Health Center Program Site Visit Report

TA Request Details

TA Request Number: TA000441

Grantee Information: **West Oakland Health Council, Inc.**
700 Adeline Street
Oakland, CA

Contact: Robert Cooper; robertc@wohc.org; (510) 835-9610, ext. 3703

Type of Visit: Program Requirement Verification Site Visit

Date(s) of Visit: June 4 – 6, 2014

Consultants

(b)(5) **(Clinical);** (b)(5)
(b)(5) **(Financial);** (b)(5)
(b)(5) **(Team Lead, Admin./Management);** (b)(5)

Site Visit Participants

Name	Title	Interviewed	Entrance	Exit
Robert Cooper, MD	Executive Director	Yes	Yes	Yes
Steve Nakamoto	Director of Accounting	Yes	Yes	Yes
Adrionne Beaseley	Director, Legal/Risk Management	Yes	Yes	Yes
Adrian James, MD	Physician	Yes	Yes	Yes
Ola Bennett	Mental Health Director	Yes	Yes	Yes
Delores Powe	Asst. Dir. of Reg., Billing, and Collections	Yes	Yes	Yes

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.

(b)(6)	IS Developer/Trainer	No	Yes	Yes
Steve Gardner	HR Director	Yes	Yes	Yes
Norma Mason	Social Services Director	No	Yes	Yes
Barbara Turner, NP	Director of Nursing	Yes	Yes	Yes
Gayle Quinn, MPH	Director of Health Ed. and Risk Reduction	No	Yes	Yes
Henry Horn	Director, Substance Abuse	No	Yes	Yes
Merritt Smith, MD	Physician	No	Yes	No
(b)(6)	Data Processing Manager	Yes	Yes	Yes
Geraldine Vayson	Pharmacy Director	No	Yes	No
Michael O'Connor	Planning Director	No	Yes	Yes
Cloteal Davis	Secretary to the Board	Yes	Yes	Yes
Loyd Ware	Board Member	Yes	Yes	Yes
Thomas A. Harris	Board Treasurer	Yes	No	Yes
Donald Williams	Board President	Yes	No	No
Brenda Jeff	Board Member	Yes	No	No
Gloria Harmon	Board Member	Yes	No	No
Irvella Albert	Board Vice President	Yes	No	No
Rodney Jones	Board Member	Yes	No	No
(b)(6)	Prospective Board Member	Yes	No	No
Jana Dulaya, DDS	Dentist	Yes	No	No
(b)(6)	Supervisor, Nrsg. Services	Yes	No	No

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 Requirement Compliance Review Summary

Program Requirement Compliance Review	Compliance Status
1. Needs Assessment	Met
2. Required and Additional Services	Not Met
3. Staffing Requirement	Not Met
4. Accessible Hours of Operation/Locations	Not Met
5. After-Hours Coverage	Not Met
6. Hospital Admitting Privileges and Continuum of Care	Not Met
7. Sliding Fee Discounts	Not Met
8. Quality Improvement/Assurance Plan	Not Met
9. Key Management Staff	Not Met
10. Contractual/Affiliation Agreements	Not Met
11. Collaborative Relationships	Met
12. Financial Management and Control Policies	Not Met
13. Billing and Collections	Not Met
14. Budget	Met
15. Program Data Reporting Systems	Not Met
16. Scope of Project	Not Met
17. Board Authority	Not Met
18. Board Composition	Met
19. Conflict of Interest Policy	Not Met

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.

Section 1. Need - Program Requirement #1

Program Requirement #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 (k)(3)(J) of the PHS Act)

Compliance Status: Met.

Documents reviewed onsite or in advance:

Most recent Needs Assessment(s)
Service Area Map
UDS patient origin data
Health center's list of sites with service area zip codes (Form 5B)

Compliance Review Findings:

West Oakland Health Council, Inc. (WOHC) has a written Needs Assessment and a defined service area. The grantee conducted a recent comprehensive Needs Assessment of the target population and service area in 2012 and a UDS zip code analysis in 2014.

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.

Section 2. Services - Program Requirement #2

Program Requirement #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) and (h)(2) of the PHS Act)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Health center's official Scope of Project for services (Form 5A)
Clinical Practice Protocols and/or other policies and procedures that support the delivery of health center services
Contracts, MOAs, MOUs, etc. for services provided via formal written agreements and/or formal written referral arrangements, including general tracking and referral policies and procedures

Compliance Review Findings:

All required primary, preventive, and enabling health services and additional health services as appropriate and necessary are provided. Prenatal care is provided by the center's part-time obstetrician and nurse midwife. Patients are then delivered at either Alameda County Hospital or at Alta Bates Summit Hospital by physicians or midwives there. Patients are then referred back to WOHC for care. There is no formal arrangement for this – either in the form of a contract or an MOU with the OB at Alta Bates. The contract with Alameda County speaks to the provision of care for Medi-Cal patients but does not address the uninsured or under-insured.

The patient population of the grantee includes a significant number of Hispanics at the East Oakland site. Signage and pamphlets there are bilingual English/Spanish and several of the staff are bilingual.

