.

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<sup>1</sup> Here and throughout the PIN, "health center" refers to designated look-alikes and all organizations funded under section 330 of the PHS Act, as amended, including all health centers funded/designated under section 330(e), (g), (h) and/or (i). Previously, look-alikes were sometimes referred to as Federally Qualified Health Center (FQHC) Look-Alikes.

## II. APPLICABILITY

This PIN applies to all health centers funded under the Health Center Program authorized in section 330 of the PHS Act (42 U.S.C. § 254b), as amended. In addition, this PIN applies to those organizations designated as look-alikes under the authority of section 1861(aa)(4) and section 1905(l)(2)(B) of the Social Security Act.<sup>2</sup>

The Health Center Program governance requirements do not apply to health centers operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act that are funded under section 330 or designated as look-alikes.<sup>3</sup> However, such organizations are strongly encouraged to review the governance requirements set forth in this PIN for guidance for ensuring patient participation and input in the direction, organization, and ongoing governance of the health center.

## III. GOVERNANCE REQUIREMENTS

Governance requirements for health centers have been set forth in statute, regulations and through various HRSA policies.<sup>4</sup> This PIN clarifies HRSA's policies in implementing the statutory and regulatory governance requirements of the Health Center Program. Per section 330(k)(3)(H) of the PHS Act (42 U.S.C. § 254b), as amended, all health centers<sup>5</sup> must demonstrate the establishment of an independent governing board that assumes full authority and oversight responsibility for the health center.<sup>6</sup> The health center's application must identify and document the members of this governing board that have or will assume full authority and oversight for the health center.

The Health Center Program's implementing regulations (42 C.F.R. § 51c.304 and 42 C.F.R. § 56.304) set forth specific governing board requirements for health centers which are funded under sections 330(e) and (g) as Community Health Centers (CHC) and Migrant Health Centers (MHC), respectively. As there are currently no implementing regulations for 330(h) and 330(i) health center programs, throughout the PIN, statements marked by an asterisk (\*) will indicate regulatory requirements that are strongly recommended but not required for health centers funded/designated solely under 330(h) and 330(i). It should be noted, however, that these regulations complement the statutory governance requirements and while specific applicability is tied to section 330(e) and (g) grantees only, they are best practices that all health centers should follow, regardless of the specific community being served.

<sup>2</sup> These policies and guidelines also apply to Look-Alikes, as per section 1861(aa)(4) and section 1905(l)(2)(B) of the Social Security Act, as amended, they must meet the requirements for health centers funded under section 330 of the PHS Act, as amended, including compliance with governance requirements.

<sup>3</sup> Per section 330(k)(3)(H) of the PHS Act.

<sup>4</sup> Section 330(k)(3)(H) of the PHS Act, as amended, 42 C.F.R. § 51c.304 for CHCs, and 42 C.F.R. § 56.304 for MHCs.

<sup>5</sup> Except where noted in statute, see 330(k)(3)(H) of the PHS Act, as amended.

<sup>6</sup> Health centers that receive New Access Point funding must be operational and providing services in the community within 120 days of receiving a grant award, including documentation that they are compliant with the requirements of section 330. Look-alikes must be fully operational, including meeting the statutory, regulatory, and program requirements for grantees funded under section 330 of the PHS Act to be eligible to apply for Look-Alike designation.

## A. Governing Board Size

The governing board size parameters are designed to ensure the board achieves diverse representation across the health center's target population(s) and service area as well as provides the expertise necessary for appropriate oversight while maintaining a size that functions effectively for timely decision making.

- The bylaws must define either a specific number of board members or define a limited range.
- Boards must have at least nine and no more than 25 members.\* The size of the board may vary based on the complexity of the organization and the diversity of the community served.

Please note that all boards should seek an adequate number of members to ensure the presence of a quorum at each board meeting should there be absent board members, while balancing the need for board functioning. Choosing the minimum number (9) of required members for the board may be problematic and inefficient for board functioning, as the health center will be out of compliance if it loses a board member. Likewise, choosing the maximum number of required (25) members for the board may be problematic and inefficient for board functioning, as decision making may be more difficult for a board of this size.

