California Primary Care ASSOCIATION

CPCA / Epic Strategic Partnership

Business Model and Plan – CPCA Board Meeting

July 14, 2017

Executive Summary

- CPCA is exploring a partnership with the Epic Systems Corporation that would offer the complete Epic HIT platform to Health Centers in California.
  - CPCA staff will negotiate a contract that binds the terms and conditions of this partnership to the CPCA Board for approval later in 2017.
  - This presentation is an update on the status of the development of this partnership, including an overview of the business model.

About the Epic Systems Corporation

Based on preliminary conversations with Epic and CEO Judy Faulkner, CPCA feels Epic is a good cultural and business fit for CPCA CHCs. Epic:

1. is privately held and not accountable to shareholders/investors.
2. has a similar vision for the role of Health IT in improving access and the health of communities.
3. understands patient-centric care, social determinants of health, population health management, and specifically the importance of provider usability.
4. is a leader in interoperability, which will allow us to meet the requirements of our partners while protecting our patients
5. is making the most considerable investments in R&D compared to other EHR vendors, in our estimation.

History of this opportunity

When	What
2014	• CPCA members ask CPCA to explore challenges with EHR legacy vendors servings California Health Centers.
2015	• CPCA holds exploratory meetings with 4 leading EHR vendors to understand long term strategy and vision for serving the needs of FQHCs. ▪ Vendors: eCW, NextGen, GE, Athenahealth
2016	• Several CPCA member Health Centers are approached by hospitals to share EHRs. • Carmela sends letter to Epic CEO Judy Faulkner to explore opportunities for a different Epic model for California CHCs. • Preparations for a face to face meeting begin.
2017	• CPCA engages members in a survey to determine likelihood of switching from legacy EHR vendors, interest in Epic, and interest in potential CPCA Epic offering. • CPCA staff and members visit Epic HQ to see demo of product and learn more about Epic culture. • Epic hosts Technical Advisory Committee made up of CPCA member CIOs and CMOs to demonstrate product capabilities. • CPCA and Epic explore additional preparations necessary to form agreement to make the Epic HIT Platform available to CPCA members.

Hypothesis

- Epic has the starting point platform and the necessary resources to keep pace with the accelerating demands being placed on CHCs by value-based payment models.
- Health Centers have limited options for engaging with Epic.
- Therefore, a California specific, CHC-led option for adopting the Epic platform offers a desirable choice for some California CHCs.
  - For the purpose of discussion, we refer to the Epic “HIT Platform” as including EHR, scheduling, revenue cycle, population health management, analytics, and associated tools for administration of the platform.

Goals of an Epic Partnership

1. Offer the best possible terms and conditions for acquiring the Epic HIT platform.

2. Build a California-specific standard configuration to reduce total cost of ownership.

3. Deliver the HIT platform with professional configuration, implementation, hosting, and management.

4. Seek opportunities to leverage shared HIT platform for enhanced strategic positioning.

Goal 1: Best terms and conditions

Factor	Tactics
Competitively priced offering	1. The Technical Advisory Committee will negotiate group pricing, seeking favorable pricing from Epic. 2. Understandable and predictable pricing model.
Flexible “on-ramp”	1. Standard pricing for CHCs that can afford up-front implementation cost. 2. “All-inclusive” monthly pricing for CHCs that need to amortize switching and implementation costs.
Standardized, yet customizable implementation plans	1. All-inclusive pricing: training, implementation support, data migration, license, and support and maintenance for a single monthly fee.

Goal 2: California-Specific, Standard Configuration for CHCs

Factor	Tactics
California's unique requirements, including potential APM, will drive EHR requirements	1. Develop a "starting point" standard configuration that meets common state-level and regional requirements.
Competitive positioning will require system flexibility and responsiveness to new requirements	1. Governance by the participating California CHCs 2. Professional management to include the vendor and potential third-party professional IT 3. Ability to scale to meet CHC-specific requirements 4. Leverage Epic "personalization" versus "configuration" pathways

Goal 3: Professional Configuration, Implementation, Hosting, and Maintenance

Factor	Tactics
EHR hosting business models have been challenging for CHC-led initiatives	1. Epic to host the product in their professionally managed data centers 2. Epic to handle all product updates
Management of a standard configuration will require adherence to IT Governance best practices	1. Engage Epic or third-party to serve in key configuration, implementation, support, and maintenance role 2. Develop organizational and governance model to manage centralized decision-making for participating health centers. 3. Centralized staff to project manage system enhancements
State-level expertise and relationships necessary to ensure success	1. Create a dedicated team at CPCA to support non-technical aspects of EHR initiative

Goal 4: Leverage Collective Strength in Strategic Positioning

Factor	Tactics
Changing expectations on primary care delivery require new data sets	1. Standardize the model for incorporating health system and payer data sources 2. Develop and enhance state-wide catalog of social supports for patients with unmet social determinants of health 3. Build once, leverage by all the capability of Epic interoperability/interfaces including hospital, lab, imaging, HIE, etc.
Increased need to participate in meaningful information exchange with key partners	1. Develop standard engagement model for CHCs ability to share patient-level data with clinical partners 2. Offer additional options for those CHCs that wish to engage more intensely on shared patients.

