Dahl Memorial Clinic

Municipality of Skagway

TO: Mayor Sam Bass and the Skagway Municipal Assembly

FROM: Albert E. Wall, Executive Director, Dahl Memorial Clinic

DATE: April 18, 2024

SUBJECT: Health Resource and Services Administration (HRSA), Notice of Award and Conditions, 6 H80CS08232-17-07 dated January 8, 2024

On October 31, 2023, our federal partners HRSA conducted an On-Site Visit (OSV) as part of a routine compliance audit on the Dahl Memorial Clinic (DMC). This visit was specifically looking at the requirements surrounding our HRSA Section 330 grant which began on May 1, 2021, and ends on April 30, 2024. On January 8, 2024, the Notice of Award for CY2024 was issued along with four Conditions which must be addressed:

1. Board Authority – b. Required Authorities and Responsibilities.
2. Required and Additional Health Services – a. Providing and Documenting Services within Scope of Project.
3. Board Authority – a. Maintenance of Board Authority Over Health Center Project.
4. Board Composition – a. Board Member Selection and Removal Process.

The timeline for addressing Conditions issued on a Section 330 grant follows a 90/60/30-day protocol. That is, the Conditions must be addressed within 90 days of notice (by April 7). If the response to HRSA is insufficient, the 60-day window opens on the subsequent date of notice. If the response to HRSA is still insufficient, the 30-day window opens on the next date of notice.

Condition #2 was a matter of aligning current services with reporting them in the correct area of the HRSA online grant tracking and reporting system (the Electronic Handbook or "EHB") and has been addressed.

Conditions #1, 3, and 4 are matters of Clinic Board authority and impact our Co-Applicant Agreement and the organizational structure, authorities, and responsibilities of both the Clinic Board and the Municipality of Skagway. The Clinic Board cannot sufficiently address

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the Conditions alone and, at a Special Meeting on April 10th, directed me to provide the Assembly this report, outlining some of the options available for addressing the Conditions that HRSA has placed upon our grant. While the following options are not exhaustive, they are options that have been used in various places in the country to address similar issues, reduce reliance upon local, public funding, and produce a more efficient Community Health Center (CHC) with greater impacts on local healthcare and accessibility to that healthcare.

Requirements for a Community Health Center Board of Directors

The Health Center Program Compliance Manual Chapter 19 addresses Board Authority while Chapter 20 addresses Board Composition[1]. This is a lengthy document, and the following is a summary list of those specific areas that impact the Conditions on the Clinic:

- The health center governing board must develop bylaws which specify the responsibilities of the board[2].
    - The health center's organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the health center governing board maintains the authority for oversight of the Health Center Program project, specifically:
        - The organizational structure and documents do not allow for any other individual, entity, or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions;
        - In cases where a health center collaborates with other entities in fulfilling the health center's HRSA-approved scope of project, such collaboration or agreements with the other entities do not restrict or infringe upon the health center board's required authorities and functions; and
        - For public agencies with a co-applicant board; the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.
- The health center governing board must assure that the center is operated in compliance with applicable Federal, State, and local laws and regulations[3].
- The health center governing board must approve the selection and termination/dismissal of the health center's Project Director/Chief Executive Officer (CEO)[4].
- The health center bylaws or other internal governing rules must prescribe the process for selection and removal of all governing board members. This selection process

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[1] https://bphc.hrsa.gov/compliance/compliance-manual.
[2] Chapter 19.
[3] Ibid.
[4] Ibid.

must ensure that the governing board is representative of the health center population. The selection process in the bylaws or other rules is subject to approval by HRSA[5].

Summary

The challenges faced by the Dahl Memorial Clinic are many but have solutions. These current Conditions regarding governance and structure are administrative symptoms which compound, highlight, and in many cases, exacerbate other issues. Governance structure. Adherence to widely accepted practice in healthcare. Agility in responding to emergent need or changes in practice. A complete understanding and application of the benefits and tools provided by the Federally Qualified Health Center (FQHC). A strong, well trained, and respected governance board. These things are what provide a small Community Health Center with the clinical and financial ability to meet its mission. These are the things that provide the stability and confidence a medical staff needs to perform, and without them, the mission suffers.