If Not Met - Steps/Actions Recommended for Compliance:

Either a contract or an MOU must be developed without delay for the provision of obstetric care. This document must include the process by which the referral will be made as well as the process for the return of the patient to the care of the health center. It must include sufficient information to assure that tracking and recall occurs and that patients are not lost to follow-up. The agreement must also include the manner in which this outside information will be documented in the medical record, how the policies and procedures of the grantee will be applied, including the Sliding Fee Scale, and how the services will be paid for.

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.

Section 2. Services - Program Requirement #3

Program Requirement #3 - Staffing

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)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Staffing Profile
Provider contracts, agreements, and any subrecipient arrangements related to staffing (as applicable)
Credentialing and Privileging Policies and Procedures
Documentation of provider licensure or certification for all licensed or certified health center practitioners
Privileging Lists

Compliance Review Findings:

The grantee has sufficient staff to provide care to the patient population currently being served. There are slightly less than [redacted] FTE providers (not including the Health Services Director who does not practice) who provide primary medical care, and approximately [redacted] FTE dental staff ([redacted] dentists and [redacted] support staff). As the grantee has less than three exam rooms per medical provider and a drastically falling number of patients, additional staff would not be warranted at this time. It would appear that the Behavioral Health and Substance Abuse Department holds the highest number of staff positions with [redacted] FTE provider staff and additional support staff. It should be noted that several of the mental health providers are not yet certified and can therefore not claim third-party reimbursement.

The grantee has a Board-approved Credentialing and Privileging Policy dated May 14, 2013. Credentialing files are incomplete. Board certification and CME for non-Boarded practitioners is absent or outdated in several files. There is no evidence of current CPR certification of any kind. Immunizations and TB status are not present. There is no evidence of hospital privileges being held nor are there performance appraisals for most providers. In addition, other than a national data bank search, there has been no credentialing of the non-physician mental health staff.

Some privileging has been carried out, but several providers have signed and approved privilege requests in which no privileges have been requested.

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.

If Not Met - Steps/Actions Recommended for Compliance:

Files must be brought into compliance. If primary source verification is done through a third party, it must be reviewed to ascertain that all needed components are present. If done by the agency, primary source verification must be completed and noted.

Privileging must be appropriately completed for all licensed staff.

Section 2. Services - Program Requirement #4

Program Requirement #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)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Hours of operation for health center sites
Most recent Form 5B: Service Sites (*Note that the form lists only the TOTAL number of hours per week each site is open, not the specific schedule.*)
Service Area Map with site locations noted

Compliance Review Findings:

The hours of operation for most West Oakland Health Council sites and services are 8:30 a.m. to 5:00 p.m., Monday – Friday. There are no evening or weekend hours of operation other than for patients in the substance abuse recovery programs. While this may be appropriate for this community, the only data to support the center's assurance that access to health care through extended hours is unnecessary is a Board action from December 13, 2012, that extending hours is unnecessary based on the results of the Patient Satisfaction Survey and other reports. In addition, the center's Accessibility and Continuity of Care Policy dated December 12, 2012 states that: "Patient input and feedback on hours of operation will be provided directly or indirectly by: a. Patient Satisfaction Surveys, internal and external, which ask patients, (1) if they would prefer additional hours, (2) if they would use additional hours and (3) if they are satisfied with the existing hours." Having reviewed the survey completed October 28, 2013-November 2, 2013, the only question on the survey related to hours is, "Are the hours the clinic is open poor, fair, good or great?" without any mention of the other questions mandated in the center's own policy. This would indicate that the grantee is out of compliance with its own policy. No other data was presented. The survey itself measured only 5% of patients seen during the survey week and is therefore not necessarily a representative sample of patients.

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.

The health center's locations appear to be situated in appropriate areas of the community, but not all services are available at each of the four primary care sites. Only the East and West Oakland sites have all services available for patients including phlebotomy and radiology. (b)(4) decision to have only limited services at the Rumford and Thomas sites may indeed be (b)(4)

If Not Met - Steps/Actions Recommended for Compliance:

WOHC must re-visit the examination of hours of operation and come into compliance with its own policy for determining the appropriateness of its hours of operation. The Board must critically examine the data put forth as well as their own knowledge of the needs of community members.

The locations and breadth of services provided at each location must also be reviewed by the Board at least with every grant submission, if not biannually.

Section 2. Services - Program Requirement #5

Program Requirement #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))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Health center's After-Hours Coverage Policies and Procedures
Most recent Form 5A: Services Provided, see Emergency Medical Services

Compliance Review Findings:

The WOHC policy regarding after-hours coverage states that after-hours coverage is provided through telephone access to a "covering clinician who can exercise independent professional judgment in assessing a WOHC patient's need for care, etc." The current practice for this coverage is for a single physician to be on call all evenings and weekends. As this organization provides a full range of primary care services, including prenatal as well as behavioral health and substance abuse services, having a single practitioner on call does not provide the access needed by this breadth of patients. When tested, WOHC's telephone was forwarded to an after-hours answering service. There is no precaution given that in case of emergency the patient should call

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.

911 or go to the nearest emergency room. Additionally, the operator at the service stated that the doctors arrive at 8:30 a.m. and that she could take a message to give to the doctor when the clinic opened. No assessment of need was made. (b)(4)

(b)(4)

Patients are made aware of the availability of after-hours coverage through patient brochures that are available at the registration desk. There is no signage available at the entrance to the clinics to advise patients of how to contact a provider after hours.

