The MetroHealth System

Board of Trustees

Wednesday, September 17, 2025

1:30pm - 3:00pm

The MetroHealth System Board Room K-107 or via YouTube Stream

Population and Community Health Committee

Regular Meeting

The MetroHealth System Board of Trustees

POPULATION AND COMMUNITY HEALTH COMMITTEE

DATE: Wednesday, September 17, 2025
TIME: 1:30pm – 3:00pm
PLACE: MetroHealth Board Room (K107) or via YouTube Stream:
              https://www.youtube.com/@metrohealthCLE/streams

AGENDA

I.   Approval of Minutes
       Committee Meeting Minutes of April 30, 2025

II.   Information Items
       A. Population and Community Health Strategy
       B. New Operational Structure: 4 Pillar Strategy
            ● Introduction to the Index of Disparity
       C. Review of Restated Committee Charter

III.   Recommendation / Resolution Approval
       A. Approval of Amendment to Restate to the Charter of the Population and
            Community Health Committee

The MetroHealth System Board of Trustees

POPULATION AND COMMUNITY HEALTH COMMITTEE
REGULAR MEETING

Wednesday, April 30, 2025
3:00pm – 5:00pm
MetroHealth Board Room (K107) / Virtual

Meeting Minutes

Committee Members:	Nancy Mendez-I, John Corlett-I
Other Trustees:	Artis Arnold, III-R, Sharon Dumas-R, Dolores (Lola) Garcia-R, Ronald Dziedzicki-R, Michael Summers-R, E. Harry Walker, MD-R[1] (late)
Staff:	Christine Alexander-Rager, MD-I, Robin Barre-I, Bridget Barrett-I, Romona Brazile-R, Nabil Chehade, MD-I, William Dube-I, Joseph Golob, MD-I, Matthew Kaufmann-I, Srinivas Merugu, MD-I, Thomas Minor-I, Connie Moreland, MD-R, Kate Nagel-I, Nichole Oocumma-I, Kathryn Plummer-I, Allison Poulios-R, Tamiyka Rose-I, Adebanjo Solaru-I, John Daryl Thornton, MD-R, James Wellons-I, Mara Wilber-I, Gregory Zucca-I
Guest:	Guests not invited by the Committee are not listed as they are considered members of the audience and some were not appropriately identified.

Ms. Mendez called the meeting to order at 3:00 pm, in accordance with Section 339.02(K) of the Ohio Revised Code.

(The minutes are written in a format conforming to the printed meeting agenda for the convenience of correlation, recognizing that some of the items were discussed out of sequence.)

I.   Approval of Minutes
The minutes of December 18, 2024, Committee meeting was approved by majority vote as presented.

II.   Information Items

A.   Introductions – Get to Know Members
Ms. Mendez began the meeting for the committee members to introduce themselves in a roundtable of introductions. Each member shared their professional background, personal motivations and commitment to population health and addressing social determinants of health across the MetroHealth system and the community.

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[1] I-In-person, R-Remote

B.   Review of Charter

The Committee discussed the renaming of the committee to the "Population and Community Health Committee" and reviewed its new draft charter. The charter's purpose statement was read and discussed. A key point of discussion was the definition of "holistic care," which was defined as looking beyond a patient's clinical diagnosis to address the full scope of social drivers of health (e.g., housing, food security). There was also a discussion about ensuring the committee's work is collaborative and does not represent "mission creep" by replacing the work of public health agencies, but rather partnering with them to improve outcomes for MetroHealth's patient population. The Committee also reviewed the responsibilities outlined in the charter, which include identifying health disparities, recommending evidence-based interventions, and ensuring accountability through measurable outcomes. It was noted that oversight for supplier diversity, previously under this Committee's purview, would be moved to Human Resources. Additionally, an amendment will be made to the charter to remove the paragraph regarding the creation of subcommittees, as a process for the board and committee chairs to assign work and invite guests already exists.

C.   Inclusion of Community Representatives

The meeting transitioned to a discussion centered on the inclusion of community representatives in the committee's work. While there was strong support for incorporating authentic community voices, committee members acknowledged legal and logistical complexities, including compliance with Ohio Revised Code and potential conflicts of interest. Suggestions included leveraging existing community focus groups, such as the Patient and Family Advisory Council and the Federally Qualified Health Center (FQHC) board, and forming ad hoc advisory groups to gather input without formal appointments. Governance Committee Chair, Mike Summers, encouraged the use of ad hoc groups to pilot community involvement, allowing the committee to learn and refine an approach before formalizing any changes. Legal counsel confirmed that while the board has the authority to appoint community members, any permanent changes would require bylaw amendments. The committee agreed to proceed cautiously, as existing structures provide immediate avenues for gathering authentic community feedback while a more formal process is being developed.

D.   Next Steps

Dr. Merugu announced that the committee is nearing completion of a strategic roadmap designed to operationalize the Health Equity pillar of the system's strategic plan. A draft of the roadmap will be reviewed and discussed at an upcoming meeting.

III.   Executive Session

Ms. Mendez asked for a motion to move into executive session to discuss hospital trade secrets as defined by ORC 1333.61. Mr. Corlett made a motion and Dr. Walker seconded. Upon unanimous roll call vote, the Committee went into executive session to discuss such matters stated by Ms. Mendez. Members of the public were excused, and the Committee went into executive session to discuss the identified matters at 4:25pm.

Return to Open Meeting

Following the executive session, the meeting reconvened in open session at approximately 5:16 pm.

IV.   Recommendation / Resolution Approvals

A. Recommendation for the Approval of Restatement of Name and Charter of the Health Equity & Diversity Committee

Ms. Mendez asked for a motion for the approval of restatement of name and charter of the Health Equity & Diversity Committee, which was given, seconded and the resolution was passed to be presented to the Board of Trustees for approval.

With no further questions from the Board members in attendance, the meeting was adjourned at approximately 5:17 pm.

