



July 1, 2024 – December 31, 2025

Common Value-Based Payment Model Guide for Primary Care Physicians & Payers

Payment Model Demonstration Project
California Advanced Primary Care Initiative



California Quality
Collaborative



Integrated
Healthcare
ASSOCIATION

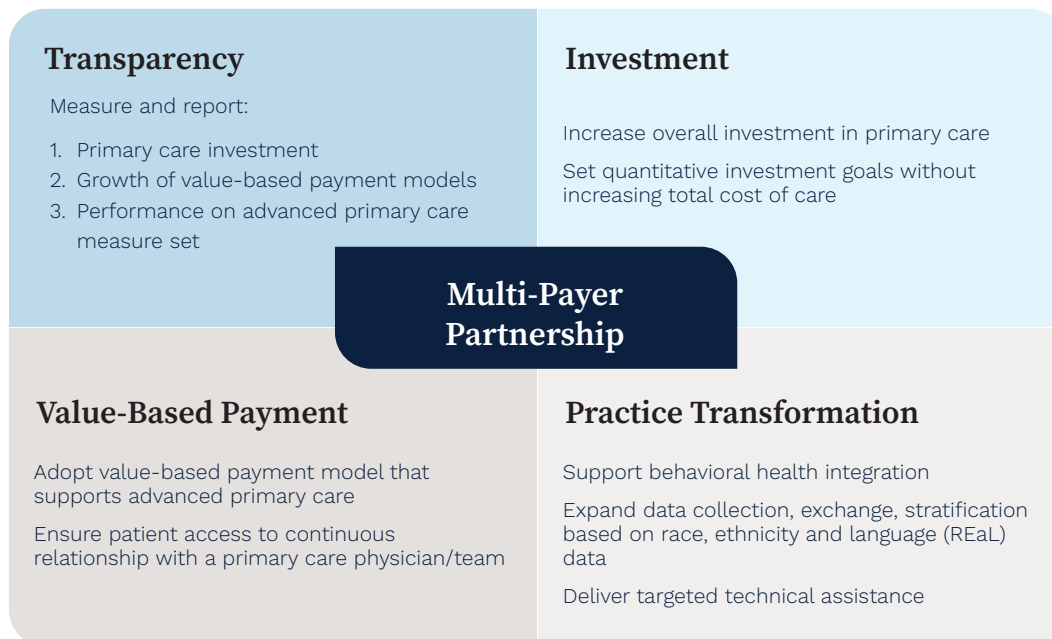
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What is the California Advanced Primary Care Initiative?

Convened by the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA), the California Advanced Primary Care Initiative is an effort comprised of a group of California-based health care payers — predominantly health plans — who have voluntarily partnered to support providers in strengthening primary care delivery. The group shares a common definition for Advanced Primary Care based on attributes and measures that was collaboratively built by care providers, health plans and other health system partners.

The initiative is working towards increasing adoption of payment models that provide increased resources, more flexibility, and rewards for quality to primary care practices piloting value-based payment models that invests more into primary care. Due to the range of payers that practices contract with, implementing payment changes collectively has the potential to yield greater positive impact compared to individual plan-driven efforts.



Value-Based Payment

What is Value-Based Payment?

Value-based payments tie health care provider payments to the quality of care delivered. Better outcomes will yield higher payment. These payments are generally designed to be flexible, as they are not tied to delivering specific services. Value-based payment generally holds providers more accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time.

How is Value-Based Payment Beneficial to Primary Care Physicians?

Providers receiving payment through a fee-for-service (FFS) model are often not compensated for all the work they do. Running a practice and managing the health of a population involves more than interacting directly with patients. Shifting to value-based payment creates flexible revenue for all the additional work clinicians and their team do when not directly engaging with patients, such as hiring and training new staff, chart review, referral research, patient calls, care coordination, process improvement and business administration. Value-based payment also pays more for high-quality outcomes.

Why Are Multiple Plans Paying This Way Together?

There is general agreement on the concept of value-based payment, but what counts as “value” or “high quality” varies. When multiple payers work together to pay primary care providers more using similar criteria, providers can focus on what is most important — providing high-quality patient care — and confusion and administrative burden are reduced. When a larger portion of the patient panel is paid under an aligned value-based model, it enhances value to the provider by increasing the opportunity to earn more based on performance while supporting sustainability.

