Equity and Quality at Independent Practices in Los Angeles

Final Evaluation Report • July 2025

EQuIP-LA

CCHE CENTER FOR COMMUNITY HEALTH AND EVALUATION

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Executive summary

Program overview

Launched in 2023, EQuIP-LA was a two-year improvement collaborative to invest in and support small independent practices that deliver care to a significant portion of Medi-Cal patients in Los Angeles, but typically receive less support. The program aimed to strengthen advanced primary care capabilities and reduce health disparities. Using a train-the-trainer model, EQuIP-LA provided funding, technical assistance, coaching, and data support to four Provider Organizations (POs)—i.e., three Independent Practice Associations (IPAs) and one health plan's direct network—which in turn supported 31 practices that care for over 50,000 Medi-Cal enrollees.

Evaluation design

The evaluation used a mixed-methods approach to collect and analyze data, including monthly clinical performance data, a practice capability assessment, interviews, surveys, observation notes, and program documents.

Key learnings

1. Improved Clinical Quality Measures:

EQuIP-LA drove statistically significant improvements ($p<0.01$) in three priority clinical measures (Controlling Blood Pressure, Colorectal Cancer Screening, Glycemic Status Assessment for Patients with Diabetes >9%) across almost all participating practices.

- 30 of 31 independent practices improved at least one measure.
- More practices met national benchmarks by program end.
- Effective strategies included patient outreach, education, documentation improvements, and at-home screening kits. Practices reported limited staff capacity and patient engagement were key challenges to further improving performance.

2. Strengthened Primary Care Capabilities:

EQuIP-LA enhanced foundational capabilities through coaching and quality improvement (QI) tools.

- Capability assessment scores improved across most of the seven domains of foundational primary care by at least 1 point on average (0–3 scale). Most practices reached the maximum score in at least one domain and reported that the program contributed to these improvements.
- While stronger capability assessment scores correlated with better performance on clinical

measures, almost all practices made progress. Those with lower capabilities may require more time to reach the same performance benchmarks.

- Practices reported increased confidence in sustaining new workflows, engaging in future QI efforts, and accessing quality incentive programs. They also indicated that they would need further support to scale QI and data capabilities beyond their specific EQuIP-LA efforts.

3. Sustainable Provider Organization Capacity Built through Train-the-Trainer Model:

POs used different structures and approaches when supporting practices; however, all POs provided individualized coaching, disseminated tools and resources, and assisted practices in completing program assignments.

- POs built lasting internal QI and data infrastructure, including increasing knowledge, advancing data reporting capabilities, and improving coaching skills.
- POs strengthened relationships and improved communication with practices; this took time and intentional effort to build trust, which often delayed the start of specific improvement efforts.
- All POs planned to continue coaching and collaboration with practices after the program. Some POs noted that it was important to use staff who were already trained as practice coaches or invest time in training upfront, given it may be a new skillset for existing staff.

4. High Engagement and Satisfaction:

EQuIP-LA resulted in sustained engagement from all practices and POs. Program components contributed to building capacity and improving performance.

- All program elements were rated as useful and seen as complementary and synergistic. When asked to rate components:
    - Practices most valued QI resources, capability assessment, and funding.
    - POs rated data support, learning events, and funding as most helpful.
- Some POs reflected that they could have seen more impact if the program was longer, given it was difficult to use all the information they received and achieve all their goals during the program.

5. Embedded Health Equity Focus:

Equity was both part of the program approach and an outcome for EQuIP-LA. It was integrated into EQuIP-LA's design, curriculum, and structure. This included intentionally recruiting independent practices serving diverse populations, prioritizing health equity approaches (e.g., targeted outreach) and patient-family engagement content, and establishing a multi-stakeholder steering committee, including a patient representative, to advise on program direction. The focus on equity was not linear and required ongoing attention throughout the program. Program implementers reflected that the

initiative could have been bolstered by stronger patient-family engagement and earlier inclusion of all partners to ensure alignment. Among participating POs and practices:

- EQuIP-LA increased awareness of health equity concepts and strategies among participants, including engaging patients and families.
- Examples of early-stage operationalization of equity concepts were limited but included data stratification to look at disparities, tailored outreach, and social health screening.

Implications and considerations

EQuIP-LA offers valuable insights for supporting independent practices serving Medi-Cal enrollees. Focused investment and tailored support can drive meaningful improvements in clinical quality.

For independent practices:

- Participate in programs like EQuIP-LA to prompt reflection, identify improvement opportunities, and access needed resources.
- Build relationships with health plans and independent practice associations (IPAs) to help access data and get support for meeting benchmarks.

For health plans and IPAs:

- Provide tailored support to help practices meet benchmarks.
- Provide individualized data and support to drive practice-level improvements.
- Improve availability and consistency of demographic data and enable stratification to address disparities.
- Align incentive programs with high-priority clinical quality measures.

For supporters of independent practices (e.g., philanthropy, technical assistance providers):

- Customize support to each practice's context.
- Prioritize trust building early in program implementation.
- Set realistic expectations, recognizing many practices are early in their QI journey.
- Embed health equity from the start, with clear definitions and processes for how it is being operationalized in the program.

Introduction and background

Small independent practices are an important part of the primary care delivery system in California. Over half of Medi-Cal primary care visits in California occur outside of community health centers; in Los Angeles (LA) County, it's closer to 70% of visits.[1] Independent practices have many strengths but grapple with common health care ecosystem challenges, including rising costs, administrative complexity from multiple payers, and low Medi-Cal reimbursement, often with less internal infrastructure and resources. Independent practices also typically receive less support and lower payment than Federally Qualified Health Centers, including exclusion from many federal, state, and philanthropic improvement and clinical transformation programs.[2]

The Equity and Quality at Independent Practices in LA County (EQuIP-LA) program aimed to bring additional investment and support to small independent practices in Los Angeles County. Launched in 2023, EQuIP-LA was a two-year improvement collaborative dedicated to improving health care outcomes experienced by Medi-Cal enrollees of color. The goals of EQuIP-LA were to:

- Build capacity within independent practices to implement an equity-centered approach to quality improvement (QI).
- Strengthen practice capabilities for delivering advanced primary care.[3]
- Improve health outcomes and narrow health disparities within participating small, independent practices that serve communities of color.

EQuIP-LA steering committee

EQuIP-LA convened a steering committee to engage all program partners and other key interest holders. The committee provided guidance and feedback including how current environmental factors relate to the program (e.g., policy changes, ecosystem shifts). The steering committee was comprised of representatives from the implementation partners, as well as health plans, Independent Practice Associations (IPAs), a person with lived experience, and other subject matter experts (e.g., patient-family engagement, clinical quality improvement).

For the purposes of this report the term **Provider Organizations (POs)** is being used to refer to 3 Independent Practice Associations (IPAs) and 1 health plan's direct network. These 4 entities participated in the train-the-trainer model to support practices in their networks.

1 DuPlessis, H.M., & Goddeeris, M. (2022). What Portion of Medi-Cal Primary Care Visits Are Provided by Health Centers? An Analysis by Region, Race, and Ethnicity. California Health Care Foundation. https://www.chcf.org/resource/portion-medi-cal-primary-care-visits-provided-health-centers/

2 Yegian, J.M. (2024). Strengthening Independent Primary Care Practice in California. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2024/11/StrengtheningIndependentPCPractices2024.pdf

3 California Quality Collaborative. (2022). Advanced Primary Care: Defining a Shared Standard. Purchaser Business Group on Health. https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf

The EQuIP-LA theory of change posited that foundational capabilities related to QI, health equity, and advanced primary care were necessary for improving practices' performance on clinical measures, resulting in more equitable outcomes for patients. EQuIP-LA specifically focused on three clinical measures related to diabetes, hypertension, and colorectal cancer screening.

Patient engagement and voice

With guidance from PFCCpartners, EQuIP-LA established structures to incorporate patient involvement throughout the initiative. EQuIP-LA held a virtual patient listening session with Medi-Cal enrollees during the design phase to inform its strategies. The session directly shaped the program's focus on timely access and culturally competent care. PFCCpartners also supported the curriculum and technical assistance for POs and practices related to patient-family engagement throughout the program.

Program structure and curriculum

Program design and structure

EQuIP-LA included a design process to engage key partners, identify participants, and develop program structures and implementation approaches to achieve its goals.

EQuIP-LA had an intentional focus on health equity. This informed how the program was designed (e.g., recruitment criteria, collaborative structures among partners, specific curriculum) and was assessed in program outcomes (i.e., reducing health disparities). While equity-related progress and outcomes are mentioned throughout this report, full results related to health equity are discussed on pages 43–51.

EQuIP-LA engaged partners with diverse perspectives and expertise to design, manage, and oversee the program (Figure 1).

- The California Quality Collaborative (CQC) led EQuIP-LA implementation in partnership with Community Partners, with funding support from the California Health Care Foundation (CHCF).
- HealthBegins was engaged as a key implementation partner for expertise on health equity approaches and curriculum.
- Two LA-based health plans (Health Net and L.A. Care) were engaged in program design and implementation.
- Other key subject matter experts were engaged through the EQuIP-LA steering committee (see box) with some members supporting program delivery in collaboration with CQC, such as PFCCpartners (Figure 1).

EQuIP-LA used a train-the-trainer model to provide education, technical assistance, data analytics support, and improvement advising to four provider organizations (POs). POs participated in monthly webinars, semi-annual in-person convenings, and bi-weekly improvement advising calls with CQC to build knowledge and skills related to equity-centered QI and advanced primary care concepts. **PO staff then provided coaching to 31 independent practices**. PO coaches worked closely with practice's health care teams to build internal QI capacity, support improvement projects, identify and address care gaps, and promote a culture of continuous learning and improvement.

POs and practices received funding to support their participation in the program. POs received up to $75,000 while practices received $30,000. To receive the full amount, PO contracts included guaranteed funding for participation and payment contingent on meeting performance milestones.

Participating provider organizations

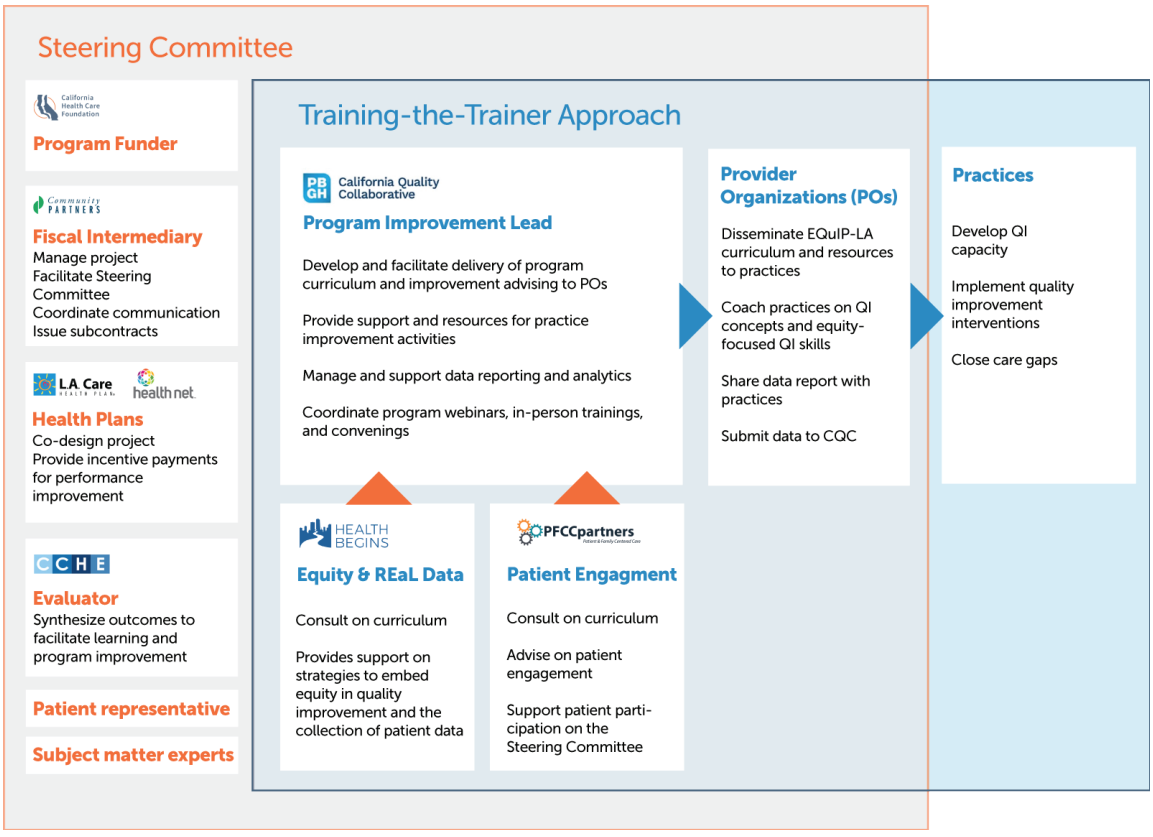
Allied Pacific IPA – network of medical professionals serving the San Gabriel Valley

Angeles IPA – multi-specialty network serving communities across LA and Orange Counties

L.A. Care Direct Network – directly-contracted network of physicians with L.A. Care Health Plan

Omnicare Medical Group – multi-specialty network serving communities in and around Lynwood and Compton

Figure 1. EQuIP-LA program structure incorporating a train-the-trainer approach



Program curriculum and evaluation

Program curriculum was informed by evidence-based frameworks that support high-quality, advanced primary care, including the Model for Improvement and the 10 Building Blocks of Primary Care. Content included:

- Equity-centered QI
- Team-based care
- Data stratification
- Patient-family engagement (see box, page 7)

Specifically, **EQuIP-LA aimed to address disparities in care related to chronic disease management and preventive screening**, focusing on diabetes, hypertension, and colorectal cancer screening.

Program partners saw an opportunity for the program to advance learning about supporting small independent practices to improve performance through an external evaluation. Initial evaluation design efforts were led by The Mirror Group. In early 2024, CHCF engaged the Center for Community Health and Evaluation (CCHE) to refine the design and implement the evaluation.

Program participants

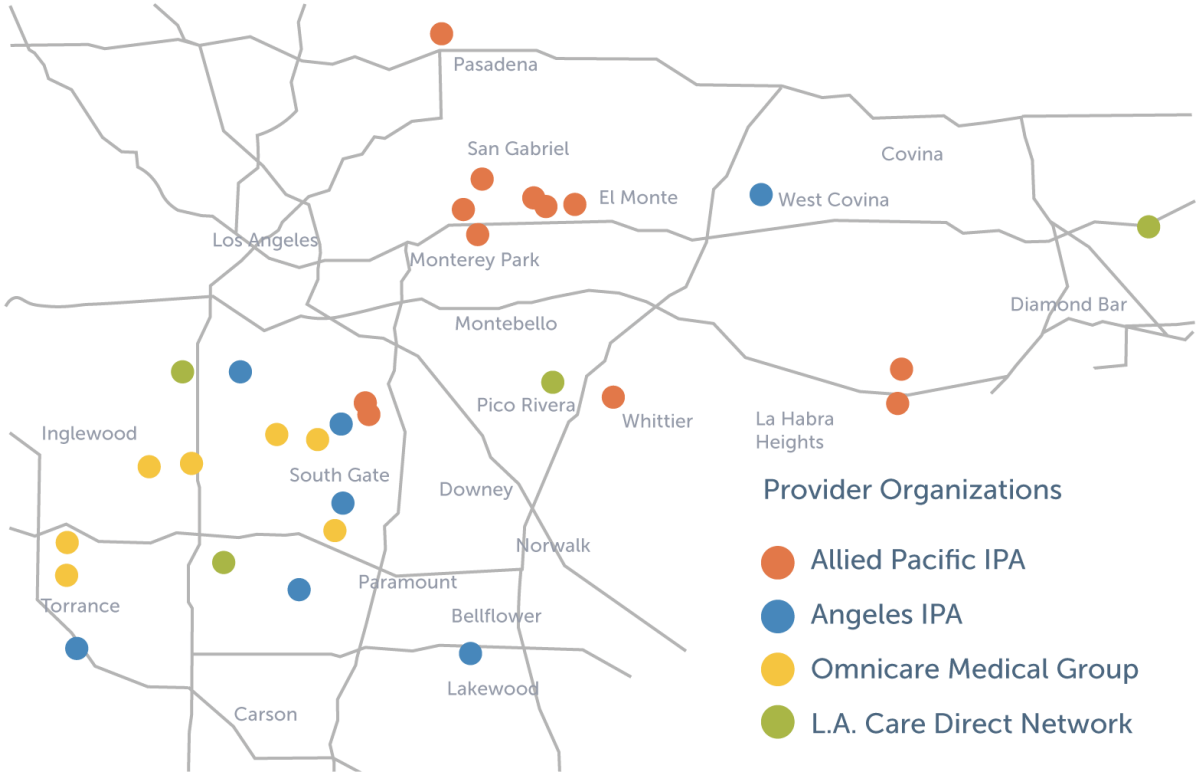
EQuIP-LA funded four provider organizations (POs), three independent provider associations (IPAs) and one health plan's direct network. The POs worked with 31 independent practices across LA County that collectively served over 50,000 Medi-Cal enrollees most of whom identify as people of color.[4]

Most EQuIP-LA practices (24/31) served fewer than 2,000 Medi-Cal enrollees, with another six serving 2,000-5,000 (one served 5,000-10,000). Most practices had small care teams of 1-3 providers. All practices served members across the two participating health plans—Health Net and L.A. Care. **Practices often had complex business operations and were contracted with an average of four IPAs (maximum of nine)**. All practices were deeply rooted in serving their communities. In total, EQuIP-LA practices had a total of nearly 100 providers, with about two-thirds being medical doctors (MDs) and one-third being mid-level providers, mostly Nurse Practitioners. Providers at EQuIP-LA practices were diverse: 45% self-identified as Asian, 21% as Hispanic or Latino, 12% as White, and 11% as Black or African American.[5]

4 California Quality Collaborative. (2025). Approaches to Designing Equity-Centered Quality Improvement Projects. Purchaser Business Group on Health. https://www.calquality.org/wp-content/uploads/2024/12/Final-Approaches-to-Equity-Centered-QI.pdf

5 Note that race and ethnicity were asked about separately so percentages will not add up to 100%.

Figure 2. EQuIP-LA practices[6]



6 Map developed by CQC for EQuIP-LA

Evaluation approach

Design and planning

Evaluation design and planning began in April 2023 with the Mirror Group collaborating with other EQuIP-LA implementation partners. The Center for Community Health and Evaluation (CCHE) joined the program in January 2024, building on the Mirror Group's foundational work to refine and finalize the evaluation design. CCHE attended program meetings and events and conducted in-depth discussions with program partners to inform the design process. CCHE also developed a logic model to visualize the program's structure, goals, and the intended outcomes, as shown in Figure 3 (detailed logic model in Appendix B).