If Not Met - Steps/Actions Recommended for Compliance:

The After-Hours Coverage Policy must be implemented immediately to provide care for patients at all West Oakland Health Council facilities. A true after-hours call system that gives patients access to a provider must be established without delay. The policy must address having an on-call provider for adult medicine, pediatrics, OB, dental, and substance abuse programs. This must include referral to 911 for life-threatening situations and contact with a provider for other serious issues. The accompanying procedure should include a system for the center to have access to documentation of all after-hours calls received. In addition, patient brochures should be examined to determine the appropriateness of the level at which they are written and the method for contacting the center after hours should also be posted on the front door.

Section 2. Services - Program Requirement #6

Program Requirement #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)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Hospital admitting privileges agreements/documentation
Most recent Form 5C: Other Activities/Locations (If applicable, hospitals where health center providers have admitting privileges should be noted on the form.)

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.

Compliance Review Findings:

The center's pediatricians have admitting privileges at the Children's Hospital. In general, adult WOHC patients are hospitalized at either Alameda County Hospital or at Alta Bates Summit Hospital. In speaking with providers, they are able to interact with hospitalists and arrange aftercare for patients who have been sent for hospitalization. There is a contract with Alameda County for Medi-Cal patients, but not for all patients, and there is no formal arrangement for all patients with either institution that speaks to discharge planning or tracking for continuity of care.

If Not Met - Steps/Actions Recommended for Compliance:

A formal mechanism for hospital care must be established without delay. Primary care physicians must have admitting privileges at one or more local hospitals to ensure continuity of care, discharge planning, and patient tracking. Memoranda of Agreement must be formally established with local hospitals, especially Alameda County Hospital, for emergency and inpatient care. A policy for discharge planning and patient tracking must be developed and implemented.

Section 2. Services - Program Requirement #7

Program Requirement #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. (Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f) and (u))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Schedule of Fees/charges for all services in scope
Sliding Fee Discount Schedule/Schedule of Discounts (often referred to as the Sliding Fee Scale)
Implementing policies and procedures for the Sliding Fee Discount Program
Sliding fee signage and/or notification methods
Sliding Fee Application Form(s)/eligibility criteria
Other: Sliding Fee Brochure

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.

Compliance Review Findings:

The Sliding Scale is correctly aligned with the 2014 Federal Poverty Levels (FPL). The scale correctly provides for a full discount for patients below 100% of FPL and caps out at 200% of FPL. There are two scales, one for medical and one for dental. The scale states: "The Sliding Fee Discount Schedule is applicable for all council services." A policy statement was provided during the end of the visit, but there was no documentation seen on site indicating the Board's approval of a policy, the services to be included, and the revised 2014 scale. There was an additional document communicating the policy; it was a tri-fold brochure and dated from 2000. It stated "for medical, dental and/or optometry services." Discounts are being provided for services outside of the approved scope. Signage is not readily available in the registration areas. The Patient's Rights and Responsibilities brochure includes the statement, "Fees for uninsured individuals are adjusted according to income and family size," indicating that the discounted services are not extended to all patients. It does not state specifically that no patient will be denied services based upon their inability to pay. The Sliding Fee Applications are printed in numerous languages to reflect the local population. During a sample audit of income verification, the results were spotty. Some accounts had no supporting documentation, while some others included incorrect math. While none of the sample results identified patient accounts that were providing an incorrect discount percentage, (b)(4)

(b)(4)

If Not Met - Steps/Actions Recommended for Compliance:

The Sliding Fee Policy must be written, approved by the Board and the approval noted in the Board Meeting Minutes. The policy must be corrected to include only services in scope and directly state that no patient will be denied services based upon their inability to pay. Since the scale does not mention how lab, radiology, OB, mental health and substance abuse services are to be discounted, the policy must address these services and whether separated scales are needed. The staff responsible for receiving and processing applications must be retrained to ensure accurate and consistent handling of the discount program. Signage must be placed in the clinics in a manner which is readily available for all patients to read in all of the most often used languages of the area.

Section 2. Services - Program Requirement #8

Program Requirement #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. (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))

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.

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Quality Improvement/Quality Assurance (QI/QA) Plan and related and/or supporting policies and procedures (e.g., Incident Reporting System, Risk Management Policies, Patient Safety Policies)
Clinical Director's job description
HIPAA-compliant Patient Confidentiality and Medical Records Policies and Procedures
Clinical Care Policies and Procedures
Clinical Information Tracking Policies and Procedures

Compliance Review Findings:

WOHC has a comprehensive Quality Assessment and Improvement Plan (QAIP), which encompasses a review of clinical performance; medical records; appropriateness of care; quality control of pharmacy, laboratory and radiology; and patient satisfaction. The QAIP was approved December 12, 2012 and revised in May, 2013. The plan is very broad in scope, but does not clearly speak to the use of information collected and analyzed to examine the necessity for any modification in services provided. The Quality Assessment and Improvement Committee (QAIC) is comprised of executive level members representing all departments and programs within the health center and also recently has added two line staff to the committee. Dr. James, Internal Medicine, was appointed Chair of the QAIC Staff Committee in January 2012. The QAIC meets monthly, but attendance is inconsistent. Minutes are recorded and reflect some discussion and actions of the committee. Peer review was begun in April 2014 and has been done once.