What is the Impact on Patients?

The overarching goal of value-based payment is to incentivize providers for high-quality performance and equip them with the resources necessary to deliver better patient care — leading to improved outcomes for patients.

Payment Model Demonstration Project Overview

The California Advanced Primary Care Initiative is conducting an 18-month demonstration project of the common value-based payment model. The demonstration project will partner with up to 30 independent primary care practices in the southern California and Central Valley regions, with the following goals:

- Test the payment model (for more details about all tracks of the payment model, see pages 6-13).
- Build advanced primary care capabilities within participating practices through payment and direct technical assistance, enabling care team success in value-based payment models (for more details about the support for practices, see pages 18-19).
- Improve outcomes for people served by the participating practices.

Four health plans — Aetna, Anthem Blue Cross, Blue Shield of California and Health Net — collaborated to build a framework for a common value-based payment model that enables prospective Population Health payments, provides flexibility in how prospective payments are invested, rewards improvement and high performance, and potentially increases total payment. To demonstrate the impact of value based primary care, these health plans are jointly conducting a demonstration project with practices that contract for commercial PPO with at least one of the plans, and ideally multiple plans, that account for a significant portion of the practice's panel. This will enable business and clinical transformation across the whole practice.

By coordinating this demonstration project among shared practices and aggregating resources and technical assistance to practices in one collective approach, the project can demonstrate that collective impact is greater than individual efforts and needed change can be accelerated.

Payment Model Overview

The initiative's payment model aims to increase pay for primary care providers and do so differently, in a manner that invests in primary care in California and promotes value-based care. The payment model includes three elements of payment to participating practices. Together, these three elements of payment are intended to increase revenue to practices, support patient relationships and care coordination, and improve provider satisfaction.

For participating practices under the common payment model, there is a potential to earn up to an additional 30% above base payments across the three elements listed below. While the distribution of the increased payment allocation amongst the three elements may differ from plan to plan, the initiative aligns on the unified target of 30% potential increase in payment.

	Element 1 Direct Services Payment (Three Tracks)	Element 2 Population Health Management Payment	Element 3 Performance Incentive Payment
Track A	Fee-For-Service Plus: Plans continue to pay FFS for all direct patient care services.	A prospective, adjusted regular payment based on PMPM to support Advanced Primary Care attributes such as population health management functions <ul style="list-style-type: none"> • referral & follow up • patient outreach • coordination with other resources • transitions of care • team care • infrastructure, data & reporting, etc. 	Rewards practice performance on common measure set <ul style="list-style-type: none"> • Payment for meaningful improvement (10% relative) if original score is between simple numerical targets loosely tied to the national 25th to 66th percentile benchmarks • Payment for attainment if scores above around the 66th percentile (higher) • Pay more for improvement or attainment on equity sensitive measures.
Track B	Basic Capitation: Pays a prospective, adjusted PMPM payment for E&M, all other services paid FFS		
Track C	Intermediate Capitation: Pays a prospective, adjusted PMPM payment for E&M and additional services, all other services paid FFS		

Payment Element 1 tracks B and C and Element 2 will be adjusted for clinical risk and social risk

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Payment Model Elements

1. Element 1: Direct Services Payment (Three Tracks)
 - a. FFS+
 - b. Basic Capitation
 - c. Hybrid Capitation
2. Element 2: Population Health Management Payment
3. Element 3: Performance Incentive Payment

Element 1: Direct Services Payment

Direct services is all patient care that is billable. The direct services payment includes payment for eligible direct care services for patients. There are three voluntary tracks for direct services payment: A) Fee For Service +, B) Basic Level Capitation Hybrid Model and C) Intermediate Level Capitation Hybrid Model that practices may be able to choose from, depending on health plan offerings and provider preference. It is possible for a practice to participate in more than one track if the practice contracts with multiple health plans, but practices will only participate in one track per health plan.