Figure 3. EQuIP-LA logic model

Goals

The evaluation aimed to help partners understand the successes and limitations of EQuIP-LA, assess and document participant experiences, and support program learning and improvement. Goals for the evaluation included:

1. **Document participating practice characteristics** including program team size and roles, provider demographics (race and ethnicity), and support practices are receiving from other sources
2. **Describe program impact** and changes among program participants (POs and practices), including progress towards aim statements, benefits to specific patient populations, incentives earned, impact on equity and disparities, enablers and barriers to progress, and likelihood of sustainability.
3. **Assess participant utilization of and satisfaction with support** provided through EQuIP-LA, including the value, contribution, benefits, and burdens of different program elements and requirements.
4. **Document EQuIP-LA implementation partners' progress and lessons learned** related to collaboration and program implementation, particularly regarding integration of health equity principles.
5. **Facilitate learning and program improvemen**t during the program to inform future strategy, including identifying promising practices.

Data collection

A mixed methods approach was used to collect and analyze data. A detailed description of all data collection methods and analysis processes are in Appendix C. Data sources included:

- **Monthly performance data** submitted by POs on three clinical quality measures: controlling blood pressure (CBP), colorectal cancer screening (COL), and glycemic status assessment for patients with diabetes >9% (GSD)
- **Implementation Milestone Assessment Tool (IMAT)** completed by practices at baseline (July 2023), midpoint (July 2024), and endpoint (March 2025)[7]
- **Interviews** with POs and practices (July–August 2024; March–April 2025)
- **Reflective conversations** with the steering committee and implementation partners (May and July 2025)
- **Patient voice case study interviews** (March–April 2025)
- **Surveys** from POs, practices, steering committee members, and implementation partners (April–May 2025)

7 The Implementation Milestone Assessment Tool (IMAT) was developed by CQC and informed by the 10 Building Blocks of High-Performing Primary Care.

- **Observation** of EQuIP-LA events and activities: in-person convenings (June 2024, March 2025); Commons webinars (monthly), implementation partner meetings (monthly), and steering committee meetings (monthly through March 2024, then quarterly)
- **Document review** of program materials (e.g., SMARTIE aim statements, implementation partner collaborative processes documentation, evaluation activities prior to January 2024)

Clinical quality measures definitions

Controlling blood pressure (CBP): The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. [source: Medi-Cal Managed Care Accountability Sets (MCAS) MY20239]

Colorectal cancer screening (COL): The percentage of patients, 45-75 years of age, who were screened for colorectal cancer. [source: Covered California Quality Rating System (QRS) MY20237]

Glycemic status assessment for patients with diabetes >9% (GSD): The percentage of patients 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0 percent). Note: evaluation inverted analysis for this metric to look at percentage of patients who did not have poor control of HbA1c. [souce: Medi-Cal Managed Care Accountability Sets (MCAS) MY20239]

Findings

Evaluation results are organized into five key findings: (1) improvements in clinical quality measures; (2) changes in practice capabilities; (3) outcomes of the train-the-trainer model; (4) EQuIP-LA participant experience; and (5) integration of health equity throughout the program.

1. Practices participating in EQuIP-LA improved on three clinical quality measures of focus and narrowed gaps between performance and benchmarks.

POs worked with practices to improve performance on three clinical quality measures that are high priority for statewide efforts across California – controlling blood pressure (CBP), colorectal cancer screening (COL), and glycemic status assessment for patients with diabetes >9% (GSD).[8,9]

The three measures were selected for EQuIP-LA because they are included in the list of measures used by California's Department of Health Care Services (DHCS), Covered California, and CalPERS as indicators of health outcomes and health disparities.[10,11] The measures are also commonly tied to health plan performance incentives.

Most (23/31) practices set SMARTIE aim statements in the beginning of the program to improve all three measures. One PO, with eight practices, more narrowly focused aim statements on improving CBP.

Cohort-level improvements

The program achieved statistically significant improvements ($p<0.01$) for all three clinical measures and contributed to closing the gap to performance benchmarks. At baseline (May 2023), the aggregate performance of all 31 practices in the program was below the performance benchmarks for the three measures. Aggregate absolute performance improved for each of the measures —13% for CBP, 11% for COL, and 7% for GSD — which helped to reduce the gaps between performance and benchmarks (Figure 4).

EQuIP-LA used benchmarks to gauge the program's improvement on the three clinical measures. The benchmarks for CBP and GSD were set at the national Medicaid minimum performance level (MPL) (measurement year (MY) 2023), and the benchmark for COL was set at the national level for the CMS High Quality Rating System MPL (MY 2023) (Figure 4).[12]

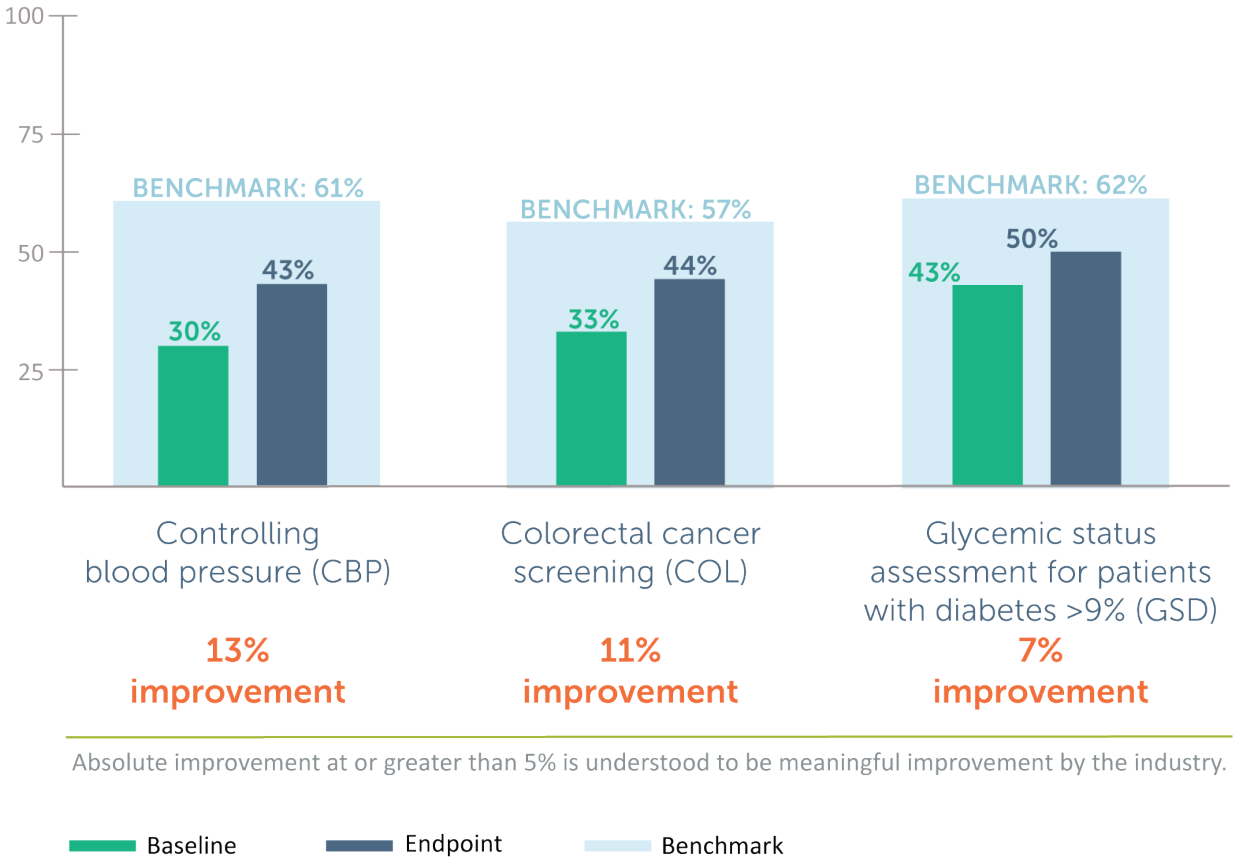
8 Medi-Cal Managed Care Physical Health External Quality Review Technical Report Contract Year 2023–24. California Department of Health Care Services. https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2023-24-Medi-Cal-Managed-Care-Physical-Health-External-Quality-Review-Technical-Report-Vol1-F1.pdf

9 Release Year 2024 (RY2024) MY2023 Quality Rating System (QRS) Measures Plan Performance Report. Covered California. https://hbex.coveredca.com/data-research/plan-performance-reports/2024/Release%20Year%202024%20PPR%20-%20MY2023%20QRS%20Measures.pdf

10 CalPERS driving improvements in healthcare: The quality alignment measure set and Incentives. CalPERS. https://www.calpers.ca.gov/calpers-driving-improvements-in-healthcare-quality-alignment-measure-set-and-incentives

11 Medi-Cal Accountability Set (MCAS) for Health Care Delivery Systems Measurement Year 2023. California Department of Health Care Services. https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2024.pdf

Figure 4. Improvement in clinical measure performance



As shown in Figure 4:

- CBP started with the largest gap (31%) between aggregate baseline performance and benchmark and improved by the greatest absolute amount (13%).
- COL started with a gap of 24% between aggregate baseline performance and benchmark and improved by an absolute amount of 11%.
- GSD started with the smallest gap (19%) between aggregate baseline performance and benchmark and improved by the smallest absolute amount (7%).

Additional details about work to improve each of these measures are discussed on pages 18–23.

12 Minimum performance level (MPL) is a commonly used benchmark for understanding how practices are doing on clinical measures relative to other Medi-Cal (statewide) or Medicaid (nationwide) providers. For Medi-Cal, MPL represents the National Committee for Quality Assurance's (NCQA) national Medicaid 50th percentile. In California, managed care plans are required to meet or exceed the MPL or face additional DHCS oversight and quality strategy requirements.

Practice-level improvements

The program helped 30 of 31 practices improve performance on at least one measure, with many practices improving on multiple measures and about half of practices meeting at least one benchmark.

Most (28/31) practices improved performance by at least 5% on at least one clinical measure (Table 1). Nearly 30% of practices (9 of 31) improved by at least 5% on all three measures.[13]

Table 1. Number of practices improved on one or more measure(s)

	Number of practices with any improvement	Number of practices with ≥5% improvement
3 measures	13	9
2 measures	13	14
1 measures	4	5
Total	30	28

When looking at improvements by each measure, **almost 75% of practices (23/31) improved both CBP and COL by 5% or more,** with a few additional practices making some improvement on each measure. For both measures, practices described specific QI interventions related to workflows and patient outreach that contributed to improved performance (discussed on pages 18–23).

Just under half of practices (14/31) improved GSD by 5% or more, with an additional four practices showing some improvement. Although practices did not describe as much focused work on this measure, these improvements suggest that they may have leveraged overall QI interventions and care gap reports to improve their performance despite the GSD measure being perceived by practices as more difficult to improve.

While nearly all participating practices made improvements, most remained below benchmarks. At baseline, 12 practices met benchmarks on one measure. **At endpoint, 15 practices met at least one benchmark, with 10 of these practices meeting two benchmarks and one practice meeting all three benchmarks** (Table 2). Most of the practices that met at least one benchmark at endpoint (14/15) were from two of the four POs.

13 There is not agreement in the field for how much improvement is needed to be "meaningful" change for quality measures versus normal, periodic fluctuations. Interpreting the extent of improvement depends on multiple factors including: size of the practice, organization/patient population (i.e., rates can have bigger swings with smaller denominators); starting point of the measure (i.e., it can be easier to make progress on a measure if starting performance is very low). With input from key EQuIP-LA partners, the evaluation team set the threshold for meaningful improvement at 5% given the size and starting point of participating practices.

Table 2. Total number of practices meeting benchmarks at baseline and endpoint

	Number of practices meeting benchmark at baseline	Number of practices meeting benchmark at endpoint
CBP (n=31)	4	11
COL (n=31)	0	7
GSD, A1c >9% (n=31)	8	9

For each measure, more practices met benchmark at the end of the program than at baseline (Table 3).

Table 3. Percent of practices meeting benchmarks at baseline and endpoint for each measure (n=31)

	Baseline	Endpoint	Percent change in cohort meeting benchmark
CBP (n=31)	4	11	+22%
COL (n=31)	0	7	+23%
GSD, A1c >9% (n=31)	8	9	+7%

Practices that met benchmarks and/or improved by more than 5% on multiple clinical measures started the program with stronger overall primary care capabilities (discussed on pages 24–31). These practices also tended to have larger project teams (two or more people) that included a mix of care delivery and administrative roles and tended to be more engaged in EQuIP-LA. These factors (higher baseline capability, multi-disciplinary teams, high engagement) set practices up to successfully improve clinical quality measures within the program period.

Whether or not practices met benchmarks, EQuIP-LA contributed to meaningful improvements in clinical quality measures across the cohort. Many practices with the lowest performing clinical measures at baseline were able to achieve a larger amount of absolute improvement – up to 44% – even though they were not yet meeting benchmarks at endpoint. More details about the level of improvement for each measure can be found on pages 18–24.

Measure-specific improvements

The following explores progress on each of the three measures and discusses the specific QI efforts implemented through EQuIP-LA that contributed to performance improvements.

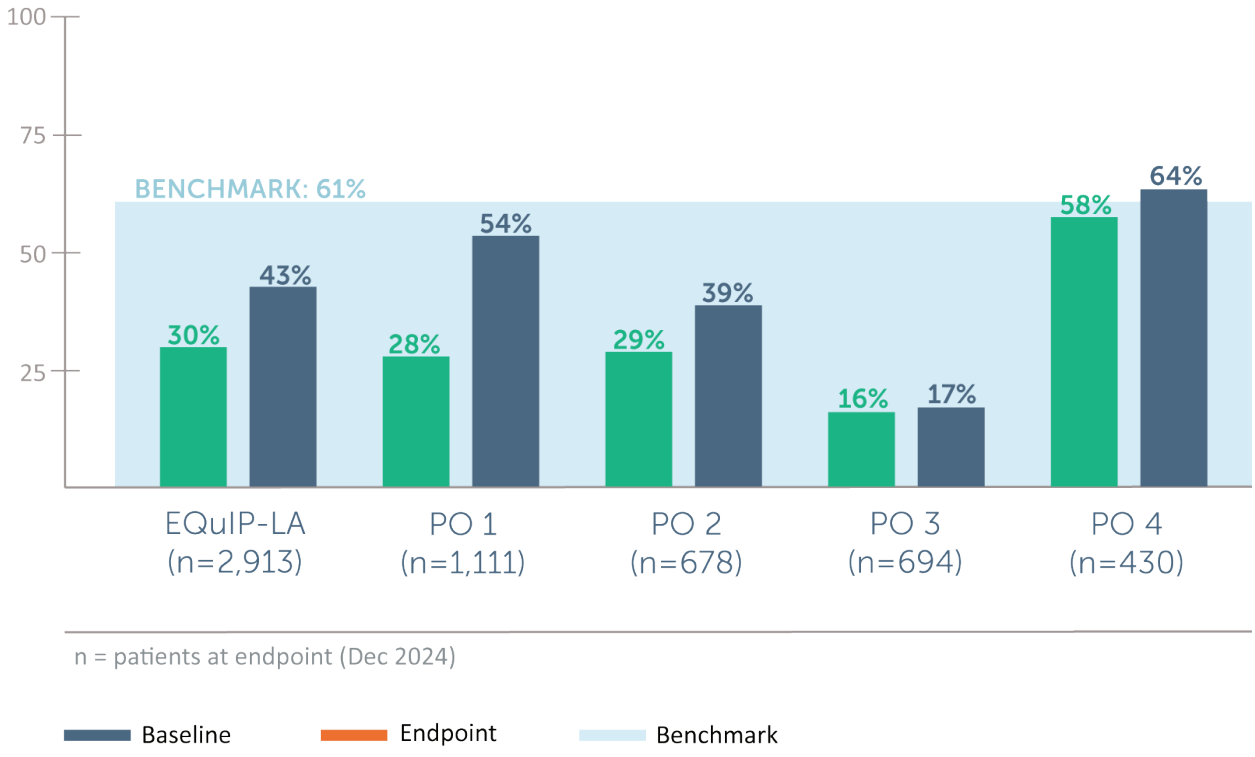
Controlling Blood Pressure

Across the *cohort*, the controlling blood pressure (CBP) rate increased by 13% (absolute change); a statistically significant improvement (p<0.01).

