Project H.O.P.E. Strategic Plan
2014 - 2016
# Project H.O.P.E. 2014 – 2016 Strategic Plan

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Executive Summary

Dear Project H.O.P.E. Community Members,

It is with pleasure that we introduce Project H.O.P.E.’s 2014 Strategic Plan. As the new benefits of the Affordable Care Act become effective, Project H.O.P.E. looks for ways to improve access to care and modify workflow to improve the health and well-being of our patients. Our map to future improvement is captured in our Strategic Plan. This plan represents the culmination of over a year of planning activities: bringing together Project H.O.P.E. stakeholders to evaluate the needs of our patient population, the community and our organization and to strategize on how to take advantage of current opportunities, and most importantly to continue to provide high quality medical care and social services for homeless and at risk individuals throughout the Camden area.

This plan is a living document that will be routinely evaluated and updated to take advantage of new concepts, technologies, and to adapt to internal and external conditions. Since the release of our Strategic Plan 2010–2013, much has been achieved, much has been learned, and much has changed. We have received federal funding to construct a new facility to better serve our increasing number of patients, we have transitioned completely to an Electronic Health Record (paperless), and we have begun to functionally realign our model of care to integrate primary care and behavioral health services.

With the Strategic Plan 2014–2016 we are preparing the organization for the future by changing workflows to create a Patient Centered Medical Home model of care in a new facility that will result in improved access to care and improved clinical outcomes for our patients.

This planning process comes at a critical time for Project H.O.P.E. Even as millions of Americans gain access to insurance coverage under the Affordable Care Act, Project H.O.P.E. and other health centers recognize that there are millions who remain without access to a primary health care physician, according to a report by the National Association of Community Health Centers. At this time of struggle and opportunity, it is critical for Project H.O.P.E. to determine how to serve the evolving needs of our community through increasing organizational effectiveness and strategizing for the future. This Strategic Plan outlines our goals to deliver and maintain excellent primary care for the population that we serve.

As you read, I invite you to continue to work together with Project H.O.P.E. to better serve and strengthen our community. I would like to take this opportunity to thank all of the Project H.O.P.E. stakeholders, including current patients, Board Trustees, staff members, and volunteers, who contributed to the strategic plan. We could not have done it without you!

Sincerely,
Patricia DeShields
CEO
Mission Statement
The Board of Trustees adopted the following mission statement on May 18, 2010:

The mission of Project H.O.P.E. is to improve the health and well-being of homeless persons and others in need within the greater Camden, New Jersey area by providing primary, preventative and related health care services.

This statement serves as the public representation of Project H.O.P.E.’s goals and methodology as well as a guide and internal compass for the Project H.O.P.E. staff and governing boards.

For the past twenty years Project H.O.P.E. has fulfilled its mission by assisting more than 11,000 homeless persons in their journey to permanent housing and self-sufficiency. Project H.O.P.E. is unique in that it is the only provider of medical services specifically for the homeless in Camden County and one of five Federally Qualified Health Center (FQHC) homeless projects in New Jersey.

Project H.O.P.E. currently operates a full time health center providing culturally sensitive comprehensive primary health care serving patients at three locations: its main site, Bergen Lanning Health Center, a satellite center at the Camden City Volunteers of America site, and through its Mobile Health Van which takes health care, mental health and substance abuse services to the streets and points where homeless people gather in Camden.

Stakeholders
Project H.O.P.E. stakeholders include patients, staff members, volunteers, Board Trustees, funding agencies, donors, organizational partners, Community Advisory Board (CAB) members, local government, public officials, neighbors, the Camden area community, local health providers, and local homeless service providers.

Mandates
The Bureau of Primary Health Care (BPHC) under the Human Resources Service Administration (HRSA) of the United States government has defined nineteen key requirements that must be met in order to operate and receive funding as a Federally Qualified Health Center (FQHC). These requirements relate to defining need, breadth of services, management and services, and governance. In order to remain an FQHC, Project H.O.P.E. must continue to be in compliance with the requirements, which are listed in Appendix A as summarized by the BPHC. Through striving to fulfill its mission in the most responsible and efficient manner, Project H.O.P.E. will simultaneously be working to meet the 19 BPHC requirements prescribed by HRSA and included in Appendix A.