## B. Board Composition

Health center governing boards are comprised of individuals who contribute their time and energy to creating an operationally and fiscally strong organization for the purpose of improving the health of their communities and populations. Health centers must meet the following board composition requirements:

- No board members shall be an employee of the health center or an immediate family member (i.e., spouse, child, parent, brother, or sister by blood, adoption, or marriage) of an employee.\*
- The Chief Executive Officer may serve only as non-voting, ex-officio<sup>7</sup> member of the board.\*

### 1. Patient<sup>8</sup> Board Members

- A majority of members of the board (at least 51 percent) must be individuals who are served by the health center.
- Patient board members must be a current registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one or more in-scope service(s) that generated a health center visit.<sup>9</sup>
- 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.

<sup>7</sup> The CEO is generally a member of the board by virtue of being CEO of the health center.

<sup>8</sup> Patient board members are also often referred to as "user" or "consumer" board members. However for the purposes of this document, only the term "patient" or "non-patient" board member will be used for ease of reference.

<sup>9</sup> Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient.

- A legal guardian of a patient who is a dependent child or adult, or a legal sponsor of an immigrant, may also be considered a patient for purposes of board representation.<sup>10</sup>

## 2. Non-Patient Board Members

- The members must be representative of the community currently served by the health center.\*
- The board must be comprised of members with a broad range of skills, expertise, and perspectives. Such areas include but are not limited to: finance, legal affairs, business, health, managed care, social services, labor relations, and government.\* Any one board member (patient or non-patient) may be considered as having expertise in one or more of these areas. In addition, the board does not necessarily have to include specific expertise in all six of these areas and/or may include additional areas of expertise beyond these areas as appropriate.
- No more than one half (50 percent) of the non-patient representatives may derive more than 10 percent of their annual income from the health care industry.\*

## 3. Special Population Representation

Health centers that receive funding/designation under multiple section 330 subparts (section 330(e) and also section 330(g), (h), and/or (i)) must have patient representation on the governing board from the populations targeted and served by the health center, including the special population(s) specifically defined under sections 330(g), (h), and/or (i) (migratory and seasonal agricultural workers,<sup>11</sup> homeless individuals,<sup>12</sup> and residents of public housing,<sup>13</sup> respectively).

Patient representation must be reasonably reflective of the populations targeted and served. At a minimum, there must be at least one board member that is representative of each of the special populations for which the health center receives section 330 funding/designation. The intent is not to impose targets on board membership, but to be consistent with the statute to ensure that governing boards are sensitive and responsive to the needs of all of their patients, including those who are members of special populations.

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<sup>10</sup> Students may participate as board members subject to applicable state law regarding any minimum age requirements for non-profit board members.

<sup>11</sup> A migratory agricultural worker means an individual principally employed in agriculture on a seasonal basis within the last 24 months who establish temporary housing for the purpose of this work. A seasonal agricultural workers means an individual employed in agriculture on a seasonal basis, who is not also migratory. Agriculture meaning farming in all its branches, as defined by the Office of Management and Budget-developed (OMB) North American Industry Classification System (NAICS) under the following codes and all sub-codes within—111, 112, 1151, and 1152.

<sup>12</sup> A homeless individual means an individual who lacks housing (without regard to whether the individual is a member of the family), including an individual whose primary residence is a supervised public or private facility that provides temporary accommodations and an individual who is a resident in transitional housing, and includes residents of permanent supportive housing or other housing programs that are targeted to homeless populations.

<sup>13</sup> The residents of one or more public housing developments (section 3(b)(1) of the United States Housing Act of 1937 (42 U.S.C. § 1437a(b)(1)) and the surrounding areas, as appropriate. This includes agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than Section 8 housing vouchers.

Consistent with legislative intent, patient representation of special populations is best achieved through patients who are members of the special population. Inclusion of advocates who have personally experienced being a member of, represent, have expertise in, or work closely with the special population, however, would meet the requirement for multi-funded/designated health centers to have representation of all the populations for which the health center receives funding/designation. These advocates would not be included in calculating whether the governing board met the patient-majority requirement unless they were also health center patients. Additionally, while advocates may represent special populations on the board as outlined above, health centers should continue efforts to efforts to recruit patient board members from the targeted special population.

For MHCs funded/designated solely under section 330(g), the following differences in MHC board composition, per the regulations in 42 C.F.R. § 56.304, should be noted:

- A majority of members of the board (51 percent) must **be migratory and/or seasonal agricultural workers (current or retired due to age or disability)** and/or members of their families who are served by the health center; and
- No more than **two-thirds** of the non-patient representatives may derive more than 10 percent of their annual income from the health care industry.

