

APSYS SOLUTIONS | EPIC IMPLEMENTATION RESOURCES

Epic Go-Live Readiness Assessment

30 Critical Tasks Before the Switch Flips

Built from real go-live failures — not vendor documentation. Use this before every readiness review.

38%

of organizations fully meet Epic go-live expectations

KLAS Research, 2024

50–70%

of healthcare IT projects miss timeline or budget targets

Industry consensus, multiple sources

\$266M

operating loss partly attributed to one Epic implementation

MD Anderson Cancer Center

Most Epic go-lives don't fail because the software doesn't work. They fail because the organization wasn't operationally ready — training was incomplete, interfaces weren't tested against real workflows, the Clarity reporting layer was treated as an afterthought, and the command center was understaffed for what day one actually demands. **This checklist exists because those failure patterns repeat across organizations of every size.**

Each item is ordered by the frequency with which its absence causes a delayed go-live or a chaotic first week. Work through this document 90, 60, and 30 days out. Items marked **CRITICAL** are non-negotiable: an unresolved critical item at T-30 days is not a yellow flag. It is a red one.

HOW TO READ THIS CHECKLIST

☐ **CRITICAL**

Non-negotiable. Go-live date at risk if unresolved.

☐ **STAFF AUGMENTATION**

Certified external resources required or strongly advised.

☐ **STANDARD**

Required for successful go-live. Internal lead with oversight.

PHASE 1 PROJECT GOVERNANCE & SCOPE CONTROL

The decisions made in the first 30 days of an implementation determine whether the go-live date is achievable. Most schedule slippage is committed before the build even starts.

☐ **01 Governance structure with a named executive sponsor who has real authority — CRITICAL**

Not a committee. One person with the authority to stop scope creep, resolve cross-departmental conflicts, and sign off on go/no-go decisions. The single most common predictor of a delayed go-live is a governance vacuum — no one with authority to say no when a department asks for a mid-project customization that wasn't in the original scope.

▲ Real-world failure pattern: *NYC Health + Hospitals' \$764M troubled rollout cited political pressure overriding operational readiness as a primary driver of patient safety failures post-go-live.*

☐ **02 Signed scope document with a formal change control process for any additions — CRITICAL**

Every uncontrolled scope addition adds risk to the timeline and budget. Document what's in scope, what's explicitly out of scope, and what process a department must follow to request a change. Any change request that touches the go-live date requires executive sponsor sign-off before being accepted.

⚠ Real-world failure pattern: *Healthcare IT Leaders research found that unchecked scope creep is the leading cause of budget overruns on Epic implementations. Organizations without formal change control boards routinely exceed budgets by 20–40%.*

- ☐ **03 Weekly project status report with a public issues log and owner-assigned action items**
 Issues that aren't written down don't get fixed. The status report should show the top 10 open risks, the owner of each, the due date, and whether it's trending toward resolution or getting worse. The command center director and executive sponsor should both receive this weekly.
- ☐ **04 Budget tracker updated monthly with actuals vs. plan across consulting, hardware, staffing, and training**
 Go-live budget overruns are almost always predictable 90 days before go-live — but only if someone is tracking. Hidden costs cluster around three areas: extended consulting hours for scope adds, additional staffing for go-live support that wasn't planned, and infrastructure upgrades surfaced late in integrated testing. Track them early.

PHASE 2 BUILD COMPLETION & MODULE LICENSING

Every licensed module must be production-ready on day one. Partial builds, unlicensed modules, and unvalidated configuration are leading causes of day-one clinical workflow failures.