NEXT MEETING: Wednesday, September 17, 2025 – 1:30pm - 3:00pm
MetroHealth Board Room K107 and via Zoom

THE METROHEALTH SYSTEM

Nancy Mendez, Chairperson

MetroHealth

Population and Community Health Committee

Date: September 17, 2025

Time: 1:30pm – 3:00pm

Place: MetroHealth Board Room (K107) or via YouTube Stream

Population and Community Health Committee

Agenda for September 17, 2025

I.   Approval of Minutes

    A.   Committee Meeting Minutes of April 30, 2025

II.   Information Items

    A.   Population and Community Health Strategy

    B.   New Operational Structure: 4 Pillar Strategy

       • Introduction to the Index of Disparity

    C.   Review of Restated Committee Charter

III.   Recommendation/Resolution Approval

    A.   Approval of Amendment to Restate to the Charter of the Population and Community Health Committee

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Meeting Objectives

- Review initial strategy for Population and Community Health Committee (the "Committee")

- Review the restated Committee Charter

- Define the structure for execution on Committee objectives

- Introduce 4-pillar leads and objectives for 2025 and 2026

- Understanding and interpreting the Index of Disparity

- Seek approval for the Committee Charter

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What is Population Health?

- Refers to the health outcomes of a group of individuals, including the distribution of outcomes within the group.
    - Can be used at the individual, practice, institutional, and community levels
- Interdisciplinary approach that uses partnerships among different sectors of the community – public health, industry, academia, health care, government – to achieve positive health outcomes.
- Brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in a population.
- Pays attention to social and environmental as well as medical determinants of health.
- Focuses on wellness instead of sick care, uses data to improve care, and engages patients in their care.

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Population and Community Health Strategy

Ensure Population & Community Health is Built into MetroHealth Strategy

- Unify and measure **systemwide contributions** to population and community health

- Amplify the community health work that **MetroHealth has been doing since its inception**

- **Hold the system accountable** to its population & community Health goals

- Be grounded in **the MetroHealth Enterprise strategic plan**

Defining Current Challenges

- Socioeconomic factors and community dynamics contributing to poor outcomes

- Significant change in external support and finance for this work

- Operational constraints and reorganization

- Lack of analysis in existing structures potentially contributing to poor outcomes

- Variability in interventions and spread across many different domains.

Promote and ensure compassionate and holistic care for all patients!

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Population and Community Health Strategy

Driving for better outcomes

- We must ensure the presence of a patient-centered workforce to enhance patient engagement and quality outcomes

- We must develop upstream solutions for population health by identifying and executing strategies to reduce barriers to health

- We must understand quality care and outcomes and ensure system priorities align and support with rigorous process improvement

- We must engage community partners to leverage influence and resources at factor outside of the health system

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Four Pillars to Support our Population and Community

Promote and ensure compassionate and holistic care for all patients.

Pillar 1:
Patient-Centered Workforce

Pillar 2:
Barriers to Health

Pillar 3:
Quality Outcomes and Performance Improvement

Pillar 4:
Community Engagement

The Population and Community Health Committee

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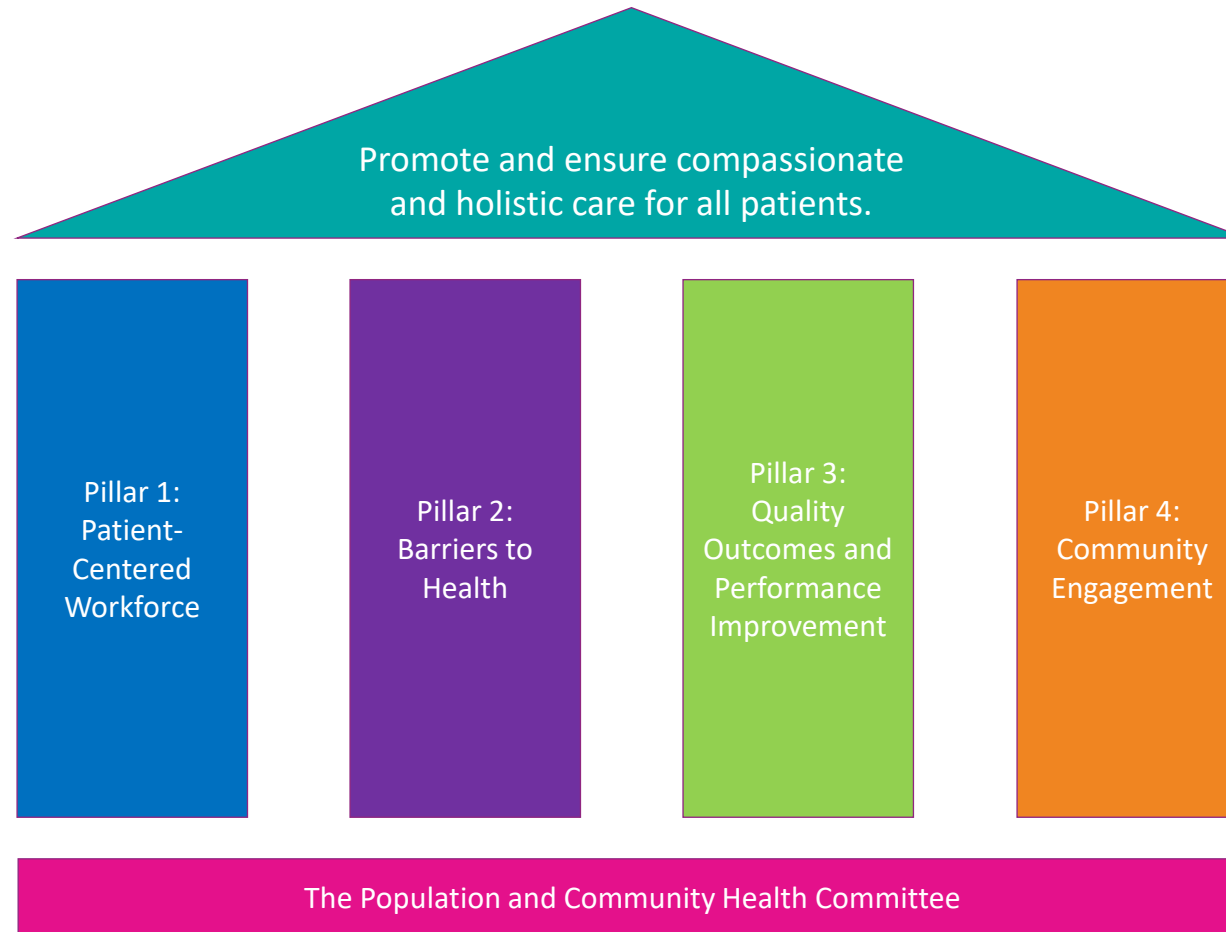
Pillar 1: Patient-Centered Workforce