### C. Organizational/Corporate Bylaws

Organizational/corporate bylaws must be established and approved by the health center's governing board through a board resolution that is signed and dated by the Secretary of the board or other designated official. Individual health center bylaws will vary based on a number of factors, including the size, complexity, and needs of the organization, as well as State laws. As the health center evolves, the bylaws should be reviewed and modified as necessary to remain current. Health center bylaws must specify the following:

- Health center mission.
- Authorities, functions, and responsibilities of governing board as a whole.
- Board membership (size and composition).
- Individual board member responsibilities.
- Process for selection/removal of board members.
- Election of officers.
- Recording, distribution and storage of minutes.
- Meeting schedule and quorum.
- Officer responsibilities, terms of office, and selection/removal processes.
- Description of standing committees (which may include but are not limited to, executive, finance, quality improvement, personnel, and planning committees) and the process for the creation of ad-hoc committees.
- Conflict of interest provisions.
- Provisions regarding board dissolution.

#### D. Board Authority, Functions, and Responsibilities

The governing board of a health center provides leadership and guidance in support of the health center's mission. However, day-to-day direction and management responsibility for the health center must rest with staff under the direction of the Chief Executive Officer (CEO) or Executive Director. Together, the board, the CEO, and other members of the management team (e.g., Chief Clinical Officer, Chief Financial Officer, Chief Information Officer) comprise the leadership for the health center. To succeed, they should work together to ensure a strong organization.

The board is legally responsible for ensuring that the health center is financially stable and is operating in accordance with applicable federal, state, and local laws and regulations as well as its own established policies and procedures.<sup>14</sup> Therefore, boards should be knowledgeable about the community and marketplace trends and be willing to adapt their policies and positions so the health center may react to these trends. In addition, ensuring the financial health of the organization and developing appropriate short and long term goals for the strategic direction of the health center are critical functions for the board. To effectively fulfill these functions, the board must be engaged in health center planning throughout the year. **The health center governing board must retain (i.e., may not delegate) the following unrestricted authorities, functions, and responsibilities:**

- Holding monthly meetings<sup>15, 16</sup> and maintaining records/minutes that verify and document the board's functioning.
- Approving applications related to the health center project, including grants/designation applications and other HRSA requests regarding scope of project.
- Approving the annual health center budget and audit.
- Long-term strategic planning, which would include regular updating of the health center's mission, goals, and plans, as appropriate.
- Evaluating the health center's progress in meeting its annual and long-term goals.
- Selecting services beyond those required in law to be provided by the health center, as well as the location and mode of delivery of those services.
- Determining the hours during which services are provided at health center sites that are appropriate and responsive to the community's needs.
- Approving the selection/dismissal and evaluating the performance of the health center's CEO or Executive Director.
- Establishing general policies and procedures for the health center that are consistent with Health Center Program and applicable grants management requirements.

Examples of specific health center policies and procedures to be approved and monitored by the Board include but are not limited to: board member selection and dismissal procedures,

<sup>14</sup> Section 330(k)(3)(D) and (k)(3)(H), 42 C.F.R. § 51c.304(d)(3)(iii), and 42 C.F.R. § 51c.304(d)(3)(v).

<sup>15</sup> Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

<sup>16</sup> Health centers funded/designated solely under 330(g) may meet less than once a month during periods of the year, as specified in the bylaws, where monthly meetings are not practical due to migration out of the area. (42 C.F.R. § 56.304(d)(2))

employee salary and benefit scales, employee grievance procedures, equal opportunity practices, codes of conduct, quality improvement system, fee schedules for services, the sliding fee discount program, billing and collections, financial policies that assure accountability for health center resources, and avoidance of conflict of interest.

In cases where the governing board bylaws establish an **Executive Committee** that has the authority to act on behalf of the full governing board, the actions of the Executive Committee must not supersede the full health center governing board's authorities, functions, and responsibilities. The bylaws must specify the circumstances in which the full health center governing board authorizes the Executive Committee to act on its behalf. The Executive Committee must report all actions taken independently and on behalf of the board to the full governing board, and the full governing board must vote on these actions and record them in the board minutes.

#### IV. PUBLIC CENTER GOVERNANCE

The term "public center" is defined by the Health Center Program's authorizing statute as a health center funded (or to be funded) through a section 330 grant to a public agency.<sup>17</sup> Public agencies (e.g., state, county, or local health departments) that receive any type or combination of section 330 funding (including section 330(g), 330(h), and/or 330(i) to serve special populations) or look-alike designation **must comply with all health center requirements and regulations except as specifically allowed through an approved waiver or the co-applicant structural exception described further below.**

Public centers may be structured in one of two ways to meet the program requirements. In a direct arrangement, the public agency independently meets all the health center program governance requirements based on the existing structure and vested authorities of the public agency's governing board. In a co-applicant arrangement, the health center project as a whole, because of the public agency and co-applicants' complementary roles, meets all health center program requirements.