Plan Development
The following resources were used to develop Project H.O.P.E.’s strategic plan:
- Review of progress on 2010-2013 Strategic Plan goals
- Project H.O.P.E. Online Survey completed by 66 people including 18 staff, 4 board members, and 41 consumers between September and October 2013.
- Facilitated SWOT Discussion with Board and staff on July 18, 2013.
- Needs Assessments including:
  - Camden County, NJ - CHNA Final Summary Report 2013

SWOT Analysis
To inform the development of this strategic plan, Project H.O.P.E. completed a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. The SWOT analysis is based on the results of the Project H.O.P.E. Online Survey and the Facilitated SWOT Discussion.

Strengths
- 98.48% of Project H.O.P.E.’s online survey respondents indicated that Project H.O.P.E.’s “mission accurately represents the organization's work.”
- Project H.O.P.E.’s Street Outreach Team brings services to the homeless, provides referrals for available resources and follows up with medically and socially complex patients to make sure they are obtaining appropriate and timely care.
- Provide health services via mobile van throughout service area every day Monday through Friday
- Staff is committed, diligent, competent and uses existing resources very well
- Board is dedicated, committed and diverse
- Every patient is treated as an individual with unique needs and everyone feels valued
- Training opportunities offered to Board members
- Improvements in Clinical Performance Measures 2012 – 2014 including:
  - Diabetes (Percentage of patients with a A1c is less than 9)
  - Hypertension (Percentage of patients with a BP less than 140/90)
  - Cervical Canter (Percentage of women who received a Pap Test)
  - Began Tobacco Use and Assessment
  - Began providing Tobacco Counseling
- Organizations such as New Jersey Patient Care Association and the National Health Care for the Homeless Council provide great learning opportunities, resources and best practices
- Fiscally sound
- Long history of HRSA making sure that FQHCs remain open and operational
- Small staff allows organization to change direction and implement changes quickly and nimbly
- Due to geographic size of Camden and regional transportation, services are accessible to patients
Weaknesses

- Board retention is an issue and existing workload on individual Board members hinders growth opportunities.
- Struggle to attract, retain and support a strong Clinical and Administrative workforce due to inability to provide adequate base salaries and raises.
- Project H.O.P.E. is challenged with recruitment and retention of clinical and administrative staff which impacts our ability to provide timely, comprehensive primary health care services.
  - Project H.O.P.E. has made considerable improvements in base salaries since 2012, but higher salary and benefit packages at other health centers, hospitals and medical practices in the area remain a contributing factor to recruitment and retention.
  - Another significant contributing factor to retention is the stress associated with providing care to a special population.
- Staff is at risk of exposure to high levels of stress because they devote so much time and energy to helping clients obtain needed medical care, housing, and social services. As a result, we see the signs and symptoms of stress which are strongly associated with absenteeism and increased staff turnover.
- Do not do enough fundraising
- Wait time for walk in patients remains long
- Do not provide sufficient opportunities for Board to meet outside of meetings with each other and with staff to get to know each other
- No capital planning process has been developed