Having noted these things, the QAIP continues to have some deficiencies:

- The plan speaks to the responsibilities of the committee as to review and revise the plan annually and submit it to the Executive Director for approval and of reporting QI findings to the Executive Director. There is no mention of the need for the Board of Directors' approval of the QAIP and the QI Chair does not currently interact with the Board.
- Any QI information that comes to the Board does so through the Executive Director/Health Services Director. The QI Representative of the Board does not attend the QI meetings nor does he/she present QI issues to the Board.
- While the QI Committee does review charts and systems, there is little evidence to suggest that any changes have been implemented as a result. The QI Committee appears to have little authority in this regard and must request permission for actions from the Executive Director/Health Services Director.
- The Peer Review Policy is combined with the performance appraisal process. While these two functions have an inter-relationship, peers must not perform performance appraisals. Peer review measures the quality/appropriateness of the care provided to patients and not punctuality, attendance, working relationships or productivity. 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.

results of peer audits may be considered by the individual's supervisor in completing his/her review, but should in no way substitute for that review.

- Many clinical policies and procedures have not been updated for more than eight years.
- While there are a few clinical guidelines for diagnosis and treatment, they are cumbersome and difficult for providers to easily access in a clinical setting.
- There are no policies and procedures that address electronic medical records. The Medical Records Policies and Procedures that exist are old and outdated.

If Not Met - Steps/Actions Recommended for Compliance:

- The QAIP must be revised to better define the role of the Board of Directors. If the WOHC Board is satisfied with having one member with QI responsibilities, that person must have interaction with the QI Committee of the staff and should also be charged with presenting QI findings to the full Board.
- QI findings must be used in determining whether the current scope and provision of services is adequate to meet the needs of the population or if that scope should be revised.
- Either the QI Chair or the QI Board person must report QI findings to the full Board at least quarterly.
- Annual performance appraisals must be completed by the employee's immediate supervisor.
- Peer review must be carried out on a regular basis and must include not only documentation but appropriateness of the care provided.
- Clinical Policies and Procedures must be reviewed at least biannually and revised as needed. Policies must be Board-approved.
- Clinical guidelines must be clear and readily available for providers to use not only for clinical care, but also for peer review guidelines.
- Policies and procedures must be developed to ensure the safety and confidentiality of patient records.

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.

Section 3. Management and Finance - Program Requirement #9

Program Requirement #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)(I) of the PHS Act, 42 CFR Part 51c.303(p), and 45 CFR Part 74.25(c)(2)-(3))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Health center Organizational Chart
Key Management Staff position descriptions and biographical sketches
Health center's official Scope of Project for Services and Sites (Form 5A and Form 5B)

Compliance Review Findings:

WOHC provided two different Organizational Charts for review during the Site Visit; both were undated. Neither contained evidence of Board review or approval. According to the WOHC Organizational Chart provided at the start of the Site Visit, Key Management Staff includes 14 positions that report directly to the Executive Director/Health Services Director. Positions include the Executive Secretary; Health Services Director; Director of Mental Health; Director of Planning; Director of Accounting Services; Director of Substance Abuse Recovery Services; Director of General Services; Director of Legal Affairs/Risk Management; Director, Registration, Billing, and Collections; Human Resources Director; Social Services Director; Director of Nursing; Health Education/Health Risk Reduction Director; and Pharmacy Director. The Executive Director position reports directly to the Board of Directors. The positions of Executive Director and Director of Health Services are held by the same individual, who has held both positions for more than 30 years.

The positions of Chief Financial Officer (CFO), Chief Operations Officer (COO), and Chief Information Officer (CIO) do not exist within the organizational structure.

Another Organizational Chart was provided on the last day of the Site Visit. It reflected a different organizational structure, including a COO position, which is vacant. Seven staff members now report to the COO position. The position of Director of General Services was removed. With the COO position vacancy, all staff continue to report to the ED.

WOHC does not have a CFO. The Director of Accounting is the highest position within the organization, and the individual performing those duties has a long tenure with the organization. In Fiscal Year (FY) 2013, WOHC experienced a substantial loss due to reductions

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.

in Medi-Cal reimbursements. (b)(4)

(b)(4)

The position of Health Services Director (Medical Director) is held by the ED, who is a non-practicing pediatrician. Having both positions held by the same individual decreases both the time and current expertise necessary for providing medical leadership for the clinical staff.

There is no Succession Plan for recruitment of new Key Management Staff.

While performance evaluations have been conducted for a majority of the directors, there are no performance evaluations for providers.

If Not Met - Steps/Actions Recommended for Compliance:

WOHC's Key Management Staff must be appropriate for the needs of the health center, including the hiring of a CFO and Medical Director. The grantee would benefit from a CFO-level individual who would work closely with the ED in directing the organization. In addition, the grantee should have a practicing physician, separate from the ED, as Medical Director.

WOHC must document the creation and review of the corporate Organizational Chart. The Organizational Chart and practice must be aligned.

A Succession Plan for Key Management Staff must be developed.

Section 3. Management and Finance - Program Requirement #10

Program Requirement #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)(I)(ii) of the PHS Act, 42 CFR Part 51c.303(n) and (t), Section 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a)(2))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Contract(s) or sub-award(s) (subrecipient agreements) for a substantial portion of the Health Center Project
Memorandum of Understanding (MOU)/Agreement (MOA) for a substantial portion of the Health Center Project

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.