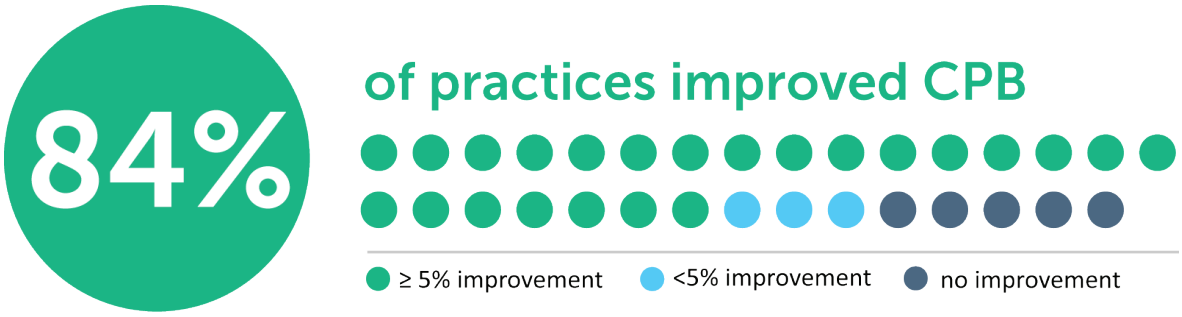
CBP improved from an average of 30% to 43% across all participating practices.

The overall cohort performance remained below the benchmark, but the difference between performance and benchmark decreased from a 31% gap at baseline to 18% at endpoint (Figure 5).

Figure 5. EQuIP-LA and PO-level changes in Controlling Blood Pressure



All four POs improved their aggregate perfomance on CBP; including one PO that reached MPL by endpoint (Dec 2024) (Figure 5).



At the *practice level*, 23 of the 31 practices improved their CBP rates from May 2023 to December 2024 by at least 5%.

- **Additionally, 11 practices (35%) met benchmark at endpoint; an increase of 8 practices compared to baseline.**
  - Most of the practices that met the benchmark at endpoint were in the top half of performers at baseline (9/11); however, they still made notable improvements, ranging from 4-46% absolute improvement.
  - **Two of the practices that met the benchmark at the end were among the lowest performers at baseline and reported improvements of 65% and 73%**.
  - Three of the four POs had at least one practice that met benchmark for this measure.
  - There was variation in the characteristics of the eight practices that improved to meet the benchmark, including clinic size (i.e. number of providers), level of engagement in EQuIP-LA, and baseline capabilities. **This variation suggests all types of practices have the potential to make improvements and meet benchmarks with focused effort and support**.
- Of the practices performing in the bottom third at baseline on this measure (n=10), six practices improved significantly more than the 5% threshold, with a range of 12% to 73% improvement, including the two mentioned above that met benchmark.

IMPROVEMENT DRIVERS

Practices that improved on CBP engaged in specific QI efforts aligned with their improvement goals, including:

- **Targeted patient outreach to close care gaps**, including mailing reminder postcards in multiple languages and calling patients to schedule appointments that included blood pressure checks.
- **Improved documentation**, including chart review, adding a vital signs cover sheet to patient charts, training staff on how to accurately record vitals in the patient record to ensure blood pressure readings were captured and coded for billing.

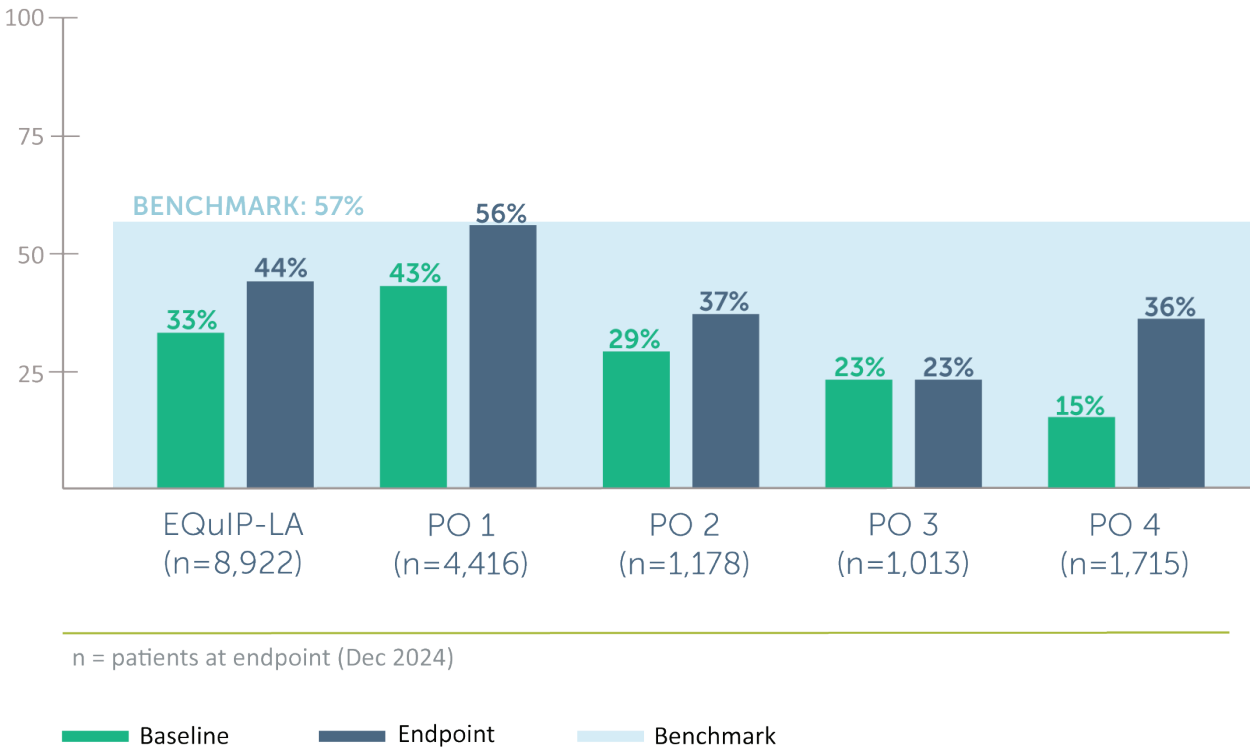
Colorectal Cancer Screening

Across the *cohort*, the colorectal cancer screening rate (COL) increased by 11% (absolute change); a statistically significant improvement (p<0.01).

COL improved from an average of 33% to 44% across all participating practices.

The overall cohort performance remained below benchmark but the gap between performance and benchmark decreased from a 24% gap at baseline to 13% at endpoint (Figure 6).

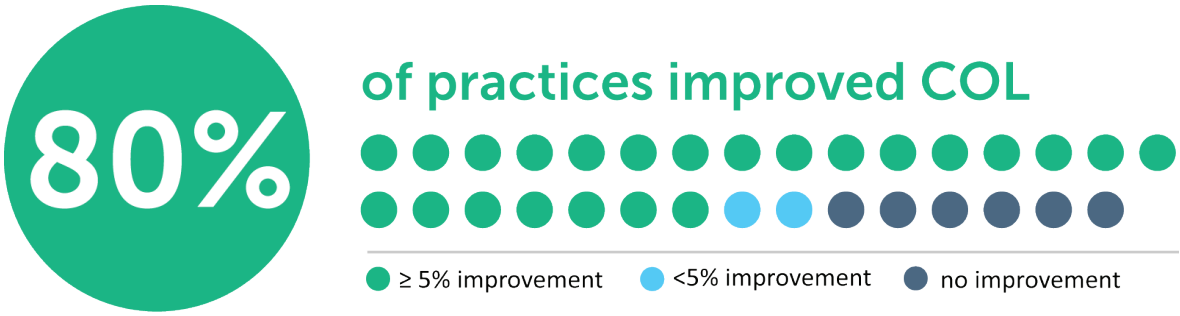
Figure 6. EQuIP-LA and PO-level changes in Colorectal Cancer Screening



As Figure 6 shows:

- Three of the POs improved COL across their participating practices, with one almost reaching the benchmark. The fourth PO's performance was unchanged.
- Aggregate program improvements were likely driven by the improvements made by PO 1, which improved its COL rate by 13%, from 43% to 56%. This PO's patient population made up almost half of the denominator for this measure.[14]

14 The total number of patients who are eligible for inclusion in each clinical measure varies among patient populations for each PO; patient count for clinical measures is not indicative of the PO's total patient count for EQuIP-LA or the number of practices participating in the program.



At the *practice level*, 23 of the 31 practices improved their COL rates from May 2023 to December 2024 by at least 5%.

- **Seven practices (23%) met the benchmark at endpoint, which was an increase from zero practices at baseline**. All seven of these practices:
  - Started with baseline rates in the top third of practices in the program.
  - Showed more improvement than other practices, averaging 18% absolute improvement compared to 10% for those not meeting the benchmark.
  - Had relatively high average capacity at baseline and endpoint (measured by IMAT, discussed more in the next section).
  - Were rated by their practice coaches as having demonstrated significantly higher QI capacity during the program.
- Most of the seven practices (6/7) were part of PO 1's network and were smaller practices with 1-2 providers, which may have made it easier to implement practice-level changes.
- Of the practices performing in the bottom third at baseline (n=10), five practices improved significantly more than the 5% threshold, with a range of 15% to 39% improvement.

IMPROVEMENT DRIVERS

Practices that made improvements in COL engaged in specific QI efforts aligned with their improvement goals, including:

- **Targeted patient outreach to close care gaps**, including mailing reminder postcards and calling patients to schedule appointments for annual wellness exams that included discussion of colorectal cancer screening.
- **Distributed at-home colorectal cancer screening kits** either via mail or during patient visits. One practice offered patients a cash incentive for completing and returning their screening kits.
- **Increased patient education**: one practice provided educational materials about screening to patients during appointments.

Glycemic status assessment for patients with diabetes >9%

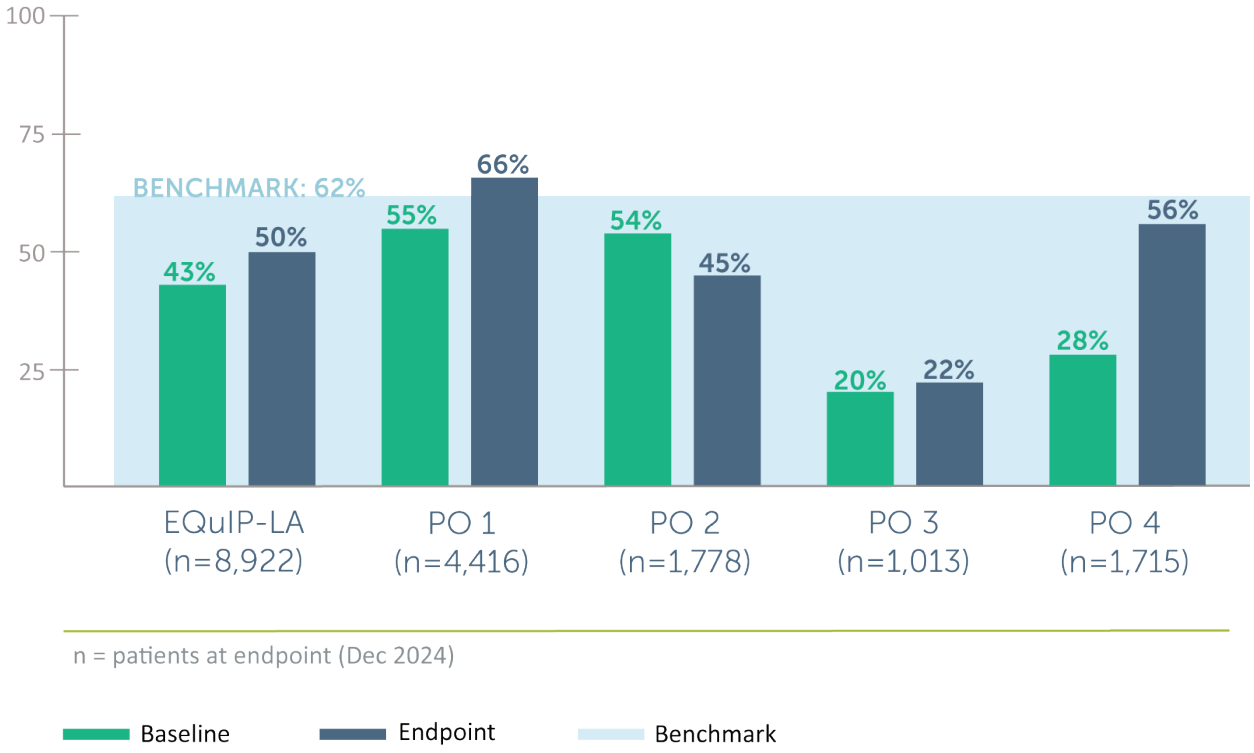
Across the *cohort*, the glycemic status assessment for patients with diabetes (GSD) improved by 7% (absolute change); a statistically significant improvement (p<0.01).

EQuIP-LA tracked practices' performance on the measure of patients with diabetes whose glycemic status assessment indicated their hemoglobin A1c was not in control (>9%). To aid in interpreting the data, the measure is inverted. Please note this is different from the measure of patients with diabetes in control (i.e., <8%), which is another common clinical measure.

The GSD average improved from 43% to 50% across participating practices.

The overall cohort performance remained below benchmark but the gap between performance and benchmark decreased from a 19% gap at baseline to 12% at endpoint (Figure 7).

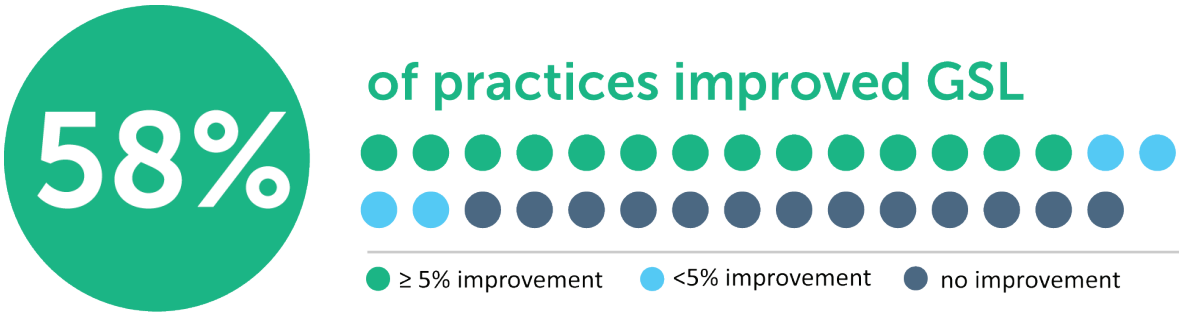
Figure 7. EQuIP-LA and PO-level changes in Glycemic status assessment for patients with diabetes greater than 9% – (measure inverted, showing percent of patients 'not out of control')



As Figure 7 shows:

- Three of the POs improved GSD across their participating practices. PO 1 exceeded the benchmark by endpoint.
- One PO's performance declined from baseline to endpoint.[15]

15 The total number of patients who are eligible for inclusion in each clinical measure varies among patient populations for each PO; patient count for clinical measures is not indicative of the PO's total patient count for EQuIP-LA or the number of practices participating in the program.



At the *practice level*, 14 of the 31 practices improved their GSD rates from May 2023 to December 2024 by at least 5%.

- Nine practices (29%) met the benchmark at endpoint, which was an increase from eight practices at baseline.
- Of the eight practices that were meeting the benchmark at baseline, five maintained performance at or above the benchmark and three fell slightly below benchmark by endpoint. Four additional practices met or exceeded the benchmark during the program.
- Over half of practices (6/9) that met MPL at endpoint had baseline performance rates in the top third of practices in the program. Similar to other measures, these practices also improved by a greater amount than practices that did not meet MPL (16% absolute improvement compared to 4%).
- Three POs had at least one practice that met MPL on this measure by the end of the program.
- Most of the practices (6/9) that met benchmark for GSD at endpoint were smaller practices with 1-2 providers, which may have made it easier to implement practice-level changes.
- Of the practices performing in the bottom third at baseline (n=10), six practices improved significantly more than the 5% threshold, with a range of 23% to 44% improvement, including two that met benchmark at endpoint.

IMPROVEMENT DRIVERS

To drive these improvements, **practices engaged in specific QI efforts** aligned with their GSD improvement goals.

- **A few practices implemented targeted outreach** to schedule patients due for a hemoglobin A1c test.
- **Other practices implemented broader QI interventions aimed at improving multiple clinical measures**, which may have contributed to improving their GSD rates, such as sending reminder postcards to patients due for annual wellness exams and improving documentation in patient charts.

Some practices noted that GSD can be more challenging than other measures to improve because of the long timeframe and sustained health behavior changes that patients must adhere to for their hemoglobin A1c to decrease below the 9% threshold.

2. Practices reduced care gaps by increasing their quality improvement, data analytic, and other primary care capabilities.

As discussed earlier, EQuIP-LA was designed to strengthen practices' foundational capabilities related to quality improvement (QI), health equity, and advanced primary care. The program believed these were necessary capabilities to improve practices' performance on clinical quality measures and reduce health disparities. To accomplish this, program partners needed to understand the current state of capabilities at each practice to support learning and improvement.

