Board of Directors

Friday, July 13, 2018
10:15a – 12:15p
CPCA Office

Scott McFarland, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Scott McFarland, Chair	A
II. Approval of Agenda		Scott McFarland, Chair	A
III. Consent Calendar • Approval of Minutes • Approval of 2019 Meeting Calendar	• April 27, 2018, Minutes • July 3, 2018, Board call Minutes • 2019 Meeting Calendar	Scott McFarland, Chair	I/D/A
IV. CEO Report	• Final 2018 Board Calendar • *Memo:* Training & TA Report • *Concept Paper*: Planning for the Future of Health Center Leadership	Carmela Castellano-Garcia	I/D
V. Financial Presentation	• Board Financial Presentation (3.31.18 and 5.31.18) • Balance Sheets as of 5/31/18 (3)	Sandy Birkman	I/D/A
VI. Epic Discussion	• PowerPoint slides from 7/3/18 Board call	Scott McFarland, Chair	I/D/A
VII. Association Health Plan Vendor Update	• *Memo*: Association Health Plan Strategy		
VIII. Strategic Plan Update	• PowerPoint slides	Carmela Castellano-Garcia	I/D
IX. Approval of Committee Action Items and Brief Informational Reports	• Audit • Clinicians • Executive • Finance/Ventures Finance • 330 • Governance • Government Programs • Legislative • SPARC • Workforce	• Tony Weber • Ellen Piernot • Scott McFarland • David Vliet • Louise McCarthy • Ben Flores • Robin Affrime • Kevin Mattson • Tim Rine • Paulo Soares	I/D/A
X. NACHC Update (recurring)	• NACHC Report to CPCA Board of Directors	David Vliet, NACHC Region IX Representative	I
XI. RAC Update (recurring)		Henry Tuttle, RAC Chair	I

XII. *Guests:* Jim Luisi, NACHC Board Chair and CEO/ED at North End Waterfront Health; and Lathran Woodard, CEO, South Carolina PCA and NACHC Chair-elect	• Bio – Jim Luisi • Bio – Lathran Woodard • Listening Tour Framework	James Luisi and Lathran Woodard	I/D
XIII. Closed Session (for Board members only) re: CEO Assessment		Scott McFarland, Chair	I/D/A
XII. Adjourn		Scott McFarland, Chair	A
Additional Attachments:	• CPCA Code of Conduct • Board Attendance Policy		

Board of Directors Meeting

April 27, 2018

Meeting Minutes

Board Members Present : Scott McFarland (Chair), Robin Affrime, Isabel Becerra, Doreen Bradshaw, Deb Farmer, Ben Flores, Cathy Frey, Naomi Fuchs, Jane Garcia, Britta Guerrero, Nik Gupta, Sherry Hirota, Kerry Hydash, Deb Lerner, Marty Lynch, Kevin Mattson, Louise McCarthy, Danielle Myers, Christine Noguera, Tim Rine, Ralph Silber, Paulo Soares, Graciela Soto-Perez, Marty Szecsey, Henry Tuttle, Richard Veloz, and Paula Zandi

Members Absent: Anitha Mullangi, Jackie Ritacco and David Vliet

Guests: Carl Coan, Becky Lee, Rakesh Patel, Andrew Principe, Karen Lauterbach

Staff: Carmela Castellano-Garcia, Robert Beaudry, Heather Barclay, Sandy Birkman, Andie Patterson, Meagan Nousaine, Michael Helmick, Kearsten Shepherd, Ginger Smith, Cindy Keltner, Nataly Diaz, Emili LaBass, Tiffany Ruvalcaba, Emily Henry, Peter Dy, Andrea Chavez, Buddy Orange, Lucy Moreno, David Anderson, Beth Malinowski, Meaghan McCamman, Val Sheehan, Mike Witte, Jodi Samuels

3. Closed Session

The meeting began with a Closed Session for Board members only for the purpose of discussing the CEO's annual evaluation.

1. Call to Order

Board Chair Scott McFarland called the meeting to order at 11:00a.

2. Approval of Agenda

Motion

A motion was made and seconded to approve the agenda as presented. (Bradshaw/Gupta). **The motion carried.**

4. Consent Calendar

Motion

A motion was made and seconded to approve the Consent Calendar as presented. (Farmer/Soares). **The motion carried.**

5. CEO Report

Carmela Castellano-Garcia provided a brief report, noting her appreciation of both staff and members for another successful Day at the Capitol yesterday. She noted the 2018 Conference Awardees will be

Herrmann Spetzler (posthumously) as a CPCA Hero and Robin Affrime as a Clinic Legacy awardee given her retirement this year. A training/TA update memo was provided in the meeting packet, as well as a Programs update and EHR update memo. CPCAs internal organizational development efforts are moving ahead under Buddy Orange's direction and leadership.

6. Speaker – Erica Murray, President and CEO, Calif. Association of Public Hospitals

Erica briefly introduced herself and members were provided with PowerPoint slides that she reviewed. Members Ralph Silber and Marty Lynch were thanked for their CAPH Board service. Erica spoke to the CPCA/CAPH partnership and the similarities between the two organizations. She detailed CAPHs efforts around delivery system, payment reform and the delivery system reform incentive program (DSRIP) and also discussed 1115 waiver efforts. She also reviewed the benefits of standardization and the application of lessons learned from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. Erica detailed Alternative Payment Methods and other waiver programs, including Global Repayment Program and whole person care, including related successes. She concluded with sharing lessons around the conversion from volume-based funds to a performance-based structure, noted there is still much work to be done, and that further improvements in care delivery need to focus on population health and social determinants of health, and there is time to do this work as the next waiver, if there is one, would likely begin in 2021.

Erica then took a few questions from the members and one item she stressed is that the Safety Net Institute is a value-based strategy/program where everything comes back to data. She noted that UCLA acceptance of managed care will be changing. She welcomes the opportunity for direct outreach if anyone has anything to discuss in further detail.

7. Financial Presentation

Sandy Birkman, CPCA's Director of Finance and Operations, provided a financial report update at the request of the Board. She detailed the current financial report and there was discussion about how loss items are budgeted and how cash from prior years was used to cover any losses. Cash was restricted at the time of receipt and was intended for a specific project. There was discussion about combining Advocates, which is a CPCA subsidiary, and staff had been requested to show all three (CPCA, Advocates and Ventures) at once for transparency. On the Profit and Loss statement, there will be a deficit shown as $1.8M from restricted funds was already recognized on the books, so technically a loss will be shown. It was clarified that the Finance Committee will still have an opportunity to report out during Committee Action items – this is only a supplemental presentation. It was also noted that the FY Budget should be its own line item for approval.

Motion

A motion was made to remove the FY 2018-19 Budget from the Consent Calendar, to be voted on during the Finance Committee report. (Fuchs/Bradshaw). **The motion carried.**

8. Epic Partnership Update

Scott McFarland provided the motion made by the Executive Committee to kick-off this item:

Motion

A motion was made and seconded to recommend the Board approve CPCA staff to develop definitive documents (aka contractual agreements) for the loans, health center contracts and Epic contract and bring them back, along with financial ratios and a related term sheet, for review by a joint Committee (Executive and Finance) which will make a final recommendation to the Board of Directors. (McFarland/Bradshaw). **A vote was not called and discussion ensued.**

Robert Beaudry and consultant Andrew Principe provided an update on negotiations and partnership developments. Since negotiations began, there has been a 22% decrease in related costs. For loans, Capital Impact, NCB and PCDC will be considered. It was noted that a special Board meeting will likely be needed before July to move forward in a timely manner with Epic. This item is being held for further discussion under Committee Action reports.

9. Approval of Committee Action Items

Audit – no report.

Clinicians – no actionable items.

Executive - Chair Scott McFarland re-read the motion from Executive Committee:

> **Motion**
>
> A motion was made and seconded to recommend the Board approve CPCA staff to develop definitive documents (aka contractual agreements) for the loans, health center contracts and Epic contract and bring them back, along with financial ratios and a related term sheet, for review by a joint Committee (Executive and Finance) which will make a final recommendation to the Board of Directors. (McFarland/Bradshaw). **A vote was not called and discussion ensued.**

Andy and Robert answered members' questions, noting that the health centers who use the product generate the revenue. The current per encounter rate negotiated with Epic is $4.50/encounter and there are no additional licenses to purchase or upfront costs to gain access to the software, and this is the first time Epic is doing this. The program will be fully-hosted and will not include licenses. There may be some fees such as data transfer fees but most items are already capitalized into the product. The direct cost to Epic for hosting averages $3.78, so overhead is kept to $.75/encounter. These numbers could still change but estimates have been made conservatively. The first three (3) participants will be heavily involved in developing the CA-specific configuration. The total to get the first three (3) centers going is approximately $4.6M, of which about $1.4M would be for the CA-specific configuration. This does benefit clinics who join later and will reap these benefits. Members would like to see the ongoing vs. one-time costs. CPCAs estimates to date do include staffing and what it will take to get through the standard configuration.

There was concern about potential conflicts of interest with the eight (8) members who have signed MOUs. Carmela noted that we did get a legal opinion on that matter and that it doesn't present a conflict, noting that Centene and the branding campaign were also items that were voted on by

members with an interest, and that conflicts are intended to be personal conflicts, of which there are none regarding an Epic partnership. Members also reiterated they are here with their Board hats, not clinic hats, on and are voting for risks to CPCA, not to individual member health centers.

Members who have signed an MOU to date are:

- Western Sierra Medical Clinic
- Mountain Valleys Health Center
- Community Medical Centers
- Golden Valley Health Center
- AltaMed Health Services
- San Ysidro Health Center
- Neighborhood Healthcare
- Borrego Community Health Foundation

There are still some risk and loan concerns and the motion addresses the desire to see more information in those areas. Recouping the loan is another risk piece to examine further.

Motion

A motion was made and seconded to recommend the Board approve CPCA staff to develop definitive documents (aka contractual agreements) for the loans, health center contracts and Epic contract and bring them back, along with financial ratios and a related term sheet, for review by a joint Committee (Executive and Finance) which will make a final recommendation to the Board of Directors. (McFarland/Bradshaw). Three (3) "nay" votes and four (4) abstentions were noted. **The motion carried.**

Finance – Kevin Mattson, acting Chair, presented a revised FY 2018-19 budget, noting that previously received income becomes reserves as CPCA cannot recognize funds twice. Accordingly, the budget should show a $1.7M deficit. In 2015/16 Foundation funds were received (mostly for consultant dollars) and recognized as a contribution and funds will be expended this year. Members noted the budget is still balanced and the funds are being used as intended. It was suggested that for the FY 2019-20 budget, an initial draft be presented in January 2019 so the Committee can look at trends going forward. The current trends resulted from the CP3 monies received in 2015/16 (which showed a $2.6M profit that year). Members were reminded about the clean fiscal audit presented last October, and if the $1.7M were fixed costs, the situation would be different.

Motion

A motion was made and seconded to approve the FY 2018-19 Budget as presented. (Mattson/Lynch). **The motion carried.**

330 Committee – Louise McCarthy presented two items:

Motion

A motion was made and seconded that CPCA approach DHCS and negotiate a written definition of "incentives" that may be excluded from reconciliation, to be used on a go-forward basis,

based upon the P4P white paper that was previously approved by the Board. (McCarthy/Myers). **The motion carried.**

Motion

A motion was made and seconded to approve CPCA staff's proposition to utilize the same methods to engage members in providing feedback as was used for SPA 18-003. This process included CPCA staff directly meeting with DHCS approximately every 2-4 weeks and then holding a webinar or call with the SPA subcommittee in between the DHCS meetings. Feedback gathered from members during those meetings is then shared with DHCS. One additional component CPCA proposes to include is to facilitate a health center and DHCS meeting per each major item of the Four Walls, i.e. homeless, telehealth, etc. (McCarthy/Myers). **The motion carried.**

There was brief discussion about meetings being cancelled frequently by DHCS and that there is value in holding the meeting with just members to enhance discussion.