- ☐ **05 All licensed Epic modules are fully built, validated, and signed off by clinical owners — CRITICAL**
 Not “mostly built” and not “IT signed off.” Each module needs a named clinical owner — a department lead or CMIO-level designee — who has reviewed the build against real workflows and signed a formal approval. Modules that are IT-validated but clinically unreviewed are a known source of post-live workarounds and rapid-cycle build changes during hypercare.
⚠ Real-world failure pattern: *KLAS research consistently finds that IT-driven implementations without clinical workflow validation generate 3–5x higher post-live help desk volumes than clinically co-designed builds.*
- ☐ **06 Epic license counts confirmed against actual projected user volumes with 15% headroom — CRITICAL**
 License shortfalls discovered at go-live are expensive, slow to resolve, and create access barriers at the worst possible moment. Reconcile licensed user counts against HR rosters, contractor headcounts, and any recently acquired practices or sites being brought in-scope. Build in at least 15% headroom.
- ☐ **07 Custom SmartForms, SmartPhrases, order sets, and preference lists reviewed by clinical leads**
 These are the tools physicians and nurses will use 50 times a day. If they're poorly designed, providers create workarounds that bypass the intended workflow and generate documentation gaps. Every clinical department lead should have reviewed and approved their order sets and SmartForms no later than T-60 days.
- ☐ **08 Downtime procedures documented, tested, and printed for every department — CRITICAL**

Downtime will happen. Network outages, planned maintenance windows, and unexpected failures are all real events in healthcare environments. Every department needs a printed, tested downtime procedure that doesn't assume system availability. "We'll figure it out if it happens" is not a downtime procedure.

⚠ Real-world failure pattern: *Multiple post-go-live incident reports cite the absence of tested downtime procedures as contributing to patient safety events during the first 90 days of Epic operation.*

PHASE 3 INTEGRATED TESTING

Integrated testing is where Epic go-lives are saved or lost. Most organizations underinvest in this phase, then pay for it with interface failures and data integrity problems in the first 30 days of live operation.

☐ 09 Integrated Systems Testing (IST) completed with all third-party interfaces passing end-to-end — CRITICAL

IST tests Epic as it will actually operate — with ADT feeds, lab results, imaging, pharmacy, billing, and any other connected system sending and receiving real message types. Every interface should be tested with production-representative data volumes. "The interface connects" is not the same as "the interface handles edge cases, errors, and peak message volume."

⚠ Real-world failure pattern: *Healthcare IT Leaders: "Sufficient testing of workflows, interfaces, and integrated systems often results in post-go-live disruptions, including system slowdowns, incorrect data transfers, and workflow failures." Insufficient was the intended word.*

☐ 10 Integrated Build Validation (IBV) completed and all P1/P2 defects resolved before T-30 — CRITICAL

IBV stress-tests the complete Epic environment as a system. P1 (patient safety) and P2 (operational blocker) defects must be fully resolved, regression-tested, and signed off before the 30-day final readiness gate. P3 defects should be documented with a post-go-live remediation plan.

☐ 11 User Acceptance Testing (UAT) completed with representative end users from every affected department — CRITICAL

UAT run only by the build team is not UAT. Floor nurses, attending physicians, registration staff, and revenue cycle analysts must walk through their actual daily workflows in the environment they'll use on go-live day. Issues caught in UAT cost hours to fix. Issues caught on go-live day cost patient safety and staff confidence.

☐ 12 A full mock cutover rehearsal has been completed, timed, and debriefed

Cutover is a compressed, high-stakes operational window. The first time your team runs through it should not be the real one. Run a mock cutover with the actual team, clock every step, and document what ran over time. The debrief from a mock cutover is one of the most valuable risk-identification exercises in the entire project.

PHASE 4 DATA MIGRATION & CUTOVER INTEGRITY

Data migration failures are frequently silent — partial loads that complete without error codes but write incomplete or inaccurate records. By the time clinicians notice, the damage is done.

☐ **13 At least three full test migrations completed with reconciliation reports reviewed by clinical leadership — CRITICAL**

A single successful test migration is not validation. Run at least three, compare the reconciliation reports across all three, and have a physician or clinical informatics lead review high-risk data categories: active medication lists, allergy records, problem lists, and pending orders. Anything less is an untested assumption.

▲ Real-world failure pattern: *ClinDCAST: “Poor mapping, incomplete records, and validation gaps lead to missing patient history or compliance issues if not handled carefully. The highest level of scrutiny must be applied to high-risk clinical data.”*

☐ **14 Cutover plan is sequenced hour-by-hour with named owners for every task and clear go/no-go gates — CRITICAL**

The cutover window compresses decisions that would normally take days into hours. Every task needs a named owner, a time budget, and a clear criterion for what constitutes completion. Go/no-go gates at regular intervals during cutover let leadership intervene before a delay becomes a missed go-live.