Opportunities

- New facility will:
  - Increase patient capacity and improve patient flow
  - Allow space for on-site services such as mental and substance abuse services, improving patient continuity of care
  - Include dedicated community space for Project H.O.P.E. and partner organizations to hold events and meetings
  - Generate positive public relations and increase visibility in the community
  - Improve patient privacy and staff morale
- Implementing latest best clinical practices to improve services to the poor including:
  - National Committee of Quality Assurance (NCQA) clinical standards
  - National Health Care for the Homeless Council (NHCHC) Recommendations for the Care of Homeless Patients
  - NHCHC Treatment and Recommendations for Patients who are Homeless with Diabetes
  - NHCHC Treatment and Recommendations for Homeless Patients with Hypertension, Hyperlipidemia & Heart Failure
- Implementing regulatory requirements including N.J.A.C. Title 8, Chapter 43A. Standards for Licensure of Ambulatory Care Facilities and HRSA’s 18 Program Requirements
• Working with patient population can provide advocacy and partnership opportunities with organizations serving homeless population
• At the front lines of what impacts the poor giving organization unique position to help empower the poor and help them move toward self-sufficiency
• Continue to leverage mobile health van to increase community presence throughout Camden
• New medical school in Camden (Cooper Rowan) provides opportunity for pool of qualified and motivated medical students to work with Project H.O.P.E.
• Legal and regulatory changes such as Affordable Care Act and Medicaid expansion provides more opportunities for organization to serve target population and provide much needed mental health services to patients

Threats
• Potential for gentrification and corresponding changes to where our client base lives as well as increased animosity towards organization because of client base
• Local competition for resources as other organizations in Camden seek FQHC status
• Emergency rooms and other hospitals continue to serve as a viable option for organization’s patients
• Meeting and maintaining the Board consumer participation remains a challenge
• Reimbursement over time by payer class may not remain stable

Goals
Based on a review of Project H.O.P.E.’s 2010-2013 Strategic Plan, our progress towards meeting those goals as well as the Project H.O.P.E. Online Survey, Facilitated SWOT Discussion, and a review of various needs assessments, Project H.O.P.E.’s goals for 2014 to 2017 include:

Goal 1: Fundraising Development
• Establish a Capital Plan to raise $142,000 by April 2015 to cover required expenses for new facility. The Capital Plan will also include a designated volunteer or staff member that focuses on raising private and public donations.
• Continue to develop and hold periodic small fundraising events throughout the fiscal year (at least 2 each fiscal year). These serve to provide increased Community Awareness and involvement with Project H.O.P.E. These events provide opportunities for Board Members and Staff to interact and develop “Team Spirit” outside of the Board Room and Health Center.
• Plan an initial fundraising event to be targeted to be held late 2014 or early 2015 as the initial event in a larger fundraising campaign.

Goal 2: Provide Behavioral and Substance Abuse Health Care Services
Project H.O.P.E.’s patient population requires behavioral and substance services. The plan includes:
1. Provide individual and group counseling sessions
2. Provide community meeting space for Self Help groups such as AA and NA to hold weekly meetings
3. Continue to serve as site for those engaged in training to provide counseling services such as schools of social work and programs training psychologist
4. Identify referral resources that can provide comprehensive care to patients with traumatic brain injury

Goal 3: Increase Community Involvement and Awareness

- Continue to collaborate with other agencies and service providers to work together to provide a continuum of care (Medical, Behavioral Healthcare, Substance Use Disorder Treatment, Case Management).
- Apply for funding opportunities that involve collaboration/coordination of care with other local organizations
- Continue attendance at community meetings (e.g. Bergen Lanning community meetings) and participate in community and neighborhood events appropriate to Project H.O.P.E.’s mission.
- Continue conducting community events that increase awareness of the issues of homelessness and healthcare.

Goal 4: Improve HRSA Compliance

Project H.O.P.E. will maintain compliance with the 19 HRSA Requirements and all Federal Regulations. The assignment of a Compliance Officer, to provide associated updates to the Board on goals, progress and priorities is imperative.

- Compliance Program:
  - Develop compliance policies and procedures
  - Develop Compliance Training and Education Policy
  - Develop Code of Conduct
  - Repeat Gap Analysis in 2016
  - Review and Revise the Internal Control Policies
- Improve communications between CEO and Board regarding compliance requirements. CEO will ensure that Board is made aware if and when the Board is out of compliance immediately so that compliance issues can be corrected in a timely fashion.
- Provide Board training opportunity at least once every six months