Business Plan

1. Create a straight-forward pricing proposal inclusive of standard configuration
2. Recruit initial cohort of CHCs
3. Develop distinct governance model for EHR-related issues
4. Select professional management partner, develop and execute staffing plan
5. Initiate implementation, including collaborative development of standard configuration
6. Go-live with pilot site(s)
7. Develop rolling marketing, sales, and implementation plan

1. Pricing proposal

- Initial pricing received
  - Pricing model is complex and includes multiple inputs
  - We are developing a simplified pricing model to CHCs
  - Based on initial pricing, we can be price-competitive with other acquisition options
  - Simple, monthly pricing will include software, hosting, maintenance, support, and participation in governance
- We are gathering additional information to prepare a 5 year pro forma.
  - Detailed pro forma to be available ahead of July Board meeting

1. Pricing Proposal (continued…)

- Our progress on financial pro forma to date:
  - We have initial Epic pricing
  - We just (6/28) walked through and assessed likely staffing models with Epic
  - We are waiting for updated hosting proposal (we discovered some issues in the original proposal)
  - A hypothetical ramp-up plan has been established with optimistic, realistic, and pessimistic adoption estimates
  - We are working through staffing and architectural assumptions with the Technical Advisory Group
- As we finalize the pro forma, we will determine break-even points, and possible contribution to support CPCA programming in payment reform readiness, health analytics, and quality improvement.
- Negotiation on price and other terms will begin in earnest once we have finalized the pro forma.
  - Focus to date has been on understanding the complexity of the pricing model
  - Negotiation will focus on reducing total cost of ownership for all participants and leveraging Epic commitment to supporting FQHCs

2. Recruit initial cohort of participants

- Ensure achievement of discount milestones
  - 400,000 annual encounters at go-live
  - 1M annual encounters at year 5
  - 2M annual encounters at year 10
- Based on initial interest, these milestones are attainable
- CPCA will need to develop commitment “toll-gates” to formalize commitments:
  - Interest expressed
  - Board and executive commitment made
  - Financial commitment made
  - Training and implementation scheduled
  - Product live

3. Distinct governance

- Prioritization for EHR development will be a key to success
  - Maintenance of a standard configuration requires ongoing governance with an increasing user base
- CPCA has engaged legal counsel with experience in creating partnerships with Epic
  - Counsel will be advising further on how to define role of existing CPCA governance versus need for new HIT Program governance
  - Standard configuration and other HIT Program related issues should be decided only by those health centers participating in the HIT Program:
  - A series of committees and dedicated staff from the implementing CHCs will work towards decision-making about the day-to-day decisions of successful EHR implementation and maintenance.

4. Professional Management / Staffing

(All TBD – pending discussion with Tech Adv. Committee.)

- Epic will provide the hardware and host the Epic instance in its data centers in Wisconsin with redundancy in a second data center.
  - This includes hardware maintenance, database maintenance, connectivity, and security.
- The vendor (or qualified third party) will assist in configuration, implementation planning, and go-live support.
- In consultation with Epic, CPCA intends to develop staff in the following areas:
  - Program Director, Training Managers, Interfaces Manager, Analyst Managers, Site Readiness, and others TBD
- CHCs will maintain staff in the following areas:
  - Primary Analysts, Superusers, Physician Champions, Helpdesk, Reporting Analysts, and others TBD

5. Implementation / Configuration

- In consultation with Epic, we are evaluating bringing three large CHCs live in an initial pilot cohort to begin in October 2017 and to finish in late 2018.
  - Selection of pilot sites would be based on readiness, willingness to participate in early design, and how soon they can make formal commitments.
- These CHCs will be required to offer dedicated staff to the configuration and implementation planning, whereas other interested CHCs may wish to dedicate staff ahead of their implementation.
- CPCA will have made key hires in time for training at Epic (preliminarily November 2017.)