Practices completed an assessment using CQC's Implementation Milestone Assessment Tool (IMAT)[16] to rate capabilities important for improving clinical outcomes (see Appendix C for IMAT details). **Baseline data suggested many EQuIP-LA practices were early in their journeys related to these foundational primary care capabilities, with program-wide averages for all assessment domains in the Planning stage** (1.18-1.68). While capabilities were variable across the individual practices, these results suggested many practices had limited existing organizational capacity to implement QI interventions.

In interviews, POs and practices noted that familiarity with QI concepts was variable within and across practice teams. For some practices, providers were familiar with QI concepts, but many practice staff were learning how to incorporate these skills into their work for the first time during the program.

Baseline IMAT results and initial discussions with practice staff were used to inform EQuIP-LA curriculum, as well as to tailor coaching received by each practice. During the program, practices met at least monthly with their PO practice coach to review care gap reports and plan targeted QI interventions, using concepts and tools taught by the program, such as Plan-Do-Study-Adjust (PDSA) cycles. The coaching was designed to help practices implement specific interventions to improve performance measures while

IMAT overview

Rating scale: 0-3

0 = Not Started

1= Planning

2 = Implementing

3 = Standard work

Domains:

Engaged leadership

Data-driven improvement

Team-based care

Patient-team partnership

Population health management

Access to care

Social drivers & community partners

Timeline:

Baseline = July 2023

Midpoint = July 2024

Endpoint = March 2025

16 The Implementation Milestone Assessment Tool (IMAT) was developed by CQC and informed by the 10 Building Blocks of High-Performing Primary Care.

more broadly building practice capacity to apply QI tools and use data to support clinical and operational processes.

Improvements in practice capabilities

EQuIP-LA contributed to strengthening practices' foundational primary care capabilities and increasing knowledge and use of quality improvement tools to reduce care gaps, as measured by improvements in program-wide averages for all IMAT domains. Most IMAT domains improved on the rating scale (0-3) by about one point. This shifted the average from the 'Planning' stage (1s) to the 'Implementing' stage (2s). Many practices (26/31) also improved at least one domain rating to the maximum score of 3, or 'Standard work,' contributing to the increased cohort average.

The Social Drivers and Community Partners domain showed the most improvement, starting as the lowest-rated domain with a baseline average of 1.18 and reaching 2.42 by endpoint (Figure 8). The Access to Care domain was the highest rated at both baseline (1.68) and endpoint (2.74).

Figure 8. Program-wide averages on IMAT domains at each assessment timepoint (scale 0-3)

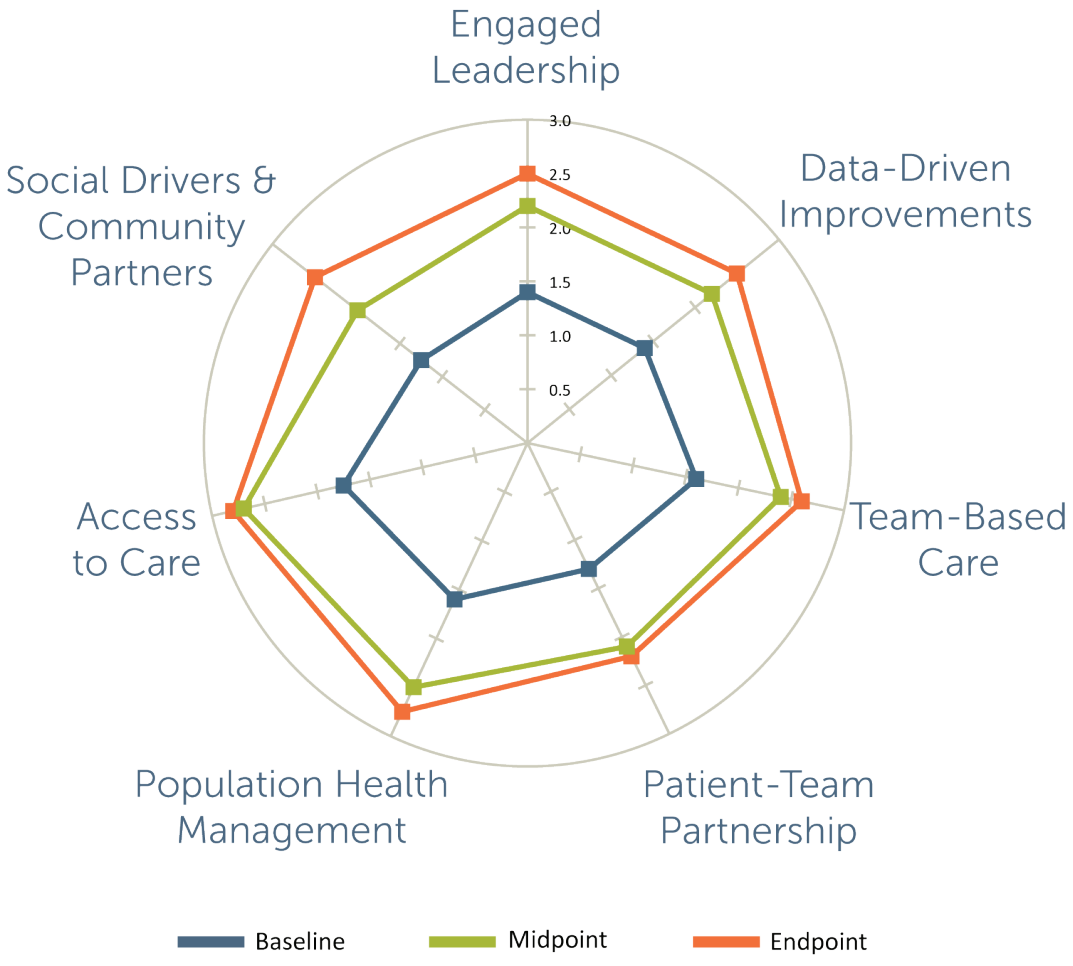


Image developed by CQC for the EQuIP-LA program.

Across the *cohort*, there was a higher degree of improvement between baseline and midpoint (average of 0.83 increase per domain) than between midpoint and endpoint (average of 0.22 increase per domain). This suggests practices were able to make incremental improvements early on, and there were milestones that were more challenging and time-consuming to improve (Figure 8). **Milestones related to data infrastructure and capacity, care team roles and responsibilities, and using care gap reports had slightly lower levels of improvement** (all less than 0.95 from baseline to endpoint) even though the program had a significant focus on these areas, suggesting these milestones might be harder to advance for independent practices with limited organizational capacity.

IMAT data suggest **EQuIP-LA's tailored support for practices effectively facilitated the development of primary care capabilities, regardless of where practices started**. While POs and their practices started in different places, all four POs and almost all practices (30/31) made incremental improvements in their IMAT scores during the program. All POs' average scores at the end were between 2-3 (scale of 0-3), indicating their practices were mostly in the Implementing stage or had transitioned to Standard work (see Appendix D). Over half of practices (18/31) had an overall score (average across all domains) of 2.5 or higher at the end of the program. When surveyed, most practices agreed the program effectively increased their staff's QI knowledge and capabilities (Figure 9).

Figure 9. Practices' level of agreement that EQuIP-LA improved elements of QI capabilities

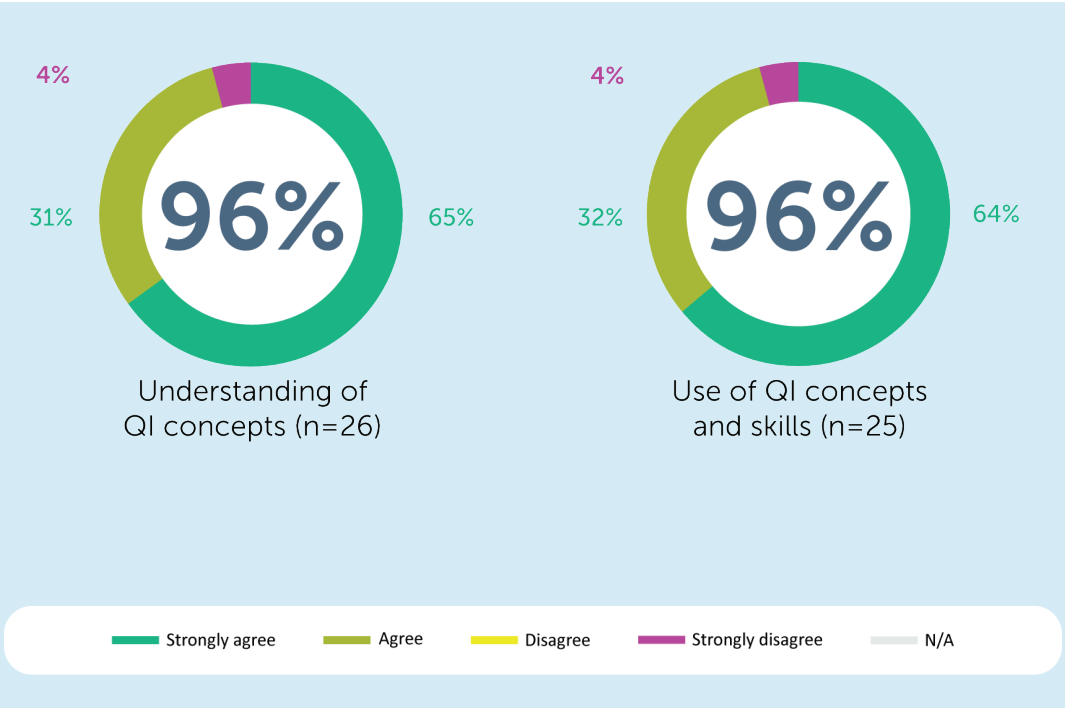
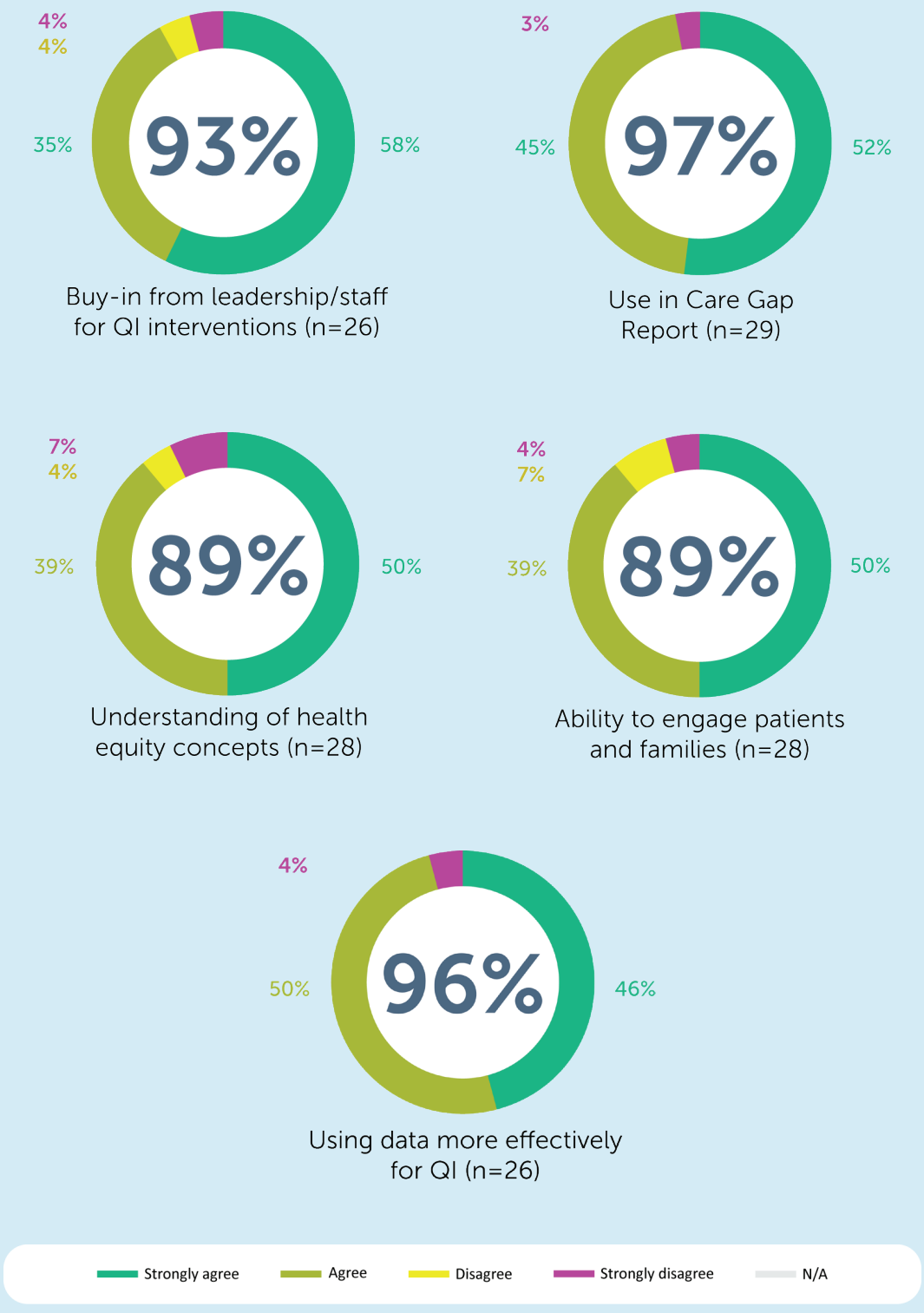


Figure 9., continued



While almost all practices improved their capabilities during EQuIP-LA, **practices with stronger foundational capabilities at baseline were more likely to also achieve improvements in their performance on clinical quality measures** (discussed in the previous section). **For example, practices with greater than 5% absolute improvement on more than one clinical measure also tended to have higher IMAT scores at baseline than practices that did not improve by 5% or more on multiple measures**. Additionally, practices that met the benchmark on at least one clinical quality measure by endpoint rated themselves as having higher starting capability in six of the seven IMAT domains (all except Engaged Leadership). Practices that met at least one benchmark also improved domain scores for Patient-team partnership and Population health management by a larger degree than practices not meeting any benchmarks, suggesting capabilities in these domains may position practices to improve performance on clinical quality measures.

Workflows to reduce care gaps

As discussed above, several common strategies were implemented across practices during EQuIP-LA to improve primary care capabilities and reduce care gaps for specific clinical quality measures (see table below).

Workflow type	Examples of changes implemented as part of EQuIP-LA
Care delivery	• Proactively reviewing patient charts before appointments to flag care gaps and make notes for the provider to address during the visit • Implementing standard work to ensure vitals are taken during visits • Providing patient education and distributing informational materials • Implementing standard post-visit follow-up with patients to support care gap closures
Patient outreach	• Systematically sending appointment reminders by mail and text to patients due for annual wellness visit or health screenings • Proactively calling patients to schedule needed appointments and follow up after hospital discharge
Documentation	• Reviewing patient charts and providing staff training to ensure visit data, such as patient demographics, vitals, services, and screenings, are being accurately captured and coded for documentation and billing • Routinely collecting patient demographic data
Data utilization	• Leveraging care gap reports from POs to inform outreach, scheduling, and pre-visit planning • Reviewing PO scorecards to track practice's overall performance on clinical quality measures

When asked whether these new workflows would continue beyond the program, practices indicated that they had become standard work and would be sustained.

> **"We actually print out a paper and give it to the provider before the visit about what the patient needs for closing the care gap or what is supposed to be assessed for the patient when they're coming in."**
>
> **– Practice participant**

> **"The other staff see how we onboarded with this. Now they are trained on really following [the workflow] with patients to ensure all those things are done – compliance, diet, exercise, etc. It's become a habit already for the employees to discuss with patients, so it's just going to be an ongoing thing."**
>
> **– Practice participant**

Program contribution to increasing practices' capabilities

Reflective conversations with practices and PO project teams provided examples of how EQuIP-LA contributed to practices strengthening their primary care capabilities and QI skills to reduce care gaps.

Area of capacity	Description	Example quote
Increased knowledge and understanding of QI fundamentals	Through the program, practices increased understanding of and were able to implement QI concepts and skills (e.g., PDSAs, leveraging data to inform QI).	"For the practices, one of the goals was to track one of the measures, and once we saw the outcomes, they were able to see the progress of how the patients were returning the FIT kits. I think that was very positive for them." – PO participant
Increased **buy-in and participation of providers and staff** in QI work	EQuIP-LA supported practices in engaging their staff to learn about QI and understand its role in improving primary care delivery and performance on clinical quality measures.	"I feel like [EQuIP-LA] has been good, because it forced us to look at the practice from another perspective—to look at our workflows. When we have something already in place, it's really easy to just keep things as is. But with EQuIP-LA, it forced us to take a step back, reevaluate, and see how we could do things better." – Practice participant

Area of capacity	Description	Example quote
Improved workflows and introduced standard work to close care gaps	POs and practices reported successful implementation of targeted workflows to reduce care gaps and sustain progress on clinical measures (discussed above).	"[As a result of the program] practices are more aware of workflows and roles and responsibilities within their team. They were already doing the work, but now they're more aware of it." – PO participant

Practices were also asked about factors affecting program engagement to help understand what may be influencing their progress. ***Staffing shortages*** **and/or staff turnover were the most common and significant barriers**. ***Competing internal priorities*** **and patient engagement were also frequently rated as barriers**. PO practice coaches worked with practices to address these challenges. **The program's participation requirements and customized support promoted accountability and helped mitigate challenges such as limited staff capacity and high turnover, enabling practices to still make progress in resource-constrained environments**. For example, practice coaches slowed down and reinforced foundational QI skills and concepts when there were staffing transitions or more limited capacity.