Governance – Ben Flores presented two (2) membership applications for approval

Motion

A motion was made and seconded to approve community health clinic membership to Families Together of Orange County. (McCarthy/Becerra). **The motion carried.**

Motion

A motion was made and seconded to approve community health clinic membership to White Memorial Community Health Center. (McCarthy/Becerra). **The motion carried.**

Legislative – Britta Guerrero presented the motions from this Committee as follows:

Motion

A motion was made and seconded to direct CPCA staff to use the 2018 policy priorities to guide budget advocacy. Staff are advised to prioritize 340B and Medi-Cal coverage expansion, while also being supportive of other budget proposals that are in keeping with our core priorities. (Guerrero/Farmer). **The motion carried.**

Motion

A motion was made and seconded to move from WATCH to SUPPORT on AB896 (Garcia, Eduardo) Public Health: graduate medical education. (Guerrero/Myers). **The motion carried.**

Motion

A motion was made and seconded to move from WATCH to SUPPORT on AB1975 (Gipson) Emergency medical services: behavioral health facilities and sobering centers. (Guerrero/McCarthy). **The motion carried.**

Motion

A motion was made and seconded to move from WATCH to SUPPORT on AB 2850 (Rubio) Nurse assistant training programs: online and distance learning (Guerrero/Flores). **The motion carried.**

Motion

A motion was made and seconded to approve all recommended bill positions from staff on both new bills of interest and changes to current gills as presented on April 26, 2018. (Guerrero/Myers). **The motion carried.**

Motion

A motion was made and seconded to approve CPCAs Proposed Califonria Health Center Vision and Principles for the Future of a Health Care System guidelines dated March 3, 2018, and presented to the committee on April 26, 2018. (Guerrero/Myers). **The motion carried.**

SPARC – no report.

Workforce – no report.

10. NACHC Report

Henry Tuttle provided a brief report in David Vliet's absence, noting that NACHC Board Chair James Luisi will be coming out to California for a "Listening Tour" and will be coming to the July Board meeting to hear from CPCA.

11. RAC Report

Henry Tuttle, RAC Chair, provided a brief report noting that RAC has a Rural Retreat coming up in May. The group plans to recommit to the vision of RAC and will also discuss priorities for established goals. There will also be a statewide assessment/Consortia Scan report component with Bobbie Wunsch and Laura Hogan. A related report will be shared with Funders in June.

12. Adjourn

Motion

A motion was made to adjourn the meeting at approx. 1:00p. (McCarthy/Becerra). **The motion carried.**

Board of Directors Informational Call

July 3, 2018

Meeting Minutes

Board Members Present : Scott McFarland (Chair), Robin Affrime, Isabel Becerra, Deb Farmer, Cathy Frey, Naomi Fuchs, Britta Guerrero, Nik Gupta, Kerry Hydash, Marty Lynch, Louise McCarthy, Tim Rine, Ralph Silber, Graciela Soto-Perez, Henry Tuttle, and David Vliet

Guests: Andrew Principe

Staff: Carmela Castellano-Garcia, Robert Beaudry, David Anderson and Heather Barclay

Board Chair Scott McFarland began the meeting at 1:05p and noted that this is an informational call only; no action is being requested of the Board today.

Consultant Andy Principe reviewed the PowerPoint presentation which also served as the agenda for the call. He provided status updates with regard to contract and pricing negotiations and there was discussion about the different related fees associated with the $4.50 per encounter pricing, and it was noted that health centers will pay monthly based on encounter usage. There are additional implementation and training costs that were detailed.

There was a question about the health center contract what additional services as detailed in the contract will cost. David Anderson noted the contracts being reviewed by the Technical Advisory Group (TAG) and staff will be sure to address this as there is a missing piece regarding implementation costs. Implementation estimates have been provided previously, but costs will depend on the level of support a health center requires. The complete cost of entry per health center was requested (as accurate as can be estimated). David noted two scenarios: 1) initial implementation (per encounter; including localized costs and training); and separately, 2) additional services that could be needed and what are those costs? Members requested more definitive information about these potential costs, including data migration/conversion.

David also reviewed potential penalties: A) in event a contract is terminated, a 12-mo. fee would be due; B) Costs associated with the loan is second piece and would be added to the 12-mo. fee. That is the penalty/reimbursement required. No health center collateral is required in this initiative. There was inquiry if we'll be reviewing members' financial statements to ensure solvency and that information would be reviewed with Epic, not the Board. Health center contracts have not yet been finalized, so member qualifications are still TBD. There was an inquiry of what it will take for the initiative to be profitable and that depends largely on which health centers sign up and how many encounters they estimate, but essentially 5-6 health centers bringing 200-300k encounters would reach the "break even" point. Bigger health centers are needed to reach the 3.6M annual encounter goal.

It was noted that BKD will be doing an independent analysis of this initiative in advance of the July 13 Board meeting. Robert Beaudry noted that when we built the model, we used PCDC, NCB, Starling Advisors, PivotPoint consulting, and Epic.

Worst case scenarios were discussed in the event the encounter numbers are not met, and who would be responsible for payment to Epic. In short, CPCA would be on the hook if all funds were drawn down and we didn't reach our goal numbers. Terms are amortized over 15 years but the repayment model is for 7 years' repayment. If numbers aren't reached in 7 years, we can spread the costs over the full 15 year period. Robert reiterated that funding Option C – the New Market Tax Credit, is what is recommended. If the Board approves the funding mechanism, we'd get started on the underwriting process immediately. A traditional loan would be set up more quickly than the NMTC, which requires setup costs.

It was noted that BKD will review and format the Pro Forma as requested and to ensure it meets accounting standards. Staff was requested to double check all figures. Overhead costs will also be reviewed by BKD. Members had questions about the implementation costs and per encounter fees, including payout to previous vendors which has an impact on the encounter pricing and it was noted that running two systems at once is not recommended.

There was also discussion about this initiative compared to OCHIN. The benefits and differences were reviewed, including the benefits of CPCA being in the EMR arena with other vendors and having an industry-driving option. The initiative was also taken on at the request of members.

Board Chair Scott McFarland reiterated that BKD will be conducting an independent review of the CPCA/Epic initiative and more information will be provided at the July 13 Board member. Members were thanked for their participation and the call was concluded at 2:15p.

DRAFT CPCA 2019 BOARD MEETING CALENDAR

** Dates will be based on event space availability, even after Board approval.

Board & Committee Meetings

Thursday - Friday, February 7-8, 2019 — Sacramento – CPCA Office

(NACHC Winter Strategy Mtg. - January 23-25, 2019 in Delray Beach, FL)

Day at the Capitol / Board & Committee Meetings *

* Dates are proposed; requests can be submitted to Capitol 12 mos. in advance

Wednesday, Apr. 24, 2019	Day at the Capitol & Reception	Sacramento
Thursday-Friday, Apr. 25-26, 2019	Committee & Board meetings	Sacramento

(NACHC P&I – March 27-31, 2019 in Washington, D.C.)
(NACHC Conf. for Agricultural Worker Health – May 6-8, 2019 in Albuquerque, NM)

April 20-27, 2019	*(Passover Week)*
April 21, 2019	*(Easter Sunday)*

Board & Committee Meetings

Thursday-Friday, July 11-12, 2019 — Sacramento – CPCA Office

(NACHC CHI – August 16-20, 2019 in Chicago, IL)

**** Annual Conference / Board & Committee Meetings**

Tuesday-Wednesday, Oct. 15-16, 2019	Board & Committee meetings	Sheraton San Diego Hotel/Marina
Thursday-Friday, Oct. 17-18, 2019	Annual Conference	Sheraton San Diego Hotel/Marina

(NACHC FOM/IT Conference – Oct. 23-25, 2019 in Chicago, IL)
(NACHC PCA/HCCN Conference – Nov. XX, 2019 in XX)

Sept. 30, 2019	*(Rosh Hashanah)*
Oct. 9, 2019	*(Yom Kippur)*
Oct. 14-20, 2019	*(Sukkot)*

CPCA 2018 BOARD MEETING CALENDAR

** Dates will be based on event space availability, even after Board approval.

Board & Committee Meetings

Thursday - Friday, January 18-19, 2018 — Sacramento – CPCA Office

(NACHC Winter Strategy Mtg. – January 25-27, 2018 in Delray Beach, FL)

Day at the Capitol / Board & Committee Meetings

Wednesday, April 25 2018	Day at the Capitol & Reception	Sacramento – CPCA Office
Thursday-Friday, April 26-27, 2018	Committee & Board meetings	Sacramento – CPCA Office

(NACHC P&I – March 14-18, 2018 in Washington, D.C.)
(NACHC Conf. for Agricultural Worker Health – May 1-3, 2018 in San Antonio, TX)

Mar. 31-Apr. 7, 2018	*(Passover Week)*
April 1, 2018	*(Easter Sunday)*

Board & Committee Meetings

Thursday-Friday, July 12-13, 2018 — Sacramento – CPCA Office

(NACHC CHI – August 24-28, 2018 in Orlando, FL)

**** Annual Conference / Board & Committee Meetings**

Tuesday-Wednesday, October 2-3, 2018	Board & Committee meetings	Sacramento – CPCA Office
Thursday-Friday, October 4-5, 2018	Annual Conference	Sacramento Conv. Ctr.

(NACHC PCA/HCCN Conference – Nov. 14-16, 2018 in New Orleans, LA)
(NACHC FOM/IT Conference – Oct. 16-18, 2018 in Las Vegas, NV)

Sept. 10, 2018	*(Rosh Hashanah)*
Sept. 19, 2018	*(Yom Kippur)*
Sept. 24-30, 2018	*(Sukkot)*

California Primary Care Association

INFORMATIONAL

Date: July 2, 2018

To: CPCA Board of Directors

From: Erin Perry, Assistant Director of Education and Training

Re: CPCA Training Program

MEMORANDUM

Attached is the training report for the 1st quarter of the 2018-2019 fiscal year. Below are the highlights of this report:

- FY 2018-2019 Quarter 1
  - **29** learning opportunities
    - Cohort 10 of CPCA's HealthManagement+ Program launched in July with 24 participants.
    - Webcasts, free recordings of training online, have been added for the first time to this report. The PRAPARE webcast had 156 views.
  - **Over 2,300 attendees** at in-person and online sessions
  - Average Satisfaction Score of 4.19 on a 5-point scale

- What's Ahead:
  - Cohort 11 of HealthManagement+ is slated to begin in September.
  - CPCA's Billing Managers Conference is on August 14-15, 2018 in Monterey, CA.
  - CPCA's CFO Conference is in Monterey, CA on August 16-17, 2018.
  - CPCA Annual Conference is October 4-5, 2018 in Sacramento.
  - And much more… take a look at the events calendar at www.cpca.org.

Any questions or inquiries regarding the Training Program can be addressed to eperry@cpca.org.