6. Go-Live with Pilot Sites

- First sites will be live in late 2018.
- In order to keep staffing levels down one model that has been explored, at the recommendation of Epic, is to have some CHC staff “roll forward” to support next wave of CHCs – with appropriate compensation to the home CHC.
- Ongoing governance will address system maintenance and enhancements.
- CPCA will strengthen training programs based on initial experience of pilot sites.
- Ongoing user group meetings to begin within 6 months of initial site go-live.

7. Marketing and Sales Plan

- Initial pilot will likely achieve 5-year requirement for number of encounters.
- To achieve 10-year requirement for number of encounters, we anticipate adding:
  - 2-3 additional large health centers
  - 4-6 medium health centers
  - 5-10 small health centers
- Appropriate marketing and sales programs will be developed to attract these additional sites.
- The earliest a non-pilot could go live based on anticipated staffing is 2019 based on our initial staffing plan.
- Should significant demand emerge, plan would be adjusted.

MARKET ANALYSIS

Market Analysis

- Market Assessment: CPCA Member Survey, January 2017

Question	Percent of Respondents	Clinical Providers Represented (Total FTEs)
Considering replacing their Certified Electronic Health Record (CEHRT) at some point between 2017-2020	26% of total survey respondents	659
Considering Epic in some capacity, either in partnership with a local hospital, with OCHIN or by some other means	77% of respondents considering changing their CEHRT	626
Are interested, or possibly are interested in an Epic offering under terms negotiated through CPCA	38% of respondents considering a move to the Epic platform	535

- Competitor Assessment:
  - Technical Advisory Group able to contrast Epic capabilities w/ current product platforms
  - Comparison of hosting prices

BUSINESS MODEL/FINANCIAL ANALYSIS

High Level Financial Analysis

- An ongoing cost of $4.80 per encounter for the comprehensive Epic platform will be highly competitive in the market.
- Health Centers with approximately 2M annual encounters have expressed serious interest:
  - With 2M annual encounters, we can reach $5.39 per encounter pricing (before price negotiation.)
- Recruiting 3M total encounters is considered realistic:
  - With 3M annual encounters, we can reach $4.60 per encounter pricing (before price negotiation.)

Financial Keys to Success

- Negotiate more favorable terms and conditions:
  - Consider external expert opinion on hosting cost.
  - Seek discounting on key drivers of cost.
  - Accelerate discounting at 2M versus 3M.
- Develop a plan for onboarding additional Health Centers:
  - Only 8 Health Centers are needed to reach 2M and 14 to reach 3M (assuming blend of small, medium, and large.)
  - Exceeding 3M reduces cost further.

Legal Analysis

- Engaged Stoel-Rives as legal counsel
- Counsel conducted legal analysis and provided guidance, summarized in legal memo included in board packet

Risk & Mitigation Strategy

- Risk of financial harm / liability to CPCA:
  - Engaged Stoel-Rives as legal counsel
  - Counsel conducted legal analysis and provided guidance, summarized in legal memo included in board packet
- Risk of technical failure / inability to achieve implementation base:
  - Relationship with Epic for hosting and technical assistance
  - Program governance model
  - Staffing for success
  - Negotiation specifically focused on reducing hosting cost – include seeking an outside expert opinion on appropriateness of proposal
- Availability of capital to start program:
  - Seek partnership with large Health Centers who wish to move first and can fund implementation activities, in return for payback as more Health Centers come online
  - Consider negotiation for deferred payment terms to smooth cash flow needs
  - Seek outside partnership

Updated timeline

July – November 2017

- June 30 – Executive Committee update
- July
  - July 7 – next meeting with Technical Advisory Committee
  - July 14 – Board meeting
  - Finalize pro forma with Exec / Board input
  - Finalize governance model
  - Begin contract negotiation
- August
  - Initial commitments from pilots
  - Negotiate contract with Epic
  - Prepare contracts with pilots
  - Special Board meeting
- September / October
  - Preparations for implementation
- November
  - Epic training in Madison

STOEL RIVES LLP

MEMORANDUM

July 6, 2017

ATTORNEY-CLIENT PRIVILEGE; ATTORNEY WORK PRODUCT

TO: CARMELA CASTELLANO-GARCIA
ROBERT BEAUDRY

FROM: SASKIA M. DE BOER

CLIENT: California Primary Care Association

RE: Electronic Health Records

This memorandum summarizes our conversations regarding the legal, operations, and governance considerations for CPCA to structure and implement a new community electronic health record program (CEHR).

1. Risk Management: Liability and Privacy. The CEHR venture poses risks including compliance with privacy and security regulations, compliance with data breach notification and remediation requirements, and medical malpractice claims associated with the unauthorized disclosure of patient information. Liabilities in these areas include costs of providing notification, litigation costs and settlements, and government fines and penalties.