> **"Our incentives are coming now [...] Because every time that we used to get [an incentive payment] report, the provider said, 'This is 50 percent, what's going on?' And he called me in and was like, 'See? It's working!'"**
>
> **– PO Participant**

> **"Maybe one practice out of [all of them] might be able to [implement a QI project on their own]. Because it was really a team effort. They didn't fly solo."**
>
> **– PO Participant**

Practices also felt EQuIP-LA advanced their readiness for future QI efforts. Almost all (93%) practices agreed that the program improved their ability to engage in other care transformation or QI programs. Similarly, 90% of practices agreed EQuIP-LA increased their ability to access performance incentives from IPAs or health plans. Qualitatively, **practices noted the skills and knowledge they gained during EQuIP-LA would serve as a foundation to inform other work and internal QI efforts**.

While practices reported high confidence that new workflows during EQuIP-LA would be sustained, practices may need further support to scale QI and data capabilities beyond the specific work implemented as part of the program. POs reported that practices improved their foundational understanding of QI concepts and skills but had not yet developed the ability to independently apply those learnings to new processes or workflows important for incentive programs.

Practices agreed they would need support to further develop QI capabilities and successfully implement additional QI projects. **This suggests EQuIP-LA was an opportunity for practices to strengthen capabilities, learn tools and strategies, and that this work is part of a longer-term transformation to develop QI infrastructure and processes to improve health outcomes**.

3. EQuIP-LA's train-the-trainer model built sustainable knowledge and skills at provider organizations (POs) to support quality improvement and data-driven decision-making at practices in their networks.

EQuIP-LA provided POs with education, tools, and coaching related to foundational primary care capabilities including team-based care approaches, fundamentals of quality improvement (QI), and data analytics. POs were expected to share these learnings and resources with participating independent practices through coaching. **This model successfully built capabilities at two levels of the system—POs (described below) and practices (as described in the previous section)**.

Train-the-trainer structure

POs engaged an internal multi-disciplinary team to perform the requirements of EQuIP-LA. Team size varied across the organizations (range 3-10) and typically consisted of one or more practice coaches, a data analyst, and a project lead.

POs used different structures and approaches when supporting practices. They met with most practices at least monthly. One PO had shorter meetings bi-weekly and another talked about how they would integrate EQuIP-LA support into other interactions they had with practices (i.e., other provider relations work). Two POs met virtually with practices, one in person, and one a mix of both.

> **"Trying to talk to them monthly. But we talk to them often and if there are other opportunities or reasons to be in touch, then we use that as a time to bring up the program. Some we might talk to weekly [...] woven into other conversations."**
>
> **– PO participant**

All the POs shared materials from the EQuIP-LA curriculum with practices but took different approaches in how information was disseminated. Some forwarded materials to practices and then were available to answer any questions, while some sent materials with guidance on how to interpret and apply information. Some POs tailored information to each practice's specific circumstances.

> **"One of the things we included in our monthly check-in was a scorecard, so [practices] can see the month-to-month progress or where they were at the same time last year. I feel like that encouraged them as well, and motivated them to say: 'okay, let's continue to apply those changes that we're making.'"**
>
> **– PO participant**

All POs provided intensive support to help practices complete program assignments and implement QI projects, including dedicated time to review and discuss data and monitor changes. **POs reflected that this level of structured support helped foster engagement and build momentum for improvement efforts**. Examples of support beyond what POs provided in the past included: meeting in-person, delivering hard copies of materials and resources to practices, teaching practice staff how to interpret and use data, creating tailored performance dashboards to guide discussion, and breaking down workflow changes or QI skills (e.g. PDSAs) into bite-sized pieces for practice to implement. Generally, POs reported taking a more collaborative approach with practices to understand barriers and determine potential solutions to improvement.

Both program partners and participants (i.e., POs and practices) elevated the importance of relationship and trust building for the model to be effectively implemented. This included relationships between the EQuIP-LA improvement advisors from CQC and POs, as well as between POs (particularly the practice coaches) and practices. **Program implementers and POs observed that progress moved more slowly during the first several months of the program while relationships and trust were built**.

When asked about the potential future role of POs to play this "trainer" and coach role, one PO representative saw the promise for their organization to efficiently and effectively fill the "trainer" role since they already have relationships with their practices that can be leveraged and deepened to support improvement efforts. However, POs also noted the importance of having staff who are already trained as practice coaches. Staff who were new to this role experienced additional challenges in taking on this work. One PO commented that this model may work best for IPAs or health plans that already have staff with care transformation experience in place. Without that previous experience, practice coaches had to manage their own learning curve at the same time they were supporting this work with their practices.

Improvements in PO capabilities

The train-the-trainer model was designed for POs to support building capabilities across their network of practices, but the model also built and strengthened capabilities within their organizations. **All POs *agreed* EQuIP-LA increased learning and capabilities in various ways both for individual PO staff members and for PO organizations overall** (Figures 10 and 11).

Figure 10. Impact on *individual* PO participant learning

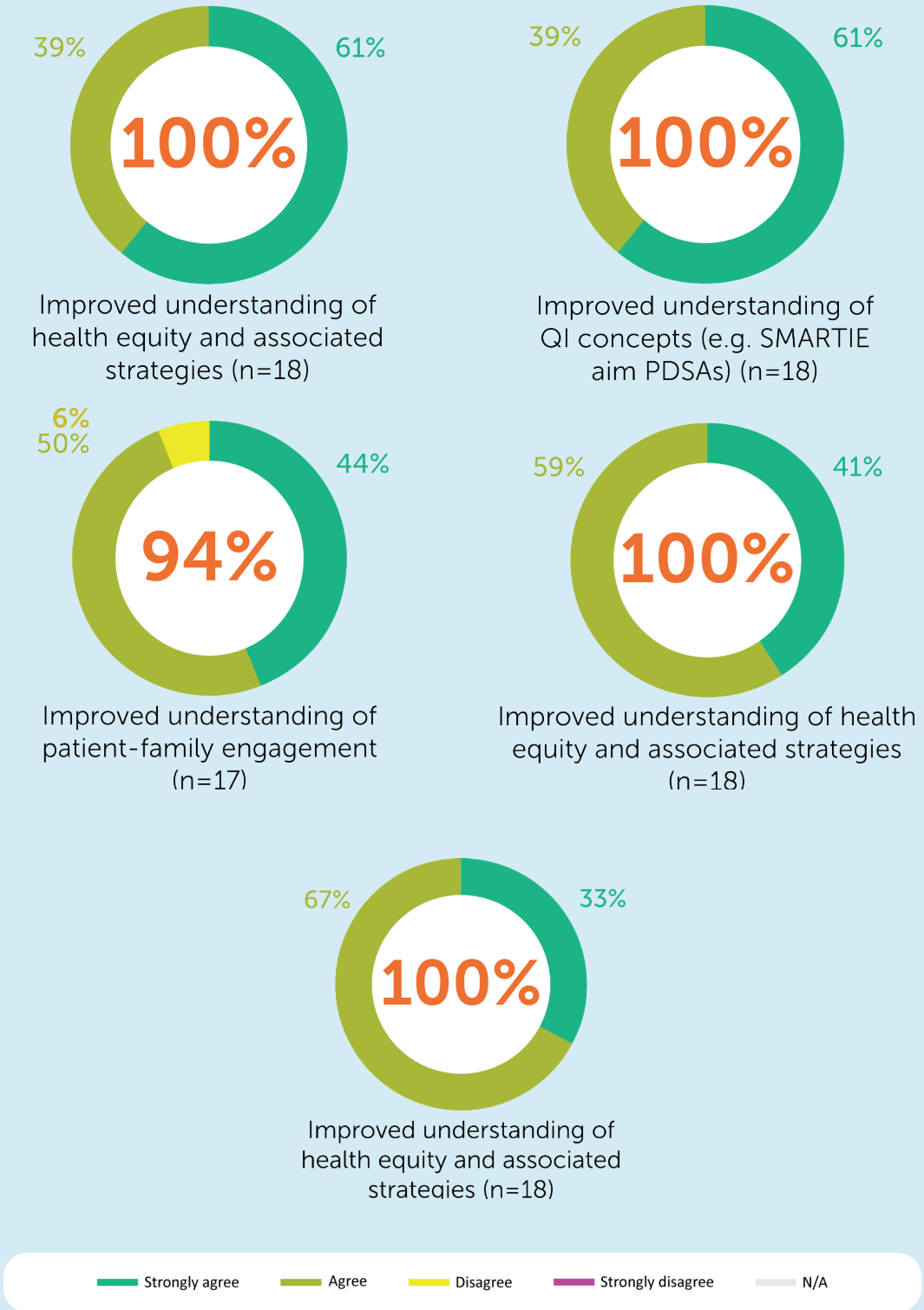


Figure 11. Impact on PO *organization* learning

POs qualitatively described their capability improvements in five areas:

Area of capacity	Description	Example quote
Increased knowledge of QI, population health management, and other advanced primary care concepts, tools, and approaches	PO staff members gained a better understanding of fundamental QI concepts like PDSA cycles, SMARTIE aim statements, as well as foundational elements of population health management (e.g., team-based care, outreach and follow-up).	"At the beginning of the program, I was unsure of how to define certain terms or was having difficulty wrapping my mind around [QI]. But now that we have heard about it so consistently, it has helped." – PO participant
Increased awareness and buy-in for applying health equity concepts to QI work	EQuIP-LA supported POs in understanding the connection between QI and health equity and how to broach these concepts with practices. The program also increased POs' focus on stratifying data by race and ethnicity and identifying populations for targeted outreach (discussed more in key finding 5).	"CQC has helped us by providing a lot of useful [health equity] tools and resources that we didn't have before in working with practices and explaining these things to them." – PO participant

Area of capacity	Description	Example quote
Advanced data capabilities	As a result of the program, POs were better able to navigate platforms to access data and reported more confidence in analyzing and stratifying data. They translated this learning into actionable reports to use in practice coaching, which promoted practice engagement and partnership. POs also reflected on the importance of building collaborative relationships within their organization to do this work, such as between the practice coaches and the data team.	"CQC was really helpful in walking through [the data] with us to figure out what we had access to and how to pull it. [They also provided support to] make sure the data were accurate and stable, so we could be reporting correctly." – PO participant
Improved practice coaching capabilities, which expanded the types and level of support they can provide to practices	POs reported increased skills in various aspects of practice coaching, including being better able to: • Explain QI and health equity concepts to practices • Present and discuss care gap data with practices and actively partner to understand barriers and identify solutions • Break improvement efforts down into step-by-step processes	"[Through EQuIP-LA], I learned the difference between a provider relations specialist and practice coach. Going to seminars helped me understand what that role entailed. It wasn't just being at the practices and saying hey, 'I need this done.' It's 'I need this done, so let's work on how we can get it done.'" – PO participant

Area of capacity	Description	Example quote
Strengthened relationships with practices	POs reported improved communication and collaboration with practices, which contributed to increased trust. EQuIP-LA provided the time and structure for building the trust needed for deeper partnerships.	"Now [coaches and practices] know each other by first names and they know they can always reach out to them, whether they need us or vice versa." – PO participant

All four POs reported that they intended to sustain some of the activities and approaches learned during EQuIP-LA, including:

- ***Practice coaching skills and strategies***: POs reported thinking differently about what it takes for practices to achieve improvements in clinical quality measures. They indicated that the new capabilities and lessons from the program will inform how they engage with practices in their network in the future. Although they cannot provide the level of support they provided in EQuIP-LA to all their practices due to limited organizational capacity, **POs saw opportunities to offer more intensive, tailored support and partnership to practices who are struggling and need extra help to reach performance benchmarks.**
- *Data applications*: **Much of the data infrastructure and capabilities built at POs were expected to sustain beyond the program**. One of the POs mentioned that reviewing performance data will continue to play a prominent role in their relationships with practices, including updated reports that will incorporate the rolling 12-month measurement method that was implemented for EQuIP-LA's clinical measures.

> **"I feel like overall [EQuIP-LA] helped us not just improve and have an impact in these practices, but it spread throughout the network and how we approach looking at quality performance across all of the practices that we support."**
>
> **– PO participant**

> **"We've implemented that same [data reporting] strategy for a couple of other reports we have, where instead of always looking at it from the start of the year, we're pulling back the full 12 months."**
>
> **– PO participant**

Practices reported that they appreciated the support they received from the POs and most anticipated they will continue to use their PO partners as a resource in their improvement efforts in the future. More specifically, 86% of practice respondents (25/29) indicated they were at least *somewhat likely* to continue seeking QI support from their PO, with 62% (18/29) stating they were *very likely*.

4. Sustained participant engagement in EQuIP-LA's program components contributed to capacity building and performance improvement.

Participant engagement

EQuIP-LA achieved sustained engagement from all four POs and 31 practices.

- **Nearly all practices (93%) were at least *somewhat engaged* in EQuIP-LA program activities; 71% (20/31) reported being *highly engaged***. Engagement for practices consisted primarily of regular participation in monthly sessions with their practice coach and completing EQuIP-LA assignments.
- **All PO survey respondents reported being at least somewhat engaged in the program with most (71%, 13/17) reporting high engagement**. Engagement primarily consisted of participation in improvement advising calls with CQC and program events (e.g., Commons webinars, in-person sessions) and completing program assignments and data reporting requirements.

There was some variation in practice engagement across POs. Most practices were *highly engaged* for two POs, while only half were *highly engaged* for the other two POs. When comparing practices' self-reported level of engagement with POs' ratings of practice engagement, practices often reported their engagement as higher than what coaches indicated. Coaches' ratings could have been influenced by reported key challenges, including finding time to meet with practices. There were not clear differences in the approaches across the POs that facilitated or hindered engagement, which suggests that differences in level of engagement were likely driven by practice context rather than the structure of support provided.

Participant satisfaction

PO and practice participants reported high satisfaction with the EQuIP-LA program overall—around 90% of each group reported being *satisfied* (26/29 practices and 16/18 PO team members). **Practices appreciated the support and resources they received, particularly related to QI and data, that helped improve clinical quality measures and patient care**. Most practices were also *satisfied* with the frequency and content of practice coaching meetings, including the QI resources and tools provided and collaboratively reviewing performance data (over 84% were *satisfied* on all three items, 25/29). Higher practice satisfaction was generally aligned with higher engagement. The three practices that reported lower satisfaction were spread across three of the four POs. Despite having lower levels of satisfaction, 2 of 3 of these practices still reported strengthened capabilities and made improvements in all of the clinical quality measures.

> **"Instead of just relying on just doing the same thing over and over and not getting a result. Working with this program was an opportunity for a deeper dive, ensuring practices have line of sight on their patients. It was a good way for us to develop best practices and understand what is happening at the practices, so we can improve our quality scores and not be put on corrective action plans with the health plans."**
>
> **– PO participant**

Both POs and practices were generally satisfied with clarity in communication and expectations for program participation, although one PO reported lower satisfaction than the others and elevated the same challenges discussed below related to practice coach experience.

Most PO survey respondents (78%, 14/18) were satisfied with the train-the-trainer model; however, within the PO teams, practice coaches reported lower levels of satisfaction (64%,7/11) compared to other project team roles (100%, 7/7). Given practice coaches were responsible for directly supporting the practices and ensuring they completed program responsibilities, this lower satisfaction might stem from challenges encountered. These included:

- ***Workload and time management***. POs struggled to find time for the various meetings (with practices and CQC) and balancing additional assignments with their other work responsibilities. A few respondents noted feeling overwhelmed by the demands of the program on POs (e.g., number of meetings, assignments, measurement requirements).
- ***Program communications***. POs were challenged by not having a clear program curriculum articulated from the outset, as well as initial onboarding difficulties and mid-program changes (e.g., unexpected assignments, additional requirements). This impeded their ability to communicate the various expectations to practices in a timely manner.

> **"A calendar of [program] activities ahead of time would allow [practices] to plan around them, instead of asking a month in advance. That way they can schedule or assign a proxy to participate, too."**
>
> **– PO participant**

- ***Practice engagement***. POs said it was difficult keeping practices engaged due to their competing priorities and patient care demands. Also, there was limited time for practices to implement the recommended improvement, data, and care transformation strategies due to other responsibilities within the practice, including care delivery.

EQuIP-LA program components

EQuIP-LA program components helped increase capabilities at practices and POs and contributed to improvements in clinical measures.

EQuIP-LA was a highly customized program with several components (see box). All components were reported to be important and had at least some contribution to increased capabilities at POs and practices. Practices and POs engaged in the program differently and therefore differed in which program components were perceived to be the most or least valuable to them.

The evaluation assessed the contribution of five key program components.

Funding: Practices received up to $30,000 and POs received up to $75,000 to support program participation.

Coaching: Individualized improvement advising from CQC to POs and practice coaching from POs to practices.

QI assignments and resources: QI tools and materials to support practice-level improvement

Data-related support: Data reporting requirements for POs to stratify performance data by race and ethnicity, including technical assistance from CQC. Data-related capability building was also integrated into QI assignments and practice coaching (e.g., review of care gap reports).

Learning events: Virtual and in-person sessions focused on providing education on key topics and facilitating peer exchange.

Practices

Overall, more than half of practices rated most program components as having high contribution to increasing their QI capabilities and implementation of improvement projects. Practices rated the QI assignments and resources, the Implementation Milestone Assessment Tool (IMAT), and funding as having the highest contribution to building capabilities (Figure 12). The QI assignments (e.g., Plan-Do-Study-Act cycles) and IMAT were two of the most concrete program components and some practices reflected that they helped them identify where they needed to focus.