☐ **15 Legacy system access plan confirmed: who can access what, for how long, and through what process**

Clinicians will need legacy data after go-live. Medication histories, past visit notes, imaging, and lab results don’t automatically appear in Epic on day one. Document the access path for legacy data, communicate it to all clinical staff, and confirm the legacy system can support concurrent access volumes during the transition period.

☐ **16 Data governance lead named with authority to approve or reject record reconciliation decisions**

Data migration reconciliation generates decisions that have patient safety implications — which medication record is authoritative when two systems disagree, what to do with partially converted allergy records, how to handle duplicate patient registrations. These decisions need a named, qualified person with the authority to make them, not a committee.

PHASE 5 TRAINING COMPLETION

Training completion is the single most consistent predictor of post-live help desk volume and physician frustration. Going live with less than 90% completion is not a manageable risk. It is a foreseeable crisis.

☐ **17 Training completion rate at or above 90% for all user roles, tracked by department — CRITICAL**

The 90% threshold is not arbitrary. Organizations that go live below 85% completion consistently generate 2–3x the help desk ticket volume in the first 30 days compared to those at or above 90%. Track completion by department, not organization-wide — an 88% average can mask a critical care unit at 60% and a surgical floor at 40%.

▲ Real-world failure pattern: *Providence Health’s Epic training protocol requires an 80% minimum proficiency assessment pass rate before providers receive system access. Below 80%, providers are assigned the full training curriculum and retested.*

⚡ STAFF AUGMENTATION TRAINER CAPACITY & AUGMENTATION

☐ **18 Trainer-to-learner ratio assessed: if internal trainers cannot achieve 90% completion on schedule, external certified trainers are engaged — STAFF AUGMENTATION**

Internal training teams are frequently undersized for the scale of an Epic go-live. A team built for ongoing training is not the same as a team built for a compressed implementation window where every department needs to be trained in 8–12 weeks. If the math doesn't work — number of learners ÷ trainer capacity ÷ available weeks — external certified Epic trainers need to be on-site before the training schedule slips.

□ 19 **Superuser program operational: one trained superuser per unit/department, briefed on their role during go-live week**

Superusers are the first line of defense on go-live day. They are not IT staff. They are department-level staff who know Epic well enough to answer the basic questions — “Where is the medication reconciliation button?” — without calling the command center. Every department needs at least one. Emergency, ICU, surgical, and inpatient units need two. They must be trained and briefed on their specific role, not just given Epic access.

□ 20 **Physician training completion tracked separately, with a physician champion in each service line responsible for stragglers — CRITICAL**

Physicians are the highest-risk training non-completers in every Epic implementation. They are busy, they resent mandatory training, and they will not call the help desk on day one — they will create workarounds, document inadequately, or stop using the system. A physician champion in each service line who can personally reach out to the non-completers before go-live is worth more than three reminder emails.

PHASE 6 GO-LIVE COMMAND CENTER & STAFFING

The command center is where go-live crises are contained or allowed to spiral. Its effectiveness is entirely determined by who is in it and whether they have the authority and expertise to resolve issues in real time.

⚡ STAFF AUGMENTATION COMMAND CENTER & AT-THE-ELBOW STAFFING

□ 21 **Command center staffed with named leads for: Clinical, Technical (Epic), Interfaces, Help Desk, and Executive Escalation — CRITICAL**

A command center is not a room with computers. It is a decision-making structure. Five functions must be continuously staffed from go-live through the end of hypercare: clinical workflow issues (physician champion or CMIO), technical Epic issues (certified analyst leads), interface/integration failures (integration engineer), help desk triage coordination, and an executive escalation path for P1 patient safety issues that need immediate authority. If any of these seats is empty, issues will queue.