Goal 5: Recruit and Retain 5 Patient Representatives on Board

Project H.O.P.E. received another waiver from HRSA regarding the requirement that 51% of the Board must be patient representatives or consumers of Project H.O.P.E. However, Project H.O.P.E.’s goal is to achieve 51% patient representation on the Board by 2016. Project H.O.P.E. has been able to recruit patient representatives over the last year but has had some difficulty retaining these members. In order to recruit and retain patient representatives, Project H.O.P.E. will:

- Cultivate new Board members through CAB membership
- Continue to utilize available training resources to provide CAB leadership training and prepare interested CAB members for eventual Board membership
- Expand current board member orientation and education process to a mentoring program beginning in 2015
• Ensure that patient representatives are supported and not overwhelmed when first joining Board
• Obtain feedback on quarterly basis from Board patient representatives to ensure that their needs are being met

**Goal 6: Improved Clinical Outcomes**
• Pursue and achieve National Quality Recognition, as through NCQA
• Increase consumer involvement in QI/QA activities
• Implement Advanced Access Scheduling
• Develop discharge follow-up process with Cooper University Hospital to ensure receipt of patient information within 3 days of discharge. Improve follow-up of our high risk patients to potentially prevent hospitalizations.
• Explore cost-effective options for the provision of pharmacy and dental services onsite.

**Accomplishments 2010-2013**
In our 2010 – 2013 Strategic Plan, Project H.O.P.E. identified the following strategic goals:

1. **Strengthen Governance**
2. **Develop Project H.O.P.E. Staff and Succession Plan**
3. **Increase Community Awareness and Involvement**
4. **Create a New Clinical Facility for Project H.OPE**
5. **Integrate Primary Medical Care with Behavioral Health Care Services**
6. **Maintain and Improve Organizational Sustainability**

This section highlights the major accomplishments made towards each of these goals over the past 3 years.

**Strengthen Governance**
• Revised and updated bylaws making changes to improve administrative practices and reflect latest best practices for FQHCs.
• Increased potential number of members allowed on Board (from 9 to up to 25) and focused on Board recruitment and retention.
• Identified an average of 2 new prospective Board members each month in 2013 and made decisions for all regarding potential membership.
• In an effort to improve retention, added a bylaw allowing members to take a leave of absence for up to 3 months.
• Increased the number of patient representatives on the Board (although patient representatives do not yet comprise a majority of the Board).
• Provided regular Board training opportunities including NACHC Board Member Boot Camp, NJPCA training and HRSA technical assistance.

**Develop Project H.O.P.E. Staff and Succession Plan**
• All management positions filled.
• Provided cost of living raises every fiscal year, established promotion and professional development opportunities for employees.
• Ongoing staff involvement in QA/QI and risk management process.
Developed **Staff and Succession Plan** in 2012.
Cross trained staff to undertake intake responsibilities in other positions.

**Increase Community Awareness and Involvement**
- **Increased the use of volunteers** through a United Way Day of Caring Service project initiative.
- In the period 2011-2013 Project H.O.P.E. partnered with AmeriCorps, Haverford College, Bridging the Gap and DeSalles Service Works to employ **5 interns**.
- **Redesigned website** in 2012.
- Began distributing **quarterly newsletter**.
- **Redesigned marketing materials and business cards** for community and patient market.
- Received coverage in **magazine, newspaper and local TV news**.
- **Got involved with local community organizations** including Bergen Community Meetings (attended monthly meetings), Cathedral Kitchen (diabetic cooking class for Project H.O.P.E. patients), Camden Coalition, Twin Oaks Behavioral Health, Hispanic Family Services, Cooper University, and Camden County’s Continuum of Care (CoC).
- Provided support and training opportunities to **Consumer Advisory Board (CAB)** and encouraged CAB to develop their own organizational priorities and identity.
- Obtained necessary license to operate **Mobile Health Van** providing services Monday through Friday at 5 locations throughout Camden.

**Create a New Clinical Facility for Project H.O.P.E.**
- **Awarded $4.7 million to build new facility on existing site**.
- Established a **Board Construction Oversight Committee**.
- Involved staff throughout the **design process**.
- **Hired General Contractor** and on target to break ground on new facility in **Spring 2014**.
- **Attended Bergen Lanning monthly community meetings** to get input on construction process.