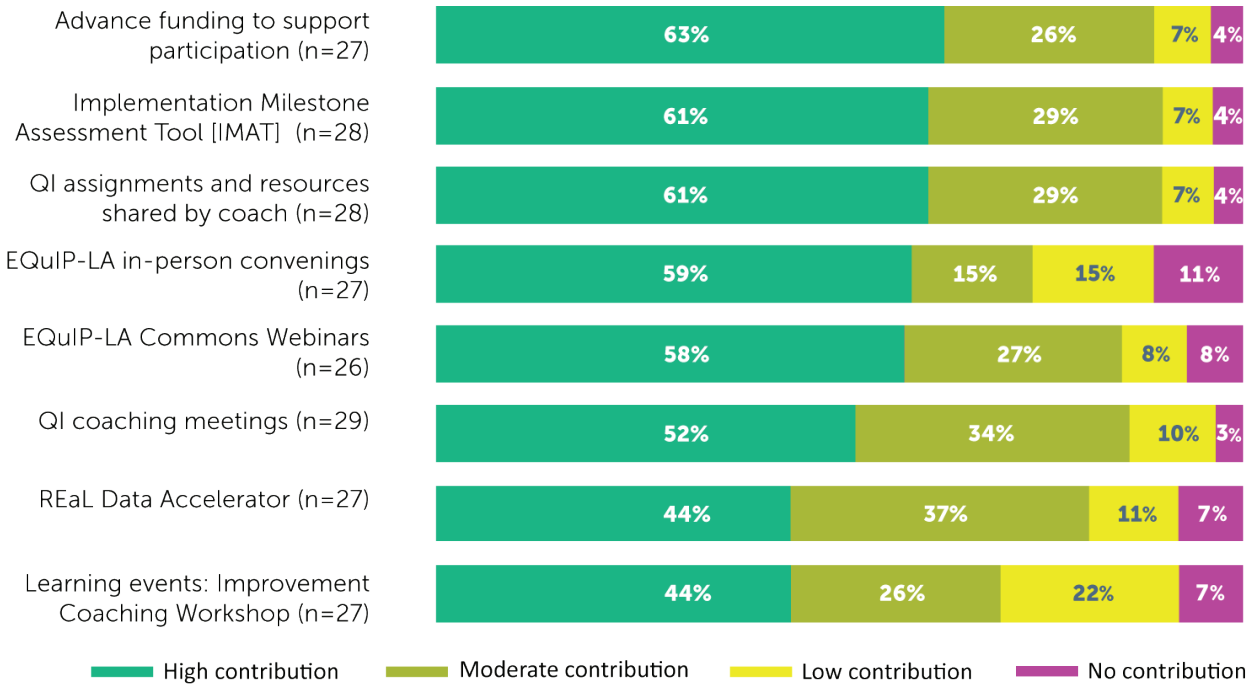
> **"A lot of times [the practice coach] will present me the data for last month, which definitely gets me to know what things I need to work on."**
>
> **– Practice participant**

Although rated somewhat lower by practices, POs and program implementation partners reflected that individualized practice coaching was needed to support practices in successfully understanding and operationalizing the QI tools and resources to complete the assignments. Qualitatively, practices were generally satisfied with the coaching received from POs and felt that it helped build relationships between them and their PO partners. Two practices mentioned that reviewing data and having support with data systems during coaching sessions was beneficial. One practice commented that coaches helped with accountability and built momentum for QI efforts.

The items most often rated as having low to no contribution by practices were program events—virtual and in-person, in which most practices did not participate due to limited time and competing priorities.

There were no differences in satisfaction or contribution of program components based on practice characteristics (e.g., PO partner, solo versus multi-provider practices, or program team size).

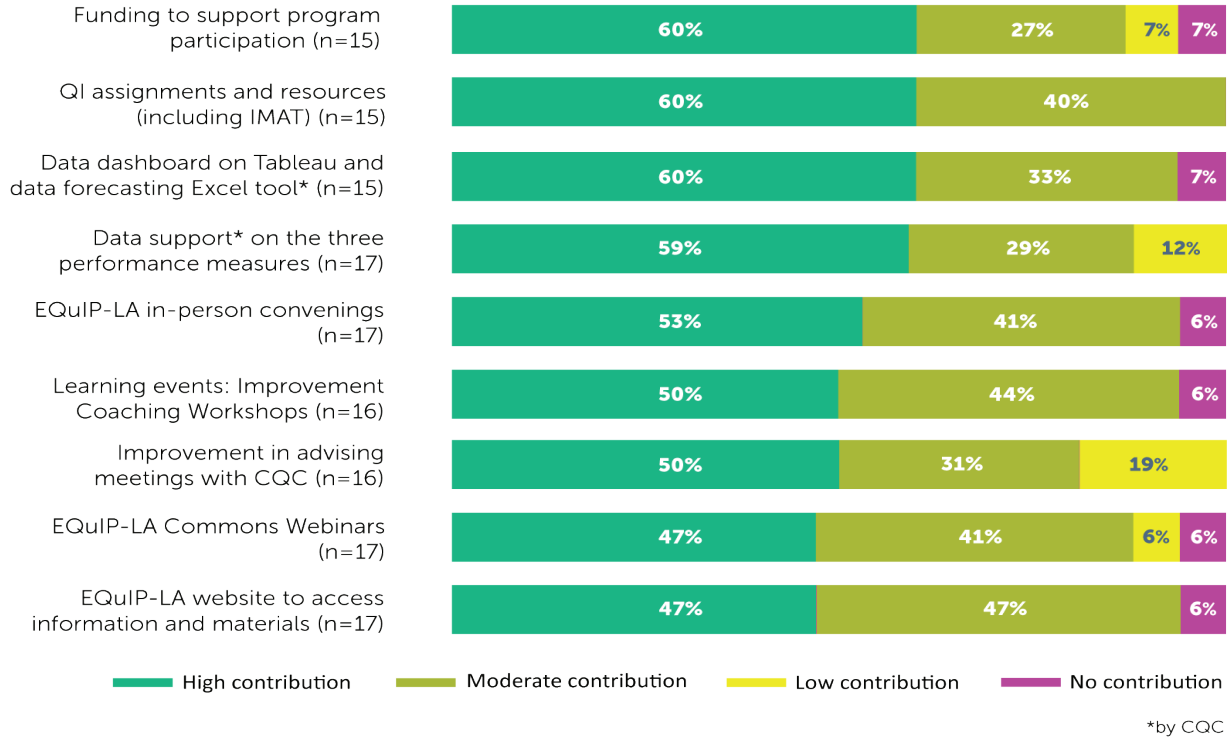
Figure 12. Practices' ratings of EQuIP-LA program component's contribution to QI capacity



POs

Overall, most PO survey respondents (72% or more) rated all program components as having at least moderate contribution to their ability to support practices in building their QI capabilities (Figure 12).

Figure 13. POs' ratings of EQuIP-LA program component's contribution to QI capacity



They rated data-related support from CQC, including both the individualized technical assistance and the data tools (i.e., Tableau dashboard and Excel forecasting tool (Figure 14) as having the highest contribution. The clinical quality data reporting requirements were an initial challenge for POs, particularly accessing the needed data, data stratification, and reporting on a rolling measurement year. CQC technical assistance was intensive over the first several months for some POs so they could report as requested. The program's data tools, along with care gap reports, were integrated into practice coaching and likely contributed to practices' improvements in clinical quality measures. See Appendix E for an example of CQC's data tools.

Other program components rated as *high contribution* by at least half of PO respondents included: the in-person convenings, QI assignments and resources, and funding to support program participation. Qualitatively, all POs appreciated the peer learning at the in-person sessions and wished that more practices had been able to attend.

> **"I think having the in-person meetings puts us in a place where we got to see how everybody's doing [...] So it gave us a better understanding on who was facing the same issues that we were or if they were doing something different that we can [try]."**
>
> **– PO participant**

POs found the EQuIP-LA curriculum and assignments helpful. **They elevated the topics of health equity, QI fundamentals, and team-based care approaches as the most useful content to support building practice capabilities**. Some POs felt that the information could have been made more digestible and actionable for small, independent practices. As mentioned earlier, a couple of POs adapted materials before sharing with practices to make it more useful to them.

Although rated most often as having a *low contribution* (17% of respondents), POs indicated in interviews that improvement advising meetings were helpful for accountability and appreciated CQC's support, guidance, and feedback. A few PO representatives perceived the bi-monthly improvement advising meetings to be more frequent than needed.

> **"I think maybe two years is not enough time. You might spend the first year trying to get them engaged, and then the second year trying to do the work, and then maybe you need another year or two."**
>
> **– PO representative**

Two POs reflected on the amount of information they received and the number of things they were trying to do during the program and suggested that the program needed to be longer to see impact across all practices.

Since all program components were generally rated as having value, the evaluation was unable to isolate the effectiveness of each component. Data suggested that program components were complementary. For example, funding provided practices and POs the time to engage in program activities like coaching or learning events. The curriculum, tools, and resources were complemented by individualized coaching that helped explain the content and make it actionable for practices. While lessons from the program can be implemented, the multi-faceted and interdependent components of the program may make it difficult to fully replicate without dedicated funding for practice and PO participation, as well as technical assistance and support.

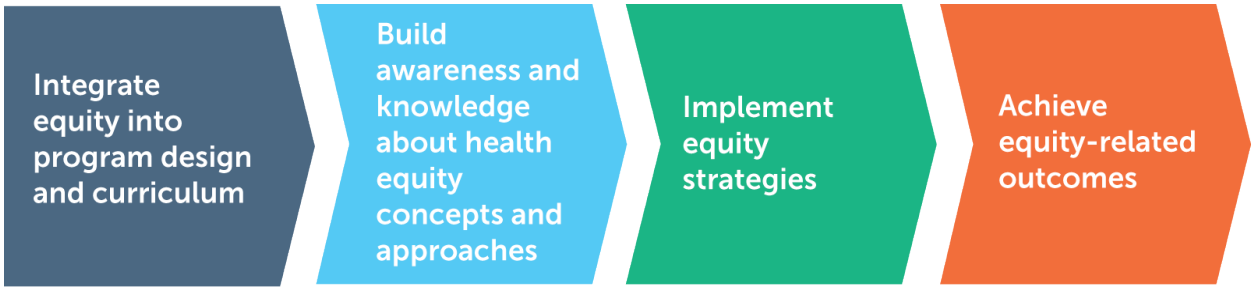
5. EQuIP-LA's focus on health equity and health disparities increased awareness about health equity concepts and approaches among participating organizations.

Advancing health equity was seen as both part of the program approach and an outcome within EQuIP-LA. **Progress included successfully (1) building equity concepts and approaches into the**

EQuIP-LA program design, structures, and curriculum and (2) increasing health equity awareness and knowledge among practices, POs, and for program implementers. Putting health equity strategies into practice primarily occurred at the program level, with more limited concrete examples of operationalizing health equity among practices and POs. **Health equity work within the program was not linear and required ongoing attention to ensure it was successfully integrated**.

Results in this section are discussed along an implementation pathway (Figure 15) for program partners and program participants. This pathway aligns with the EQuIP-LA theory of change and implementation approach, which posits that effectively advancing health equity requires embedding equity concepts and approaches through all aspects of program implementation. In addition, through building awareness, knowledge, and capacity to implement equity-centered strategies, the program can contribute to equity-related outcomes such as reduced health disparities.

Figure 14. Health equity implementation pathway for EQuIP-LA



EQuIP-LA program partners

Integrate equity into program design, curriculum, and practice recruitment

One outcome of EQuIP-LA was successfully embedding health equity into practice recruitment, curriculum, and program structure. The specific ways that the program achieved this are discussed below.

Practice recruitment	**Focus on independent practices**: Independent practices in California serve high proportions of communities of color and have historically received fewer resources and less support from both government and philanthropic entities. EQuIP-LA aimed to begin to address that long-standing, entrenched inequity. **Selection and recruitment of diverse practice**s: EQuIP-LA worked with LA County health plans to identify practices whose Medi-Cal populations were at least 60% enrollees of color.

Curriculum development & delivery	**Integration of patient-family engagement (PFE)**: Program partners engaged PFCCpartners during the planning process to facilitate a listening session with Medi-Cal patients to gather input on program design and implementation. They continued as a key implementation partner supporting the engagement of a person with lived experience on the EQuIP-LA steering committee and providing education, support, and resources on PFE to POs and practices throughout the program. **Addition of a health equity-focused implementation partner**: EQuIP-LA added HealthBegins, an organization with deep expertise in integrating health equity into clinical quality improvement and health care transformation efforts, as a key partner on the program implementation team. **Equity-centered QI tools and resources**: Through program curriculum and improvement advising, POs were taught various strategies for embedding health equity into traditional QI tools and approaches that they then shared with practices through monthly coaching sessions. This included: • Developing SMARTIE (Specific, Measurable, Ambitious, Relevant, Inclusive and Equitable) aim statements to articulate their goals and ensure they were considering equity from the outset. • Considering how to more robustly engage patients and families. • Integrating health equity into PDSA cycles, reflecting on how QI efforts impacted different segments of their populations, and considering potential tailored change interventions (including targeted outreach strategies). More information on equity-centered QI is available in CQC's implementation spotlight: Approaches to Designing Equity-Centered Quality Improvement Projects **Data stratification by race/ethnicity**: Stratifying performance data is necessary to understand existing disparities and monitor the impacts of change interventions on specific patient populations. EQuIP-LA included grant requirements and technical assistance for POs and practices to build capability to stratify data by race and ethnicity. This included individualized data analytics support from CQC and implementation of the REaL (Race, Equity and Language) Data Accelerator, a 6-week, webinar-based training program led by HealthBegins.

Program structure	**Community-based coaching**: EQuIP-LA's train-the-trainer model focused on building capacity of PO representatives to serve as community-based coaches. These were QI professionals with a deep understanding of a community's needs and resources, which they leveraged to tailor improvement interventions to meet specific needs. See CQC's implementation spotlight Empowering Change: The Role of Community-Based Coaching in Health Care Transformation for more information. **Multi-partner steering committee**: As discussed earlier, program partners worked to include diverse perspectives in EQuIP-LA through a relatively complex collaborative implementation structure and a steering committee to provide oversight and guidance, including a person with lived experience. There was ongoing, intentional attention to ensure all relevant perspectives were represented and additional partners were engaged as needed. **Program evaluation**: Documenting and assessing progress related to health equity was a key component of the EQuIP-LA evaluation. This included an internal equity review of the evaluation plan to ensure health equity considerations were embedded throughout. There was also an explicit effort to integrate patient voice and perspective into the evaluation (see pages 47–49).

Build awareness and knowledge about health equity concepts and approaches among program partners

Program implementation partners reflected throughout the EQuIP-LA program about the program structure and focus on equity. During the first year of the program, the implementation partners realized that there were gaps in its collaborative structure that impeded its focus on health equity. Given implementing partners were brought into the program at different stages, there was not a shared understanding of the equity goal or the collective strategies and processes to achieve it. This disconnect manifested in difficulty navigating new relationships among implementation partners and various collaboration challenges such as power dynamics, lack of role clarity, unclear governance, decision-making and communication processes, and lack of agreement on definitions of equity.

Implement equity strategies

To address these early challenges among program partners, the program engaged an external facilitator to lead a process to identify and articulate challenges and build a stronger foundation for collaboration. This process prompted direct discussions and helped the program:

- Establish a common understanding of health equity and how it was being addressed in the program among partners

- Develop a collectively agreed-upon program goal
- Articulate clear roles and responsibilities
- Clarify decision-making processes
- Establish regular communication structures

Program implementation partners agreed that these efforts improved collaboration but some challenges with governance and decision making persisted throughout the program. While all partners agreed that health equity principles were embedded into all aspects of program implementation, only 11% (1/9) strongly agreed (Figure 16), which suggests that most partners felt there were opportunities to strengthen how health equity was embedded into the program. Towards the end of the program, some partners reflected that the program implementation structure was overly complex and shared that **earlier engagement of key implementation partners and a more inclusive planning process could have further embedded equity and better integrated people with lived experience into the program**.