##### A. Public Center Co-Applicant Provision

When the public agency's board cannot independently meet all applicable health center governance requirements, a separate "co-applicant" must be established whose governing board meets section 330 governance requirements. In the co-applicant arrangement, the public agency receives the section 330 grant or the look-alike designation and the co-applicant serves as the "health center board" with the two collectively considered as the "health center" or "public center."

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, and its members must be identified and documented in the public center's application for section 330 funding or look-alike designation. The co-applicant arrangement may not allow the public agency to override or overrule the final approvals and required decision-making authorities of

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<sup>17</sup> Sentence following section 330(k)(3)(M) of the PHS Act, as amended.



the co-applicant board (e.g., through a dual or super-majority voting or prior approval requirements).

The co-applicant provision in section 330(k)(3)(H)(ii) recognizes, however, 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:

#### **Fiscal Policies**

- Internal control procedures to ensure sound financial management procedures.
- Purchasing policies and standards.

#### **Personnel Policies**

- Employee selection, performance review/evaluations and dismissal procedures.<sup>18</sup>
- Employee compensation, including wage and salary scales and benefit packages.
- Position descriptions and classification.
- Employee grievance procedures.
- Equal opportunity practices.

While the public agency is the recipient of the health center grant/look-alike designation and is the legal entity held accountable to HRSA for carrying out the approved Health Center Program scope of project, the term “co-applicant” is used, based on the fact that the public agency would not qualify on its own as meeting all the Health Center Program requirements. As noted earlier, for programmatic purposes, HRSA considers both the public agency and the co-applicant collectively as the “health center.” Although the co-applicant governing board must retain the ultimate decision-making on duties and authorities beyond the general types of fiscal and personnel policies described above, the co-applicant arrangement should allow for the co-applicant board and the public agency to work collaboratively in the exercise of governance responsibilities.

### **B. Additional Governance Requirements for Public Center with Co-Applicant**

To facilitate the co-applicant arrangement, HRSA strongly encourages the health center co-applicant board to be formally incorporated to ensure maximum accountability for the patient-majority board per the intent of the Health Center Program. HRSA requires public agencies and their co-applicants to execute and present, for HRSA review and approval: a formal co-applicant agreement between the public agency and the co-applicant; co-applicant governing board bylaws; and articles of incorporation (if applicable). These documents must assure that the co-applicant arrangement meets all applicable Health Center Program requirements including retaining authorities as described above.

The co-applicant agreement is a separate document from the bylaws. This agreement must describe the delegation of authority and define roles, responsibilities, and authorities of each

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<sup>18</sup> Please note that the co-applicant governing board must approve the selection, performance evaluation, retention, and dismissal of the health center’s CEO or Executive Director.

party in the oversight and management of the health center, including any shared roles and responsibilities in carrying out the governance functions. Such agreements must ensure that the relationship is structured in compliance with section 330 of the PHS Act, as amended, implementing regulations, and clarifying policies. Decisions regarding how roles and responsibilities may be shared are a matter of choice for the public agency and co-applicant governing board; however, any shared roles and responsibilities, as well as the exercise of retained authorities by each party must be articulated in the co-applicant agreement. Given the level of shared responsibility between the public agency and the co-applicant governing board, it is advisable to include provisions for dispute resolution.

Public centers with co-applicant arrangements are reminded that, as with private non-profit centers, no board member shall be an employee of the health center or an immediate family member (i.e., spouse, child, parent, brother, or sister) of an employee. Since together the public agency and the co-applicant board form the “health center,” no employee or immediate family member of an employee of the public agency or the co-applicant may serve as a member of the co-applicant board.

## **V. WAIVERS OF GOVERNANCE REQUIREMENTS**

Section 330(k)(3)(H)(iii) of the PHS Act allows for the Secretary of Health and Human Services to waive the governance requirements for health centers receiving funds pursuant to subsections 330(g), (h), (i), or (p).<sup>19</sup> Specifically, the statute states that “upon showing of good cause the Secretary shall waive, for the length of the project period, all or part of the requirements of this subparagraph in the case of a health center that receives a grant pursuant to subsections (g), (h), (i), or (p).” In all cases, the existence of an approved waiver does not relieve the health center’s governing board from fulfilling all of the other board responsibilities, authorities, and functions, as described in this PIN and as applicable to the type of health center.