Figure 1: Three Potential Tracks for Element One- Direct Services Payment

A. FFS+ Model Direct Services: All direct services are reimbursed Fee For Service (FFS)
B. Basic Level Capitation Hybrid Model Direct Services: Evaluation and management services are capitated Per Member Per Month (PMPM), all other services remain FFS
C. Intermediate Level Capitation Hybrid Model Direct Services: Evaluation and management services and additional services (transitional care management, advance care planning, non-oral drugs, certain small surgeries, some ultrasounds) are capitated PMPM, all other services FFS

Table 1: Capitated Services and CPT Codes – Basic Level Capitation Hybrid Model (B)

Services Covered Under Capitation	Services to be Paid Fee for Service
E&M 992xx	Immunizations 90281–90756, G0008–G0010
Other E&M 99300-99499	Annual well visits 99381–99387, 99391–99397 Home visits Rest home visits SNF
	All other direct, billable services rendered by primary care practice

Table 2: Capitated Services and CPT Codes – Intermediate Level Capitation Hybrid Model (C)

Services Covered Under Capitation	Services to be Paid Fee for Service
E&M 992xx	None
Other E&M 99300-99499	Home Visits, Rest Home Visits, Skilled Nursing Facility (SNF)
Medicine Services 90757-99756, HCPCS – S & Q codes	Echocardiograms, Specimen handling, Inhalation treatment, Filing of inflatable pump, COVID testing, Flu Vaccines, IV tubing, IV infusion, Pap smear, IUDs, Abortion
Temporary HCPCS – G & C Codes	COVID testing
Drugs, non-oral and chemo – HCPCS – J Codes	Ceftriaxone, Progesterone, Asthma-related, Nausea-related, IV Fluid, IUDs, Estradiol, Cortisone, Chemo
Category III – Codes ending in T	None
	All other direct, billable services rendered by primary care practice

This Guide outlines the model’s recommended metrics and methodology. Each participating plan will determine whether they will adopt the recommendations or modify them to meet their business needs and any regulatory requirements.

Element 2: Population Health Management Payment

Population health management payment supports population health and care coordination activities and will be paid either monthly or quarterly to the practice. The payments are based on a PMPM calculation. The population health management payment is additive to payment for direct care services (Element One). The monthly PMPM calculated amount may be adjusted for clinical and social risk based on the methods outlined in this section.

As stated above, the Initiative recommends a potential 30% increase to base payment amongst the three elements, with flexibility for plans to allocate a higher share of the increase in payment to one or more of the elements as they see fit. As a result, the Population Health Management amount may vary slightly from plan to plan while commitment to an overall increase of up to 30% in payment remains aligned.

The initiative recognizes the activities for investment may vary from practice to practice but will require that dollars are put toward strengthening the advanced primary care attributes. Technical assistance coaches will work one-on-one with practices, at no cost to the practice, to assess where these additional funds may be best utilized depending on each unique situation and will be tracking progress via surveys and regular collection tools. See pages 18-19 for additional information on technical assistance.

Element 3: Performance Incentive Payment

Background

In developing the model for performance incentive payment, the initiative convened a physician workgroup to help create an incentive design that is simple, meaningful, and that reinforces the message that every practice that excels will be rewarded. The initiative is working to move beyond longstanding incentive models based on percentiles within a cohort that force competition among participating practices and instead will put forth numerically simple target scores drawn loosely from national percentiles. This will ensure each practice has the opportunity to succeed for performance on each measure compared to a benchmark that is simple to understand and remember and will not change during the demonstration project. The initiative understands that quality measurement can be a significant undertaking and one of many competing priorities providers must juggle, and it incentivizes improvement on the path to quality performance excellence.

Methodology

Similar to the Population Health Management payment, there is flexibility for plans to allocate a higher share of the overall increase in primary care payment to Element 3: the Performance Incentive than the other two elements. This allows for flexibility while remaining aligned to the overall target of the potential 30% increase in overall payment to the participating practices. As a result, the maximum performance incentive amount may vary from plan to plan. The Performance incentive will evaluate Quality, Efficiency, Cost and Patient Experience and incentivize practices that achieve improvement or attainment.

The initiative's performance incentive payment will reward both attainment and improvement, with increasing payment for better performance. There will be a smaller incentive for practices that do not reach the Attainment Threshold (as described below) but demonstrate meaningful improvement.

