

CONTRA COSTA
HEALTH



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CCH Outpatient Services

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4/13/2026

Overview of Services

- 9 Outpatient Health Centers



- Full Scope Primary Care at all clinics
- Specialty Care Services at the 3 largest clinics – West County, Martinez and Pittsburg
- Approximately 128 Primary Care Providers + 39 Family Medicine Residents
- 229K People empaneled with CCH, 30K identify as Black/African American
- Over 90% of our patients qualify for Medi-Cal

Primary Care:

- Adult Medicine
- Family Medicine
- Pediatrics
- Women's Health
- Prenatal Care
- Laboratory
- Addiction Medicine



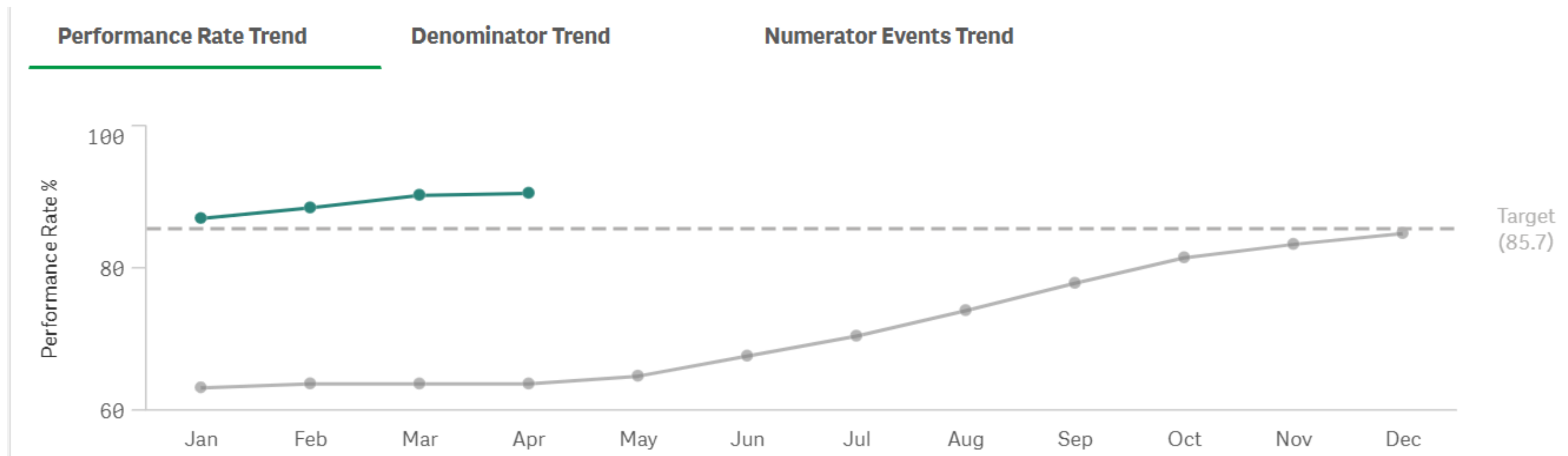
Examples of Services Offered:

Specialty Care:

- Audiology
- Cardiology
- Dental
- Dermatology
- Ear Nose Throat
- Gastroenterology
- Gender Clinic for Transgender Patients
- OB/GYN
- Neurology
- Oncology/Hematology
- Ophthalmology
- Orthopedics
- Plastic Surgery
- Podiatry
- Pulmonary/Bronch
- Rehabilitation – Physical and Occupational Therapy
- Renal
- Rheumatology
- Surgery Clinic
- Urology

QIP – Quality Incentive Program (MediCal Waiver Program)

- Incentive program for California’s public hospital systems
- Numerous measures with a strong outpatient focus
- CCRMC needs to meet targets each year to achieve maximum potential revenue
- This has led to many improvement teams and projects
- This program has led to high level dashboards where we can look at the different measures by clinic, insurance, race, ethnicity, language, etc.



2 Strategies to Address Population Health Needs

Inreach – Addressing items at appointments or other points of contact with the health system

- More effective and less resources
- “Care Gaps” are addressed by nursing staff and providers at primary care visits
- Examples: 1. Annual Fall Screening for older adult presenting for a follow up visit for blood pressure
2. Addressing needed vaccines at a child’s sick visit
3. Colon Cancer screening discussed at a routine visit for osteoporosis

Outreach – Reaching out to patients to address care needs

- Often very hard to reach people. Takes high person hours to see effective impact.
- Examples:
 1. Mailing FIT (colon cancer screening) tests to patients
 2. Calling people to ask them to come in for blood pressure check
 3. Contacting parents to let them know that their child is overdue for physical or vaccines

QIP Equity Measures – Defined by the State

- Controlling Blood Pressure – African American/Black Population
- Child and Adolescent Well Care Visits (3-21yo) – African American/Black Population
- Glycemic Status Assessment – African American/Black Population

Have developed many InReach and OutReach over the years to address the above 3 measures.

Able to evaluate ALL of the QIP Measures based on race

Pediatric Disparities for African American/Black Patients

- Across all ages large gap in Immunizations- especially prenatal, pediatric and adolescent populations
- Large disparity gaps in Pediatric measures – despite efforts to focus on these areas!
- Track these closely and efforts include targeted outreach, contacting “no-shows” and incentive programs

Metric	Total Population	African American	% Disparity Gap
Childhood Immunization	38	18.3	19.7
Adolescent Immunization	60.33	43.2	17.13
WCV* 0-15 Months	80.47	67.4	13.07
WCV* 15-30 Months	80.64	69.6	11.04
Child and Adolescent WCV*	57	52	5
Developmental Screening	80.5	74.9	5.6

*WCV = Well Child Visit (physical)

Prenatal Disparities for African American/Black Patients

- Prenatal measures also with disparities especially Immunizations and Prenatal Care
- Prenatal improvement teams very focused on improving experience and outcomes for African American/Black patients

Metric	Total Population	African American	% Disparity Gap
Prenatal Immunization	44.6	20.5	24.1
Prenatal Care	86.16	75.5	10.66
Post Partum Care	88.83	85.8	3.03

Adult Cancer Screening and Chronic Disease Disparities for African American/Black Population

- **Variable** disparities and success for these areas.
- Cancer screening with less disparities overall.
- Hypertension has been particularly challenging. Previously at 8-9% disparity and then reduced to 0.5%, but lately increased to 4.5%
- Glycemic control for diabetes – currently at 2.65% disparity with total population
- Diabetic retinopathy screening at 8.7% disparity with total population
- Asthma control – 8.4% disparity with total population.

Opportunities and Conclusions

- 9 Health Centers with full scope Primary Care including geriatric, prenatal, pediatric and adult medicine
- Engaged and interested in reducing health disparities
- Sophisticated data system to track progress
- Areas of particular concern – Pediatric Immunization and Well Visits, Prenatal Immunizations and Visits and Asthma
- Collaboration with more community partners would be welcome and appreciated

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**Thank you for inviting CCH
Clinics to present today.**

Special Thank you to Nooshin Abtahi for
preparing disparity data.