Dr. Connie Moreland

About Me

Patient-Centered Workforce

Office of Provider Pipeline Development and Engagement (PPDE)

Outline:

1. Definitions of Patient-Centered

2. Why Patient-Centeredness Matters

3. MetroHealth Patient Demographics

4. MetroHealth Employee Demographics

Two Approaches to building a Patient Centered Staff:

1. Align workforce with the needs of the patient population. Identify physicians and staff that complement the patient demographic. Department Leadership drives the decision making in collaboration with PPDE.

2. Educate and train the current workforce. Engage in training current physicians and staff to become more patient-centered in collaboration with PPDE.

Demonstrating these principles using:

- "The Audition" (promoting a positive birth experience)

- "The right person right place"

- PPDE Strategy

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Patient-Centered Workforce

- **CDC (Centers for Disease Control and Prevention):**
"Congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable effective work in cross-cultural situations."

- **Office of Minority Health (U.S. Department of Health & Human Services):**
"Ability of health care providers and organizations to understand and respond effectively to the cultural and language needs of patients in a healthcare encounter."

- **American College of Obstetricians and Gynecologists (ACOG):**
"Ability to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery of care to meet patients' social, cultural, and linguistic needs."
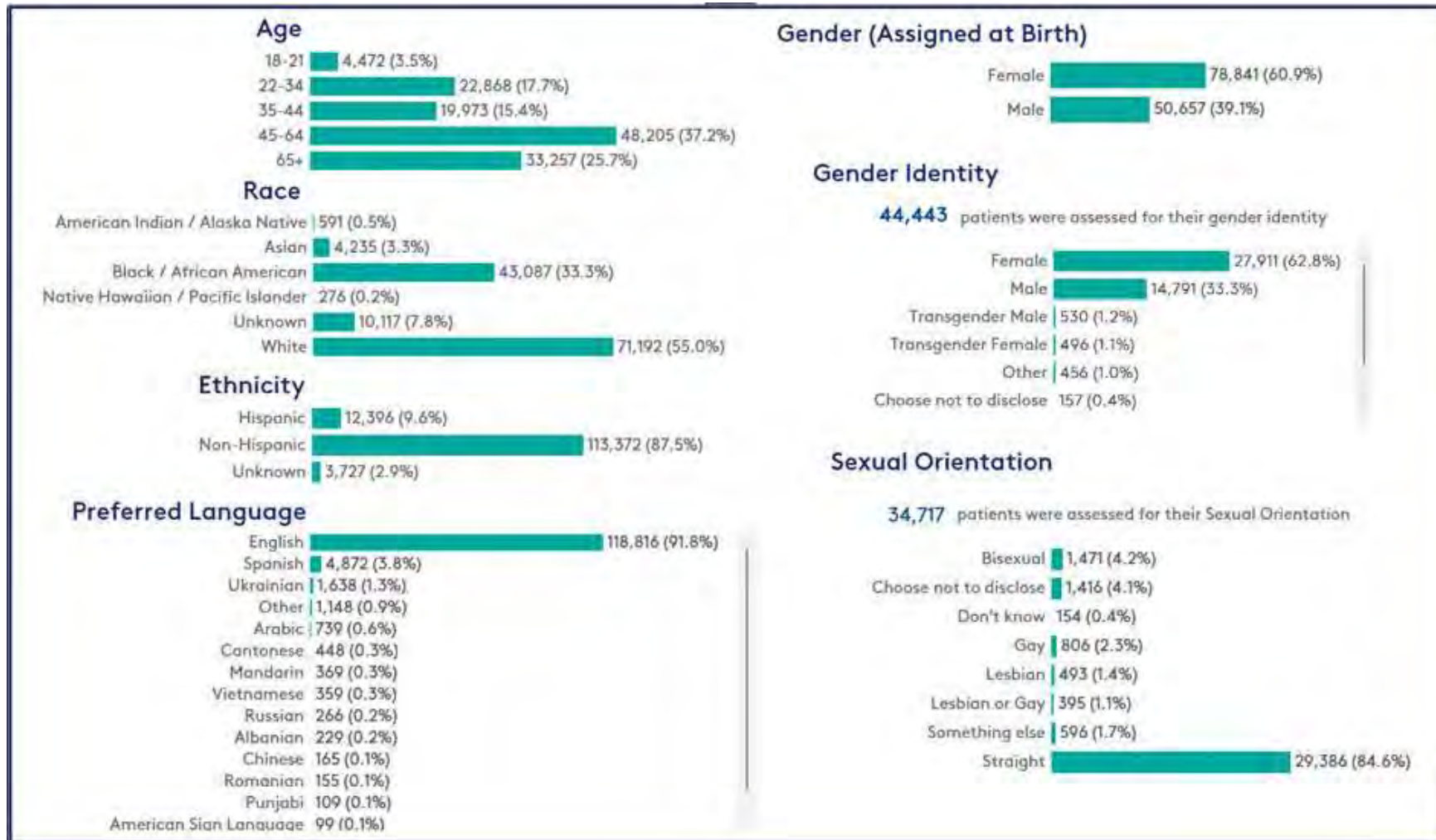