- The initiative intends to use clinically meaningful levels of performance based on national percentiles as benchmarks, and targets will remain steady for the duration of the demonstration project and ideally going forward.
- The performance incentive will be paid based on performance on the standard primary care measure set listed below. Measure payouts are determined individually by each measure where practice data is available.

Table 3: Advanced Primary Care Measure Set

Standard California Primary Care Standard Measure Set	Measure Type	Source/ Benchmark Source	Population
Depression PROMs (DSF-E) Phased approach: screening → monitoring → remission	Quality	NCQA	Adult/pediatric
Breast Cancer Screening (BCS)	Quality	NCQA	Adult
Controlling High Blood Pressure* (CBP)	Quality	NCQA	Adult
Colorectal Cancer Screening* (COL)	Quality	NCQA	Adult
Glycemic Status Assessment for Patients with Diabetes <8.0%* (GSD)	Quality	NCQA	Adult
Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD) Info only for demonstration, not eligible for incentive	Quality	NCQA	Adult
Asthma Medication Ratio (AMR)	Quality	NCQA	Adult/pediatric
Childhood Immunization Status: Combination 10* (CIS)	Quality	NCQA	Pediatric
Immunizations for Adolescents: Combination 2 (IMA)	Quality	NCQA	Pediatric
Emergency Department Utilization (EDU)	Utilization	NCQA/IHA Atlas	Adult
Acute Hospital Utilization (AHU)	Utilization	NCQA/IHA Atlas	Adult
Total Cost of Care using standardized pricing (TCOC)	Cost	HealthPartners	Adult/pediatric
Patient Experience (CG-CAHPS) Addressed through technical assistance only, not eligible for incentive	Patient Experience	AHRQ	Adult/pediatric

* The National Committee for Quality Assurance (NCQA) and Covered California are requiring these measures to be reported stratified by race and ethnicity, because they tend to be equity sensitive. This means they exhibit a greater range of performance when stratified across demographic variables. Additionally, these measures are emphasized in Covered California's [Quality Transformation Initiative](#). This version of the payment model demonstration project will not be evaluating based on stratified scores for race and ethnicity.

** All utilization and cost measures will be risk adjusted

As the table above illustrates, there are eleven total measures included in the Advanced Primary Care measure set and eligible for the performance incentive. Variance on the number of measures applicable at each practice depends on the type of practice and the population for which each measure applies. For Mixed Practices, or practices that

serve both adult and pediatric population with neither making up a strong majority, all measures apply. For Adult practices, there are nine measures and for Pediatric practices, there are five measures.

Along with guidelines for both attainment and improvement in this section, there is a table included in both the attainment and improvement sections that models out the proportion of the maximum total incentive amount for each of the applicable measures for the three types of practice (Mixed/Adult/Pediatric). For example, for a pediatric practice that has five applicable measures, each measure will be worth a larger proportion of the total incentive amount than a mixed practice where there are eleven measures. The intention is that each practice, regardless of the type of population they serve, is eligible for the maximum incentive amount set by each payer. It is also important to note that Non-QTI measures are consistently worth about two-thirds of QTI measures in an effort to emphasize the importance of equity sensitive measurement.

A practice's performance on each measure will fall into one of three categories: 1. score is ineligible for an incentive as it does not meet the minimum threshold score, 2. score meets the minimum performance threshold but does not meet or exceed the attainment threshold and is eligible for an improvement incentive, or 3. score meets the attainment threshold and is eligible for an attainment incentive.

Performance incentive payments are recommended to be paid at least bi-annually, with an initial payout from health plans based on projected amount earned and another payout to reconcile the difference.

Element 3: Performance Incentive Payment: Improvement Incentive

The performance-based incentive payment will reward improvement within the Improvement Range from the Minimum Performance Threshold which loosely aligns with the national 25th percentile (from the National Committee for Quality Assurance) for all lines of business up to the Attainment Threshold which aligns loosely with the national 66.7th percentile.

Improvement Incentive Guidelines

- If a practice's performance is within the Improvement Range, it is recommended the practice receive a payment if their performance closes at least 10% of the gap between baseline performance and the Attainment Gold Standard (roughly the national 90th percentile).