We assessed forming a separate entity (Newco) to house the CEHR and operating the new program within CPCA. Both approaches have legal and operational benefits. Typically, a company would choose to house a new line of business in a separate entity in order to achieve one or more of the following goals: (i) isolate the investment risks and potential liability exposure associated with the new line of business from the revenues, resources and goodwill associated with the established line(s) of business; (ii) provide a vehicle for obtaining investment in or financing the new line of business; (iii) provide a vehicle for sharing control and profits with a partner whose resources or expertise is essential to the success of the new endeavor; or (iv) maintain a separate set of customer relationships. Tax avoidance, isolating regulatory compliance responsibilities and positioning a business for sale or merger are other common reasons to employ subsidiaries. In the context of a separate entity providing a CEHR, privacy compliance and information system usage must also be factored into the analysis.

We understand CPCA's primary driver in considering forming Newco is as a means to create a liability shield and isolate CPCA from CEHR liabilities. To successfully create such a shield, CPCA and Newco must be entirely separate, both in legal structure and operations.

Newco would be incorporated with its own governance structure, and would be operated with separate management, personnel, office equipment, capital, and legal and tax/financial requirements and filings. If all of the activity and support necessary to successfully operate the CEHR will be fully isolated and located in Newco, a separate entity strategy could assist in isolating risk and compliance obligations. However even if the corporations and ongoing operations were separate, if CPCA or its personnel would provide any services to Newco that require access to PHI, there would be a basis for direct regulatory liability for CPCA. In addition, without corporate independence and autonomy from CPCA, a court may hold CPCA vicariously liable for damages despite the existence of Newco.

In addition to the legal and liability issues above, governance, management and marketing are other factors to consider in assessing structure. One of CPCA's great strengths is its leadership and staff, and operating CEHR within CPCA allows capitalizing on both its strong people and systems. The CPCA board can provide a broad and forward-looking perspective to the project and ensure alignment with CPCA's mission. To operate the project from Newco would require a separate board and staff. Having two organizations could be an asset if the skills and perspectives needed for the two lines were separate and distinct enough so that different people were better suited for different roles. However, if there is alignment in the mission and skill needs, two companies would result in operational inefficiencies and could result in Newco's revenue being directed outside of CPCA's mission. Marketing CEHR as a CPCA program allows CPCA to take advantage of its reputation. How the program ultimately fares determines whether marketing it as a CPCA program is a positive or negative: if CEHR is successful, its success is CPCA's success; if CEHR is not successful, its negative press is publicized under a Newco's name.

Because the ongoing operations will likely involve CPCA personnel, we concluded that CPCA should explore implementing the CEHR as a CPCA program, while also proactively pursuing critical risk mitigation measures noted below. In arriving at this conclusion we reviewed the costs and logistics of maintaining separate entities and discussed the myriad ways CPCA would be involved in the CEHR ongoing operations and would use its data in mission-driven advocacy. We also noted how the financial revenue generated by CEHR would accrue back to supporting CPCA infrastructure and furthering its mission.

2. Tax Matters. Any time CPCA considers taking on an activity that will generate a stream of funding, it must assess whether the income generated is unrelated business taxable income. Based on our understanding that CPCA will offer the CEHR to its members, all of whom are FQHC's, nonprofits or public charities, and none of whom has access to a similarly priced commercial alternative for the same consolidated services, and also based on the understanding of the proposed fee CPCA will charge members relative to its cost, we believe the proposed CEHR program has a causal relationship to CPCA's exempt purpose and is not unrelated business.

3. Risk Mitigation Measures. We recommend CPCA proactively engage in risk mitigation measures, including, but not limited to, the following: obtain appropriate types and levels of additional insurance; develop and use its own BAA template; draft User license agreements; conduct comprehensive review of existing policies, procedures, risk management

plan and other safeguards to update and include CEHR requirements; implement audit controls, hardware and software, and procedural mechanisms.

4. Governance. A successful launch of the new CEHR venture will require CPCA to dedicate significant resources, including staff time and funding. It will also require an effective operations and oversight framework. After reviewing CPCA's governing documents and structure, we recommend the following roles and responsibilities

Executive Committee of the Board of Directors. The CPCA Bylaws create this 10-member committee, and grant its power and authority. The Executive Committee would serve in its fiduciary capacity to provide governance oversight and ensure CPCA has adequate resources and proper controls in place to successfully advance this new component of the organization's mission. If CEHR is operated as a CPCA program, the Executive Committee and the Board of Directors would be the ultimate decision-makers regarding CEHR. The Executive Committee could approve the business plan and budget, review and sign the EPIC agreement, and establish and monitor benchmarks for the CEHR program. CPCA staff would provide the Executive Committee with updates regarding progress, challenges and timelines. The Executive Committee would keep the Board of Directors informed and would identify items to present to the full Board for information or approval.