FY2018-19 Post Training Report

Quarter 1: April 2018 - June 2018
Updated: July 2, 2018

Date	Training Category	Title	Type	Number Attended/Lines**	Number of Additional Webinar Attendees*	Satisfaction Score (1-5)
4/3/2018	PCHH	Introduction to PCMH 2017	In Person	145	-	-
4/5/2018	PCHH	Advanced PCMH 2017	In Person	106	-	-
4/10/2018	HCO	Mental Health of Immigrant Children and Their Parents	Webinar	42	37	3.8
4/11/2018	HIT	RAND STUDY: Embedding WET Into Collaborative Care for PTSD	Webinar	61	-	-
4/12/2018	CP3	Cultivating and Diversifying California's Behavioral Health	Webinar	91	-	-
4/19/2018	Advocacy	Day At The Capitol: Preview Webinar	Webinar	129	-	-
4/19/2018	HCO	Building Readiness for Addressing SDOH: PRAPARE in CA	Webcast	156	-	-
5/3/2018	Workforce	Effective Onboarding: How to Set Up New Hires for Long-Term Success	Webinar	65	-	-
5/4/2018	O&E	2018 Outreach & Enrollment: Southern California Summit	In Person	87	-	-
5/9/2018	HCO	Public Charge: What Is It & How Changes Might Impact Clinics	Webinar	158	95	4.49
5/10/2018	Workforce	Taming Talent Tremors: Recruit, Onboard, & Develop CHC Staff	Webinar	35	5	3.9
5/15/2018	HIT	CPCA & NextGen: Understanding The MOU & New Solutions	Webinar	89	9	4.38
5/17/2018	EP	CMS EP Surveyor Training Part 1	Webcast		-	-
5/17/2018	EP	CMS EP Surveyor Training Part 2	Webcast		-	-
5/31/2018	HCO	Preparing for Your HRSA Site Visit	Webinar	179	49	3.95
5/30/2018	HCO	Breaking the Barriers: Colorectal Cancer Screenings in a Largely Hispanic FQHC	Webcast		-	-
6/2/2018	Clinical	Training for New Clinical Directors	In Person	29	-	-
6/3/2018	Clinical	2018 Region IX Clinical Excellence Conference	Boutique	154	-	4.3
6/7/2018	Data	Engaging Health Center Staff in Data Validation & Analytics	Webinar	75	29	3.9
6/12/2018	HIT	NextGen Interoperability	Webinar	55	2	4.5
6/13/2018	HCO	PACE: National Resources & Opportunities	Webinar	25	3	4
6/14/2018	Workforce	Physician Leadership: Key to HC Vitality (W)	Webinar	28	3	3.9
6/14/2018	PCHH	Q&A Office Hours with PCHH Practice Transformation Coaches	Webinar	63	-	-
6/19/2018	HCO	FTCA University	In Person	111	-	-
6/19/2018	CP3	SDOH Learning Cohort Webinar #3	Webinar	34	-	-
6/20/2018	HCO	Ensuring Access To Care Amidst Immigrant Fears	Webinar	24	11	4.6
6/21/2018	Human Resources	HealthManagement+ Cohort 10 Launch	Mixed	24	-	-
6/27/2018	Workforce	Shortage Designation Modernization Project	Webinar	75	19	4.5
6/29/2018	O&E	Outreach & Enrollment Northern California Summit	In Person	84	-	-
Totals/Average:			**29**	**2124**	**262**	**4.19**

*Includes additional attendees on connection with attendee for webinars as identified in evaluation data
** Not including Sponsors & Exhibitors
- Data not collected, pending, or not applicable.

Planning for the Future of Health Center Leadership
Concept Paper

Overview and Summary

The community health center (CHC) movement that started in the 1960's produced dynamic and visionary leaders who were committed to achieving social justice. The movement has benefitted tremendously from having these leaders involved and at the helm of their institutions for decades, but today, we are seeing many of those leaders step down and retire from their organizations. Anecdotally, at CPCA's 2017 Annual Conference, we honored nine Legacy Awardees, many of them long-time CEOs and executive directors and even founders of their health centers. The leadership turnover of CHCs creates a very timely and unique opportunity to examine the importance of leadership development and succession planning among CHCs.

One of the challenges facing CHCs is developing and supporting a strong pipeline of diverse leaders who have the skills, knowledge, and passion to be at the helm of CHCs in this ever-changing health care environment. CPCA's trusted position as the statewide association for CHCs and proven track record in training and education uniquely position it to play a central role in leadership development and succession planning. To address this issue and seize the opportunity to provide an innovative and comprehensive new leadership pathway, CPCA plans to (1) conduct a landscape survey and produce updated research about diversity within existing CHC leadership; (2) utilize these results to identify current and future pipeline gaps and needs; and (3) develop a new leadership program that builds upon the success of existing programs, such as the Clinic Leadership Institute and HealthManagement+; that is based on a sound and sustainable business model, and that includes a focus on building vertical diversity with CHCs.

Health Center Leadership & Diversity

Conversations about diversity in the health care workforce and awareness of ongoing disparities experienced by various minority groups have increased exponentially over the past few years. Within the overall non-profit environment, recent studies have revealed that women remain underrepresented within leadership roles. A 2015 study by the University of Denver and The White House Project found that women constitute only 21% of leadership roles among nonprofits with budgets in excess of $25 million even though they make up 75% of the workforce. Additionally, the latest data from the Council on Foundations Grantmakers' Salary and Benefits research found that women hold only 31% of the CEO positions in the largest foundations (those with over $1 billion in assets), and only 41% of all surveyed foundation board members are women. This is despite the fact that women represent 73% of full-time foundation staff.

Although specific data around current diversity in leadership for CHCs isn't readily available, CPCA knows that CHCs continue to face multiple difficulties in recruiting, developing, and retaining leaders, from pending retirement of existing C-Suite executives to geographic barriers to competition from other health care organizations. Fortunately, CHCs also recognize a need

for greater alignment between the communities they serve and the diversity of their leadership and staff.

Back in 2008, a series of reports from BTW *informing change*, funded by the Blue Shield of California Foundation and Community Clinics Initiative, culminated in the summary document *Community Clinic Leadership in California: The State of the Field & Implications for the Future*, which presents key findings about CEOs, Medical Directors, and emerging leaders in CHCs. These reports laid the groundwork for development of the Clinic Leadership Institute (CLI), as the documents revealed gaps and needs for leadership at CHCs, particularly for emerging leaders. The majority of emerging leaders aspired to a senior leadership position but faced numerous barriers to achieve their goal due to the following factors:

- Robust and disciplined succession planning in community clinics is uncommon
- 97% of emerging leaders who aspire to senior leadership positions are not receiving professional development explicitly to advance in their organization
- 36% do not feel they will have the opportunity to take on new responsibilities and/or be promoted within their current organization
- 47% believe there is no room for advancement at their current organization

Diversity in leadership is not just a CHC issue. Within the broader health care community, challenges around diversity in leadership were highlighted in the 2011 study by Witt/Kieffer, *Building the Business Case – Healthcare Diversity Leadership: A National Survey Report*. One of the key findings included: Minority representation was still weak, with only 25% reporting that minority executives were well-represented in their management teams and about the same percent agreeing that the diversity of their management teams reflected patient demographics. More recent statistics from hospitals also show that increasing diversity among patients isn't reflected in leadership positions, according to a June 2016 brief from The Hospitalist, *Does the U.S. Healthcare Need More Diverse Leadership?* To appropriately deliver patient-centered care, provider organizations need to be reflective of their communities and populations, throughout all levels of the workforce, including upper management and the C-Suite. Accomplishing this goal will require active commitment and investment to intentionally increase diversity and gender parity among CHC leadership and within the leadership pipeline.

CPCA is poised and ready to take on this challenge. We have already begun to look internally at our own practices around diversity and talent development, beginning with creation of a new position now occupied by David "Buddy" Orange, our Vice President of Human and Organizational Development. Buddy leads a cross-departmental Human and Organizational Development (HOD) team that is tackling the tough issues of diversity and equity within CPCA and how our practices, policies, and procedures can and should support the vision of an inclusive work environment in which everyone is recognized and appreciated for the unique qualities and characteristics they bring to the organization. We are eager to take advantage of this opportune moment in time to advance these issues for CHCs as the Clinic Leadership Institute comes to a close and HealthManagement+ continues to grow.

Clinic Leadership Institute – Overview & Outcomes

Since 2008, the Clinic Leadership Institute (CLI) Emerging Leaders Program has provided an intensive professional development opportunity to more than 200 participants from a range of health centers, regional clinic consortia, and CPCA. CLI was created through a partnership with Blue Shield of California Foundation (BSCF) and the center for Health Professions at the University of California, San Francisco (USCF). BSCF provided funding for CLI to support 10 cohorts, and the final CLI cohort graduated in June 2018.

CLI provides a total of six in-person sessions, each lasting three to five days, over the course of 18 months. A maximum of 25 participants are included in each cohort, with no more than one participant per organization in any given cohort. Criteria for admission to the program includes having a minimum of three years' experience in the health center field, holding a management or supervisory role with the ability to oversee and motivate staff, nomination by organizational leadership, and the expectation of moving into an executive role within 5-8 years. CLI also includes a capstone project, peer networking, mentoring, and a robust Alumni Network.

A formal evaluation of CLI was completed in May 2015[1] and included results from the first five cohorts of the program. Data from up to 114 participants showed positive trends for graduates' career growth since the beginning of the program:

- 77% advanced to a more senior role or position
- 60% received a salary increase of 10% or more
- 46% experienced significant growth in responsibilities
- 44% experienced much greater job satisfaction

CLI alumni also showed increased knowledge, confidence, and skills in understanding the healthcare landscape, holding a broader organizational perspective, leading people and projects, and making data-driven decisions. The impact of CLI graduates on their organizations has also been significant, helping health centers overall to become stronger thanks to increased leadership capacity, enhanced ability to respond to rapid changes in the health care environment, and a stronger pipeline of emerging leaders.

CPCA recognizes that development of CLI was a very thoughtful process that was informed by a number of stakeholders, including a CEO Advisory Group that has continued to be committed to the success of the program. We also understand that many CLI alumni feel a strong sense of identity with their peers from their own cohort as well as with other graduates whom they've met through the CLI Alumni Network. This sense of dedication to the program and to the opportunities it has provided over the past ten years is invaluable and reveals how CLI has impacted individual participants as well as the overall CHC environment. After all, graduates from CLI have spread across the health care spectrum beyond CHCs, and yet these leaders remain connected to CHCs and their shared CLI experiences through the Alumni Network. CPCA truly appreciates and respects the legacy of CLI, and our intent is to honor the program's

[1] "Preparing the Next Generation of Health Center Leaders: The Experience of the Clinic Leadership Institute's Emerging Leaders Program." Prepared by Informing Change. May 2015.

accomplishments as we explore ways to develop the next iteration of the program in order to meet the ongoing need to cultivate diverse and passionate CHC leadership.

HealthManagement+ - Overview & Outcomes

HealthManagement+ (HM+), was created through a partnership with CPCA and the Kiely Group and launched in 2013. As of May 2018, HM+ has trained eight cohorts, reaching more than 200 participants. Cohorts 9 and 10 are currently in session and will finish in June 2018 and January 2019 respectively, and Cohort 11 will begin in September 2018. HM+ is a fully self-sustaining program that recently attracted philanthropic support for the first time in the form of scholarship funds for participants from Orange, Riverside, and San Bernardino counties thanks to a discretionary grant from The California Wellness Foundation.

The program consists of three in-person sessions, each lasting one and a half or two days, and five webinars over nine months. Cohorts range in size from 20-30, and organizations are able to send multiple staff to a single cohort. Participants are not required to have a minimum amount of experience in the health center field but are identified as and interested in becoming future leaders, secure the support of their managed or supervisor, and complete an application process to indicate their interest in and commitment to the program. HM+ includes informal peer networking and an Alumni Network that was launched in 2018.

An informal evaluation of HM+ was begun by CPCA in 2015 and continues through annual surveys with the intent to show both short-term and long-term impacts of the program. The most recent survey was completed in August 2017, which included graduates of the first five cohorts. Analysis of the responses revealed two particularly important quantitative impacts on graduates' career growth after completion of HM+:

- 76% have received at least one pay increase
- 50% of respondents have been promoted at least once

In addition, HM+ alumni demonstrate increased knowledge and skills in understanding trends that are shaping health care, applying critical thinking skills, developing deeper self-insight into personal management style and leadership aspirations, enhancing day-to-day managerial decision-making, coaching others for enhanced performance, and leveraging internal and external relationships to enhance organizational success.

CPCA plans to maintain what is working well about the HM+ program, but will also examine ways to leverage its success in a way that takes advantage of new opportunities. HM+ has proven to be successful and impactful, as demonstrated by the consistently large number of application received for each cohort. In fact, interest in and demand for HM+ have increased to such an extent that we now support multiple overlapping cohorts each year. However, HM+ can't fulfill all of the needs for future health center leadership, and it may not sufficiently meet the needs of those who actively aspire to C-Suite or other executive level positions.