**Integrate Primary Medical Care with Behavioral Health Care Services**
- Obtained United Way funds and **implemented SBRIT**.
- **Partnered with Twin Oaks** to provide psychiatric and behavioral care services and track referrals to and from Twin Oaks.

**Maintain and Improve Organizational Sustainability**
- Held **fundraising events** every year.
- Developed financial monitoring tools including **Quarterly Financial Dashboard**.
- **Increased net income year over year** (November 2012 - $52,741.14; December 2011 - $29,346.59; 2013 $387,710.64).
- May change ever so slightly with the 2013 Audit.
- Revised Sliding Fee Scale **collecting nominal fees from all uninsured patients**.
- **Increased number of unduplicated patients** (2011: 2,216 unduplicated patients; 2012: 2,685 unduplicated patients; 2013:2,851 unduplicated patients).
- Actively pursuing **Patient Centered Medical Home Status** as described in Joint Commission
Standards.

- Made improvements in Clinical Performance Measures from 2012 to 2014
  - Diabetes (Percentage of patients with a A1c is less than 9)
  - Hypertension (Percentage of patients with a BP less than 140/90)
  - Cervical Cancer (Percentage of women who received a Pap Test)
  - Tobacco Use and Assessment
  - Tobacco Counseling

- Received increases in HRSA grant award funding

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- Upgraded donor database and began using the Donor Perfect software for tracking current and former supporters.
### Appendix A: HRSA’s 19 Requirements for FQHCs

#### NEED

1. **Needs Assessment**: Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)

#### SERVICES

2. **Required and Additional Services**: Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act). Note: Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. (Section 330(h)(2) of the PHS Act)

3. **Staffing Requirement**: Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged. Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act)

4. **Accessible Hours of Operation/Locations**: Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)

5. **After Hours Coverage**: Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))

6. **Hospital Admitting Privileges and Continuum of Care**: Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)

7. **Sliding Fee Discounts**: Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay.
   - This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.*
   - No discounts may be provided to patients with incomes over 200% of the Federal poverty guidelines.*
   - No patient will be denied health care services due to an individual’s inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived. (Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))

8. **Quality Improvement/Assurance Plan**: Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:
   - a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*
   - periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
     - be conducted by physicians or by other licensed health professionals under the supervision of physicians;*
     - be based on the systematic collection and evaluation of patient records;* and
     - identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated. (Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))
9. **Key Management Staff:** Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(l) of the PHS Act, 42 CFR Part 51c.303(p) and 45 CFR Part 74.25(c)(2),(3))

10. **Contractual/Affiliation Agreements:** Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(l)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(I)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2))

11. **Collaborative Relationships:** Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(l)(B) of the PHS Act and 42 CFR Part 51c.303(n))

12. **Financial Management and Control Policies:** Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)

13. **Billing and Collections:** Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)

14. **Budget:** Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(l)(ii), and 45 CFR Part 74.25)

15. **Program Data Reporting Systems:** Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(l)(ii) of the PHS Act)

16. **Scope of Project:** Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)

**GOVERNANCE**

17. **Board Authority:** Health center governing board maintains appropriate authority to oversee the operations of the center, including:

   - holding monthly meetings;
   - approval of the health center grant application and budget;
   - selection/dismissal and performance evaluation of the health center CEO;
   - selection of services to be provided and the health center hours of operations;
   - measuring and evaluating the organization’s progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization’s mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;*
   - Establishment of general policies for the health center.
   (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

   Note: In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv))

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. Specifically:

- Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*
- The remaining non-consumer members of the board shall be representative of the community in which the center’s service 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 service agencies within the community.*
- No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.*

Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

19. **Conflict of Interest Policy:** Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.

- No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.*

(45 CFR Part 74.42 and 42 CFR Part 51c.304(b))
Appendix B: References

Camden County, NJ - CHNA Final Summary Report 2013
Project H.O.P.E.’s 2013 Homeless Needs Assessment