### **A. Eligibility for Waiver Requests**

Upon showing of good cause, the following types of health centers are eligible to request a waiver of the 51 percent patient majority governance requirement:

- Any section 330 funded health center or look-alike serving a sparsely populated rural area (section 330(p) of the PHS Act); or
- Section 330 funded health centers/look-alikes that receive MHC, Health Care for the Homeless (HCH), and/or Public Housing Primary Care funding/designation only and do not receive section 330(e) funding/designation.

While eligible to request a waiver, health centers funded/designated solely under 330(i) and health centers serving a sparsely populated rural areas should carefully note the good cause definition and criteria (see Section V.C: Waivers of Governance Requirements: Criteria and Requirements for Waiver Requests) in considering the submission of a waiver request. Since the target populations of these health center types do not generally face the same barriers as those

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<sup>19</sup> Section 330(p) health centers are those serving sparsely populated rural areas. For the purposes of determining eligibility for a governance waiver, a health center is defined as serving a sparsely populated rural area only if its entire service area can be classified as having seven or fewer people per square mile at the time of the waiver application.

served by MHC and HCH health centers, compelling and clear evidence about the characteristics of their patient population must be provided that sufficiently documents their limitations from serving on the health center boards.

**Requests for waivers of any other statutory or regulatory governance requirements will not be accepted for consideration.<sup>20</sup> Please note that past HRSA practice has allowed health centers to request waivers of the requirement for monthly board meetings. HRSA will no longer allow such waivers given the improved uses of telecommunications and other information technology to overcome previous geographic barriers to monthly meetings.**

## **B. Length of Waiver Approval**

For section 330 funded/look-alike designated health centers, governance waivers are in effect for the length of the approved project period. At the end of the project period, as part of the Service Area Competition (SAC)/Look-Alike Renewal of Designation application, health centers that request to continue their waiver must follow the process for governance waiver requests as described in Section V.D: Waivers of Governance Requirements: Waiver Request Process.

## **C. Criteria and Requirements for Waiver Requests**

Eligible health centers requesting waivers of the 51 percent patient governance requirement must demonstrate good cause (as defined below) as to why the health center cannot meet the statutory requirement. In addition, they must present alternative strategies detailing how the health center intends to meet the intent of the statute for ensuring patient participation in the organization, direction, and ongoing governance of the center.

### **1. Good Cause**

Demonstrations of “good cause” must be based upon the unique or innate characteristics of the health center’s special population or service area imposing an undue hardship and/or posing a significant barrier to the health center’s ability to establish a patient majority governing board that meets the statutory requirement. For example, health centers serving a predominately homeless population would demonstrate good cause if they are unable to recruit and retain sufficient numbers of homeless board members; or health centers serving a sparsely populated area would demonstrate good cause if they are unable to retain a patient majority on the board because of the limited number of people available to serve on the board.

An eligible health center requesting a waiver must present adequate documentation that the unique/innate characteristics of the health center’s patients and/or the service area clearly impose undue hardship and significant barriers to the health center in establishing a 51 percent patient governing board. Such documentation must include:

- A description of the population to be served and the characteristics of the population or service area which would necessitate a waiver;
- A description of the health center’s attempts to meet the requirement(s) to date; and

<sup>20</sup> Existing waivers of statutory or regulatory health center governance requirements beyond the 51 percent patient majority governance requirement, including those granted under the authority of section 330(e)(1)(B), will expire consistent with the effective date of this PIN. See Section VII: Effective Date.

- An explanation of why these attempts have not been successful.

## 2. Alternative Mechanism Plan for Addressing Patient Representation

An eligible health center that successfully demonstrates good cause, per the criteria above, must present an acceptable plan for complying with the intent of the statute via an alternative mechanism (see “Sample Alternative Mechanisms” section below for examples). Such a plan must ensure patient input and participation in the organization, direction and ongoing governance of the health center. The plan must provide all of the following:

- Clear description of the alternative mechanism(s) for gathering patient input. If advisory councils or patient representatives are proposed, include a list that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
- Specifics on the type of patient input to be collected.
- Methods for collecting and documenting such input.
- Process for formally communicating the input directly to the health center governing board (e.g., monthly or quarterly presentations of the advisory group to the full board, monthly or quarterly summary reports from patient surveys).
- Specifics on how the patient input will be used by the governing board in such areas as: 1) selecting health center services; 2) setting health center operating hours; 3) defining budget priorities; 4) evaluating the organization’s progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