Need & Opportunity for Future Planning

The CLI evaluation included a number of key recommendations, based on both successes and challenges of the program to date. These lessons learned provide an important foundation for

additional exploration of how to move the program forward, now that it is coming to a close in its current iteration. The need for continued training of future health center leaders, and for leadership succession planning, remains an important consideration for the field, in particular with a focus on actively addressing vertical diversity and representation.

Being able to pause and take time to re-evaluate the program design, content, and outcomes of CLI provide a unique opportunity for CPCA to confirm what health centers need – and what they are willing to invest – in order to inform development of the next iteration of the program, which must designed with a self-sustaining business model for long-term success and impact. In addition, strategies to support the CLI Alumni Network need to be considered so that the skills and knowledge of these graduates continue to positively impact the field.

To ensure that the health center leadership pipeline continues to be robust, diverse, and prepared to lead well into the future, CPCA proposes a one-year planning project with the following objectives:

1. Understand current diversity landscape of health center leadership in order to identify areas for improvement
    a. Conduct research, focus groups, and stakeholder interviews, including outreach to CLI stakeholders and RAC
    b. Produce updated series of reports focusing on CEOs, Medical Directors, Emerging Leaders, and Summary of Key Findings
2. Understand current landscape of health center leadership programs and succession planning at the local, state, and national levels in order to identify needs and gaps
    a. Conduct research on existing programs and succession planning initiatives, including outreach to CLI stakeholders and RAC
    b. Analyze program design, outcomes, and participant data
    c. Identify successes and challenges
    d. Determine ongoing needs and gaps, including barriers hindering vertical diversity into the C-Suite
    e. Explore options for regional strategies with input from RAC
    f. Assess and provide recommendations for integrating CLI and HM+ alumni to leverage strength of broader network
3. Develop a new self-sustaining health center leadership program that builds on the successes of CLI and HM+
    a. Utilize results of landscape survey research to inform program design
    b. Conduct market research to determine most effective program design and delivery as well as appropriate price point
    c. Produce recommendations for program format, curriculum, and delivery modality
    d. Create business plan for self-sustaining program

We anticipate contracting with consultants to complete the research and landscape surveys as well as inform the resource and program development. Based on a prospective scope of work

and project estimate submitted to CPCA by Sage Growth Partners, we anticipate that the project will require an investment of approximately $250,000.

Financial Year End 3-31-18

	March 31, 2017				March 31, 2018			
	CPCA	Ventures	Advocates	Combined	CPCA	Ventures	Advocates	Combined
Statement of Financial Position								
ASSETS:								
Current Assets								
Cash & Equivalents	$ 3,090,327	$ 4,168,171	$ 1,063	$ 7,259,561	$ 2,285,298	$ 2,327,588	$ 134,852	$ 4,747,738
Grants Receivable	$ 510,692			$ 510,692	$ 461,156		$ -	$ 461,156
Dues and Accounts Receivable	$ 324,242			$ 324,242	$ 785,085		$ -	$ 785,085
Current Portion of Loan Receivable		$ 2,278,200		$ 2,278,200		$ 2,351,527		$ 2,351,527
Prepaid Expenses/Undeposited Funds	$ 186,649		$ 846	$ 187,495	$ 104,660		$ 24,777	$ 129,437
Due from (to) affiliate	$ 99,241	$ (128,849)	$ 29,608	$ -	$ 433,744	$ (314,757)	$(118,987)	$ -
Noncurrent Assets								
Certificates of Deposit	$ 806,713			$ 806,713	$ 873,715		$ -	$ 873,715
Loan Receivable, Net		$ 4,099,373		$ 4,099,373		$ 6,141,716	$ -	$ 6,141,716
Property and Equipment, Net	$ 4,871,647			$ 4,871,647	$ 4,627,660		$ -	$ 4,627,660
TOTAL ASSETS	**$ 9,889,511**	**$ 10,416,895**	**$ 31,517**	**$ 20,337,923**	**$ 9,571,318**	**$ 10,506,074**	**$ 40,642**	**$ 20,118,034**
LIABILITIES & NET ASSETS								
Current Liabilities								
Accounts Payable	$ 215,905			$ 215,905	$ 397,337	$ -	$ 3,138	$ 400,475
Accrued Expenses	$ 275,029			$ 275,029	$ 294,233	$ -	$ -	$ 294,233
Deferred Revenue	$ 427,794			$ 427,794	$ 187,945	$ -	$ -	$ 187,945
Current Portion of Loan Payable	$ 131,925	$ 44,954		$ 176,879	$ 128,235	$ -	$ -	$ 128,235
Loan Payable (net)	$ 3,635,667			$ 3,635,667	$ 3,688,370	$ -	$ -	$ 3,688,370
								$ -
TOTAL LIABILITIES	**$ 4,686,320**	**$ 44,954**		**$ 4,731,274**	**$ 4,696,120**	**$ -**	**$ 3,138**	$ 4,699,258
								$ -
TOTAL NET ASSETS	**$ 5,203,191**	**$ 10,371,941**	**$ 31,517**	**$ 15,606,649**	**$ 4,875,198**	**$ 10,506,074**	**$ 37,504**	**$ 15,418,776**
Unrestricted	$ 3,062,255	$ 10,371,941	$ 31,517	$ 13,465,713	$ 3,050,188	$ 10,506,074	$ 37,504	$ 13,593,766
Temporarily Restricted	$ 2,140,936			$ 2,140,936	$ 1,825,010	0	0	$ 1,825,010
Cash on Hand - how many days organization could operate with no further cash				*257 days*				*172 days*
Current Ratio - compares current assets to current liabilities to show ability to meet short-term financial obligations				*9.64*				*7.99*
-								
Profit and Loss								
Total Income	$ 9,693,951	$ 200,582	$ 703,017	$ 10,597,550	$10,756,339	$ 189,254	$ 911,183	$ 11,856,776
Total Expenses	$10,128,130	$ 151,986	$ 703,017	$ 10,983,133	$10,950,598	$ 55,142	$ 905,195	$ 11,910,935
Net Income	**$ (434,179)**	**$ 48,596**	**$ -**	**$ (385,583)**	**$ (194,259)**	**$ 134,112**	**$ 5,988**	**$ (54,159)**

Financial 5-31-18

	March 31, 2018				May 31, 2018			
	CPCA	**Ventures**	**Advocates**	**Combined**	**CPCA**	**Ventures**	**Advocates**	**Combined**
Statement of Financial Position								
ASSETS:								
Current Assets								
Cash & Equivalents	$ 2,285,298	$ 2,327,588	$ 134,852	$ 4,747,738	$ 3,955,500	$ 2,470,064	$ 68,357	$ 6,493,921
Grants Receivable	$ 461,156		$ -	$ 461,156	$ 175,488			$ 175,488
Dues and Accounts Receivable	$ 785,085		$ -	$ 785,085	$ 446,904			$ 446,904
Current Portion of Loan Receivable		$ 2,351,527		$ 2,351,527		$ 2,319,269		$ 2,319,269
Prepaid Expenses/Undeposited Funds	$ 104,660		$ 24,777	$ 129,437	$ 13,500			$ 13,500
Due from (to) affiliate	$ 433,744	$ (314,757)	$(118,987)	$ -	$ (53,382)	$ (49,019)	$ 102,401	$ -
Noncurrent Assets								
Certificates of Deposit	$ 873,715		$ -	$ 873,715	$ 875,569			$ 875,569
Loan Receivable, Net		$ 6,141,716	$ -	$ 6,141,716		$ 5,743,440		$ 5,743,440
Property and Equipment, Net	$ 4,627,660		$ -	$ 4,627,660	$ 4,627,660			$ 4,627,660
TOTAL ASSETS	**$ 9,571,318**	**$ 10,506,074**	**$ 40,642**	**$ 20,118,034**	**$ 10,041,239**	**$ 10,483,754**	**$ 170,758**	**$ 20,695,751**
LIABILITIES & NET ASSETS								
Current Liabilities								
Accounts Payable	$ 397,337	$ -	$ 3,138	$ 400,475	$ 6,794	$ -	$ -	$ 6,794
Accrued Expenses	$ 294,233	$ -	$ -	$ 294,233	$ 291,694	$ -	$ -	$ 291,694
Deferred Revenue	$ 187,945	$ -	$ -	$ 187,945	$ 1,032,245	$ -	$ -	$ 1,032,245
Current Portion of Loan Payable	$ 128,235	$ -	$ -	$ 128,235	$ 50,000	$ -	$ -	$ 50,000
Loan Payable (net)	$ 3,688,370	$ -	$ -	$ 3,688,370	$ 3,616,181	$ -	$ -	$ 3,616,181
TOTAL LIABILITIES	**$ 4,696,120**	**$ -**	**$ 3,138**	$ 4,699,258	**$ 4,996,914**	**$ -**	**$ -**	**$ 4,996,914**
				$ -				
TOTAL NET ASSETS	**$ 4,875,198**	**$ 10,506,074**	**$ 37,504**	**$ 15,418,776**	**$ 5,044,325**	**$ 10,483,754**	**$ 170,758**	**$ 15,698,837**
Unrestricted	$ 2,999,132	$ 10,506,074	$ 37,504	$ 13,542,710	$ 3,002,126	$ 10,497,054	$ 170,758	**$ 13,669,938**
Temporarily Restricted	$ 1,876,066	0	0	$ 1,876,066	$ 2,042,199	$ -	$ -	**$ 2,042,199**
Cash on Hand - how many days organization could operate with no further cash				*172 days*				*243 days*
Current Ratio - compares current assets to current liabilities to show ability to meet short-term financial obligations				*7.99*				*6.84*
-								
Profit and Loss								
Total Income	$ 10,756,339	$ 189,254	$ 911,183	$ 11,856,776	$ 1,808,585	$ 37,294	$ 360,437	$ 2,206,316
Total Expenses	$ 10,950,598	$ 55,142	$ 905,195	$ 11,910,935	$ 1,629,388	$ 59,613	$ 227,182	$ 1,916,183
Net Income	**$ (194,259)**	**$ 134,112**	**$ 5,988**	**$ (54,159)**	**$ 179,197**	**$ (22,319)**	**$ 133,255**	**$ 290,133**

CALIFORNIA PRIMARY CARE ASSN
Balance Sheet
As of May 31, 2018

	May 31, 18
ASSETS	
Current Assets	
Checking/Savings	
1000.00 · Cash	4,831,069.43
Total Checking/Savings	4,831,069.43
Accounts Receivable	
1300.00 · Grants Receivable	175,488.01
1320.00 · Due from CPCA Ventures	49,019.35
1350.00 · Other Receivables	191,653.82
1400.00 · IMIS Receivable	255,249.88
Total Accounts Receivable	671,411.06
Other Current Assets	
1490.00 · Prepaid Expenses	138,305.37
Total Other Current Assets	138,305.37
Total Current Assets	5,640,785.86
Fixed Assets	
1600.00 · 1231 I Street Suite 400	6,407,085.91
1650.00 · Furniture	331,111.39
1660.00 · Equipment	406,259.55
1670.00 · Capitalized Interest	69,592.00
1700.00 · Accumulated Depreciation	-683,801.00
1710.00 · Building Depreciation	-1,840,902.00
1740.00 · Interest Amortization	-59,732.00
1750.00 · Loss on Disposal of Assets	-1,954.00
Total Fixed Assets	4,627,659.85
Other Assets	
1810.00 · Deposits/PrePaid	-40,500.00
Total Other Assets	-40,500.00
TOTAL ASSETS	**10,227,945.71**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000.00 · Accounts Payable	318.56
2026.00 · Due to CA Health + Advocates	102,401.47
Total Accounts Payable	102,720.03
Other Current Liabilities	
2025 · Accrued Vacation	291,694.10
2030.01 · Deferred/Unearned Revenue	187,945.00
2040.00 · Prepaid Dues	790,300.04
2055.01 · Payroll FSA	6,408.66
2200.00 · Sales Tax Payable	66.33
Total Other Current Liabilities	1,276,414.13
Total Current Liabilities	1,379,134.16
Long Term Liabilities	
2035.00 · EPIC Deposits	50,000.00
2510.00 · Loan Payable IronStone Bank	3,616,181.11
Total Long Term Liabilities	3,666,181.11
Total Liabilities	5,045,315.27
Equity	
3000.00 · Opening Bal Equity	1,095,702.47
4000.00 · Net Assets	3,907,731.69