Figure 15. Implementation partner feedback on program structure and collaboration

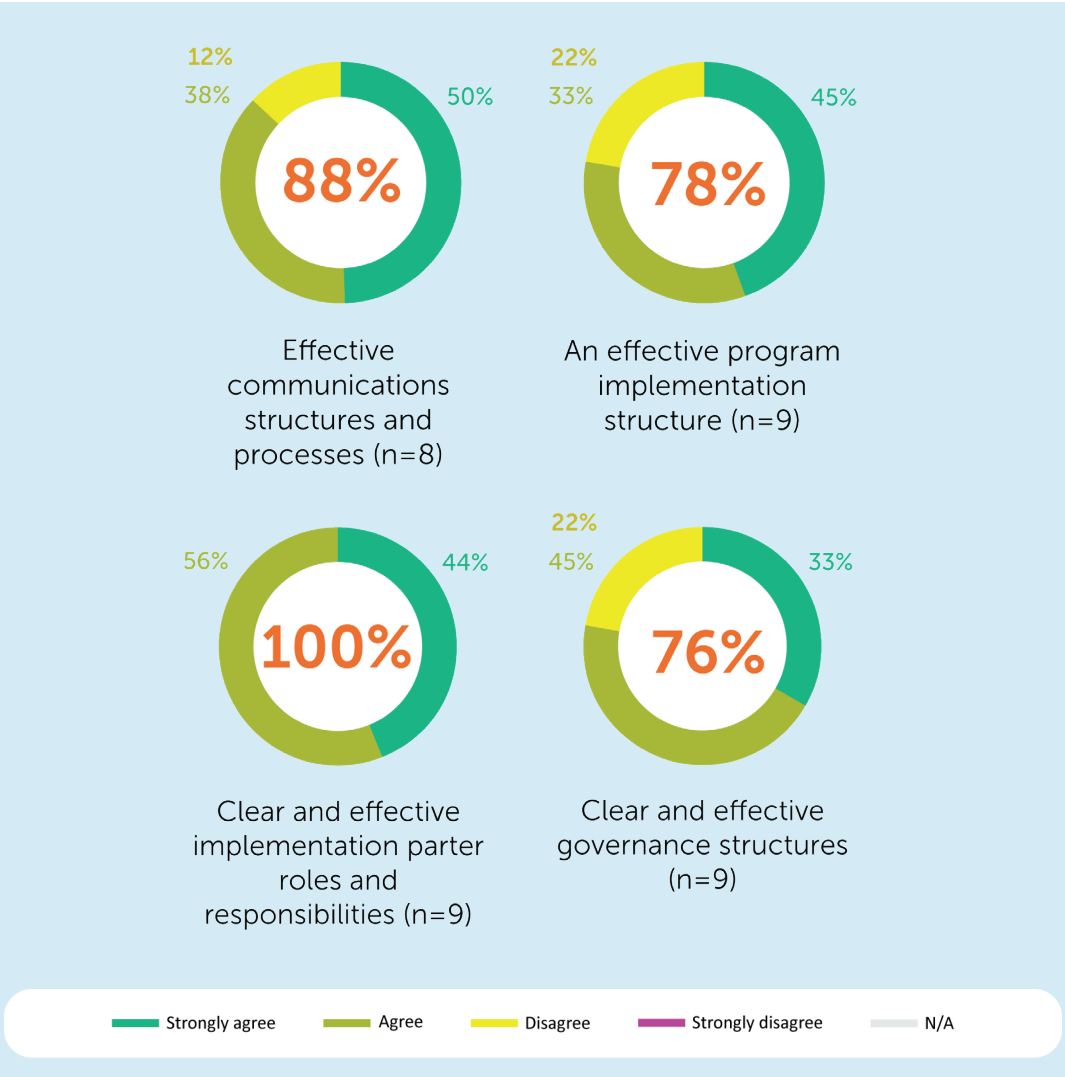
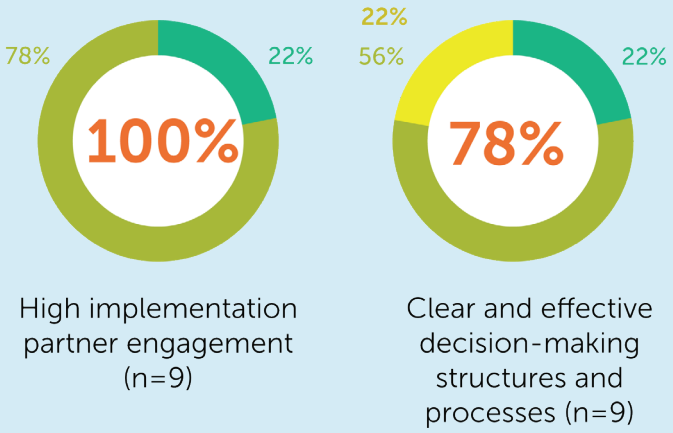


Figure 15., continued



Although some aspects of patient-family engagement were embedded into the design and structure of EQuIP-LA (e.g., engagement of PFCCpartners), some partners identified this as an opportunity for improvement both related to program implementation and evaluation:

- *Program implementation*. The primary mechanism for engagement of people with lived experience in the program was through the steering committee. While 79% (11/14) of steering committee members agreed that it was effective, this was the lowest rated aspect of the steering committee suggesting that there were opportunities to strengthen engagement of people with lived experience in the program. Additionally, while the steering committee was intended to be a mechanism to foster inclusion of various perspectives into the program's design and implementation, members shared that it functioned more like an advisory body versus providing strategy-level input and direction.

- *Evaluation*: The evaluation attempted to gather patient perspectives about the changes practices made through EQuIP-LA by talking to a small sample of patients from one practice. This approach encountered two primary challenges resulting in limited evaluation data: 1) difficulty recruiting patients who met inclusion criteria (i.e., Medi-Cal enrollees with exposure to the QI interventions); 2) patients' inability to comment directly on the changes made at practices through EQuIP-LA and instead offering general feedback about the care they received at the practice.

EQuIP-LA Participants (POs & practices)

Build awareness and knowledge about health equity concepts and approaches

Through the train-the-trainer model, POs and practices received various types of health equity education and support. POs were taught various strategies for embedding health equity into QI processes that they then shared with practices through regular coaching. As mentioned above, both POs and practices were required to develop SMARTIE aim statements to articulate their goals and ensure they were considering equity from the outset. POs and practices also received support to integrate health equity into PDSA cycles, stratify their performance data by race and ethnicity, and think about how their QI efforts affect different segments of their populations. POs also received robust training on patient-family engagement and collecting and using REaL data.

POs and practices reported increased knowledge in two aspects of health equity: understanding of QI-related health equity concepts and patient-family engagement.

Practices	POs
86% of practices (25/31) *agreed* that EQuIP-LA's practice coaching increased their: • Knowledge of health equity concepts (e.g., tailored outreach based on patient race/ethnicity data) and their connection to QI. • Ability to engage patients and families, such as using patient feedback to inform QI interventions.	• All PO respondents (18/18) *agreed* that EQuIP-LA improved their understanding of health equity and associated strategies; 61% strongly agreed. • Most (94%) also *agreed* that the program improved their understanding of PFE and how it can benefit their work, with 44% *strongly agreeing*.

Qualitatively, POs and practices agreed that explicit conversations about what health equity is and what equitable care entails were helpful. Across participants, there was variation in how practices understood equity in the context of care delivery. Some were early in their equity journeys and focused on equality at the individual level and "treating everyone the same." POs appreciated the program tools for how to broach equity-centered QI concepts with practices. One PO shared that an

effective coaching strategy was to connect practices' current strategies with their health equity goals, which provided a concrete way to begin the conversation about where additional efforts may be beneficial.

> **"This program has introduced to practices that equity can be data driven, knowing who your patients are and the importance of having a functional electronic health record [for population health management]."**
>
> **– PO participant**

Although both POs and practices reported increased knowledge about patient-family engagement (PFE) strategies in surveys, when asked about implementation of PFE strategies, **most POs and practices indicated that they did not introduce or test new feedback processes as part of EQuIP-LA**. Some discussed using pre-existing feedback channels like patient experience surveys (e.g., Press-Ganey) or comment boxes in their waiting areas to inform their EQuIP-LA QI efforts.

Implement health equity strategies

Though most POs and practices reported increased understanding of health equity concepts and strategies, there continued to be varying interpretations of what health equity meant among program participants. There was also acknowledgement that there were ongoing opportunities to strengthen these efforts.

When asked in interviews to describe how practices were operationalizing health equity, POs and practices mentioned:

- **Increasing focus on stratified, population-level data to close care gaps and reduce disparities between various patient groups**. EQuIP-LA data reporting requirements supported POs in improving their ability to stratify data by race and ethnicity and provided tools for sharing and discussing that data with practices to inform improvement efforts.

  In the practice survey, 83% (24/31) of practices indicated that they almost always systematically collect patient ethnicity and race data. However, there were issues with the quality of the race and ethnicity data submitted directly by practices in the survey suggesting that **there are still opportunities to improve collection and use of race and ethnicity data**. A couple of practices commented that the data stratification support did not change their equity-related processes, either because they felt it was already integrated into their work, or because the demographics of their patient population were too homogenous to stratify.

- **Using QI tools like root cause analysis to develop more tailored outreach strategies** to foster patient engagement in their own health care. Within EQuIP-LA, this often included creating communications and materials that aligned with patients' primary language.
- **Shifting to use a population health approach**, which included thinking strategically beyond the daily appointment list, looking across a practice's whole patient panel, and stratifying data by race and ethnicity to find improvement opportunities.
- **More focus on social determinants of health**, such as implementing social health screening and connecting patients to needed resources.

> **"When we started EQuIP-LA we weren't really talking about the social determinants of health, and I think now, for most of the practices, they are incorporating new assessments for new patients asking about homelessness, food insecurity and things of that nature... But I think that they still have a lot of work to do when it comes to equity."**
>
> **– PO participant**

Additional details on implementation of equity-centered QI are available in CQC's implementation spotlight: Approaches to Designing Equity-Centered Quality Improvement Projects.

Achieve equity-related outcomes

Despite a program focus on improving the collection of race and ethnicity data, at the cohort level there was no detectable reduction in the proportion of patients with unknown or declined responses for race and ethnicity at the end of the program. However, in the data provided by POs, **several individual practices had improvements in the availability of race or ethnicity data**:

- 55% (17/31) of practices reduced the number of patients with unknown ethnicity data
- 35% (11/31) of practices reduced the number of patients with unknown race data
- 10% (3/31) of practices decreased the proportion of patients in the unknown categories for both ethnicity and race
- 3 out of 4 POs had at least one practice that improved in collecting ethnicity data

The evaluation was unable to assess changes in disparities on the clinical quality measures, given the high proportion of missing/unknown data and relatively small denominators for different patient populations within each of the measures.

Limitations

There were several limitations that impacted evaluation of EQuIP-LA.

Limited practice engagement in the evaluation: Given the competing priorities and limited capacity of independent practices, the evaluation carefully weighed the benefits and burdens of requests to the practices, often relying on program partners and POs for updates. Direct input and feedback from practices was limited to a practice survey and short interviews with a sample of practices (8/31). Practice-level documentation on change efforts (e.g., PDSA cycles) was not available. This made it difficult to capture granular data about the changes being made as part of EQuIP-LA and the context in which the practices were working. The evaluation was also unable to assess some aspects originally included in the scope of the evaluation, including documenting what other clinical transformation support or programs the practices were participating in and accessing financial data to understand whether EQuIP-LA had an impact on practices' ability to access health plan or IPA performance incentives.

Data quality of clinical measures and patient demographics: The clinical quality measures and patient demographic data were reported by POs on behalf of their participating practices. It took several data reporting cycles and hands-on technical assistance from CQC to address data quality issues, which meant the baseline data period was May 2023 rather than the start of the program (January 2023). Additionally, while most practices reported regularly capturing patient demographic data, the data submitted by POs had a high proportion of missing/unknown race and ethnicity data. The level of missing race/ethnicity data and small denominators prevented the evaluation from assessing changes in disparities.

Reliance on self-reported data: The evaluation relied on self-reported data, including IMAT and post-event surveys that asked practices to report on the impact of the program. Self-reported data is known to contain several types of bias, including social desirability bias and recall bias.

Challenges obtaining patient voice/experience data: The evaluation design included collecting data directly from patients who received care from one practice participating in EQuIP-LA to understand their experience with QI interventions implemented during the program. Despite extensive outreach efforts, including incentives and various recruitment strategies by practice staff, patient responses were too low to inform findings. Additionally, given the types of improvements made as part of the program, patients who participated in interviews (n=2) were generally unable to comment specifically on the changes their practice made during EQuIP-LA and spoke more about their general experience receiving care from the practice.

Lack of a comparison group and attribution of changes to EQuIP-LA: While the evaluation showed that practices participating in EQuIP-LA improved clinical quality measures and primary care

capabilities, without a comparison group the evaluation cannot say these changes were attributable to EQuIP-LA. The EQuIP-LA program timeline overlapped with the state-funded Equity Practice Transformation initiative and several practices also participated in that, receiving other, related types of technical assistance and support. Qualitative and survey data provide evidence that participants perceived EQuIP-LA to have positively impacted their progress. This suggests that the program contributed to these outcomes. Additionally, EQuIP-LA used a train-the-trainer model, working closely with POs to implement the program. While evaluation data indicated this model was effective at achieving the goals of the program, the evaluation cannot comment on whether this model was more or less effective than other program designs or technical assistance approaches.

Conclusions and considerations

EQuIP-LA successfully engaged 31 independent practices—of varying sizes and capabilities—and helped them improve foundational primary care and quality improvement (QI) capabilities and their performance on priority clinical quality measures. Using a train-the-trainer model, four POs across LA County were able to leverage their expertise, data, and existing relationships to support practices' improvement efforts. POs also strengthened their internal capabilities to support QI efforts and built stronger relationships with participating practices, which they expected to build upon in future work. EQuIP-LA worked to embed equity into all aspects of the program and successfully increased knowledge about health equity concepts and potential strategies among practices and POs. While practices and POs felt the program helped increase awareness, most practices and POs had not implemented new health equity strategies as part of EQuIP-LA.

Expectations for sustainability

Additional evaluation is needed to understand the lasting effects of EQuIP-LA on practices, POs, and implementation partners. However, data suggest that participants expected changes made from the program to influence future work.

Practices now know more about how to use QI approaches and data to close care gaps. They anticipated continuing the workflow changes they made during EQuIP-LA and working with their PO partner for ongoing support with data and QI.

POs reported increased internal capacity to access and review data and provide individualized coaching and support to small, independent practices to address priority measures. They anticipated continuing to use care gap reports to partner with practices in their networks to elevate improvement opportunities and help practices find actionable solutions.

The following section provides considerations for different interest holders based on the results and learnings from EQuIP-LA.

Independent Practices

Independent practices play a critical role in delivering health care services to Medi-Cal enrollees in California. While these practices tend to be smaller and have less organizational capacity, with support and focused effort, they can successfully improve clinical quality measures. The following considerations are offered as ways for practices to successfully engage in improvement efforts.

1. **Invest in focused improvement efforts to improve clinical quality measures**. EQuIP-LA showed that, with support, independent practices of all sizes and with varied primary care capabilities can implement QI strategies that improve clinical measures. This requires dedicated time from practices to look at data and care gap reports, assess potential gaps in care and outreach, and rethink aspects of operations and/or care delivery. These efforts can position practices to access additional incentive dollars and improve quality of care for patients.
2. **Engage in programs like EQuIP-LA to drive improvement efforts**. The program provided funding and access to tools and resources that practices found valuable to engage in more intentional QI efforts. The program exposed practices to foundational QI and primary care tools and strategies, provided accountability to follow through on improvement efforts, and offered practice coaching for individualized problem solving and support. While practices are busy with the day-to-day tasks of care delivery and meeting patients' needs, programs like EQuIP-LA provide an opportunity to step back, reflect, and identify gaps and opportunities to strengthen current practices that can improve patient experience and outcomes.
3. **Partner with health plans and IPAs to access data and request additional support, as needed**. Health plans and IPAs have an interest in their network of practices performing well on priority clinical quality measures. They want to see practices improve and meet performance benchmarks and can provide practices with data, care gap reports, tools and resources, and coaching to inform improvement efforts. Practices participating in EQuIP-LA reported strengthening relationships with their PO and being more likely to reach out for support in the future.

Health Plans & IPAs

Health plans and IPAs are uniquely positioned to provide ongoing and sustainable support to independent practices within their network. The following considerations are offered as ways to optimize practice-level support.

4. **Provide data and individualized support to independent practices to support improvement efforts**. Results from EQuIP-LA suggest that health plans and IPAs can play an important role in supporting improvement efforts at independent practices. Practices reported that

the most useful support was receiving QI tools and resources and discussed the benefits of receiving timely care gap reports to inform their efforts. Participating POs noted that walking through the care gap reports, identifying challenges, and discussing potential solutions with practices, rather than just providing them with the data and telling them to improve, was a new and more effective way of partnering with practices. While this level of individualized support is likely not feasible to provide to all practices in any given network, health plans and IPAs can identify practices that are struggling to meet benchmarks and offer more targeted support. Assessment tools, like IMAT, may help them understand practice capabilities and gaps and tailor support accordingly.

5. **Invest in improving patient demographic data, including sharing demographic data between practices, IPAs and health plans, to support data stratification and more tailored improvement efforts**. Data on patient race and ethnicity was limited with a significant proportion missing or unreported. Incomplete or unavailable race and ethnicity data doesn't allow practices to stratify their data to understand disparities or where there may be different needs across various segments of their patient population. To improve health equity efforts, practices may need additional support around accessing and stratifying data by key patient demographics. This will allow them to identify where more tailored interventions may be needed. Efforts would be bolstered by improved data sharing between health plans, IPAs, and practices about patient demographics, given the differences that currently exist between demographic data from different sources.
6. **Leverage existing incentive programs to support practices' improvement efforts**. Practices meeting benchmarks on key quality measures benefits patients, practices, IPAs, and health plans. EQuIP-LA illustrates the effectiveness of focusing improvement efforts on key clinical quality measures that are high priority for many organizations. Aligning incentive programs with high-priority clinical quality measures and providing tailored support to practices to achieve benchmarks can be mutually beneficial. Performance on incentive programs may also help POs identify which practices could benefit from additional support. Additionally, EQuIP-LA demonstrated that grant funding was important to get and sustain practice engagement in the program. Incentive programs can provide a more sustainable method of offering financial incentives for improvement efforts. Short-term investments in supporting QI efforts at practices may have long-term benefits. At the end of EQuIP-LA, practices reported feeling more confident that they could access health plan or IPA incentive programs in the future.

Other Supporters of Independent Practices

Given the important roles that independent practices play in the health care environment, other types of organizations (e.g., philanthropic organizations, technical assistance providers) have shown interest in supporting these practices. The following considerations are offered as ways for organizations to provide effective support to independent practices.