Compliance Review Findings:

There is no formal arrangement, either in the form of a contract or an MOU, for the delivery of pregnant patients with the obstetrician at Alta Bates Summit Hospital.

Contract management is not well organized and controlled. Each department appears to have possession of contracts for departmental services or programs. There is no centralized contract file or system in place to monitor and manage contracts for the health center.

Current corporate bylaws require WOHC contracts to be subject to approval from the U.S. Public Health Service if they involve the expenditure of Public Health Service funds. This is not a HRSA Requirement. WOHC has not sought or received such contract approvals, which is in violation of its own bylaws.

There is no evidence that the Board of Directors has imposed contract limits or parameters regarding the Executive Director's authority to enter contracts.

If Not Met - Steps/Actions Recommended for Compliance:

WOHC must develop a formal arrangement, either in the form of a contract or an MOU, for the delivery of pregnant patients with the obstetrician at Alta Bates Summit Hospital.

WOHC must exercise appropriate oversight and authority over its contracted services including management of executed contracts. The Director of Legal Affairs/Risk Management should obtain and retain copies and/or have direct access to all executed contracts.

WOHC must institute and maintain a system to identify, oversee, manage, and control contract administration. Administration should consider developing and maintaining a formal electronic contract depository that would facilitate tracking and appropriate oversight over MOUs and contracts. The tracking system could include the following: name; agreement type; service date; location; deliverables; description; value; expiration date; renewal type (i.e., auto); review date; and term. At minimum, an Excel spreadsheet should be created as a tracking mechanism.

The Board of Directors must assume authority and responsibility for the approval of contracts and should revise its bylaws accordingly.

The Board of Directors must develop some contract execution parameters and systems of accountability to help protect the corporation and ensure compliance with HRSA Program Requirements.

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.

Section 3. Management and Finance - Program Requirement #11

Program Requirement #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 FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n))

Compliance Status: Met.

Documents reviewed onsite or in advance:

Letters of Support
Memoranda of Agreement/Understanding
Other relevant documentation of collaborative relationships

Compliance Review Findings:

WOHC has established and maintains collaborative relationships with other health care providers including Community Health Centers, the local health department, community-based organizations, faith-based organizations, and other health care and support agencies in the Oakland area. WOHC participates in several research projects conducted by the University of California San Francisco (UCSF). WOHC is also a participating member of the Community Health Center Network (CHCN) and the Alameda Health Consortium.

The grantee secures Letters of Support from existing health centers in the service area. The 2011 SAC contained Letters of Support from Asian Health Services and Lifelong Medical Care.

Section 3. Management and Finance - Program Requirement #12

Program Requirement #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) and (q) of the PHS Act and 45 CFR Parts 74.14, 74.21, and 74.26)

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.

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Most recent independent financial audit and Management Letter, including audit Corrective Action Plans based on prior year audit findings, if applicable
Most recent A-133 Compliance Supplement (grantees only)
Financial Management/Accounting and Internal Control Policies and Procedures
Chart of Accounts
Balance Sheet
Income Statement
Most recent Health Center Program required Financial Performance Measures/UDS Report
Most recent Income Analysis (Form 3)

Compliance Review Findings:

Annually WOHC receives an independent audit. The Board and management receive monthly a Balance Sheet and Income Statement for review. A Finance Committee does not meet. There were not policies that outlined the frequency of putting the audit out for bid or how to select an audit firm. (b)(4) and (b)(4) are used to record accounting and payroll activities. There was an Accounting Manual, and most of the procedures appear to have been reviewed and updated in recent years. The approval documented on the paper copy indicates that the Director of Accounting and Executive Director approved the original manual in 1999. The only subsequent signatures and dates are recorded for the Director of Accounting. The manual appears to be a set of departmental procedures and absent of needed and comprehensive corporate policies. No evidence was found of the Board's involvement in setting/adopting policies or of their knowledge level related to policies. The Chart of Accounts appears to allow recognition of activities related to funding streams. The current process of allocations appears not to be recorded from source documents but instead from reports that allocate the amounts by programmed rates. The Chart of Accounts does not currently reflect the ability to simultaneously track and allocate activities based upon funding source, location and cost center. The organization is large and complex enough that it should not have to rely upon reports to allocate funds and how exceptions are handled.

If Not Met - Steps/Actions Recommended for Compliance:

A comprehensive set of policies must be written and approved by the Board with the action being documented in the Board Meeting Minutes. The Chart of Accounts must be expanded to encompass the ability to simultaneously track activity by funding source, location and cost center to ensure proper tracking of funds.

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.

The following is a suggested list of policies. The grantee may have some of these either partially or in completeness. Some may be used infrequently by the organization but would still be beneficial to set up in advance of need.