CALIFORNIA PRIMARY CARE ASSN
Balance Sheet
As of May 31, 2018

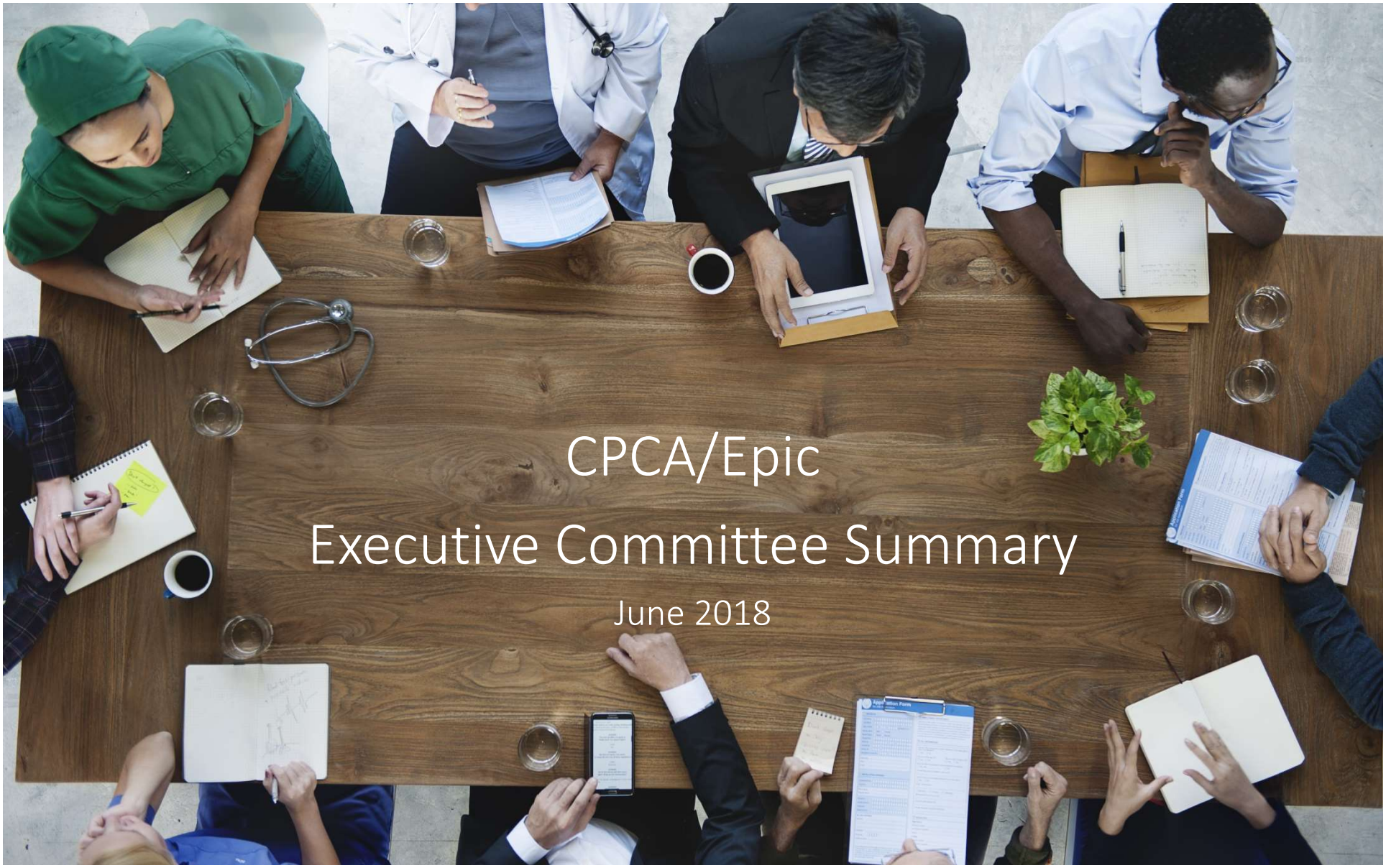
	May 31, 18
Net Income	179,196.28
Total Equity	5,182,630.44
TOTAL LIABILITIES & EQUITY	**10,227,945.71**

CPCA Ventures
Balance Sheet
As of May 31, 2018

	May 31, 18
ASSETS	
Current Assets	
Checking/Savings	
1000.00 · Cash	2,470,064.34
Total Checking/Savings	2,470,064.34
Accounts Receivable	
1450.00 · Current Portion Loans Receivabl	2,319,269.28
1461.00 · Acct. Rec. Loan - Long Term	6,099,446.76
Total Accounts Receivable	8,418,716.04
Other Current Assets	
1465.00 · Loan Loss Reserve	-356,007.00
Total Other Current Assets	-356,007.00
Total Current Assets	10,532,773.38
TOTAL ASSETS	**10,532,773.38**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2020.00 · Due to CPCA	49,019.35
Total Accounts Payable	49,019.35
Total Current Liabilities	49,019.35
Total Liabilities	49,019.35
Equity	
3000.00 · Opening Bal Equity	-0.13
3900 · Retained Earnings	10,506,073.32
Net Income	-22,319.16
Total Equity	10,483,754.03
TOTAL LIABILITIES & EQUITY	**10,532,773.38**

CaliforniaHealth Plus Advocates
Balance Sheet
As of May 31, 2018

	May 31, 18
ASSETS	
Current Assets	
Checking/Savings	
1000.00 · Cash	
1012.00 · First Citizens - checking	68,357.36
Total 1000.00 · Cash	68,357.36
Total Checking/Savings	68,357.36
Accounts Receivable	
1320.00 · Due from CPCA	102,401.47
Total Accounts Receivable	102,401.47
Total Current Assets	170,758.83
TOTAL ASSETS	**170,758.83**
LIABILITIES & EQUITY	
Equity	
3900 · Retained Earnings	37,504.16
Net Income	133,254.67
Total Equity	170,758.83
TOTAL LIABILITIES & EQUITY	**170,758.83**



CPCA/Epic
Executive Committee Summary
June 2018

Objectives

- CPCA / Epic Contract Key Provisions
- CPCA / Health Center Contract Key Provisions
- Financing Summary and Recommendation
- CPCA Financial Summary
- Discussion and Questions

Recap: Negotiation Highlights

	October 2017	April 2018
10 year commitment	2M annual encounters	4M annual encounters[1]
Cost to Health Center	$6.00 / encounter	$4.50 / encounter[2]
Startup capital	$4.0-4.5M	$4.9-5.4M[3, 4]
7 year margin	$5.4M	$5.1-6.7M[5]

1. Based on the 8 signed MOUs totaling 3.6M annual encounters, and the possibility for patient growth and the implementation of additional health centers beyond year 4.
2. The need to capitalize the implementations to secure approximately $2.0M in additional funding via New Market Tax Credits could make this number higher for a limited period in return for drastically reduced implementation capital costs. Without NMTC, the fee may be raised as high as $5.00 / encounter for a period of 36-months for each Health Center, and then reduced to $4.50 / encounter.
3. Under this model, CPCA will receive approximately $7.1M in startup capital, of which approximately $2.2M is a subsidy and $4.9M is a 7 year loan with an interest-only introductory period.
4. Increases in startup capital needs are partly driven by large health centers implementing early in the process. These numbers are likely to change somewhat as the funding strategy provides considerable flexibility.
5. Contract negotiation with Epic have been completed and documents are ready for execution.

CPCA / Epic Key Contract Provisions

- This agreement secures what CPCA believes, based on market intelligence, to be the best possible inclusive price for the Epic suite of products.
- There is no capital outlay to acquire licenses as the “per encounter” price includes access to the license, hosting, support and maintenance.
- The suite of products included is the most comprehensive suite of tools available to participating Health Centers

Epic Included Components	
EpicCare EHR with the enhanced Behavioral Health and Dental modules	Interfaces
Resolute Billing and Cadence Scheduling	Patient Kiosk (software, not hardware)
CareEverywhere (external provider access)	HEDIS Quality Measures
MyChart Portal and Haiku Mobile Apps	Cosmos (data repository)
Cogito analytics and the Enhanced Analytics Package (HealthyPlanet)	Available FQHC templates, tools, and reports (UDS, Title X, Ryan White)

Hosting / Software Agreement Key Provisions

Hosting Agreement	Software Agreement
CPCA maintains direct relationship to Epic as hosting vendor	CPCA maintains direct relationship to Epic as software vendor
Eliminates upfront capital fees for health centers	Eliminates upfront capital fees for health centers
Fee increases are capped over life of contract	Fee increases are capped over life of contract
Eliminates need for CPCA or Health Center staff to maintain server hardware	Linkage to hosting agreement regarding role of Epic
Epic staff accountable for application performance	Provision to require implementation of features when required by law, with commitment to spread cost across California customers
Suitable liability and insurance for data breaches	Transferable to an entity owned at least 50% by CPCA
Provides access to security audits	Requires continuity of staff through initial implementation, permits CPCA to work with third-party implementers (provided they sign agreement)

CPCA / Health Center Agreement Key Provisions

- Allows for CHC to access the Epic hosted platform, and includes access to all software, hosting, support, and maintenance.
- Provides a balanced agreement between CPCA and participating members.
- Provides parity between Epic/CPCA contract and CPCA/CHC contract in key areas such as indemnification, insurance requirements, etc.
- CHCs may cancel without cause, but penalty limits potential of financial harm to CPCA.
- Establishes data use and security policies.
- Defines expected service levels.
- Clarifies fee schedule and additional billing scenarios.

Financing Summary and Recommendations

	Option A	Option B	Option C	
	Line of Credit	**Conventional Loan**	**NMTC Loan**	**NMTC Subsidy**
Loan Amount	$5.0M	$5.4M	$5.1M	$7.5M
Interest Rate	LIBOR + 3% (currently ~5.03%)	5.35-5.75%	5.35-5.75%	Market rates
Loan Type	Non-revolving line of credit	Conventional Loan	Leverage loan for NMTC	Interest only
Term	7 years	7 years	7 years	7 years, no prepayment
Repayment Term	Interest only first 32 months Amortizing 52 remaining months	Interest only first 18 months Amortizing on 15 year total term month 19 and beyond	Interest only first 18 months Amortizing on 15 year total term month 19 and beyond	Interest only full 7 years
Fees	0.75%	1.00%	Closing costs and other fees of approximately $800k, paid out of loan/subsidy.	
Conditions	Debt service reserve - $1.0M Shareholder in bank - 1% of bank loan	Performance reviews Full recourse to CPCA	Performance reviews Full recourse to CPCA	
Collateral	Lien on New LLC assets Pledge of Ventures receivables	2nd lien position on CPCA property Pledge of Ventures receivables	2nd lien position on CPCA property Pledge of Ventures receivables	
Monthly Payments*	Months 1-18 - $22,083 Months 33-84 - $109,829	Months 1-18 - $26,282 Months 19-84 - $97,136	Months 1-18 - $24,241 Months 19-84 - $89,592	
* Assumes loan balance paid at end of 7 year period regardless of allowable amortization schedule.				

Option C offers the best results for CPCA: considerably greater capital at a lower total cost. In this scenario, CPCA would be compensated for up to $300k of pre-development costs, and would also be able to acquire a Learning Management System that would be instrumental in Epic program success. The LMS could also be leveraged beyond the Epic project to create new ways of leveraging CPCA training and technical assistance content.

Should New Market Tax Credits not be available, Option B is viable and preferred over Option A.

All estimates are based on highest end of interest rate range, and thus all numbers are subject to change at time of loan closing.