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Data Driven Examples

Doctor-Patient Concordance Improves Outcomes and Promotes Good Relationships

- Randomized Evidence
  - Black men randomly assigned to black physicians were more likely to accept preventive services (Esp. CV screening) could reduce the mortality gap by ~19% (Alsan et al., AER 2019)

- Mortality Outcomes
  - Black newborns cared for by Black physicians had ~1/3 lower in-hospital mortality. (Greenwood et al., PNAS 2020)
  - Women with heart attacks had better survival when treated by female physicians; worst outcomes were women with male physicians. (Greenwood et al., PNAS 2018)

- Population Level Impact
  - U.S. counties with more Black PCPs → longer life expectancy & lower mortality for Black residents, smaller disparities. (Snyder et al., JAMA Netw Open 2023)

- Language Concordance
  - Clinician–patient language match improves communication, adherence, and outcomes; professional interpreters help but do not fully close gaps. (Karliner et al., 2007; Diamond et al., 2019)

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Understanding MetroHealth's Patients

MetroHealth Patient Demographic Data

Age
- 18-21: 4,472 (3.5%)
- 22-34: 22,868 (17.7%)
- 35-44: 19,973 (15.4%)
- 45-64: 48,205 (37.2%)
- 65+: 33,257 (25.7%)

Race
- American Indian / Alaska Native: 591 (0.5%)
- Asian: 4,235 (3.3%)
- Black / African American: 43,087 (33.3%)
- Native Hawaiian / Pacific Islander: 276 (0.2%)
- Unknown: 10,117 (7.8%)
- White: 71,192 (55.0%)

Ethnicity
- Hispanic: 12,396 (9.6%)
- Non-Hispanic: 113,372 (87.5%)
- Unknown: 3,727 (2.9%)

Preferred Language
- English: 118,816 (91.8%)
- Spanish: 4,872 (3.8%)
- Ukrainian: 1,638 (1.3%)
- Other: 1,148 (0.9%)
- Arabic: 739 (0.6%)
- Cantonese: 448 (0.3%)
- Mandarin: 369 (0.3%)
- Vietnamese: 359 (0.3%)
- Russian: 266 (0.2%)
- Albanian: 229 (0.2%)
- Chinese: 165 (0.1%)
- Romanian: 155 (0.1%)
- Punjabi: 109 (0.1%)
- American Sign Language: 99 (0.1%)

Gender (Assigned at Birth)
- Female: 78,841 (60.9%)
- Male: 50,657 (39.1%)

Gender Identity
44,443 patients were assessed for their gender identity
- Female: 27,911 (62.8%)
- Male: 14,791 (33.3%)
- Transgender Male: 530 (1.2%)
- Transgender Female: 496 (1.1%)
- Other: 456 (1.0%)
- Choose not to disclose: 157 (0.4%)

Sexual Orientation
34,717 patients were assessed for their Sexual Orientation
- Bisexual: 1,471 (4.2%)
- Choose not to disclose: 1,416 (4.1%)
- Don't know: 154 (0.4%)
- Gay: 806 (2.3%)
- Lesbian: 493 (1.4%)
- Lesbian or Gay: 395 (1.1%)
- Something else: 596 (1.7%)
- Straight: 29,386 (84.6%)

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Comparison of Patient & Workforce Demographics

Patient Demographics

- **Race**
  - White – 55%
  - Black/AA – 33.3%
  - Asian – 3.3%
  - Unknown – 7.8%

  Gender
  - Female – 60.9%
  - Male -   39.1%

- **Ethnicity**
  - Non-Hispanic – 87.5%
  - Hispanic – 9.6%
  - Unknown – 2.9%

  Age
  - 45-64 – 37%
  - 65 + - 35%
  - 22-34 – 17.7%

- **Language**
  - English – 91.8%
  - Spanish – 3.8%
  - Ukrainian – 1.3%

Workforce Demographics

- **Race**
  - White – 62%
  - Black/AA – 6.2%
  - Asian – 21%

  Gender
  - Female – 43%
  - Female – 60%
  - Female – 48%

- **Ethnicity**
  - Hispanic- 2%

  Female – 58%

- **Language**
  - Largely English Speaking ?