□ 22 **At-the-elbow (ATE) support staffed at a minimum ratio of one support analyst per six end users, for the first five days — STAFF AUGMENTATION**

The 1:6 ratio is an industry-derived standard from organizations including VCU Health (1,200 ATE staff for 16,000+ end users) and multiple CereCore case studies. For high-acuity units — ICU, ED, surgical services — the ratio should be closer to 1:4 during the first 48 hours. ATE staff are not IT generalists. They are Epic-certified or Epic-experienced individuals who can resolve a workflow question at the bedside in under 90 seconds.

⚠ Real-world failure pattern: HCTec: “Many health systems approach go-lives under-resourced, with limited at-the-elbow support. The result: poor adoption, productivity loss, clinician frustration, overwhelmed help desks — and most critically, disruptions to patient care.”

□ 23 **ATE staff pre-positioned in clinical units 3–5 days before go-live for workflow familiarization — STAFF AUGMENTATION**

ATE staff who arrive on go-live day as strangers are significantly less effective than those who spent the prior week walking the units, meeting the charge nurses, and learning which physicians prefer which workflows. The pre-positioning window is not optional for complex organizations. It is the investment that determines whether your ATE staff are familiar faces on day one or confusion added to confusion.

□ **24 Issue severity levels (P1 through P4) defined in writing with response time SLAs and escalation paths**

Without defined severity levels, every issue reported on go-live day feels like a P1. With them, the command center triage team can route a “I can’t find the discharge summary button” call to an ATE support person and reserve the command center leadership for actual patient safety events. Define the levels before go-live and communicate them to every support staff member.

□ **25 Daily command center debrief scheduled for end of each shift, first two weeks**

The debrief is how the command center learns and adapts in real time. Issue patterns — three different departments reporting the same medication reconciliation problem — only become visible when someone is aggregating and reviewing the issue log at end of shift. Debrief reports should go to the executive sponsor daily during the first two weeks.

PHASE 7 REPORTING & CLARITY READINESS

Reporting is almost always the most neglected layer of an Epic go-live. Dashboards that are dark on day one are not a minor inconvenience — they’re an operational failure for every team that depends on data to run the organization.

□ **26 Clarity ETL schedule configured, tested, and validated against production data volumes before go-live — CRITICAL**

Clarity is the reporting database that feeds every dashboard, operational report, and quality metric your organization uses. It is populated by a nightly ETL process. That ETL must be configured, tested against realistic data volumes, and validated end-to-end before go-live — not after. Organizations that treat Clarity as a “post-live we’ll configure it” item routinely have dark or inaccurate dashboards for weeks.

⚠ Real-world failure pattern: *APSYS Case Study 02: An organization with 11 consecutive weeks of nightly Clarity ETL failures across seven hospitals traced the root cause to a TempDB misconfiguration and a job sequencing flaw that had been in place since initial setup. The issue was treated as a technical problem but its operational impact was felt by clinical and executive teams every morning.*

□ **27 All critical operational, clinical quality, and revenue cycle reports identified, built, and validated with live data from the test environment — CRITICAL**

Define “critical” specifically: the reports that, if dark on day one, will generate calls to the CIO’s office. Census and capacity reports. Daily admissions and discharge summaries. Charge capture and coding work queues. Quality and safety dashboards. These must be built and producing accurate data in the test environment before go-live. Not in design. Not in queue. Built and validated.

⚡ STAFF AUGMENTATION CLARITY & ANALYTICS SPECIALIST AUGMENTATION

□ **28 A Clarity-certified analyst has reviewed all critical report builds and validated execution plans against production data volumes — STAFF AUGMENTATION**

Clarity report performance at low test-environment volumes frequently does not predict performance under production load. A report that runs in 3 minutes in the test environment may run in 45 minutes in production when it's competing for SQL Server resources with 200 concurrent users and a full nightly ETL. A Clarity-certified analyst reviewing execution plans before go-live is the difference between finding this out in testing and finding it out at 6 AM when the discharge planners are waiting.