Technical Advisory Committee. The Committee charter establishes a group of dedicated members who would provide CPCA staff with input from the User perspective. The Committee would be advisory in nature, and would not be a decision-making body. This Committee provides an effective means of communication between the User members and CPCA staff: Committee members can provide CPCA staff with ongoing programmatic and technological input, and CPCA staff can solicit feedback and provide updates.

CPCA Staff. CPCA leadership would develop the business plan for Executive Committee approval, negotiate with EPIC, and engage outside support and experts in the development and implementation of the CEHR. CPCA staff would meet regularly with the Technical Advisory Committee to solicit feedback and input in developing the CEHR. CPCA leadership would provide regular updates to the Executive Committee. CPCA management would make decisions regarding the implementation and operations of CEHR within the framework established by the Board for CPCA's overall strategy and direction.

CPCA/Epic Partnership Exploration
Technical Advisory Committee Charter

PURPOSE STATEMENT

The intent of exploring a relationship between Epic and CPCA would be to develop a cloud-hosted instance of the Epic Electronic Health Record (EHR) that would be customized to meet the needs of California community health centers. **The purpose, then, of a member-driven, technical advisory committee will be to:**

- Define the specifications for a California health center-specific instance of Epic, to include such issues as standardized reports, templates, lab interfaces and user functionality.
- Identify needed processes to ensure the future development of feature sets that are integral to the delivery of care within health centers and that also ease the challenge of meeting Meaningful use, OSHPD, UDS, CP3, such as:
  - Supporting concepts such as the Patient Centered Medical Home, integrated Behavioral Health Care, integrated Oral Health Care, Quality Improvement initiatives, and other significant FQHC needs.
  - Focusing on feature & functionalities already in development by Epic for parallel markets that support member/roster management, documentation and delivery of alternative touches, approaches to billing for nontraditional touches, and maximizing revenue and quality under value-based payment models/alternative payment models.
  - Support for the broad set of enhanced primary care specialties within our California Clinics and Community Health Centers.
- Ensure Epic deployments will be configured to support interconnectivity with local/regional hospital based-Epic installs and any regional health information exchange initiatives within California to ensure patient continuity of care.
- Ensure Epic installation processes allow for local customization and reporting needs.
- Inform data governance agreements around how tool revisions and future programming needs are prioritized and moved forward.

BACKGROUND CONTEXT

The following factors play heavily into the need for a community-based health center specific EHR tool that serves as a statewide HIT aggregator and allows health centers to influence the health care system as a network of safety net, health care providers:

- Currently, the EHR concentration in California centers largely around 2 legacy vendors (6-8 years).

- There exists fragmentation and lack of coordinated deployments (100 + unique deployments)
- With current EHR deployments, there are missed opportunities for collaborative pricing negotiations and shared implementation & maintenance costs
- Communication with vendors is disjointed, and is localized by health center or consortium
- CHCs report significant hosting and downtime challenges, as well as inadequate support from vendors
- CHC vendor partnership autonomy often results in differing degrees of customization (and cost), and inhibits collaboration on CCHC content development (e.g. CP3, BH, OSHPD, UDS)
- CHCs report large physician burnout, dissatisfaction, and turnover due to EHR, further exasperating the primary care workforce shortage.
- The current EHR landscape does not readily support continuity of care and interoperability

Additionally, through conversations with statewide and national health care leadership, funders, stakeholders, and partners during CPCA's most recent strategic planning process identified the following external contextual factors as evidence for the need of an integrated HIT solution for CHCs:

- There exists patient and payer demand for increased integration and communication between providers along the health care delivery system continuum.
- HIT partnerships are being initiated by hospitals/larger health systems, and are potentially threatening CHCs ability to own and manage their own patient data (CHCs feeling vulnerable to vertical integration threats).
- Across the healthcare system, there has been a call for health care delivery system partners, including community-based health centers, to demonstrate their value and cost effectiveness through real-time, reliable data.
- The move towards population health management and addressing social determinants of health requires unique shifts within current HIT functionality – yet there is no centralized or agreed upon source that drives these necessary changes.
- CPCA and its members have recognized how integral Health IT is to the delivery of care, patient access, demonstration of value, mechanisms for reimbursement and overall sustainability of CCHCs
- The CP3 initiative in California requires specific EHR functionality, including panel management, tracking of nontraditional touches, and patient segmentation, a significant portion of which is not standardly available among current EHRs

With that said, the California Primary Care Association seeks to serve as a statewide facilitator to identify and push for needed HIT changes that support specific, community-based, health center systems of care; and to create opportunities for health centers to move towards a centralized HIT infrastructure that can collectively articulate the value of community health

outcomes in addressing the Quadruple Aim and positively impacting the communities they serve.