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Patient-Centered Workforce

THE AUDITION

Patient-Centered Workforce

Patient Satisfaction Data

Patient Experience Metric	Goals				Overall		Race						Ethnicity				Preferred Language					
							Black		White		Other[2]		Hispanic		Non-Hispanic		English		Spanish		Other	
	Baseline	Threshold (+1%)	Target (+3%)	Stretch (+5%)	Score	N-Size	Score	N-Size	Score	N-Size	Score	N-Size	Score	N-Size	Score	N-Size	Score	N-Size	Score	N-Size	Score	N-Size
Comfort talking with nurses	75.6%	76.6%	78.6%	80.6%	76.9%	281	76.3%	93	85.5%	138	78.6%	14	64.7%	68	83.0%	206	84.9%	172	69.4%	36	62.5%	24
Nurses courteous and respectful	73.0%	74.0%	76.0%	78.0%	71.2%	302	68.0%	103	82.6%	144	60.0%	15	60.6%	71	76.5%	221	76.8%	181	59.5%	37	65.5%	29
Nurses explained things understandably	71.0%	72.0%	74.0%	76.0%	76.9%	281	73.1%	93	86.2%	138	71.4%	14	69.1%	68	81.1%	206	82.6%	172	75.0%	36	62.5%	24
Nurses listened carefully	70.3%	71.3%	73.3%	75.3%	73.0%	293	72.4%	98	82.4%	142	60.0%	15	66.2%	71	77.6%	214	79.0%	176	70.3%	37	57.1%	28
Doctors courtesy & respect	75.8%	76.8%	78.8%	80.8%	81.6%	272	77.5%	89	88.9%	135	71.4%	14	81.5%	65	83.5%	200	82.6%	167	86.1%	36	73.9%	23
Doctors easily understandable	76.2%	77.2%	79.2%	81.2%	81.3%	267	78.2%	87	87.3%	134	84.6%	13	77.8%	63	84.3%	197	84.2%	165	77.1%	35	69.6%	23
Doctors listened carefully	74.1%	75.1%	77.1%	79.1%	80.4%	270	77.3%	88	85.9%	135	85.7%	14	80.0%	65	82.8%	198	83.1%	166	80.6%	36	65.2%	23
Good communication b/w staff	69.0%	70.0%	72.0%	74.0%	71.2%	260	68.7%	83	72.9%	133	75.0%	12	75.4%	61	70.8%	192	70.2%	161	82.4%	34	63.6%	22
Had enough input/say in care	74.5%	75.5%	77.5%	79.5%	75.2%	258	70.7%	82	79.5%	132	83.3%	12	70.5%	61	77.9%	190	78.0%	159	70.6%	34	65.5%	29
Rate Hospital	67.4%	68.4%	70.4%	72.4%	73.1%	223	71.4%	70	78.2%	119	75.0%	12	82.0%	50	73.8%	168	72.0%	143	89.3%	28	84.2%	19
Recommend hospital	71.7%	72.7%	74.7%	76.7%	79.3%	227	81.7%	71	86.0%	121	83.3%	12	76.9%	52	83.5%	170	81.0%	147	82.1%	28	84.2%	19

Mother -Baby[1] Patient Experience Scores By Race, Ethnicity, and Preferred Language - Last 12 Months (July 2024-June 2025)

Mother-Baby includes responses from Labor and Delivery, Nursery, and Postpartum.
Other racial group includes respondents with their race listed as Asian, Hawaiian/Pacific Islander, and Native America.

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Advancing a Patient-Centered Workforce

- We can develop and advance a patient-centered workforce by:
  - Raising awareness and consciousness about the patients we serve
    - Disease prevalence and risk is different among different patient populations
    - Not all patients have the same risks or needs
  - Developing community engagement for opportunities for dialogue, learning, and trust-building
    - Enhance the quality and delivery of care
    - Engage and enlighten staff about the needs of our population
  - Focusing on outcomes and performance to improve the overall quality of care
    - Data driven approaches
    - Focused on improvements across the entire patient population

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Pillar 2: Barriers to Health

Karen Cook

Barriers to Health

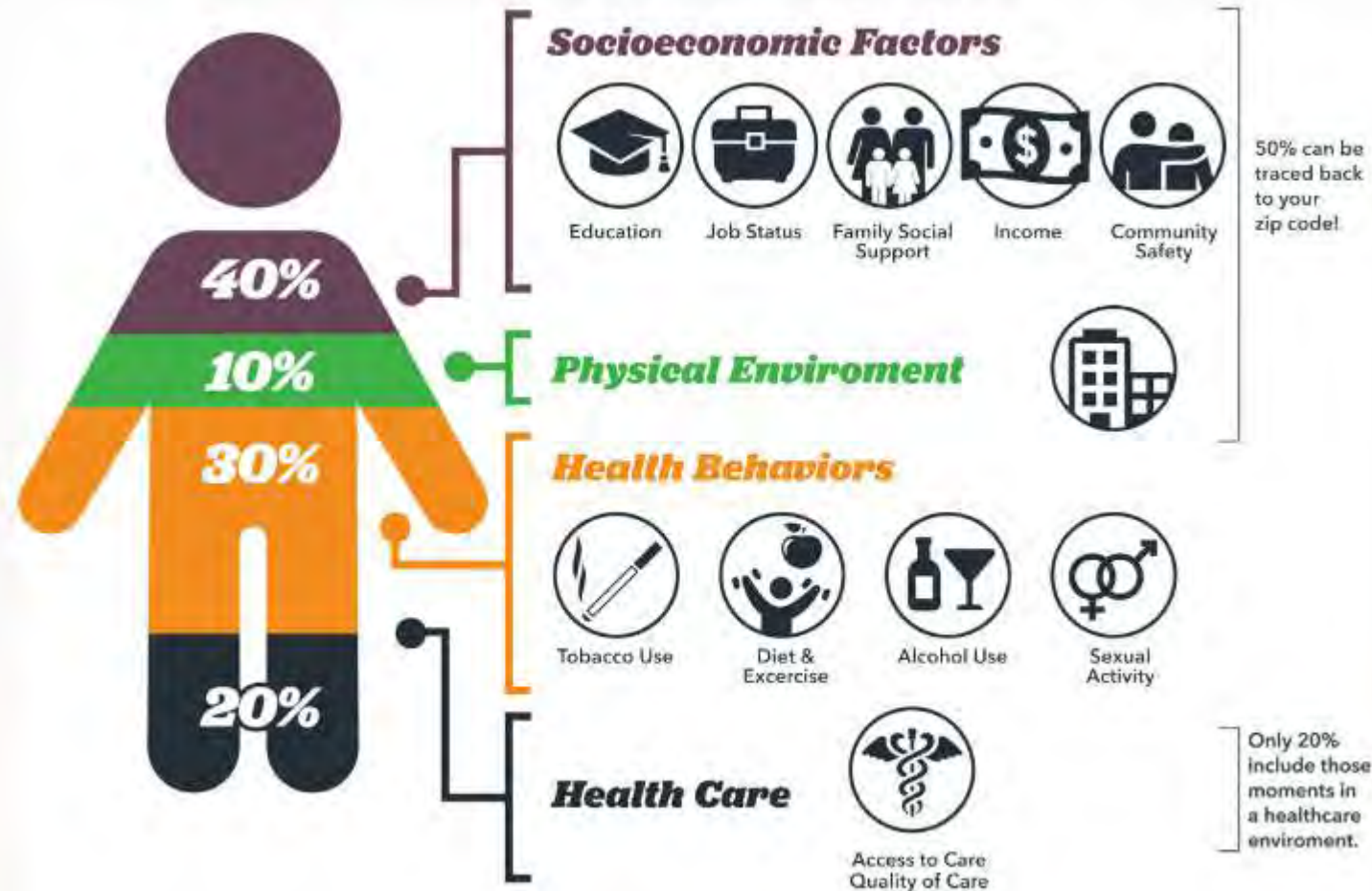## The Institute for H.O.P.E.: Health, Opportunity, Partnership and Empowerment

- **Mission**: To address social determinants of health among our patients and our community to equitably improve health and quality of life.