□ **29 SlicerDicer governance model defined: who can build reports, what data domains are accessible to which roles, and who approves new report access**

SlicerDicer gives end users direct access to Clarity data through a self-service reporting interface. Without governance, organizations find themselves six months post-go-live with dozens of conflicting reports on the same metric, users with access to PHI they shouldn't have, and no record of what was built by whom. Define governance before you turn it on.

PHASE 8 INFRASTRUCTURE, SECURITY & COMPLIANCE

Infrastructure failures don't typically delay go-lives — they cause go-live day disasters. Network capacity, device readiness, and access provisioning must be closed out before the cutover window opens.

□ **30 Network capacity validated against Epic's bandwidth requirements at peak concurrent user projections — not average projections — CRITICAL**

Epic's bandwidth requirements are documented and specific. The test is not "does the network support Epic." The test is "does the network support every user in the building simultaneously trying to open a chart during the first-hour rush." Run load testing at 125% of peak projected concurrent user counts. Anything less is an untested assumption. Wireless access points, VPN capacity for remote users, and printer network paths all need to be in scope.

□ **31 All clinical workstations, mobile devices (WOWs, tablets, phones with Haiku/Canto) provisioned and tested in production environment**

Devices that work in the test environment and fail in production due to certificate issues, proxy mismatches, or Epic version incompatibilities are a recurring day-one failure pattern. Every device class needs to be tested in the actual production environment, not just tested once and assumed equivalent.

□ **32 Epic user provisioning completed: all users have correct roles, training completion confirmed, and accounts tested by a sample group — CRITICAL**

Access provisioning at scale is error-prone. Role mismatches — a nurse with physician access, a registration staff member without ADT access — generate both patient safety risk and operational disruption. Sample-test access for at least one user from every role category before go-live. Do not find role problems at the help desk on day one.

□ **33 HIPAA access audit completed: Epic role-based access controls reviewed against the minimum necessary standard**

Epic go-lives routinely expose access provisioning decisions made quickly under deadline pressure. Before go-live, a formal minimum-necessary review of all Epic role templates ensures that the access picture in production reflects policy, not convenience. This is both a patient privacy obligation and a Joint Commission requirement.

PHASE 9 30–60 DAY HYPERCARE PLAN

Go-live is not the finish line. The 30 days after go-live determine whether the organization stabilizes quickly or spends six months fighting the same problems on repeat.

- **34 Hypercare staffing model defined: who is on-site, for how long, and at what trigger does the model scale down**

Hypercare is not just “keep the command center open.” Define the staffing levels for weeks one, two, three, and four. Define what performance metrics — daily ticket volume, open P1 count, training completion rate — authorize scaling down ATE staffing. Organizations that don’t define exit criteria for hypercare find themselves either staffing it indefinitely or cutting too early and regretting it.

⚡ STAFF AUGMENTATION POST-GO-LIVE OPTIMIZATION STAFFING

- **35 Optimization sprint planned for weeks 5–16: workflow redesign, report refinement, and targeted retraining for high-ticket departments — STAFF AUGMENTATION**

The most valuable investment after a go-live is a structured optimization sprint that acts on the patterns surfaced during go-live support. Which departments generated the most tickets? Which workflows are generating the most workarounds? Which reports are wrong or missing? An optimization sprint with certified Epic analysts — often augmented externally for the workload spike — converts a stabilized go-live into a high-adoption implementation.

A note on using this checklist: If you hit T-30 days and have unchecked critical items, the answer is not to lower the threshold for what “ready” means. The answer is to get the right resources in place immediately. Most go-live crises are foreseeable. The organizations that avoid them are the ones that looked at the readiness picture honestly six weeks out and made the decision to close the gaps — whether through internal effort, schedule extension, or bringing in a certified external team.

The staff augmentation items in this checklist are highlighted not because they require a vendor. They are highlighted because they require **a specific kind of expertise and a specific kind of capacity** — and the organizations that try to cover these items with generalist staff or undertrained resources pay for it in the weeks after go-live, not before.

Gaps on this checklist? APSIS can close them in 24–48 hours.

Certified Epic analysts, command center leads, trainers, and Clarity specialists — available now.

apsisinc.com | 813-999-4853
info@apsisinc.com

About Apsis Solutions Inc.

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