1. Annual Audit
2. Selecting the Auditor & Frequency
3. Federal Grant Procurement Procedures
4. Cash Handling and Deposits
5. Petty Cash
6. Use of Company Credit Cards
7. Corporation Status
8. Insurance Policies
9. Securing Pertinent Corporate Documents
10. Reconciling Bank Statements
11. Reconciling Credit Card Statements
12. Reconciling Other Balance Sheet Accounts
13. Remitting Payroll Taxes
14. Remitting Employee Insurance and Retirement Withholdings
15. Service Charges, Interest or Late Charges
16. Taking Cash Discounts
17. Requirements for Setting up Vendors
18. Anti-Kickback
19. Use of Company Cars
20. Use of Other Company Assets
21. Filing Form 990
22. Confidentiality of Financial Data
23. Line of Credit & Short-term Debt
24. Mortgages & Long-term Debt
25. Authorized Spending Levels
26. Financial Statements
27. Finance Committee
28. Budget & Capital Plan
29. Operating Plan
30. Bonding of Staff
31. Travel & Mileage
32. Meals & Entertainment
33. Fixed Assets/Capital
34. Equipment Inventory
35. Supplies/Pharmacy Inventory
36. Accounts Payable
37. Purchasing
38. Accrual-Based Accounting
39. Investment Accounts
40. Restricted Accounts

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.

41. Authorization to open Bank Accounts
42. Check Signing Authorizations
43. Dual Signatures on Checks
44. Securing Unused Checks
45. Voided Checks

Section 3. Management and Finance - Program Requirement #13

Program Requirement #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)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Policies and procedures for credit, collection, and billing
Encounter Form(s)
Most recent Income Analysis (Form 3)
Most recent Health Center Program Required Financial Performance Measures/UDS Report
Other: List of Medi-Cal and Medicare provider numbers

Compliance Review Findings:

A single Billing Policy was presented at the end of the Site Visit. It covered part of what is expected to be covered in policies, but it is not comprehensive enough to ensure all topics are addressed. Additionally, the policy may not have been presented to the Board, approved, and documented in the Board Meeting Minutes. A new set of procedures are currently being written and what has been accomplished so far is clear and detailed. The organization has Medicaid and Medicare numbers for the sites reflected on Table 5B. Patients have not been required to pay outstanding balances and no collection agency is used. The days in A/R have climbed to 185.3 at the end of FY 2013. This appears to be partially due to delayed reconciliation payments from Medi-Cal and poor collection efforts. A culture appears to have developed where patients are not expected to pay their financial responsibilities.

If Not Met - Steps/Actions Recommended for Compliance:

A comprehensive set of Billing, Credit and Collection Policies must be written, approved by the Board and documented in the minutes. These policies must address the Board's expectations related to patients fulfilling their financial responsibilities to WOHC.

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.

Section 3. Management and Finance - Program Requirement #14

Program Requirement #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) and (k)(3)(I)(i) of the PHS Act and 45 CFR Part 74.25)

Compliance Status: Met.

Documents reviewed onsite or in advance:

Annual budget
Most recent Income Analysis (Form 3)
Most recent Staffing Profile

Compliance Review Findings:

The Budget was approved by the Board and documented in the minutes of the April 2014 meeting. The Budget Narrative indicates that it was compiled based upon historical performance. It includes grant funds and funds generated as program income. The only indication of the impact of anticipated encounters was on income analysis. The budget is not reported on the monthly financial statements. There appears to be no comparison of actual results and budgeted amounts at the Board level. (b)(4)

(b)(4)

Section 3. Management and Finance - Program Requirement #15

Program Requirement #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)(I)(ii) of the PHS Act)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Most recent UDS Report and UDS Health Center Trend Report
Most recent Clinical and Financial Performance Measures Forms
Clinical and financial information systems (e.g., EHR, practice management systems, billing systems)

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.

Compliance Review Findings:

(b)(4) is the EMR and PMS. Currently, not all of the providers have given up physical charts and switched to EMR. The organization has not applied for any PCMH or Meaningful Use certifications. Only one MIS Policy was provided, which is insufficient in protecting all of the patient and corporate data from foreseeable threats. The UDS Reports have been completed and submitted annually. (b)(4) (b)(4) The reports did not indicate that any of the ratings had been downgraded for Calendar Years (CY) 2011 through 2013. A Strategic Plan exists, but the format indicates that it was created and used at the departmental level, not by the Board. No dashBoard report exists to provide a quick informative look at key performance indicators. The amount of analytical data compiled and shared with management and the Board appears minimal. The result of the relatively small amount of data is that a large and complex organization with financial struggles is sometimes not making decisions that are driven by data.

If Not Met - Steps/Actions Recommended for Compliance:

Tools must be developed or pulled from the available systems in understandable and useful formats to provide management and the Board with the needed insight to make informed decisions. The organization must have appropriate systems in place to ensure the accurate and complete capture of data and ability to extract it for the purposes of submitting UDS and FFR reports and tracking its Financial Performance Measures. A Strategic Plan covering the Board's input at a level appropriate for them to access the progress of the organization must be created and tracked by the Board to build financial stability and ensure services continue to be rendered for the populations served.

Section 3. Management and Finance - Program Requirement #16

Program Requirement #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)

Compliance Status: Met.

Documents reviewed onsite or in advance:

Health Center UDS Trend Report
Health center's official Scope of Project for Sites and Services (Forms 5A, 5B, and 5C)
Most Recent Form 2 - Staffing Profile

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.

Notice of Award and information for any recent New Access Point or other supplemental grant awards
Other: Service Area Competition (SAC) Application

Compliance Review Findings:

The grantee maintains its funded Scope of Project. There has been a decline in the number of patients served. The SAC indicated the estimated number of patients by the end of the project period to be 22,000. The 2013 UDS Report indicated that the unduplicated patients numbered 8,395 or 38% of the projected total. Given the remaining time in the project period and the deficit that would need to be overcome (8,105 additional patients), it appears that WOHC will not reach the required 75% of the projection before the end of CY 2015.