CPCA Financial Status

Financial Year End 3-31-18

	March 31, 2017				March 31, 2018			
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Statement of Financial Position								
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Grants Receivable	$ 510,692			$ 510,692	$ 461,156		$ -	$ 461,156
Dues and Accounts Receivable	$ 324,242			$ 324,242	$ 785,085		$ -	$ 785,085
Current Portion of Loan Receivable		$ 2,278,200		$ 2,278,200		$ 2,351,527		$ 2,351,527
Prepaid Expenses/Undeposited Funds	$ 186,649		$ 846	$ 187,495	$ 104,660		$ 24,777	$ 129,437
Due from (to) affiliate	$ 99,241	$ (128,849)	$ 29,608	$ -	$ 433,744	$ (314,757)	$ (118,987)	$ -
Noncurrent Assets								
Certificates of Deposit	$ 806,713			$ 806,713	$ 873,715		$ -	$ 873,715
Loan Receivable, Net		$ 4,099,373		$ 4,099,373		$ 6,141,716	$ -	$ 6,141,716
Property and Equipment, Net	$ 4,871,647			$ 4,871,647	$ 4,627,660		$ -	$ 4,627,660
TOTAL ASSETS	**$ 9,889,511**	**$ 10,416,895**	**$ 31,517**	**$ 20,337,923**	**$ 9,571,318**	**$ 10,506,074**	**$ 40,642**	**$ 20,118,034**
LIABILITIES & NET ASSETS								
Current Liabilities								
Accounts Payable	$ 215,905			$ 215,905	$ 397,337	$ -	$ 3,138	$ 400,475
Accrued Expenses	$ 275,029			$ 275,029	$ 294,233	$ -	$ -	$ 294,233
Deferred Revenue	$ 427,794			$ 427,794	$ 187,945	$ -	$ -	$ 187,945
Current Portion of Loan Payable	$ 131,925	$ 44,954		$ 176,879	$ 128,235	$ -	$ -	$ 128,235
Loan Payable (net)	$ 3,635,667			$ 3,635,667	$ 3,688,370	$ -	$ -	$ 3,688,370
								$ -
TOTAL LIABILITIES	**$ 4,686,320**	**$ 44,954**		**$ 4,731,274**	**$ 4,696,120**	**$ -**	**$ 3,138**	$ 4,699,258
								$ -
TOTAL NET ASSETS	**$ 5,203,191**	**$ 10,371,941**	**$ 31,517**	**$ 15,606,649**	**$ 4,875,198**	**$ 10,506,074**	**$ 37,504**	**$ 15,418,776**
Unrestricted	$ 3,062,255	$ 10,371,941	$ 31,517	$ 13,465,713	$ 3,039,458	$ 10,506,074	$ 37,504	$ 13,583,036
Temporarily Restricted	$ 2,140,936			$ 2,140,936	$ 1,835,740	0	0	$ 1,835,740
Cash on Hand - how many days organization could operate with no further cash				*257 days*				*172 days*
Current Ratio - compares current assets to current liabilities to show ability to meet short-term financial obligations				*9.64*				*7.99*
Debt Ratio - indicates the percentage of assets that are provided via debt				*0.24*				*0.24*
						with epic financing		*0.49*
Profit and Loss								
Total Income	$ 9,693,951	$ 200,582	$ 703,017	$ 10,597,550	$ 10,756,339	$ 189,254	$ 911,183	$ 11,856,776
Total Expenses	$ 10,128,130	$ 151,986	$ 703,017	$ 10,983,133	$ 10,950,598	$ 55,142	$ 905,195	$ 11,910,935
Net Income	**$ (434,179)**	**$ 48,596**	**$ -**	**$ (385,583)**	**$ (194,259)**	**$ 134,112**	**$ 5,988**	**$ (54,159)**

California Primary Care Association

California Primary Care ASSOCIATION

DISCUSSION

Date: July 2, 2018

To: Executive Committee

From: Val Sheehan, Director of Development & External Relations

Re: Association Health Plan Strategy

MEMORANDUM

Background

At the last CPCA Executive Committee meeting on April 26, 2018, the Executive Committee reviewed and discussed a memo outlining the potential opportunity to pursue an Association Health Plan (AHP) strategy. The AHP strategy is compelling because it has the potential to reduce health center operating costs by leveraging the collective buying power of CPCA members to group purchase health insurance at rates that are as good as, if not better than, what they are currently being offered. Offering robust health insurance plans is also an employee recruitment and retention strategy. At a time when workforce is on the forefront of many health center CEOs' minds, being able to offer affordable, yet robust health insurance plans can be key to recruiting and retaining high quality providers and staff.

After some discussion, the Executive Committee members agreed with staff's recommendation to form a brain trust to assist in the continued vetting of this strategy, including interviewing interested groups. Following the Board and committee meetings, CPCA staff organized a member brain trust that included:

- Victoria Abrams – Executive Vice President, Health Center Partners
- Robin Affrime – Chief Executive Officer, CommuniCare Health Centers
- Tracy Garmer – Executive VP and Chief Operations Officer, Health Center Partners
- Christine Noguera – Chief Executive Officer, Community Medical Centers
- Tim Rine – Executive Director, North Coast Clinics Network
- Mary Szecsey – Executive Director, West County Health Centers
- Henry Tuttle – Chief Executive Officer, Health Center Partners

Current Status

CPCA staff created activities and a timeline with a goal of potentially selecting a group to work with to develop an AHP. To begin the process, CPCA staff released an RFP on May 21, 2018 and shared the RFP with interested groups by using existing networks, but also by forming a new relationship with the California Association of Health Underwriters (CAHU). CPCA staff reached out to CAHU asking them to forward the RFP to their members. This strategy helped ensure that CPCA staff cast a wide net to capture the target audience.

CPCA received proposals from the following groups who were interested in partnering on some type of AHP strategy:

1. Decisely (a partner company with EPIC Insurance Brokers)
2. Essential Access Health
3. Keenan & Associates
4. Nonstop Insurance and Administrative Services
5. Shepler & Fear General Agency

A workgroup of CPCA staff reviewed and scored all proposals and presented the top 3 finalists to the brain trust for their approval. The top 3 finalists were: Essential Access Health, Keenan & Associates, and Nonstop Insurance and Administrative Services. Following a brain trust call on June 14, 2018, where brain trust members approved the staff's recommendation, all finalists were scheduled into interview slots. Interviews with the finalists were held during the last two weeks of June.

Next Steps

CPCA staff are now in the process of developing a side-by-side comparison of the offerings to inform a final discussion by the brain trust on Monday, July 9, 2018. It is the staff's expectation that a recommendation or series of recommendations will determined and will be presented at the Executive Committee meeting on July 12, 2018.

California Primary Care Association

Strategic Plan 2017 - 2020

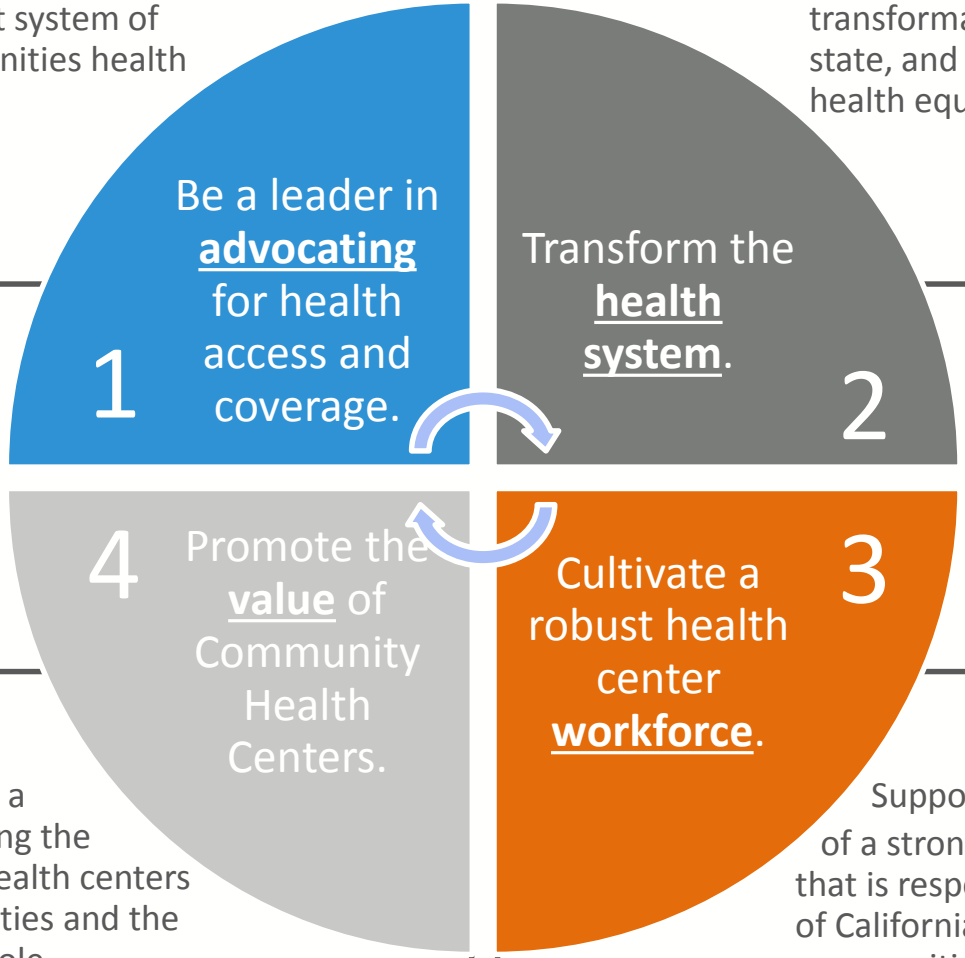
Bi-Annual Update

January – June 2018

Strategic Plan Bold Steps

- Lead a statewide advocacy agenda that supports a robust system of health for the communities health centers serve.

- Advance health system transformation at the national, state, and local levels to promote health equity for all.



- Identify and articulate a shared vision promoting the value of community health centers to California communities and the health system as a whole.

Support the development of a strong healthcare workforce that is responsive to and reflective of California's diverse communities.

Advocating for Access & Coverage
Progress to Date

Clear & Effective Advocacy Messaging

- Advocates launched its own website, electronic newsletter, and annual report to better communicate with members on relevant policy matters.
- Advocates purchased ***CQ Engage***, an advocacy management software.

Internal CHC Cultures of Advocacy

- In March, CPCA collected feedback to inform a statewide, coordinated voter engagement campaign.
- Brought on 1,000 new advocates through health center funding cliff advocacy efforts.
- Consistently developed and disseminated social media posts around the state budget and legislative efforts
- Coordinated another successful Day at the Capitol event in April, for which our Key Contact list was engaged.

Advocating for Access & Coverage
Progress to Date

Leveraging Partnerships to Advance the CHC Mission

- Immigration:
  - Together with NACHC and AAPCHO, developed the Health Center Immigration Workgroup to increase educational and advocacy campaign efforts around immigration issues.
  - In addition to working with partners to advocate against the public charge rule, CPCA applied and was awarded lead for the ***Protecting Immigrant Families*** (PIF) coalition grant. This grant seeks to educate communities and elected officials about the public charge rule.
  - Finally, CPCA continues to support immigrant partners' efforts to expand Medi-Cal to all Californians, regardless of immigration status.
- Together with RAC, successfully defended CHIP funding.
- Managed Care Partnerships: CPCA actively participates in IHA's Medi-Cal Advisory Committee, as well as with a group of statewide provider associations.
- Working with hospitals and other stakeholders, successfully protected the 340B program in Medi-Cal managed care.
- Mental Health: Continued to participate in the Behavioral Health Action Coalition, remains an active member of MHSOAC, and has been working with Senator Atkins on SB 1125 on same-day billing.

Advocating for Access & Coverage
Progress to Date

Coverage & Care for All

- Finalized a ***Care for All*** Vision that outlined the vision and principles for the future of health care delivery. The Vision was shared with the legislative committee in April.

Supporting Advocates' Efforts Towards Healthy Communities

- CPCA developed an SDOH concept paper and infographic that highlights CHC needs and programs across the state.
- Continue to build strategic relationships with statewide partners that focus on SDOH issues, such as the ***CA Food Policy Advocates*** and ***CA Housing***.
- Staff engaged the US Department of Agriculture in regards to the Advanced Notice of Proposed Rulemaking – SNAP: Requirements and Services for Able-Bodied Adults Without Dependents.