TEAM PROCESSES & MANAGEMENT

Team Meetings

Meetings will be held at least monthly via conference call, which will be coordinated by CPCA staff. CPCA staff will do their best to set meetings dates and times that are feasible for all members to join.
At this time, the Technical Advisory Committee is needed from June thru December 2017. At the end of 2017, the committee can determine if further work is needed.

Decision Making

When possible, all decisions will be made by consensus. While most, if not all, of the communication will be conducted via conference call or email, committee members may be asked to verbally indicate consent when discussing decision items.

Team Communication

We will communicate primarily through email and phone communication. A Technical Advisory committee roster will be made available to committee members ONLY to support group-wide communication.

Process Roles

- *Committee Chair*: Will work with CPCA staff lead to ensure meeting agendas are ready and will help facilitate meeting discussions.
- *Process Monitor*: CPCA staff lead will send out meeting announcements, serve as time keeper, and take meeting notes when needed.
- *Committee Members*: Committee members are expected to attend all calls/meetings. We understand extenuating circumstances happen, and the CPCA staff lead will make sure to forward meeting minutes or will solicit input from members that are required to miss a meeting.
- *Facilitation:* We have chosen to utilize outside support for the facilitation of this Advisory Committee. Starling Advisors has expertise in both EHR implementation, working with Health Centers on significant shared programs, and has been involved in developing the business planning work associated with this endeavor and will facilitate the meetings for the immediate future.

CPCA/Epic Partnership Exploration
Executive Committee Project Charter

ROLE OF THE EXECUTIVE COMMITTEE

The intent of exploring a relationship between Epic and CPCA would be to develop a cloud-hosted instance of the Epic Electronic Health Record (EHR) that would be customized to meet the needs of California community health centers. **The purpose, then, of Executive Committee project oversight will be to provide guidance and support around the partnership and business model development, ensuring the following project requirements can be met:**

- CPCA can secure the competitive standardized non-profit contract and pricing for all Epic licensing needs (including ancillary products such as patient portal) that takes into consideration:
  - Volume purchasing
  - Potential market opportunity for Epic within CCHCs
- Pre-existing non-profit pricing models for Epic
- Epic's philanthropic commitment to community health centers (significant subsidies possible as part of their commitment to FQHCs).
- CPCA is able to secure competitive standardized non-profit pricing for all Epic services, support and maintenance.
- CPCA is able to secure competitive standardized non-profit pricing for hosting by Epic (i.e. this will be hosted in full by Epic so that neither CPCA nor the CCHCs would have to purchase & maintain server hardware or software.)
- CPCA's business model incorporates a revenue stream sufficient to support related services and programs for the broader CPCA membership.
- Review/recommend approval to the board the business model for CPCA including CPCA's role in the ongoing management and support of the EHR program.
- Review/recommend approval to the board the business plan including the pro forma.
- Review/recommend approval to the board the legal structure for the business model.

BACKGROUND CONTEXT

The following factors play heavily into the need for a community-based health center specific EHR tool that serves as a statewide HIT aggregator and allows health centers to influence the health care system as a network of safety net, health care providers:

- Currently, the EHR concentration in California centers largely around 2 legacy vendors (6-8 years).
- There exists fragmentation and lack of coordinated deployments (100 + unique deployments)

- With current EHR deployments, there are missed opportunities for collaborative pricing negotiations and shared implementation & maintenance costs
- Communication with vendors is disjointed, and is localized by health center or consortium
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- CHC vendor partnership autonomy often results in differing degrees of customization (and cost), and inhibits collaboration on CCHC content development (e.g. CP3, BH, OSHPD, UDS)
- CHCs report large physician burnout, dissatisfaction, and turnover due to EHR, further exasperating the primary care workforce shortage.
- The current EHR landscape does not readily support continuity of care and interoperability

Through conversations with statewide and national health care leadership, funders, stakeholders, and partners during CPCA's most recent strategic planning process identified the following external contextual factors as evidence for the need of an integrated HIT solution for CHCs:

- There exists patient and payer demand for increased integration and communication between providers along the health care delivery system continuum.
- HIT partnerships are being initiated by hospitals/larger health systems, and are potentially threatening CHCs ability to own and manage their own patient data (CHCs feeling vulnerable to vertical integration threats).
- Across the healthcare system, there has been a call for health care delivery system partners, including community-based health centers, to demonstrate their value and cost effectiveness through real-time, reliable data.
- The move towards population health management and addressing social determinants of health requires unique shifts within current HIT functionality – yet there is no centralized or agreed upon source that drives these necessary changes.
- CPCA and its members have recognized how integral Health IT is to the delivery of care, patient access, demonstration of value, mechanisms for reimbursement and overall sustainability of CCHCs
- The CP3 initiative in California requires specific EHR functionality, including panel management, tracking of nontraditional touches, and patient segmentation, a significant portion of which is not standardly available among current EHRs

With that said, CPCA seeks to serve as a statewide facilitator to identify and push for needed HIT changes that support specific, community-based, health center systems of care; and to create opportunities for health centers to move towards a centralized HIT infrastructure that can collectively articulate the value of community health outcomes in addressing the Quadruple Aim and positively impacting the communities they serve.

Based on site visits to Epic headquarters in March and June 2017 as well as extensive conversation with Epic team members, CPCA staff and leadership are confident in Epic's commitment to safety net providers as well as the capacity of the Epic platform to meet the technical needs of FQHCs. As a privately held company, Epic is aligned with CPCA and CPCA members in its commitment to population health and continuity of care. Specifically:

- FQHC Commitment and feature set
    - CEO (Judy Faulkner) has spent several hours with CPCA team, reiterated commitment to FQHCs and CPCA team felt she demonstrated a keen understanding of FQHCs
    - Judy Faulkner's husband, Dr. Gordon Faulkner is a practicing Pediatrician at Access Community Health FQHC in Madison, WI
    - While the majority of Epic purchasers are hospitals or hospital affliated providers, Epic does have long-term experience on a national basis with FQHCs that implemented the Epic platform independently
    - Epic offers dental capabilities (interface with Dentrix and a pre-built dental platform-Wisdom); BH integration pre-existing with group visits and enhanced feature set in next release (next year) via a new module; sliding fee scale; reporting support for UDS/RSR
    - The Epic team has been supporting UDS for multiple years; Epic product managers have demonstrated UDS functionality now pre-built into Epic
    - Epic is participating in the Mitre HRSA workgroup to further automate UDS
- Epic as Unified Single Instance
    - Epic is typically deployed as a single instance (database) with personalization and branding features available at sub-levels
    - This approach has delivered significant value (Total cost of ownership, Return on Investment) with customers in reduced deployment costs, reduced support and maintenance costs, standardization, single points of integration with 3rd party vendors such as labs, and improved fiscal metrics
    - This approach will also activate population health at all levels; Epic product Health Planet provides population health management
    - This approach is different from how systems such as NextGen are implemented in significant ways – this approach is more in line with how cloud based EHRs would be deployed in the future (very little customization available and large focus on personalization/configuration)

COMMITTEE PROCESSES & MANAGEMENT

CPCA will use the existing, quarterly Executive Committee meeting schedule and decision-making processes to hold EPIC business development conversations and/or will work with CPCA Board President, Naomi Fuchs, to schedule conference calls on an as-needed basis.

Epic Partnership
Project Development Budget
March 2017 - September 2017

Consultant Costs		
Starling Advisors - General Planning	$30,000	
Starling Advisors - Business Planning	$18,000	
Starling Advisors - Technial Advisory Planning/Facilitation	$20,000	
BlueNovo - Technical Advisory Planning	$21,000	
Subtotal		**$89,000**
Legal: Structure/Contract		
Stoel Rives		**$75,000**
Travel		
March 2017 Madison, WI	$5,000	
June 2017 Madison, WI	$5,000	
Subtotal		**$10,000**
BUDGET TOTAL		**$174,000**