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.

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
Other: Board Approved Policy: Governance of WOHC - Board Authority and Board Responsibility (December 12, 2012)

Compliance Review Findings:

The corporate bylaws have not been revised since 1996, or in 18 years. Since that time, numerous changes have taken place at HRSA, the Community Health Center Program, and the health care industry.

Current bylaws do not address the following:

- Mission Statement
- Public communication and/or comment
- Confidentiality to include all corporate business
- Board self-evaluation
- Dissolution of the corporation
- Delineation and description of standing committees
- Board and Committee Meeting Minutes maintenance
- Anti-Kick Back Statute
- Indemnification

WOHC's bylaws state that the size of the Board shall be 13 persons (seven elected and six appointed). The Board is at 12 members. During the Site Visit, the Board was voting on a prospective Board member.

There are a number of problematic areas in the bylaws, including:

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.

- Bylaws Article VII, Directors, Section 1. This provision authorizes the Board to prescribe powers and duties of employees and fix their compensation.
- Bylaws Article VII, Section A, Regarding Executive Director, indicates the Board's sole authority by majority vote to hire, discipline and/or discharge the Executive Director. It does not include evaluating the performance of the Executive Director.
- Bylaws Article VII, Section B, Contracts and Consultants, states the U.S. Public Health Service has approval authority of contracts or paid consultants when those funds were used to fund said services or contracts.
- Board committees are not delineated or described in the bylaws. Board minutes do not reflect functioning committees.

The Executive Director (ED) has functioned as the Health Services Director and ED for more than 30 years. The size and complexity of the organization warrants separation of these positions.

Board Meeting Minutes do not support the Board running its meetings and conducting business as authorized and expected by HRSA. Board meeting agendas are comprised primarily of the ED's report and staff reports.

WOHC is currently operating under a five-year Strategic Plan (July 01 2010 – June 30, 2015). The plan is not quantifiable with strategies such as: improve staff competency; increase users; and enhance revenue generation and collection.

There is no Board Meeting Calendar.

The Program Requirement is not met because of the following:

- Board minutes do not document the Board's approval of the health center (330) application for the January 2014 BPR prior to submission to HRSA.
- The ED's 2013 performance evaluation was conducted by the Executive Committee, not the full Board.
- In 2013 and 2014, there was an absence of quorums for multiple Board meetings. Quorums were not met for the following meetings: January 2013, March 2013, April 2013, September 2013, January 2014, February 2014, March 2014, and May 2014.
- Minutes do not show evidence of the Board measuring and evaluating the health center's progress in meeting its annual and long-term programmatic and financial goals, evaluation of patient satisfaction, and the monitoring of organizational assets and performance.

If Not Met - Steps/Actions Recommended for Compliance:

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.

WOHC's Board of Directors should strongly consider revising the previous bylaws and its cumbersome model of elected and appointed Board members. During the meeting with Board members, they stated that discussions regarding the revision of the bylaws are ongoing. They are gathering bylaws from other Community Health Centers in the Oakland area for review.

WOHC must revise or amend the corporate bylaws to meet baseline HRSA Program Requirements, including the previously outlined provisions to enhance clarity, guidance, direction, meet requirements, and protect the corporation and the Board of Directors.

The following areas of the Bylaws require amendment and/or deletion:

- Bylaws Article VII, Directors, Section 1. This provision authorizes the Board to prescribe powers and duties of employees and fix their compensation. This provision must be deleted; it is outside the scope of Board Authority. Employee duties are determined by the Executive Director and his executive team. The Board is authorized to approve salary scales and ranges per approved and budgeted positions, but not individual salaries.
- The Board is required to regularly evaluate and document the performance of its sole employee, the Executive Director. This duty must be added to the appropriate article and section.
- Bylaws Article VII, Section B, Contracts and Consultants, states the U.S. Public Health Service has approval authority of contracts or paid consultants when those funds were used to fund said services or contracts. WOHC must remove the above provision because it is not accurate.

Board committees must be delineated in the bylaws, activated, and report back to the full Board each time they meet. Reports must include enough information to help the Board make sound informed decisions.

The Board must separate the Executive Director and Health Services Director positions.

Minutes are legal documents, and can be used to substantiate or document or provide evidence in various legal or other venues, if necessary. Therefore, minutes must be detailed enough to provide readers sufficient information to understand what took place at each Board meeting. Minutes must reflect the Board running its meetings, receiving information to make informed decisions and appropriately documenting execution of its fiduciary responsibilities. Reports must document the details of committee recommendations, findings, and discussions. The Board must be engaged in the strategic or long-term planning process for WOHC.

Going forward, the Board must review, discuss, and approve the 330 grant application (SAC/BPR) before its submission. This must be documented in the meeting minutes.

The full Board must conduct the Executive Director's annual performance evaluation.

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.

The Board must have a quorum at meetings in order to conduct business.

WOHC is strongly encouraged to request technical assistance (TA) in Board Training, including an overview of the 330 Program, from the HRSA Project Officer.