Advocating for Access & Coverage
Challenges

- CaliforniaHealth+ Advocates purchased a new **advocacy software** that has not been fully implemented due to interoperability issues that have yet to be resolved.
- **T**he Governor's January Budget proposed to eliminate **340B**, forcing a legislative advocacy battle. While we ultimately resolved the issue in our favor, time spent in this budget battle could have been spent on resolving issues around duplicate discounts.
- The **federal landscape** remained challenging into the spring of 2018, and as such, required much of our advocacy to be reactive.
- **SDOH** advocacy remains challenging within existing medical practices/processes as there simply isn't enough time or resources to fully support this work.
- **Medicaid:** Despite a favorable legislature, DHCS and this administration continue to be oppositional towards expansion of billable providers, leading to limited legislative success.
- **Coverage and Care for All:** This continues to be a complicated space for engagement. Health systems have yet to meaningfully come together, and the current administration shows a lack of interest in tacking this policy area.

Advocating for Access & Coverage
Opportunities

- CPCA's and RAC's engagement with communication firm, **Imprenta**, will allow us to more intentionally leverage expertise around a statewide communications campaign around CHC value.
- **Immigration**: With involvement in groups like the National Health Center Immigration Workgroup, CHCs are now seen as partners within larger immigration dialogue. There is also a lot of opportunity to further work in this area as the lead on the ***Protecting Immigration Families*** (PIF) grant.
- **Coverage and Care for All:** We are hopeful that the incoming administration will be very committed to health policy, and to specific dialog on expansion of care. Funds set aside in the FY-18-19 budget should also support capitol dialog on this topic later this year.

Transform the Health System
Progress to Date

Innovative & Highly Effective Care Strategies

- Reinvigorated APM conversations that have resulted in an APM 2.0 concept being discussed.
- Within the CP3 training environment, CPCA finalized a list codes for non-traditional touches and is working to develop a training module to support data collections around these services.
- Developed and disseminated educational materials around SB 323 implementation ('carving out' specialty mental health & drug Medi-Cal).
- Published the behavioral health toolkit, "Leveraging FQHC's in California's Behavioral Health Care Continuum" and used the content to provide technical assistance to several counties wishing to develop FQHC relationships.
- Continued to advocate for CHC participation in both Prop 63 (Mental Health Services Act) & Prop 64 (Adult Use of Marijuana Act) activities by participating on related coalition discussions regarding funding allocations.
- Continued to participate in monthly California Oral Health Network meetings.

Transform the Health System
Progress to Date

Integrated Delivery Networks and Bridging Gaps within Siloed System

- Developed trailer bill language that protects the 340B program in Medi-Cal and creates a system between the state, health plans, contract pharmacies, and covered entities to participate in a compliant manner to avoid duplicate discounts.
- Developed and disseminated to health plans an FQHC P4P FAQ, and engaged in discussion about how best to improve incentive plans looking ahead.
- CPCA is now tracking plan interest in expanding their Medi-Cal footprint, and have developed a ***partnership priorities*** assessment document to guide CHC and plan partnership conversations.
- CPCA continues to participate in conversations around standardized measure sets (IHA Medi-Cal Advisory Committee and through our Azara partnership), improving encounter data (also IHA), and best practice around unseen patients (new NextGen and eCW pilot)
- Continue to explore a partnership with Epic to develop a cloud-hosted, FQHC-specific instance of the Epic EHR tool, that would be customized to meet the needs of California CHCs.

Transform the Health System
Progress to Date

SDOH Advocacy

- Within the CP3 learning environment, launched an SDOH learning cohort comprised of 52 sites who will implement an SDOH data collection process
- CPCA continues to expand statewide partnerships with organizations such as ***Housing California*** and ***Food Policy Advocates*** who are working to address SDOH issues across the spectrum.

Transform the Health System
Challenges

- DHCS behavior suggests they are not interested in innovations in payment and delivery transformation and would prefer to “tweak” and scrutinize existing FFS methodologies.
- Additionally, DHCS continues to make changes to the Medi0Cal managed care delivery system with minimal opportunity for stakeholder feedback and without providing operations-level guidance, creating confusion and questions between CHCs and our health plan partners.
- Finally, there is a lack of DHCS guidance around building local strategies that support smooth transition of behavioral health care between counties, managed care plans, and FQHCs.

Transform the Health System
Opportunities

- **Behavioral Health and SUD -** With the opioid crisis receiving federal attention, we see growing opportunity for counties to partner with FQHCs and other providers in developing a robust treatment network for substance use disorders.
- **Payment reform -** There exists an opportunity to leverage our previous APM efforts to develop an "APM 2.0" that will more deeply align with the triple aim.
- **P4P -** Lack of guidance around the treatment of P4P incentives in FQHCs has created an opportunity to work with IHA and other stakeholders to build standardization into new DHCS guidance around incentives and P4P.

Workforce
Progress to Date

Pipeline: Increase Primary Care Workforce Visibility

- CPCA continued to foster relationships with pipeline partners such as the state Area Health Education Center (AHEC); the state Workforce Development Board; and John Cordova, the new Statewide Sector Navigator for the Health Workforce Initiative (community colleges).
- Along with consortia and community health center (CHC) leaders in Northern California and the Central Valley, CPCA participated in the UCD Center for a Diverse Healthcare Workforce's Communities of Practice program, which explores ways to replicate the AT Still Hometown Scholars Program.
- With member participation support, worked with the Health Career Connections program to produce an outreach video highlighting the benefit of utilizing a diverse set of health professions students in CHC settings.
- Finalized research to identify existing CHC residency training programs and activities. 35 CHC/RAC staff interviewed; a webinar outlining findings is scheduled for 7/18/18.

Workforce
Progress to Date

Primary Care Provider/Staff Training

- Continued to collaborate with the KP School of Medicine by co-developing a process/form to evaluate community health center (CHC) interest in serving as clinical training sites.
- Song Brown: Successfully advocated to ensure a second installment of funds (just over $31M) was included in the FY 18-19 state budget, and advocated on needed application changes such as defining “economically disadvantaged”, measuring exclusivity in primary care, and doubling the available expansion slot amount.
- Alongside the American Association of Teaching Health Centers, continued to advocate and inform activities around the Teacher Health Center Program.
- In May, discussed training priority items such as PRIME, IGME and Prop 56 residency funding with Dr. Cathryn Nation, UCOP.
- Leveraging the CA Future Health Workforce Commission’s stakeholder engagement process to advocate for GME reform.

Workforce
Progress to Date

Incentivizing Primary Care

- Participated on the NACHC HSPA workgroup to inform recommendations made around the Shortage Designation Modernization Project, and conducted a member webinar in June to share potential HPSA changes and how to approach the impact analyses scheduled to be shared from August 2018 thru April 2019.
- Successfully advocated to resolve the National Health Service Corp funding cliff through September 2019.

Reducing Provider Recruitment Barriers

- Continued to work with the California Board of Registered Nursing and the California Medical Board to address licensing barriers for new and out-of-state providers.
- Together with members of the HR Peer Network, made needed changes to CPCA's Compensation and Benefits Survey, to be administered in the Fall of 2018.

Workforce
Progress to Date

Retaining Providers & Advancing Team Based Care

- Leveraged lessons learned from CP3 participating community health centers (CHC) to develop three podcasts that highlight practice transformation best practices.
- Continued partnership with the Integrated Health Association and the Center for Connected Health Policy to explore telehealth innovation and supportive reimbursement methodologies.
- Expanding Behavioral Health Access: Through Advocates and in partnership with the Steinberg Institute, introduced SB 1125 to advance same day-billing. Also continued advocacy around AB 1863, which permits MFTs as billable providers.

Diversifying the Health Professions / Addressing Workforce Disparities

- CPCA continues to participate in Community College's HWI Statewide Advisory Committee, where industry and community college educators and administration meet to address the role of CCs in addressing health workforce disparities

Workforce
Progress to Date

Coordinating & Leading Statewide & National Workforce Conversations

- Research: Supported by funding from Kaiser Community Health, and in partnership with UCSF's Healthforce Center, finalized the final report in a three-part series to identify primary care workforce needs and potential solutions in California; including strategies that address physician burn-out, expanding telehealth, and advancing care team innovation.
- Workforce Policy Coalition: Facilitated a series of conference calls to prioritize and coordinate statewide advocacy efforts around proposed legislation in the areas of residency redesign, equity in education (focused on college pipeline programs), and incentivizing primary care professions.

Workforce
Challenges

- Continued challenges around licensing process for nurses practicing in underserved settings.
- Continued incentives perpetuate volume-based care, which in turn contributes to staff retention challenges.
- No dedicated resources to support Workforce Policy Coalition efforts.
- Potential unintended consequences to the HPSA scored process as a result of the Shortage Designation Modernization Project.

Workforce
Opportunities

- Continue to participate in a coalition led by MHP Salud that is advocating with other PCAs and health center leaders towards funding the use of community health workers (CHWs) in health centers.
- There remains an opportunity to leverage CPCA's relationship with the California Future Health Workforce Commission and subject matter experts to influence a statewide workforce master plan.
- A relatively new opportunity is the proposed state plan amendment (SPA 18-0032) which would authorize reimbursement under the PPS methodology for services performed by qualifying Graduate Medical Education (GME) primary care residents whose services are eligible for Med-Cal reimbursement at FQHCs and RHCs.

Value of CHCs
Progress to Date

Supporting CHC Internal Cultures of Quality

- Finalizing an RFQ process to identify subject matter/curriculum development expert to support the development of a Quality Improvement/Health Information Technology "plus" program (akin to the HealthManagement+ and CFO+ programs).
- Facilitated continued HIT User Groups and worked to support improved relationships between members and HIT vendors.
- Working to develop a train-the-trainer program, specifically for CFOs in the CP3 learning environment, that will aim to provide guidance on how best to use health plan claims data to tell a rich story about both care delivery and remaining patient need.
- In partnership with NACHC and four RAC, CPCA finalized Phase 1 of a "PRAPARE" pilot. Leading discussions on a possible Phase 2.

Value of CHCs
Progress to Date

Promoting a Shared "Value Vision"

- Engaged communication firm, Imprenta, to create a communication campaign that leverages the CaliforniaHealthPlus.org website and promotes the value of health centers. The campaign will run in late summer 2018.
- Continue to promote Patient Centered Medical Home as foundational to creating patient and community value, and hosted a NCQA PCMH 2017 standards training in California that was sponsored by HRSA.

Enhancing CHC Capacity Toward Community Partnership

- Included two workshops at the June 2018 Region IX Clinical Excellence Conference in Arizona around SDOH – one focusing on violence prevention (partner – Futures Without Violence) and one addressing SDOH (partners – CHCs in CA, HI & AZ).
- Participated in the CA School-Based Health Alliance Conference, as well as the World Health Care Congress, both of which tackled patient's social needs.

Value of CHCs
Challenges & Opportunities

Positioning CHCs to influence SDOH conversations.

With an increased focus on SDOH by philanthropy, and to some extent, by other health care providers, it is **challenging** to identify how best to position CHCs as leaders in addressing SDOH. However, this is also **an opportunity**.

For example, in January 2018, Blue Shield of CA Foundation formally revealed their new strategic direction which is much more focused on upstream strategies to affect the social determinants of health. Because CHCs have long had deep roots in the social justice space in regards to health, there is an opportunity for CHCs to leverage our existing knowledge around addressing SDOH to respond to foundations like Blue Shield.

NACHC Board Report to the CPCA Board

David B. Vliet, CPCA Representative, Region IX

June 28, 2018

The National Association of Community Health Centers (NACHC) Board of Directors convened in New York City this summer on June 21, 2018, one of four annual meetings held by the Board. The agenda for the meeting was relatively light; this report will briefly cover key highlights of the most recent meeting.