Table 4: Performance-Based Improvement Incentive Model

Measure	Adult/ Pediatric	Improvement Range	Attainment Gold Standard	Improvement Needed to Earn Incentive	Mixed Practice	Pediatric Practice	Adult Practice
					% of Total Incentive	% of Total Incentive	% of Total Incentive
Childhood Immunization Immunization Status Combo 10 (CIS)	Pediatric	45-61	70	10% gap closure	5.0%	11.0%	NA
Immunizations for Adolescents Combo 2 (IMA)	Pediatric	26-35	46	10% gap closure	3.5%	7.5%	NA
Asthma Medication Ratio (AMR)	Both	81-87	91	10% gap closure	3.5%	7.5%	4.0%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	Both	TBD	TBD	10% gap closure	3.5%	7.5%	4.0%
Total Cost of Care (TCOC)	Both	TBD	TBD	10% gap closure	3.5%	7.5%	4.0%
Breast Cancer Screening (BCS)	Adult	70-76	80	10% gap closure	3.5%	NA	4.0%
Colorectal Cancer Screening (COL)	Adult	52-63	67	10% gap closure	5.0%	NA	6.0%
Controlling High Blood Pressure (CBP)	Adult	56-67	74	10% gap closure	5.0%	NA	6.0%
Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD)	Adult	55-64	69	10% gap closure	5.0%	NA	6.0%
Acute Hospital Utilization – Total Acute (AHU)	Adult	26-21	18	10% gap closure	3.5%	NA	4.0%
Emergency Department Utilization (EDU)	Adult	146-121	107	10% gap closure	3.5%	NA	4.0%

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Element 3: Performance Incentive Payment: Attainment Incentive

If the practice's performance reaches the Attainment Threshold for a measure, the practice is eligible for an attainment incentive and is no longer eligible for an improvement incentive.

Attainment Incentive Guidelines

- If the practice's performance meets the Attainment Threshold for the measure, the practice will receive a recommended base, depending on whether it is a QTI measure, and incrementally more the closer they are to the Attainment Gold Standard.
- If the practice's performance meets the Attainment Gold Standard for a measure, the initiative recommended incentive amount increases with higher amounts given to equity sensitive measures.
- The recommended total maximum PMPM across all measures and including both attainment and improvement is as much as 15% increase to base payment.

Table 5: Performance-Based Improvement Incentive Model

Measure	Adult/ Pediatric	Attainment Threshold	Attainment Gold Standard	Mixed Practice		Pediatric Practice		Adult practice	
				Threshold % of Total Incentive	Gold Standard % of Total Incentive	Thresh- old % of Total Incentive	Gold Standard % of Total Incentive	Thresh- old % of Total Incentive	Gold Standard % of Total Incentive
Childhood Immunization Immunization Status Combo 10 (CIS)	Pediatric	61	70	7.5%	12.0%	16.5%	27.0%	NA	NA
Immunizations for Adolescents Combo 2 (IMA)	Pediatric	35	46	5.0%	8.0%	11.0%	18.0%	NA	NA
Asthma Medication Ratio (AMR)	Both	87	91	5.0%	8.0%	11.0%	18.0%	6.0%	10.0%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	Both	TBD	TBD	5.0%	8.0%	11.0%	18.0%	6.0%	10.0%
Total Cost of Care (TCOC)	Both	TBD	TBD	5.0%	8.0%	11.0%	18.0%	6.0%	10.0%
Breast Cancer Screening (BCS)	Adult	76	80	5.0%	8.0%	NA	NA	6.0%	10.0%
Colorectal Cancer Screening (COL)	Adult	63	67	7.5%	12.0%	NA	NA	9.0%	14.0%
Controlling High Blood Pressure (CBP)	Adult	67	74	7.5%	12.0%	NA	NA	9.0%	14.0%
Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD)	Adult	64	69	7.5%	12.0%	NA	NA	9.0%	14.0%
Acute Hospital Utilization – Total Acute (AHU)	Adult	21	18	5.0%	8.0%	NA	NA	6.0%	10.0%
Emergency Department Utilization (EDU)	Adult	121	107	5.0%	8.0%	NA	NA	6.0%	10.0%

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Risk Adjustment

Element 1 (Track B and C) capitation payments and Element 2 population health management payments will be adjusted for clinical severity and social risk. The initiative seeks to align with the National Academies report on primary care and recognizes that different patients will need different levels of primary care based on their unique medical situation, demographic area and other variables.