- **Vision**: We believe that people are communities should have a fair and just opportunity to attain health and be well. Our work to positively influence social determinants of health will help achieve that goal.

- **Purpose**: I4HOPE enables MetroHealth to deliver more holistic and equitable care by integrating SDOH work into system operations and strategy, resulting in improved health outcomes for every person who engages with the MetroHealth system.

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Social Drivers of Health

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Up to 80% of what impacts a person's health happens outside of the health system.

Social Drivers of Health = broad, **community-level** underlying social and economic conditions in which people live

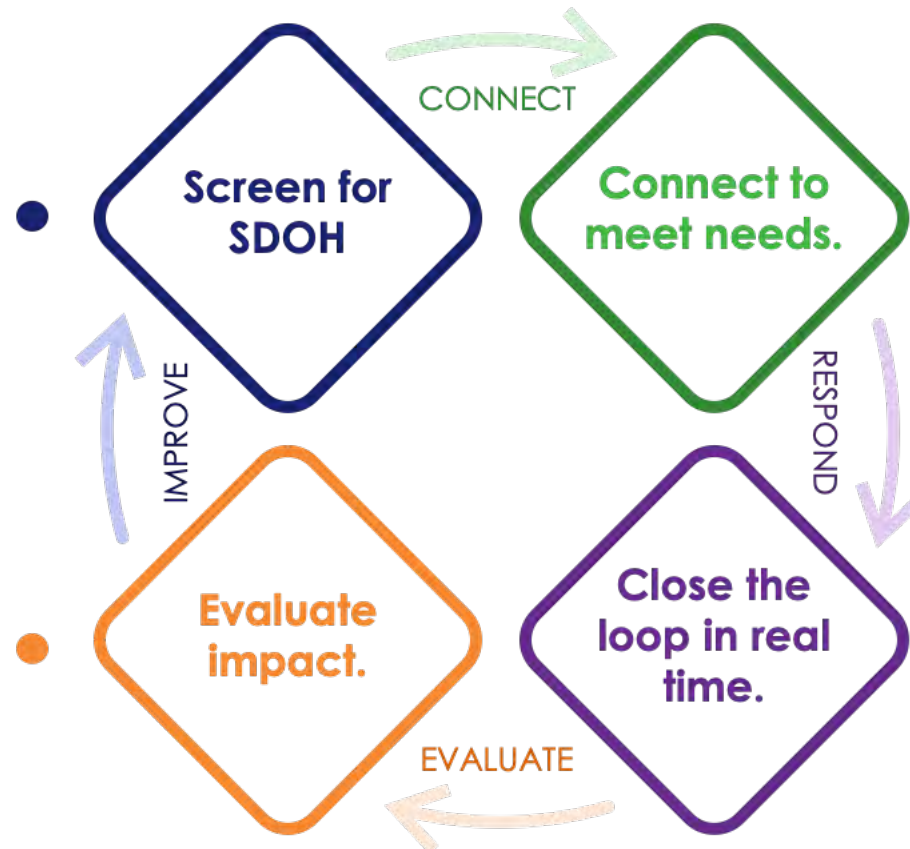**Health-Related Social Needs** = Immediate, **individual-level** social needs, often a result of SDOH

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What our approach looks like...

...utilizing process and outcome data to drive program evaluation, research and continuous program improvement

- Self > MyChart
- Provider > care setting
- CHW > community

- Electronic > Unite Ohio platform
- Curate relationships for people needing more assistance
- Design interventions based on identified community needs