California Primary Care ASSOCIATION

Roles and Responsibilities

Party	Phase 1: Negotiation and Member Engagement	Phase 2: Initial Build and Implementation (Cohort 1-2)	Phase 3: Maintenance (Cohort 2-3+)
CPCA	• Overall leadership of the program to include FTE recruitment for a Project Director, Technical Manager, Training Manager, 1-2 Application Managers, 1-3 Epic Certified Trainers (will also rely on CPCA's CMO to serve as Clinician Champion) • Incorporation into governance processes • Lead communicator with membership on program development • Lead communicator	• Convene the necessary members to participate in initial design / requirements sessions • Provide project management, training program management, and physician champion • Develop and manage program governance and member engagement structure • Maintain team of 4-6 dedicated FTEs (Project Manager, Technical Manager, Training Managers, Physician Champion, Application Managers, Epic Certified Trainers)	• Maintain team to identify and anticipate state-specific needs and maintain a member facing component to the program • Ongoing marketing of the program • Vendor management
Clinics	• Provide input to process (survey and conversational) • Initial cohort organizations to Identify Epic implementation team to serve as IT, clinical and operational lead. For the clinical lead, a typical model might be identifying 2-3 Physician Champions that can provide ***part-time*** leadership and support to the project based on their availability.	• Initial cohort will participate in the initial statewide design and build • Pilot organizations will need to hire 4+ coordinator/analyst positions to support installation (at least 1 dedicated FTE each to support Outpatient Clinical Systems, Access and Revenue Systems, Business Intelligence, and Cross Application Support)	• Tier 1 support (either staffed or contracted) o User Management o Break/fix o Login/Password Issues o Helpdesk – IT/laptop/computer o Internet/Wide Area Network connectivity

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Epic	• Demonstrating the system via webinar and in person at CPCA events.
	• Articulate the FQHC components and capabilities of the Epic system.
		• Developing the foundations FQHC module – the starting point for the CPCA-specific module.
		• Provide a project management team/resource.
		• Develop and harden the server, hosting, and security infrastructure.
		• Lead initial implementation
		• Provide cross-application analyst support
		• Provide technical/infrastructure support (via Epic hosting)
			• Tier 3 support:
			  ○ Bug fixes
			  ○ Upgrades/updates
			  ○ Code changes
			  ○ Vendor troubleshooting
			  ○ Hosting issues
			  ○ Ongoing support for implementations, including:
			  ▪ Project management
			  ▪ Train-the-trainer
			  ▪ Go-Live support

Third Party Implementation Vendor	• Technical expertise on EHR implementation processes and technology
	• Development and maintenance of initial build and implementation planning
	• Development of support model (three tiers)
		• Manage vendor relationship in collaboration with CPCA, including Ambulatory Clinical Applications and Access and Revenue Applications management
		• Participate (with Epic) in initial configuration of EHR, interfaces, and reporting needs
		• Provide analyst support for various Epic applications, including Outpatient Clinical Systems, Access and Revenue Systems, and Business Intelligence
		• Get certified with Epic on Train the trainer and develop training curriculum and rollout methodology.
		• Manage and staff implementation, training, and go-live teams as needed
		• Management of data conversion processes
			• Tier 2 support, including:
			  ○ Issue troubleshooting
			  ○ System errors
			  ○ Enhancement requests
			  ○ Advanced configuration
			  ○ Workflow changes & optimizations
			• Management of ongoing health center implementations
			• Ongoing trainings development and participation (as-needed)
			• Provide cross application support
			• Provide technical/infrastructure support
			• Provide analyst support for various Epic applications, including Outpatient Clinical Systems, Access and Revenue Systems, and Business Intelligence

Scenario 2: 5 Year Pro Forma, 3M encounters

	Oct '17 - Sep '18	Oct '17 - Sep '18	Oct '19 - Sep '20	Oct '20 - Sep '21	Oct '21 - Sep '22
Staffing	$1,337,300	$1,916,400	$1,916,400	$1,916,400	$1,916,400
Implementation Costs	$2,057,143	$1,542,857	$1,800,000	$600,000	$2,400,000
Hosting	$592,495	$2,117,850	$3,139,200	$3,566,310	$4,476,240
Software	$-	$1,004,605	$1,999,464	$2,379,464	$3,231,185
TOTAL COST	$3,986,938	$6,581,712	$8,855,064	$8,462,174	$12,023,825
Implementation Revenue	$1,371,429	$1,028,571	$1,800,000	$600,000	$2,400,000
Operating Revenue	$-	$4,706,510	$9,255,134	$11,006,747	$14,958,906
TOTAL REVENUE	$1,371,429	$5,735,081	$11,055,134	$11,606,747	$17,358,906
NET	$(2,615,509)	$(846,631)	$2,200,070	$3,144,573	$5,335,081
BREAK EVEN	$(2,615,509)	$(3,462,141)	$(1,262,071)	$1,882,502	$7,217,582

Assumptions factored into the model

1 - Health Centers pay actual implementation costs (except first three CHCs.)

2 - $6 per encounter. This is pre-negotiation.

3 - There will be exploration of other options for lessening capital required up-front.

4 - There will be agreed upon points at which per encounter cost will come down as adoption grows. This is not factored into this model at this time.