## 3. Sample Alternative Mechanisms for Addressing Patient Representation

Patient participation in governance is an essential element in designing responsive and effective health service delivery programs that adequately meet the needs of the populations served by health centers. Health centers have developed various alternative mechanisms to assure the input of special populations into the design, operation and governance of health centers. Examples include but are not limited to:

- Substantial involvement (short of a majority) of special population patient board members on the health center’s board of directors.
- Establishment of a patient **advisory council** which meets regularly (at least quarterly) and includes a significant number of special population patients. The advisory council should have a clear line of authority and communication with the health center’s governing board of directors. Members should be identified with reasons/qualifications for participation on the advisory council as part of the waiver request.

**Please note that advisory councils are not expected to meet governing board requirements, nor will they be recognized as fulfilling these requirements as they cannot act on behalf of the board of directors nor can the board of directors delegate required authorities to the advisory board. Furthermore, entities using an advisory council as their alternative mechanism must list the health center’s governing board members when completing Form 6A: Current Board Member Characteristics in their application, and NOT the members of their advisory council;**

- Inclusion of advocate board members who have personally experienced being a member of, represent, have expertise in, or work with the special population on the health center governing board;
- Focus groups of patients, convened regularly and involving a representative sample of the project's patients;
- Patient interviews conducted throughout the year, involving a representative sample of the project's patients;
- Surveys with patients of special population services; and/or
- Suggestion boxes and complaint lines.

Eligible health centers may wish to consider adopting one or more of the above approaches for assuring meaningful patient involvement under an approved waiver. In all of the above approaches, it will be essential that patient input is documented in writing and a mechanism for formal and regular communication of the input to the health center's governing board is established.

Any mechanism that does not document patients' input in writing and does not provide for formal communication of the input to the health center's governing board will not be considered an acceptable alternative mechanism to the patient majority board. Examples of such unacceptable mechanisms include:

- Written patient satisfaction surveys for populations with limited English proficiency or low literacy rates; and
- Informal input from patients conveyed through health center staff to management.

#### **D. Waiver Request Process**

Eligible health centers (i.e., new Health Center Program applicants or existing look-alikes and grantees) that request a new or renewed waiver of the patient majority governance requirement must do so using Form 6B: Request for Waiver of Governance Requirements.

Requests for new waivers may be submitted through:

- Applications for initial designation or for new funding (New Access Points (NAP))/Look-Alike Initial Designation Applications
- Applications for new project periods/SAC/Look-Alike Renewal of Designation applications
- Formal Prior Approval process.<sup>21</sup>

Waiver renewals must be submitted with the health center's SAC/Look-Alike Renewal of Designation applications.

The results of the HRSA waiver review will be communicated to the requesting health center. If the health center does not meet the criteria for good cause and the waiver request is

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<sup>21</sup> Should an immediate need arise for a new/initial waiver of governance requirements in the middle of a budget year/ Look-Alike certification year, the health center should contact their Project Officer. These situations will be resolved on a case-by-case basis.

disapproved, HRSA will provide an explanation for the disapproval, and the health center will be afforded an opportunity to resubmit the waiver request. If the waiver request is approved, the governance waiver will be in effect for the length of the approved project period. Once approved in a SAC/look-alike Renewal of Designation/NAP/look-alike Initial Designation application, a health center will be expected to provide an assurance that the approved alternative mechanism to gain patient input continues to fully meet the intent of the governance requirements.

**As noted earlier in the Eligibility for Waiver Requests section, the ONLY health center governance requirement for which HRSA will consider a request for waiver is the 51 percent patient majority requirement. Requests for waiver of the monthly meeting requirements will no longer be accepted or approved as of the effective date of this PIN.**

## VI. ADDITIONAL CONSIDERATIONS FOR HEALTH CENTER GOVERNANCE

All health centers with existing affiliation agreements or considering new affiliation agreements should examine their arrangements to assure their governing board remains in compliance with all governance requirements as described in this PIN. Specifically, health centers should determine whether any of the health center governing board's (including co-applicant board's) authorities, functions and responsibilities are being or would be compromised or limited in any way by these agreements. Agreements requiring HRSA review from a programmatic and/or grants management perspective may include, but are not limited to:

- Mergers.
- Acquisitions.
- Parent-subsidiary arrangements. In particular, when health centers exist as a subsidiary of another entity, the "parent" entity may not reserve or withhold powers that the health center governing board must exercise under the relevant statute and implementing regulations.
- Establishment of a new entity.
- Subrecipient arrangements.<sup>22</sup> Should a health center grantee enter into a subrecipient arrangement with another entity through which the health center provides a sub-award of the section 330 grant funds to the entity (the "subrecipient"), the health center grantee of record must provide adequate oversight of the subrecipient and each subrecipient must have a governing board that is in compliance with the applicable statutory and regulatory policies and the policies set forth in this PIN.
- Contracts for a substantial portion of the project (e.g., contracts for key management staff or core service delivery plan providers and/or services).