General Updates

The Association continues to look at the dues structure and the affordability of membership. In particular, smaller health centers typically pay a larger percentage in dues because of the way the dues are structured. Board Chair Jim Luisi has assembled a task force to look at this more closely and a survey was recently sent out to assess whether centers with larger budgets would be willing to sustain an increase that in essence reduce the burden of the cost of membership for smaller health centers. A report and recommendation from the Chair is forthcoming. (Note: as a member of the Membership Committee, this has been an ongoing process under several recent board Chairs over the years).

Future Funding

NACHC continues to work closely with Democratic and Republican appropriations staff in the House and Senate to assure strong fiscal support for community health centers. They report that congressional leaders have allocated $177 billion of level funding in the FYI19 Labor Health and Humans Services bill while warning NACHC congressional leaders that they "will need to balance a variety of priorities in the bills…[thus] they all acknowledge the strong level of ongoing support for health centers from the Members of Congress".*

Congress passed the VA MISSION Act which will combine seven of the Department of Veterans Affairs community care programs into one singular program, while providing a $5.22 billion extension of the current "Veterans Choice Program" and that will allow veterans to receive care from health centers - - and allow time for the VA to put these newly consolidated community care programs in to place. The new program will allow veterans to seek "private care based upon a variety of factors including wait time, distance…and includes health centers among the list of eligible walk-in service providers for veterans." NACHC submitted a letter to leaders of both Houses in support of the legislation. *

Expanding Access to Quality Substance Use Disorder and Mental Health Services Funding

By now everyone is likely aware that new supplemental HRSA substance abuse funding will be made available to "expand access to substance abuse disorder and mental health services at community health centers across the nation". (HRSA website) The funding is intended to support Health and

Human Services (HHS's) "Five Point Opioid" strategy and are intended to increase access to quality integrated care and treatment. Applications are due July 16, 2018 and offer $100,000 in base grant funding and $150,000 for one-time infrastructural investments. **

Title X

A lengthy, informative, legally-focused briefing by Jackie Leifer, Esq., long-time legal counsel to NACHC on the key concerns were held on Title X. New proposed changes would make significant changes to the program, which currently has an open-comment period that began in May. Some of the changes restricting providers from referring patients for abortion services (except in the case of rape or incest), requiring "strict physical and financial and separations between Title X activities and any abortion-related activities operated by a Title X grantee or sub-recipient". **

There was an in-depth discussion related to the potential far-reaching implications of these changes, which could include restrictions for health center insurance plans that offer pregnancy termination services (using federal grant funds to pay for such plans would be restricted). A survey is underway intended to determine the use of Title X funds for such services. Ms. Leifer suggested that larger healthcare systems be cognizant of these potentials risks. Protocols and policies are currently available online in the hopes to mitigate potential exposure.

"One and Done" and the Operational Site Visit (OSV): Reports of Improvement

Efforts are evidently being made to address the legislation directly related to the "one and done" policy related to (program compliance) with some Board members reporting "a somewhat improved" experience and "less subjectivity" related to compliance to the program requirements, with use of the new compliance guide seeming to diminish variance.

NACHC staff: 1) strongly advised that the health center's project officer be in attendance (this appears now be the practice, 2) strongly suggested that the health center report any problems to HRSA leadership, 3) suggested that health centers should not be "afraid to challenge findings, 4) suggested health center fix issues on the spot. In general, having a scheduled board meeting during the OSV can suggested in assisting in addressing issues immediately thus eliminating some cited issues as compliance concerns.

NACHC CEO and Board Chair Comments of Interest

- Mr. Van Coverden (TVC) briefly discussed the possible increase of funding for rural broadband subsidies.
- TVC, having met with several congressional budget office (CBO), discussed efforts to sustain the argument that, like the Children's Health Insurance Plan (CHI), health centers have a significant return on investment (future cost avoidance) and an impact on the net cost of care - - that this should be taken into consideration related to long-term funding.

Conclusion

This concludes my brief written summary of the most recent meeting of the NACHC Board of Directors.

I appreciate the opportunity to represent our health centers and primary care association on the NACHC Board and welcome any questions or feedback.

Respectfully submitted,

David B. Vliet, MBA, CPCA Board Member and Executive Committee Member, Tiburcio Vasquez Health Centers, Hayward/Union City, CA

*Courtesy NACHC CEO report, June, 2018

** Courtesy Alameda Health Consortia policy report, 2018

James Luisi

Board Member

CEO, North End Waterfront Health
Jim Luisi has been C.E.O. of NEW Health for over 29 years. During his tenure, he has overseen the creation of a 140 bed nursing home and an elderly housing development in the North End. Last year, he opened a community health center in New England's largest public housing development located in Charlestown which brought dental and vision services for the first time to that community.

He is a past Board Chair of the Mass League of CHCs and served for 8 years as Speaker of the House for the National Association of CHCs. He officially becomes NACHC's Board Chair in August 2017. He has testified numerous times before the U.S. Congress on the value and importance of health centers and Medicaid. Jim is a founding board member of Capital Link, the nation's financial lending and consultation organization for CHCs. For 16 years he has taught over 400 students as an adjunct professor at the Suffolk/Mass League CHC certificate program.

He is a Northeastern University graduate and holds an M.B.A. from Suffolk as well as Certificates in health care management from Harvard and Yale Universities.

His awards include a Lifetime Achievement Award from NACHC in 2009, CEO of the Year from the Mass League in 2007, a Public Service Award from the Boston Red Sox in 2005, Italian American of the Year in 2015 and Administrator of the Year from the Boston Business Journal in 2006.

Lathran J. Woodard

Lathran Johnson Woodard is the Chief Executive Officer (CEO) of the South Carolina Primary Health Care Association (SCPHCA or Association). Ms. Woodard has been with the SCPHCA for more than 30 years. She holds a degree in business administration from Southern Wesleyan University.

As the CEO for the SCPHCA, Ms. Woodard works to ensure that federally-funded community health centers and community mental health centers that provide vital services to medically underserved communities in the state are strengthened and have the capacity for growth. In addition, she is responsible for the overall operation of the Association. This includes overseeing the fourteen-state Southeast Health Disparities Collaboratives and the State Migrant Health Program funded by the Bureau of Primary Health Care along with forecasting and planning the future direction of the organization. Ms. Woodard's experience includes community and program development, staff enhancement training, and budget management. Her primary interests are in the area of local systems development relating to health care and youth self-enhancement.

Ms. Woodard is a member of several state and national organizations, which include the National Association of Community Health Centers, the National Association of Female Executives, the National Rural Health Association, the American Society of Association Executives, and the South Carolina Public Health Association. She currently serves as Chair-Elect for the National Association of Community Health Centers,

Listening Tour Framing Document: NACHC Board Chair, Jim Luisi, CEO North End Waterfront Health, Boston

Overview:

- In consultation with CPCA, board members and staff from CA attending the NACHC Winter Strategy Meeting last January planned to meet with NACHC Board Chair Jim Luisi to open a channel of communication directly between the California delegation and the NACHC Board Chair.
- Also, during that meeting, several NACHC members from across the country expressed dissatisfaction with the current culture at NACHC, particularly its weaknesses in diversity and inclusion.
- As a result, the CA delegation encouraged Jim to create an advisory committee, to be comprised of newer members with geographic and demographic diversity, to help inform the board chair on how NACHC could improve upon its diversity and inclusion.
- Also as a result, a meeting was planned during the NACHC P&I in DC to discuss with a selected, diverse group of members, areas of improvement across the six domains of diversity, inclusion, communication, positioning, innovation, and political climate. Immediately following this meeting at P&I, NACHC announced at its board meeting that Sunday the creation of a Chief Diversity Officer position in the ranks of the NACHC senior staff.
- Finally, as part of the NACHC Board Chair's advisory process, a listening tour has been established for him to hear from members across the country their opinions for improvement across these same six domains, and others as they may arise in conversation.
- As part of this listening tour, Jim will attend the RAC meeting on Wednesday, July 11 and the CPCA board meeting on Friday, July 13, as well.
- The next meeting of the Chair's Advisory Committee is being scheduled during the next NACHC meeting in Orlando in August.

Contd. on next page

Overarching thoughts in preparation for these meetings:

- We will express our sincere thanks for this opportunity to dialogue about our membership association.
- We recognize the need for a strong national organization and want to be a part of it.
- Our collective goals through this listening tour endeavor – while keeping a robust and iterative 50-state strategy top of mind, include:
    - quickly identifying issues and trends,
    - sharing information in manageable and effective ways to leverage opportunities and/or to respond to threats,
    - retaining alignment on membership and program fundamentals,
    - ensuring a coordinated approach to preventive programs (e.g., compliance) and rapid response (e.g., crisis communications); and,
    - the "raising of all boats" in the process by cultivating the membership, with particular attention to diversity and inclusion.
- In our dialogue, we will offer productive contributions and be solution-oriented – we wish to be engaged in forming solutions for today and tomorrow.

Issues/Challenges	***Signs of Progress***	***Ideal Future State***
DIVERSITY: Reflect the members' and their patients' demographics and geographics, from the street to our leadership, and governance. **Modeling is public-facing, member-facing, patient-facing, and partner-facing.**		

INCLUSION: Create a culture of member- centered inclusion: in which all members feel welcomed. **What does inclusion look like?**		
POSITIONING: Balancing federal positioning (protect) against state/local positioning (evolve & innovate). **Currently mismatched?**		
COMMUNICATION: Better understand the role of balanced communication vs instruction: from better coordinated, current, timely member communication to thought- leading conference content development. **Why do we communicate?**		
INNOVATION: Better resource and make better use of technology. **Give permission to innovate. Model it.**		
CLIMATE: Reflect sensitivity to the polarization of the current political climate. Membership in the field needs to feel included and on equal footing, **regardless of party.**		.

MOVING FORWARD: SWOT – what's worked well, what hasn't, what's the strategy going forward? **Who else should be included?**		
NEXT STEPS:		

California Primary Care ASSOCIATION

THE CODE OF CONDUCT

- Mutual respect and courtesy shall prevail at all times between all participants.
- Listen fully to others.
- Encourage diverse perspectives.
- Disagree openly and courteously.
- Share all relevant information. Confidentiality shall be strictly adhered to.
- Strive for consensus.
- Ask, rather than assume.
- Discuss interests, not positions.
- Be a good team player.
- Treat the staff with dignity and respect.
- Maintain appropriate communication boundaries with staff concerning internal operational and personnel issues.

Attendance at Board of Directors Meetings Policy

Members of the Board of Directors of the California Primary Care Association (CPCA) have a responsibility to the members who elected them to oversee the management and affairs of the Association and to set policies which guide CPCA in all of its activities.

1. All members of the CPCA Board of Directors have a duty to be present at all official meetings of the Board. The current practice is to have four Board meetings each year, however special Board Meetings may be called as necessary for items that are time sensitive.
2. All members of the CPCA Board of Directors are strongly encouraged to attend Committee meetings.
3. Per Bylaws, "Directors shall participate in at least 50% of regularly scheduled Board of Directors meetings in a given Board year. Directors who do not participate as so described shall be subject to removal from office by a majority of the Board." A Board year will be considered October through September 30th. The Board of Directors Job Description outlines a desire for a higher attendance rate at 75% in order for a Director to act in the best interest of CPCA as a whole and to exercise the legal and financial duties of the organization.
4. All minutes will reflect not only those Directors present, but those absent.
5. The Board Chair at his/her sole discretion, may (a) excuse (i.e., not count as a missed meeting) one (1) absence per Director per year and/or (b) grant a leave of absence for a Director without forfeiture of the Director's Board seat.
6. After one absence by a Director, a letter will be sent by staff to remind them of this policy.
7. After two absences, a call will be made by the Chair of the Board.
8. On the third absence in any given year, continued participation of any board member who has been unable to be present will be put to vote of the Board for removal.
9. Attendance will be tracked and reviewed regularly and a report made to the Governance Committee and Chair. All candidates running for reelection will have their attendance records in the prior year noted in election materials. Directors not meeting the 50% criteria for each year of their prior term will not be eligible to run for re-election.