7. **Invest in independent practices**. EQuIP-LA demonstrated that, with focused support, small independent practices can make improvements in priority clinical quality measures. Given the proportion of Medi-Cal patients these practices serve across the state, including diverse patient populations who experience disparities in care and outcomes, it is important to invest in and support their capabilities to improve quality of care and performance on key clinical quality measures.
8. **Customize support for independent practices**. Participating POs noted that they often had to simplify and customize program materials to resonate with practices. Many practices have very limited QI infrastructure and individual providers and staff have varying levels of experience with QI tools and resources. In EQuIP-LA, often, support needed to be simplified, and PO coaches helped practices break down improvement efforts into step-by-step processes. However, not all practices needed the same level of support, so it was important for coaches to understand the needs of practices and customize their approach to align with each practice's needs. Assessment tools, like IMAT, can be helpful to understand practices' capabilities and where support may be needed.
9. **Allocate time for relationship building at the outset of any new program/support**. Progress in EQuIP-LA started slower than program implementation partners and POs anticipated because it was important to start with building relationships and trust across the program. For example, POs needed to establish trust with participating practices. Once trust was established, practices and POs were able to collaboratively identify improvement strategies and implement small tests of change that resulted in improved performance on clinical quality measures. In future programs, time needs to be allocated to allow for relationship building, which may impact the length of the program.
10. **Build health equity in from the beginning and align key partners on how it is operationalized**. EQuIP-LA aimed to integrate health equity throughout the program. Lessons from EQuIP-LA show the importance of intentionally spending time upfront to ensure all partners have a shared definition of health equity and agreement about what the program is trying to achieve. Once a vision has been set, equity should be considered in all levels of program implementation (e.g., curriculum, modalities, engagement strategies) as well as in governance and decision-making structures. One critical aspect of embedding health equity is ensuring diverse voices are engaged, including people with lived experience, and paying attention to whose voices are not included.
11. **Set realistic program expectations for outcomes that can be achieved**. It takes time to see sustainable changes in health and health equity outcomes, so programs need to be designed with realistic expectations. EQuIP-LA was a two-year improvement collaborative. During that time, it successfully demonstrated improvements in primary care capabilities and three clinical measures. The evaluation also showed that practices that started with higher baseline capabilities were more likely to achieve benchmarks than those that started with fewer capabilities. However, practices with lower baseline capabilities were still able to strengthen capabilities

and make improvements but not at the same pace or level as those starting with higher capabilities. This suggests that with more time they may have been able to make additional progress to close the gap between performance and benchmark. Additionally, progress was slower than initially anticipated due to the need to invest in relationship building at all levels in the program and challenges with data reporting that required substantial time and support to resolve. Partners reflected that a six-month planning phase would have been useful to build relationships and address data quality issues before launching program implementation. When designing a program, it is important to understand where practices are starting, what challenges may need to be addressed, and what outcomes are feasible in the allotted time.

Appendix

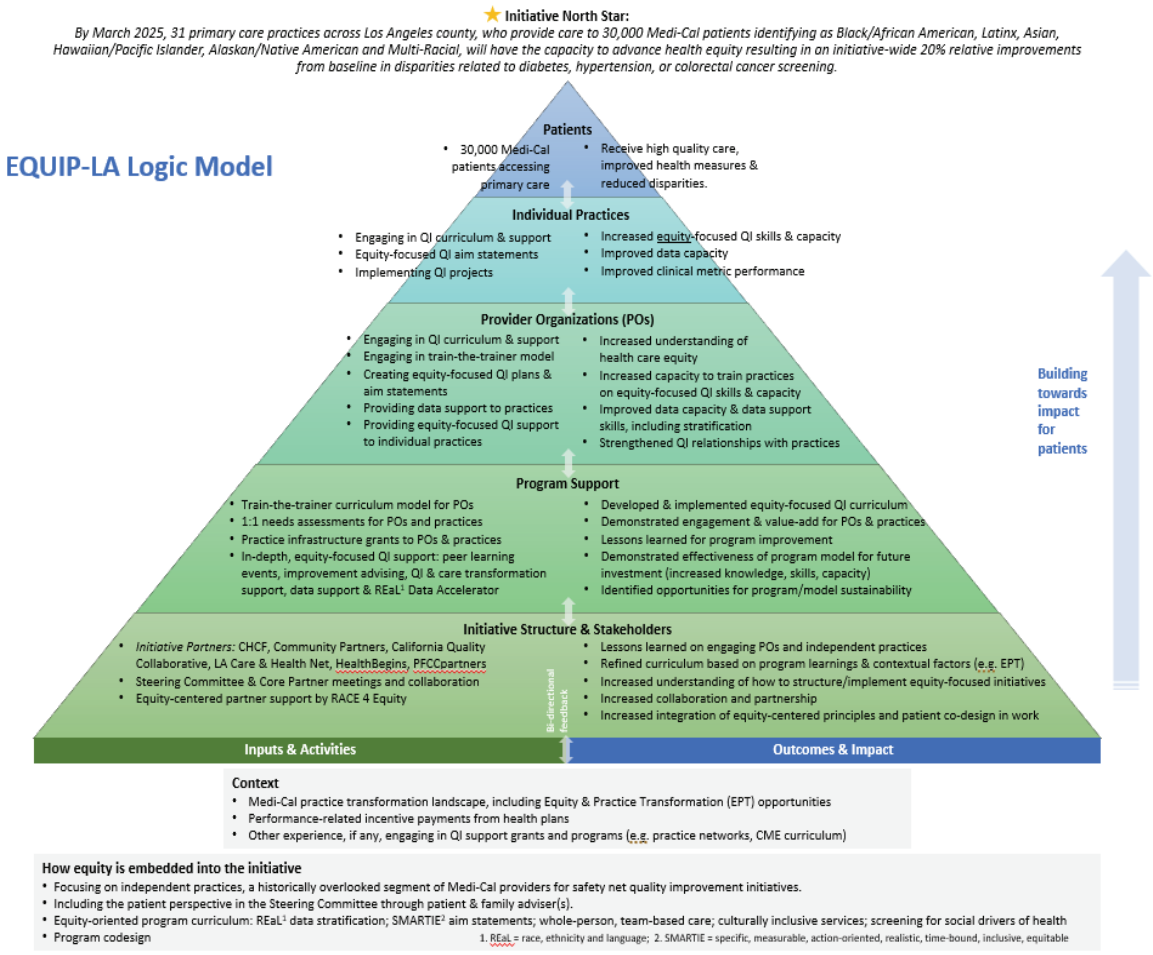
A. Practices and characteristics

PO	Practice name	Practice city (CQC data)	Number of providers (CQC data)	Patient enrollment (December 2024)
Allied Pacific	Adam Hy Do	Rowland Heights	1	636
Allied Pacific	AMG Neighborhood Care Clinic (Alhambra)	Maywood	6	82
Allied Pacific	AMG A Professional Medical Corp (Pasadena)	Pasadena	20	5,115
Allied Pacific	Ardmore Medical Group Inc	Maywood	9	2,286
Allied Pacific	Emerald S Tay MD A Professional Corp.	San Gabriel	2	981
Allied Pacific	Huynh Tran Dba Wynn Medical Center	Rosemead	1	911
Allied Pacific	Ka Woo Medical Clinic Inc.	Alhambra	1	542
Allied Pacific	Montes Medical Group Inc	Inglewood	3	1,323
Allied Pacific	Philip Y Zhuo MD Inc	Monterey Park	1	762
Allied Pacific	S.K. Medical Group Inc.	San Gabriel	1	228

PO	Practice name	Practice city (CQC data)	Number of providers (CQC data)	Patient enrollment (December 2024)
Allied Pacific	Star Health Medical	West Covina	2	708
Angeles	Baldwin Park Medical Clinic	Baldwin Park	1	415
Angeles	Clinica Del Socorro Medical Group, Inc.	Los Angeles	3	1,253
Angeles	Clinica Medica Cuzcatlan Inc	Bell	1	1,755
Angeles	First Integrated Care Medical Group	Long Beach	2	1,096
Angeles	La Star Medical Group	Lawndale	1	2,799
Angeles	Marcelo-Mangune Medical Corporation	Bellflower	1	1,107
Angeles	May Family Medical Clinic	Hawaiian Gardens	1	2,280
Angeles	Tweedy Medical Group	South Gate	3	761
L.A. Care	Centinela Medical Group	Los Angeles	9	1,046
L.A. Care	Gage Medical Clinic	Huntington Park	9	587
L.A. Care	Pico Rivera Womens And Children Health Center	Pico Rivera	1	74

PO	Practice name	Practice city (CQC data)	Number of providers (CQC data)	Patient enrollment (December 2024)
L.A. Care	Reddy Care Medical	Pomona	5	498
Omnicare	Angel Family Practice Med Grp Inc	Los Angeles	1	1,116
Omnicare	Centro Medico Inc	Hawthorne	3	843
Omnicare	Eleanor Azurin MD Inc	Huntington Park	1	317
Omnicare	Morningside Primary Care Medical Clinic	Los Angeles	2	1,752
Omnicare	Nueva Esperanza Health Care	Los Angeles	1	760
Omnicare	Ragaa Z Iskarous, MD Inc	Maywood	1	671
Omnicare	St. Francis Multi-Specialty	Lynwood	1	863
Omnicare	Valentin Hernandez, MD	Hawthorne	1	519

B. Logic Model



C. Methods

The table below presents details on each data source, how it was collected, who participated, and how data were analyzed. After analyzing all data sources, the evaluation team looked across sources to triangulate insights and identify key findings. While some findings rely more heavily on a single data source, all were derived from a mixed method, thematic analysis.

Method	Description & Analysis
Clinical performance data	POs submitted monthly performance data on behalf of each practice for three clinical quality measures: controlling blood pressure (CBP), colorectal cancer screening (COL), and glycemic status assessment for patients with diabetes, HbA1c >9% (GSD). Data for clinical quality measures were submitted for total eligible patients for each measure, as well as stratified by patient race and ethnicity. Data from May 2023 (baseline) through December 2024 (endpoint) were included in the analysis. **Analysis**: Descriptive statistics were computed using validated data in Microsoft Excel to summarize absolute improvement for each clinical measure. Paired t-tests were conducted to assess statistically significant changes from baseline to endpoint. Exploratory analysis of data stratified by patient demographics found, due to the high proportion of data with 'missing/unknown/declined' race and/or ethnicity, only the change in percentage of records with unknown values could be calculated to assess changes over time. No additional inferential analyses were conducted on demographic variables because of these data quality limitations.

Method	Description & Analysis
The Implementation Milestone Assessment Tool (IMAT)	The Implementation Milestone Assessment Tool (IMAT) was developed by CQC prior to EQuIP-LA and informed by the 10 Building Blocks of High-Performing Primary Care. It was modified with input from HealthBegins, PFCCpartners, and EQuIP-LA QI subject matter experts to align with program curriculum focus areas. It was completed by practice coaches and practices' EQuIP-LA project teams during coaching meetings in July 2023 (baseline), July 2024 (midpoint), and March 2025 (endpoint). All 31 health centers submitted responses at all three timepoints. The IMAT includes six out of 10 domains from the Building Blocks for High-Performing Primary Care, which were covered in the EQuIP-LA curriculum. The domains and individual assessment items (i.e., milestones) are listed below: **Domains** — **Milestones** Engaged leadership — • Leadership vision; • Staff training Data-driven improvement — • Data infrastructure & capacity; • Monitor progress & adjust interventions Team-based care — • Roles & responsibilities; • Workflows Patient-team partnership — • Patient engagement in care; • Patient engagement in QI Population health management — • Care gaps; • Care management; • Panel management Access to Care — • Inclusive communication and scheduling methods Social drivers & community partners — • Social Determinants of Health (SDOH); • Community partnerships

Method	Description & Analysis
(continued)	Practices were instructed to rate each milestone using the rating scale below: Not Yet Started: 0 — Indicates that the practice has not yet started to work on this domain/milestone Planning: 1 — Indicates that some preliminary planning and convening has been done to move this domain/milestone forward Implementing: 2 — Indicates that there is a collective understanding of the execution of this domain/milestone and the practice has an implementation plan in place to roll out the intervention Standard Work: 3 — Indicates that the practice has identified this domain/milestone as standard practice, all clinical teams have been notified and received proper standardized operating procedures (SOP) and workflows to execute **Analysis:** Descriptive statistics were generated using Excel. Changes over time were analyzed at the practice level for each domain, along with the Practice Organization (PO) domain averages, and aggregate cohort domain averages.

Method	Description & Analysis
Interviews and reflective conversations	Interviews and reflective conversations were conducted to understand program progress and impact, identify facilitators and barriers, identify lessons learned and promising practices, and understand participant experiences. **Practices:** 30-minute interviews were conducted with a sample of eight practices – four completed in September 2024 and four in February-March 2025. Each PO project team advised on the selection of practices sampled for interviews, with two practices identified per PO (one practice at each timepoint). POs were asked to identify practices that would represent a range of moderate and high engagement in the program. **POs:** 1-hour reflective conversations were conducted with all four PO project teams, including project leads, data leads, and practice coaches. Conversations were held twice with each PO, once in July 2024 and again March 2025. **Analysis:** Interviews were digitally recorded and then professionally transcribed. The evaluation team coded transcripts in Atlas.ti using a priori list of codes based on the discussion guides and interview protocols used. Code queries were exported from Atlas.ti to complete a thematic analysis of codes, grouped by code families that aligned with topics of interest to the evaluation (e.g., QI capabilities, data usage, workflows, challenges, facilitators, satisfaction).

Method	Description & Analysis
Patient voice case study	The evaluation team coordinated with CQC to invite POs to identify a sample of practices that would have the interest and capacity to participate in additional data collection efforts to incorporate patient experience and perspective into the evaluation. CQC then advised on selection of one practice from the nominated sample for the evaluation team to collaborate with and facilitated communication via their PO practice coach. Patients from the selected case study practice were recruited using bilingual flyers in English and Spanish that advertised the opportunity to provide feedback on their experience as a patient and receive a $25 incentive gift card as compensation for their time and insight. Practice staff assisted with distributing flyers to patients in the clinic, as well as mailing flyers to patients who had recently completed an appointment. Practice staff also assisted with making follow-up phone calls to patients receiving flyers to raise awareness of the opportunity to provide feedback. Patients who opted in to interview participation completed a brief, online survey to verify their eligibility (i.e., Medi-Cal enrollee, recent appointment, consent to be interviewed). Recruitment was conducted in March-April 2025. Two English-speaking patients completed the opt-in process and participated in interviews. Data collected was about patient experience more generally, and patients did not have feedback specific to EQuIP-LA activities or QI interventions completed at the practice. Given the limited sample (n=2), there was insufficient data to complete thematic analysis or include data in evaluation findings.

Method	Description & Analysis
Feedback surveys	Feedback surveys included a combination of Likert-type scale, multiple-choice, and open-ended questions to gather data on patient demographics, participant demographics, program impact, capacity changes, perceived facilitators and barriers to progress, and satisfaction with program participation and program components. Surveys were administered in March 2025, online via REDCap, with email distribution and reminder messaging to respondents. **Practices**: The survey was sent to all 31 practices and 29 responded (94% response rate). **POs**: The survey was sent to 26 team members, representing all project team staff from each of the four POs, and 18 responded (69% response rate). **Steering committee and partners survey**: The survey was sent to 22 participants, based on rosters for the steering committee and staff from program partners who regularly attended program implementation meetings, and 14 responded (64% response rate). **Analysis:** Descriptive statistics were calculated using Excel. Exploratory comparisons were made based on participants' roles, practice team size, their PO, and engagement level.

Method	Description & Analysis
Observation and document review	A representative of the evaluation team attended EQuIP-LA Commons webinars hosted by CQC, and REaL Data Accelerator webinars hosted by HealthBegins, for program participants from February 2024 to January 2025. Attendance was used to understand the program curriculum and conduct observational data collection on discussions and participant engagement. The evaluation team also participated at in-person convenings to contribute to program learning and conduct observational data collection on program progress, participant discussions, and engagement. Key program documents, such as SMARTIE aim statements, practice enrollment forms, program implementation briefs, and other program collateral, were reviewed to understand program curriculum, participant progress, and lessons learned. **Analysis:** Key program documents—such as SMARTIE aim statements and enrollment forms—and evaluation activities conducted prior to 2024 were reviewed alongside observations from 2024–2025 to inform evaluation planning and findings.

D. IMAT baseline and endpoint average scores for EQUIP-LA overall and each PO (scale 0-3)

	EQuIP-LA		PO1		PO2		PO3		PO4	
Domain	**Baseline**	**Endpoint**	**Baseline**	**Endpoint**	**Baseline**	**Endpoint**	**Baseline**	**Endpoint**	**Baseline**	**Endpoint**
Access to care	1.68	2.74	2.09	2.91	1.00	2.25	1.00	3.00	2.13	2.88
Population care management	1.59	2.68	2.00	2.97	1.00	2.33	0.42	2.08	2.21	2.92
Team-based care	1.58	2.56	1.86	2.82	1.00	2.19	0.25	2.38	2.44	2.69
Data-driven improve-ment	1.42	2.44	1.50	2.82	1.00	2.13	0.38	2.38	2.25	2.25
Social drivers and community partners	1.18	2.42	1.18	2.50	1.00	2.25	0.25	2.13	1.81	2.63
Engaged leadership	1.39	2.39	1.50	2.64	1.00	2.19	0.75	2.25	1.94	2.31
Patient-team partnership	1.31	2.29	1.27	2.64	1.00	2.25	0.00	0.88	2.31	2.56

E. Tableau dashboard designed by CQC

The screenshot below shows an example of CQC's program dashboard on Tableau. POs could see individual practice data, aggregate data for their practices, and aggregate data for the program cohort overall. Hovering over data points showed additional actionable data for coaches as well.