**Please note that look-alikes may not be owned, controlled or operated by another entity; therefore, parent-subsidiary arrangements, network corporations, etc., may not be eligible for designation.<sup>23</sup> Look-alikes should review PIN 2009-06 and other relevant look-alike program**

<sup>22</sup> A subrecipient is an organization that "(i)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act . . ." (§ 1861(aa)(4) and § 1905(l)(2)(B) of the Social Security Act). Subrecipients must be compliant with all of the requirements of section 330 to be eligible to receive FQHC reimbursement from both Medicare and Medicaid. The subrecipient arrangement must be documented through a formal written contract/agreement (Section 330(a)(1) of the PHS Act).

<sup>23</sup> Section 1905(l)(2)(B)(iii) of the Social Security Act, as amended.

**guidance before they submit an initial designation, renewal of designation, annual recertification, or change in scope application.**

#### **A. Executive Committee**

In addition to the overall governing board composition requirements stipulated in section 330 of the PHS Act, the implementing regulations and this PIN, the composition of the Executive Committee is especially important since it may have authority to act on behalf of the full board under specified circumstances. The extent to which Executive Committee board members may be representing or selected by any outside entity should be limited to ensure that the outside entity's authority does not limit/impede/supersede the execution of the health center governing board's required authorities.

#### **B. Delegation of Health Center Authorities, Functions or Responsibilities**

It is essential that the health center governing board be vested with its required authorities and that any potential opportunity for an outside entity to limit/deny/impede the execution of these authorities be minimized. In consideration of agreements and contracts between health centers and other entities, in the areas where governing boards must exercise independent authority (Section III.D of this PIN: Governance Requirements: Board Authority, Functions, and Responsibilities), it is important to ensure that:

- No other entity may have an overriding approval authority over the health center board;
- No requirement for a majority of the affiliating or outside entity's board to also exercise approval (i.e., a "dual majority" requirement) may be established;
- No other entity may have veto power, including "super-majority" provisions which give another entity an effective veto power;
- No other entity may have final approval of the overall strategic and operational plan and budget for the health center, except where allowed for public centers with co-applicant boards; and/or
- No other entity aside from the health center board may have the authority to select or dismiss the CEO/Executive Director. This prohibition includes cases where health centers combine the CEO position with that of any other key management staff.

#### **C. Additional Considerations**

Beyond the HRSA governance requirements, there are many other federal and state requirements for governing boards. Health centers are encouraged to seek legal advice from their own counsel to ensure that organizational documents and contractual agreements accurately reflect the boards' objectives and requirements. These include but are not limited to:

- Federal fraud and abuse provisions, including the Federal anti-kickback statute;<sup>24</sup>
- Applicable HHS grant regulations (45 C.F.R. § 74 and 92) and OMB cost circulars;
- Health Center Safe Harbor;<sup>25</sup>
- Antitrust laws;
- Tax-exempt status of the health center;

<sup>24</sup> Section 11288(b)(3)(H) of the Social Security Act, as amended.

<sup>25</sup> Section 11288(b)(3)(H) of the Social Security Act, as amended.

- Medicaid and Medicare reimbursement issues;
- State law;
- IRS requirements for non-profit boards; and
- Board member compensation.<sup>26</sup>

## VII. EFFECTIVE DATE

This policy will become effective upon issuance of this PIN. All new organizations applying for section 330 funding/Look-Alike designation will be evaluated for compliance with these policies. As described in Program Assistance Letter (PAL) 2010-01 "Enhancements to Support Health Center Program Requirements Monitoring,"<sup>27</sup> HRSA is committed to assisting health centers to remedy identified areas of non-compliance and to providing reasonable time for health centers to take necessary corrective action through the Progressive Action process.