Clinical Risk

The initiative seeks to align with the Office of Health Care Affordability (OHCA) and will adjust for age and gender in the payment demonstration project. For potential future use, the initiative will continue to explore the value of developing a more nuanced approach to adjustment that includes clinical diagnoses.

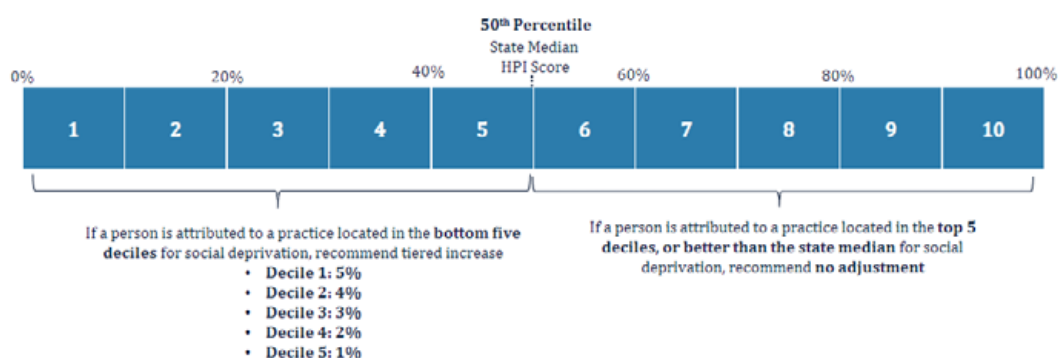
Social Risk

The initiative will use the California Healthy Places Index (HPI) to adjust payments for both direct service capitation and population health management payment. HPI was selected as the superior index, as it is a California-specific index and includes additional data sources on top of the American Community Survey commonly used in other indices.

Direct service capitation and population health management payments will be adjusted upwards only for populations lower than the California state median HPI score. HPI scores will be calculated based on practice location and every practice will be attributed to a decile. If the practice is located in the bottom five deciles for social deprivation, the recommended tiered increase is 5% upwards adjustment for the lowest decile, 4% for the second lowest decile, 3% for the third decile, 2% for the fourth decile, and 1% for the fifth decile. If the practice is located in the top five deciles, or better than the state median for social deprivation, the Initiative recommends no adjustment.

Although the additional payment for social risk is expected to increase a small amount overall, the initiative believes that incorporating a person's social environment into the primary care payment model through social risk adjustment is a step toward whole-person, integrated care.

Figure 2: Recommended HPI Adjustment Index



Attribution

Attribution will either be performed at the plan level according to a plan's own attribution methodology and provided to the common reporting platform each month or alternatively, the common reporting platform will run a common methodology for plans who choose this route.

If the common reporting platform is chosen, membership attribution will be done utilizing claims data and will map each member to one practice and then one primary care provider. Each participating practice of the initiative will have a panel of attributed members that will be updated monthly.

Common Methodology

Members will be attributed to a single primary care practice and then to a provider in that practice. Preference will be given to a primary care provider selected by a member or matched by a plan. If a member has selected or been matched to a PCP they will be attributed to their selected/matched PCP. In the absence of a selected/matched PCP, attribution will be established based on the primary care practice and provider that has been seen most frequently and recently over the past 12-month period, with a further six-month lookback period considered, if necessary.

Primary care is defined as all services provided by Family Practice, General Practice, Internal Medicine, Pediatrics and primary care-focused Nurse Practitioners and Physician Assistants and includes subspecialties related to adolescent, adult and geriatric medicine, hospice and palliative medicine* and school* and community health*.