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
UDS Summary Report
Other: Board Member Disclosure Forms, Petitions submitted by potential Board members, Board-approved Board Composition Policy (December 12, 2012)

Compliance Review Findings:

The governance of the organization is provided through a Board of 12 members. Compliance with the 51% user majority is in place through the Board members. Of the 12 Board members, eight are consumers (67%). This was verified through billing records review. The Board added a Latina Board member in response to shifting demographics in the health center populations served.

Board members have expertise in business, healthcare, and ministry. The Board does not have members with finance or legal affairs expertise. The Board is strongly encouraged to recruit non-consumer Board members with finance and legal affairs expertise. Also, Form 6A should be revised to document specific areas of expertise (e.g. hospital administration, small business experience, etc.).

None of the Board members currently work in the health care industry. One member is a retired hospital administrator.

There is a Board-approved policy for Board Composition dated December 12, 2012.

Section 4. Governance - Program Requirement #19

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 Requirement #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. (45 CFR Part 74.42 and 42 CFR Part 51c.304(b))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Corporate Bylaws
Most recent update of Conflict of Interest Policy and related procedures

Compliance Review Findings:

WOHC bylaws allow for the Executive Director to be a non-voting member of the Board of Directors. Consultant (b)(5) was present at a Board meeting on March 7, 2013 where the Executive Director introduced a motion. This is a repeat finding from the 2012 Site Visit. This was not noted in meeting minutes after the March 2013 meeting, largely due to the many meetings (2013 to present) that lacked a quorum.

WOHC has a Board-approved Conflict of Interest Policy dated December 12, 2012. It states that no Board member shall be an employee of the health center or an immediate family member of an employee. It also addresses conflicts of interest pertaining to Board members, employees, and consultants.

Disclosure of Potential Conflict of Interest Forms are signed by a majority of the Board members (9). Signed forms are needed for three Board members, including the two most recent members to join the Board.

If Not Met - Steps/Actions Recommended for Compliance:

WOHC bylaws state that the Executive Director may serve as a non-voting member of the Board of Directors with all of the other rights and privileges of the Directors. The Executive Director must not participate in a fashion that would present a conflict of interest. The bylaws must be revised to clarify the CEO's role.

WOHC should consider revising the Disclosure of Potential Conflict of Interest to allow space for Board members to specify potential or actual conflicts of interest.

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.

Section 5. Clinical and Financial Performance

Clinical Measure #1 - Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90.

Documents reviewed onsite or in advance:

UDS Trend, Comparison, and Summary Reports
Quality Improvement/Quality Assurance Plan
Most recent audit
Clinical and Financial Performance Measure Forms from most recent SAC/Designation Application

Clinical Performance Analysis:

Reason(s) for selecting the measure:

This measure was selected because of the significant percentage (27%) of West Oakland Health Council patients with the diagnosis of hypertension. The stated goal in the latest BPR for 2014-15 is 65%.

Performance measure status and trend:

The trend for improvement in the outcomes for this measure had increased from 2010 to 2011, remained stable for 2012, and has decreased for 2013. At this same time, the percentage of patients having a diagnosis of hypertension has increased from 16.5% of patients in 2011 to 26% of the population in 2013.

	2010	2011	2012	2013
Percent controlled HTN	55	60	60	55
Percent total patients with HTN		16.5	16.5	26

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.

Key factors (internal and external) contributing to and/or restricting the health center's performance on the measure:

Contributing Factors:

- The Grantee participated in the Health Disparities Collaborative and has continued the collaborative model.
- This performance measure is part of the Quality Assurance Improvement Plan (QAIP) and is monitored by chart audits.
- There is a Health Education staff person assigned to each primary care team at WOHC to provide individual patient education.

Restricting Factors:

- Many patients are reluctant to make lifestyle changes because disease progression produces few observable symptoms.
- Clinical guidelines consist of the complete JNC8 and are difficult to use in a clinical situation.

Health center's in-process and/or proposed action to improve performance on the measure:

- A focused effort in QI to determine the causes of this decrease in performance with development and implementation of a PDSA cycle;
- A more structured approach to education: group sessions, enhanced recommendations from providers for coverage of materials by the health education staff;
- A study to determine whether or not patients have acceptable access to their medication and refills; and
- Development of a more user-friendly clinical standard/guideline and adoption of a chart review document that measures provider adherence to that standard.

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.

Financial Measure #1 - Total Cost per Patient

Documents reviewed onsite or in advance:

UDS Trend, Comparison, and Summary Reports
Clinical and Financial Performance Measure Forms from most recent SAC/Designation Application

Financial Performance Analysis:

Reason(s) for selecting the measure:

(b)(4)

Performance measure status and trend:

(b)(4)

Key factors (internal and external) contributing to and/or restricting the health center's performance on the measure:

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.

During the reporting periods, direct expenses positively decreased by 1%, and indirect expenses negatively increased by 5%. Combined the total expenses negatively increased by 1%. At the same time, total patients negatively decreased by 60%. As a result, expenses remained virtually unchanged despite a 60% reduction in patients.

Health center's in-process and/or proposed action to improve performance on the measure:

The organization should align expenses with the number of patients served and encounters provided. Additionally, it is important for the organization to identify and implement strategies to attract and retain more patients.

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.

Section 6. Capital and Other Grant Progress Review

Capital Grant Program(s) Reviewed:

N/A-Grantee does not have any active capital grant funding.

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.

Section 7. Innovative/Best Practices

None noted.

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.