Screen for SDOH — CONNECT → **Connect to meet needs.**

IMPROVE ↑ ... RESPOND ↓

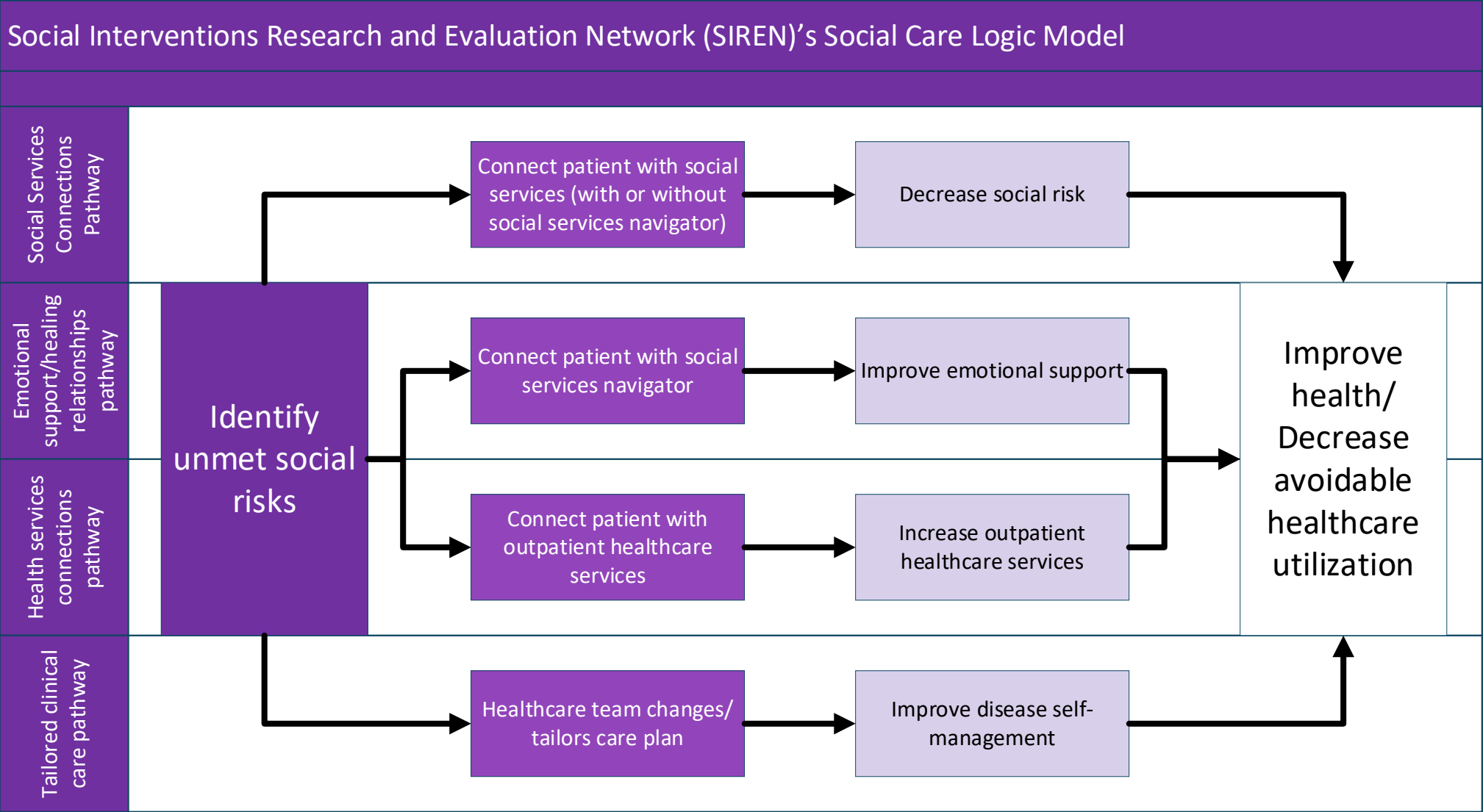**Evaluate impact.** ← EVALUATE — **Close the loop in real time.**

- Track outcomes at individual & community level
- Prove impact, outcomes, and cost-effectiveness
- Supply data and narratives to drive policy change

- Inform clinical team & CBOs
- Verify patient needs met
- Reduce duplication
- Identify strength and gaps within social service delivery system

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Social Care Logic Model

Social Interventions Research and Evaluation Network (SIREN)'s Social Care Logic Model

Social Services Connections Pathway

Multiple, complementary pathways lead from SDOH screening to improved health and healthcare utilization

Identify unmet social risks

Connect patient with social services (with or without social services navigator) → Decrease social risk

Emotional support/healing relationships pathway

Connect patient with social services navigator → Improve emotional support

Health services connections pathway

Connect patient with outpatient healthcare services → Increase outpatient healthcare services

Tailored clinical care pathway

Healthcare team changes/ tailors care plan → Improve disease self-management

Improve health/ Decrease avoidable healthcare utilization

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SDOH Screening

Screening results can help identify which social risks impact populations, conditions or health outcomes addressed by System Goals

Data analytics used to identify SDOH factors with statistically significant impact on non-compliancy with Prenatal and Postpartum Care

Link to 2025 System Goals:
- Timeliness of Prenatal Care
- Postpartum Care

Screening activates follow-up outreach by Community Health Workers, Social Workers and Care Management.

- Staff can assist patients in closing care gaps relative to System Goals and in enrolling patients in programs and services to support blood pressure and diabetes control and more.
- This outreach addresses multiple pathways linking SDOH screening with improved health outcomes, by connecting patients with resources, in an emotionally supportive way, while also linking them to appropriate healthcare services.

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Leveraging SDOH Work to Advance System Goals

SDOH Response

Design initiatives to target SDOH risks impacting populations or conditions that are the focus of System Goals

Our Food as Medicine clinic engages patients who are both food insecure and have chronic conditions impacted by diet (uncontrolled diabetes and/or hypertension) to deliver Medically Tailored Groceries intervention. Results show associated improvements in A1c, fewer inpatient stays and lower healthcare costs.

Link to 2025 System Goals:
      Diabetes: Hemoglobin A1c poor
      Controlling blood pressure

Deploy Community Health Worker team for targeted engagement relative to System Goals

Our CHW workforce engages with patients who have social needs and request assistance. They can assist with closing care gaps, scheduling appointments, enrolling patients in programs that support blood pressure and diabetes control, help to eliminate barriers to care such as transportation, and more.

Link to 2025 System Goals:
      Diabetes: Hemoglobin A1c poor
      Controlling blood pressure
      Cancer Screenings

Build partnerships to address social needs that impact System Goals

Our partnership with United Way of Greater Cleveland and Benjamin Rose provided medically-tailored home-delivered meals to MetroHealth patients with diabetes, hypertension, heart failure, and chronic kidney disease.