* service restrictions apply

Incentive Payouts

The initiative recommends incentive payouts occur every six months during the payment demonstration project, approximately a quarter after each six-month period has closed, with reconciliations as needed. The rationale for every six months (instead of a year) is to help invest more into primary care practices sooner to fuel their improvement. There would be three incentive payouts for the demonstration project. The first payout would occur in approximately March 2025 based on performance through December 2024. The next payout would be in approximately September 2025 for performance through June 2025. And the last incentive payout would be made in approximately March 2026 based on performance through December 2025. Details are displayed in the table below.

	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026
Demonstration project starts July 1, 2024		First incentive payout: March 2025 (for performance through December 2024)		Second incentive payout: Sept 2025 (for performance through June 2025)		Third incentive payout: March 2026 (for performance through December 2025)

Common Reporting Platform

The initiative will use a common reporting platform for the payment model demonstration project that requires only one login to view data on patients across plans. The intention is to create a seamless experience for practices and provide them with actionable information related to performance on the measures used for incentive payments. A common reporting platform will provide aggregated results reporting for practices, as well as tools such as member-specific care gap analysis, identification of high-risk members and attribution flagging for members who are likely to fall off a practice's attribution list. Practices will receive training and ongoing support on the platform through the technical assistance described below.

Technical Assistance

Providers contracting for any version of the initiative's common value-based payment model will engage in technical assistance to support performance improvement. Technical assistance services are provided by the [California Quality Collaborative](#) (CQC), a nonprofit regional health care improvement program of the Purchaser Business Group on Health. CQC has been serving ambulatory care practices across California for more than twenty years.

Technical assistance will include evidence-based support through a combination of on-demand virtual learning resources and personalized guidance from an improvement coach who interacts with practices in bi-monthly virtual coaching sessions and remain available to address questions and offer support throughout the duration of the initiative. The improvement coach will partner with the practice to understand needs and opportunities, set goals, guide improvement efforts and track progress. In addition, participating practices will meet together each quarter to exchange learnings, provide peer support for overcoming challenges and celebrate achievements.

Curriculum

The foundation of the technical assistance program will focus on concepts from evidence-based frameworks and best practices, including:

- [Model for Improvement](#)
A widely used framework from the Institute for Healthcare Improvement for developing, testing and implementing changes leading to improvement.
- [10 Building Blocks of High-Performing Primary Care](#)
A roadmap to identify foundational capabilities and implement these 'building blocks,' which include practice-level advanced primary care capabilities like engaged leadership, data-driven improvement, team-based care and population management. CQC has developed [webinars](#) on the 10 Building Blocks of Primary Care.
- [Practice Transformation Initiative](#)
An assessment, change package and curriculum developed by CQC and used across more than 2,000 California primary care practices to guide transformation efforts and improve care and health outcomes.

Support and Resources

In addition to learning practice-level change concepts, participants will have access to skill-building trainings such as improvement coaching, motivational interviewing and patient and family engagement techniques.

Participating practices will receive a range of technical assistance from CQC to support quality improvement and advanced primary care capabilities. In turn, each practice will work directly with their assigned improvement coach to tailor, test, implement and scale the quality improvement recommendations.

The technical assistance will focus on strategies that build upon and enhance existing practice capabilities and relationships with participating practices. Practices will leave the program with deeper insight into their practices and an improved ability to support their quality improvement work



About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of PBGH, is a health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment. The program is dedicated to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, the state and purchasers to align goals and take action to improve the value of health care for Californians.

Visit pbgh.org/program/california-quality-collaborative to learn more.

Integrated Healthcare Association

At Integrated Healthcare Association (IHA), we bring the healthcare community together to solve industry-wide challenges that stand in the way of high-value, equitable care. As a non-profit industry association, we use objective data, our decades of expertise, and our unique role as a trusted facilitator to make the healthcare system work better for everyone. We provide insights that help the healthcare system continuously improve. We build new tools that simplify how the industry works together. And we provide a forum for cross-industry leaders—through our board and our programs—to have honest conversations that guide the future of healthcare. Because we envision a future where people get the best possible care at an affordable price. Where providers can focus on delivering care, health plans can focus on serving their customers, and purchasers feel confident they're getting value for their money. A future where the healthcare system works.

Visit iha.org/who-we-are to learn more.

Contact us to learn how you can get involved: lpetersen@pbgh.org



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