Existing health centers must review their current governance structure, including bylaws, agreements, and other governance documents to ensure that their governing board structure, authorities, functions, and responsibilities are consistent with the policies in this PIN. Consistent with the Progressive Action policy and process described in PAL 2010-01, HRSA will apply applicable conditions for identified non-compliance with governance requirements and will work with existing health centers to identify appropriate corrective actions necessary to address these areas of non-compliance. While existing health centers are to comply with the policies in this PIN upon issuance, HRSA recognizes that in limited cases, health centers may be able to justify the need for additional time to alter governance structures and/or documents in order to implement corrective actions necessary to comply fully with this PIN. In light of this potential need and in accordance with Section 330(e)(1)(B) of the PHS Act,<sup>28</sup> upon written request, HRSA may allow existing health centers up to two years to demonstrate compliance with all governance requirements set forth in this PIN. Any health center that is allowed this additional time to fully comply will be required to provide HRSA with at least quarterly updates regarding its progress in demonstrating compliance.

## VIII. TECHNICAL ASSISTANCE AND CONTACTS

For further assistance regarding the governance requirements and the policies in this PIN as they specifically relate to an individual health center's circumstances, Health Center Program grantees and look-alikes are encouraged to contact their Project Officer. In addition, health centers may contact their state/regional Primary Care Association (PCA) and/or National Cooperative Agreement organizations for assistance on governing board requirements and best practices. A list of the PCAs and National Cooperative Agreement organizations can be found on the HRSA/Bureau of Primary Health Care Web site at: <http://www.bphc.hrsa.gov/technicalassistance/>. The website also

<sup>26</sup> While no board member may be an employee of the health center, 42 C.F.R. § 51c.107 permits the use of grant funds (subject to applicable State law regarding reimbursement restrictions for non-profit board members) for certain limited reimbursement of board members as follows: 1) for reasonable expenses actually incurred by reason of their participation in board activities; or 2) for wages lost by reason of participation in the activities of such board if the member is from a family with an annual family income less than \$10,000 or if the member is a single person with an annual income less than \$7,000.

<sup>27</sup> Available at <http://www.bphc.hrsa.gov/policiesregulations/policies/pal201001.html>.

<sup>28</sup> "Entities that fail to meet certain requirements. The Secretary may make grants, for a period of not to exceed 2 years, for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which the Secretary is unable to make each of the determinations required by subsection (k)(3) [(l)(3)]."



contains an overall summary of the key health center program requirements at <http://www.bphc.hrsa.gov/about/requirements/index.html>.

If you have any questions regarding this PIN, please contact the Bureau of Primary Health Care, Office of Policy and Program Development at [BPHCPolicy@hrsa.gov](mailto:BPHCPolicy@hrsa.gov).

## MOBILE MEDICAL UNIT ADVISORY COUNCIL

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### 2014-2016 SCHEDULE OF MEETINGS

*The Mobile Medical Unit Advisory Council (MMUAC)(Co-Applicant Board) serves as the patient/community-based governing board to set health center policy for the Healthcare for the Homeless Program on behalf of the Pinellas County Board of County Commissioners. As a public center, the MMUAC includes a representative majority of consumer/patient representatives, meets monthly and fulfills all the required authorities of a governing board.*

Meetings are held monthly at 3:00 pm at  
Pinellas Hope, 5726 126th Ave N, Clearwater, FL 33760  
Conference Call-In Option: TEL: 1-727-582-2255; PASSCODE: 718007

November 4, 2014  
December 1, 2014 @ 3:00 pm @ Safe Harbor  
January 6, 2015 (cancelled)  
February 2, 2015 @ Safe Harbor  
March 3, 2015 (cancelled)  
April 7, 2015 (changed to April 13, 2015)  
May 5, 2015  
June 2, 2015  
July 2, 2015  
August 6, 2015  
September 3, 2015  
October 1, 2015  
November 5, 2015  
December 3, 2015  
January 7, 2016  
February 4, 2016

The FY15 Budget Period begins November 1, 2014 and runs through February 29, 2016.

*Authorized by Pinellas County Board of County Commissioners, Pinellas County Human Services' Mobile Medical Unit (MMU) provides basic medical care and related services to homeless individuals residing in Pinellas County. These medical services, otherwise known as primary care, shall include treatment of illness or injury as well as preventive care, education, limited prescription coverage and referrals for lab work, specialty care, dental assistance, behavioral-mental health assistance and substance abuse treatment. This program is funded in part by the U.S. Department of Health and Human Services, Health Resources and Services Administration as a Federally Qualified Health Center (FQHC) specializing in care of the homeless.*

*(Grant #H80CS00024)*