It has been two years since dental services have been available in Skagway. About the same for an on-site Medical Director or a medical provider that lives in town. The Clinic absorbs the cost of hundreds of prescriptions a year, and does not fill many others, because of the limitations of its practice. We turn away thousands of visitors seeking healthcare a year which has a direct impact on a visitor's experience, accessibility to care, the financial viability of the clinic, and the reputation of our town. While this is not a direct result of our governance structure, it certainly has an impact. When recruiting medical professionals, we do a background check and a long list of checks before we are satisfied with their abilities and credentials: and they do the same for us. When providers see instability, or a process that goes against the grain of accepted healthcare practice, they are not interested in coming to serve because their license and livelihood are on the line.

Federally Qualified Health Centers are a known quantity within healthcare. They follow a prescribed set of instructions and requirements, and, in return, are given: 1) a grant to partially fund their mission, 2) a Prospective Payment System to mitigate the financial burden of providing healthcare at a less-than-market cost, and 3) a "multi-license" which gives them the ability to provide a myriad of services under one license without the astronomical burden of getting a separate license for each line of service and following the laws and regulations for each separate license. Further, the FQHC community provides a network of hundreds of clinics across the country that work together, address needs together, share tools and solutions, and provide support in situations where resources are limited. Deviation from that known quantity produces instability and uncertainty which drives up cost and limits accessibility to healthcare.

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[5] Chapter 20.

Options and Solutions

There are several solutions to the Conditions we face and none of them are perfect. When looking at options, my staff and I look for 1) those options that meet our mission "to promote the health and wellness of all residents and visitors in the community of Skagway by providing comprehensive primary, preventative, and emergency health care services," 2) those options that provide the most viable, sustainable, financially independent healthcare possible, and 3) those options which are widely understood within healthcare providers to provide stability, accessibility, and quality of care. The following are several models that can be used as templates for decision-making and planning; as stated, this is not an exhaustive list, rather those courses of action that are most likely to promote long-term sustainability and a stable relationship with our partners (federal, state, and other healthcare partners.)

<u>An Elected Board</u>

This model would keep the Co-Applicant/Public Entity model we currently have with the following changes: 1) the Clinic would establish its own bylaws, external to the Municipal Code. 2) The Clinic Board would become an elected board subject to the statutes and local regulations regarding elections. 3) The municipality would continue to provide HR/finance structure to the clinic.

On April 5th, after discussion with the Borough Manager, Borough Attorney, the Mayor, and the Clinic Board, this is the response that was provided to HRSA as a way forward. This was done to comply with the deadline of April 7th, keep the conversation with HRSA moving forward and re-set the clock, and provide the Assembly and Clinic Board time to deliberate and move forward.

Pros

- Provides a publicly elected board with structure.
- Provides separate bylaws.
- Provides continuity of finance and personnel support.

Cons

- Little statutory structure around a 'standalone' elected board not supported by other statute such as a School Board.
- Perpetuates a novel, unique model which may cause future misunderstanding with HRSA.

<u>A 501c3 Corporation</u>

This model would keep the Co-Applicant/Public Entity model we currently have with the following changes: 1) the Clinic would establish its own bylaws and articles of incorporation, external to the Municipal Code. 2) The Clinic would become a separate entity from the municipality. 3) The municipality could continue to provide HR/finance structure to the clinic.

This is the prevalent model of FQHCs in the country and is widely understood and accepted in healthcare. It provides independent structure while allowing a public entity relationship. It could be structured to revert the Clinic to the municipality should it fail, have an Assembly member on its board as a voting member, avail itself to opportunities not commonly presented to municipal governments, and provide direct community involvement.

Pros

- Provides an organizational structure recognized by grantors, healthcare organizations, and healthcare providers.
- Provides separate bylaws.
- Provides continuity of finance and personnel support.
- Provides more autonomy of the governance board while reducing municipal funding and administrative oversight.

Cons

- There is some question of how a contract might be arranged between the 501c3 and the municipality that meets the needs of municipal employees.

<u>Short Term Model</u>

This model would keep the Co-Applicant/Public Entity model we currently have with the following changes: 1) the Co-Applicant Agreement and Municipal Code would be edited to reflect the requirements of HRSA more closely. 2) The Clinic Board would establish its own Bylaws. 3) The municipality could continue to provide HR/finance structure to the clinic.

This is a faster approach and, if it meets HRSAs initial guidance, would likely need to be changed again at some future point. HRSA is consistently moving all its CHCs to an independent stance as separate, non-government entities while Public Health clinics fill the role of government entity healthcare.

Pros

- Faster.

Cons

- Perpetuates a novel, unique model which may cause future misunderstanding with HRSA, healthcare organizations and providers.

Action

I am requesting that the Assembly provide feedback and direction at its next meeting regarding which route (including options that may not be in this report) to pursue in order to comply with HRSA's timeline.