Link to 2025 System Goals:
      Kidney Health Evaluation
      Diabetes: Hemoglobin A1c poor
      Controlling blood pressure

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Pillar 3: Quality Outcomes and Performance Improvement

Nisrine Khazaal

Quality Outcomes and Performance Improvement

Transitioning from 2025 to 2026

- Align system goals with external entities and value-based care (VBC) in order to provide the highest quality care
    - Financial rewards can be reinvested in the care provided and the community served
- Focus on process improvement education and training
- Collaborate and align with the new ambulatory structure to promote quality and process improvement

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Quality Outcomes and Performance Improvement

2025 Ambulatory Quality System Goal

Measures	2025 System Quality Goals				Results												Current performance	Points	Index of disparity
	Baseline	Minimum	Target	Maximum	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec			
Diabetes: Hemoglobin A1c poor (Lower is better) (%)	23%	24%	23%	22%	73%	64%	55%	45%	39%	34%	30%						30%	0	Age - 26.1
Diabetic Eye Exam (%)	40%	40%	42%	44%	36%	36%	37%	38%	38%	39%	39%						39%	0	Age - 19.6
Cervical Cancer Screening (%)	65%	65%	66%	67%	64%	64%	64%	65%	65%	65%	65%						65%	1	Payer Category - 8.2
Breast Cancer Screening (%)	74%	73%	74%	75%	71%	71%	71%	72%	73%	73%	73%						73%	1	Payer Category - 8.8
Colorectal Cancer Screening (%)	60%	59%	60%	61%	56%	56%	56%	58%	58%	59%	60%						60%	2	Age - 12.4
Kidney Health Evaluation (%)	56%	52%	56%	60%	9%	13%	18%	23%	28%	32%	38%						38%	0	Age - 8.1
Screening for Clinical Depression & Follow Up (%)	60%	60%	61%	62%	34%	39%	45%	50%	52%	54%	56%						56%	0	Payor Category - 9.9
Controlling Blood Pressure (%)	71%	71%	72%	73%	56%	61%	65%	69%	70%	72%	73%						73%	3	Race - 4.9
Initiation & Engagement of Alcohol & Other Drug Dependence treatment (%)	7%	7%	8%	9%	4%	5%	6%	7%	7%	7%	7%						7%	1	Age - 47.3
Timeliness of Prenatal Care (%)	81%	81%	82%	83%	83%	82%	82%	82%	82%	82%	82%						82%	2	Payer Category - 19.2
Postpartum Care (%)	84%	84%	85%	86%	81%	82%	82%	82%	82%	82%	83%						83%	0	Payer Category - 22.2
Well-Child Visits in the first 15 months of Life (%)	58%	57%	58%	59%	61%	61%	60%	60%	60%	60%	60%						60%	3	Payer Category - 24.3
Childhood Immunization Status (%)	30%	30%	31%	32%	26%	28%	29%	30%	30%	30%	30%						30%	1	Race -43.2
Pediatric Lead Screening (%)	78%	77%	78%	79%	79%	80%	79%	79%	79%	79%	79%						79%	3	Language- 5.8
Completion of Medicare Wellness Visits (N)	14593	14000	14500	15000	966	1973	3281	4633	6278	7701	9249						9249	0	
Improving annual comprehensive assessments of care conditions (%)	73%	73%	74%	75%	43%	54%	52%	55%	59%	61%	63%						63%	0	
Composite Points		Min	12	Target	20	Max	28												17	

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Quality Outcomes and Performance Improvement

Goal Selection Process

- BOT and executive directives

- Align with external agencies and metric standards

- Well accepted clinical standards

- Improve performance in MCO contracts and supplemental programs

- Quality measures across the lifespan

- Understanding disparity in performance

Potential Goals for 2025	Alignment with CMS Universal Foundation	Hedis/ NQF	MCO contract alignment	Clinical	FQHC UDS	CICIP	Priorization for Index of disparity
Diabetes: Hemoglobin A1c poor (Lower is better) (%)	x	x	x	x	x		Tier 1
Cervical Cancer Screening (%)		x	x	x	x		Tier 2
Breast Cancer Screening (%)	x		x	x	x		Tier 2
Colorectal Cancer Screening (%)	x	x	x	x	x		Tier 1
Diabetic Eye Exam (%)		x	x	x			Tier 2
Controlling Blood Pressure (%)	x	x	x	x	x		Tier 1
Kidney Health Evaluation (%)		x	x	x			Tier 2
Initiation and Engagement of Alcohol and Other Drug Dependence treatment (%)	x		x	x	x	x	Tier 2
Pediatric Immunizations (%)	x	x	x	x	x		Tier 2
Pediatric Lead Screening (%)		x		x	x		Tier 3
Timeliness of Prenatal Care	x		x	x	x	x	Tier 1
Postpartum Care visit	x		x	x	x	x	Tier 1
Well-Child Visits in the first 15 months of life	x		x	x	x		Tier 1
Screening for Clinical Depression & Follow Up (%)	x		x	x	x		Tier 2
Completion of Medicare Wellness Visits (N)			x	x			
Improving annual comprehensive assessments of care conditions (%)			x	x			

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Quality Outcomes and Performance Improvement

Index of Disparity

- In 2025, with efforts to promote health equity within The MetroHealth System, Index of disparity was applied to different health care outcomes and system goals.
- **The Index of Disparity was used to understand what gaps in our System Goal Metrics exist among multiple groupings of patients.**
- Uses common demographic characteristics (i.e. age, language).

MetroHealth

Pillar 4: Community Engagement

Romona Brazile

Community Engagement

- Build bi-directional relationships by consistently engaging a wide-spectrum of diverse audiences at the resident, grassroots and large institutional levels.

- Use a public health lens and definition of community engagement.

- Leverage MetroHealth's power as a provider of healthcare, major NEO employer and institution to contribute, influence and to work in partnership with the community toward better health outcomes.

MetroHealth

Community Engagement

Community Engagement Definition

The process of working collaboratively with and through groups of people to address issues affecting the well-being of those people

Powerful vehicle for bringing about environmental and behavioral changes to improve the health of the community and its members

Involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices programs focused on issues such as social determinants of health, community health and health equity

MetroHealth

Community Engagement

System Strategy

- Shared Meaning & Understanding
- System Priorities and Guidance
- Community Engagement Framework

Structure

- Community Engagement Team
- Community Engagement Advisory Board
- Internal Cross-System Collaboration
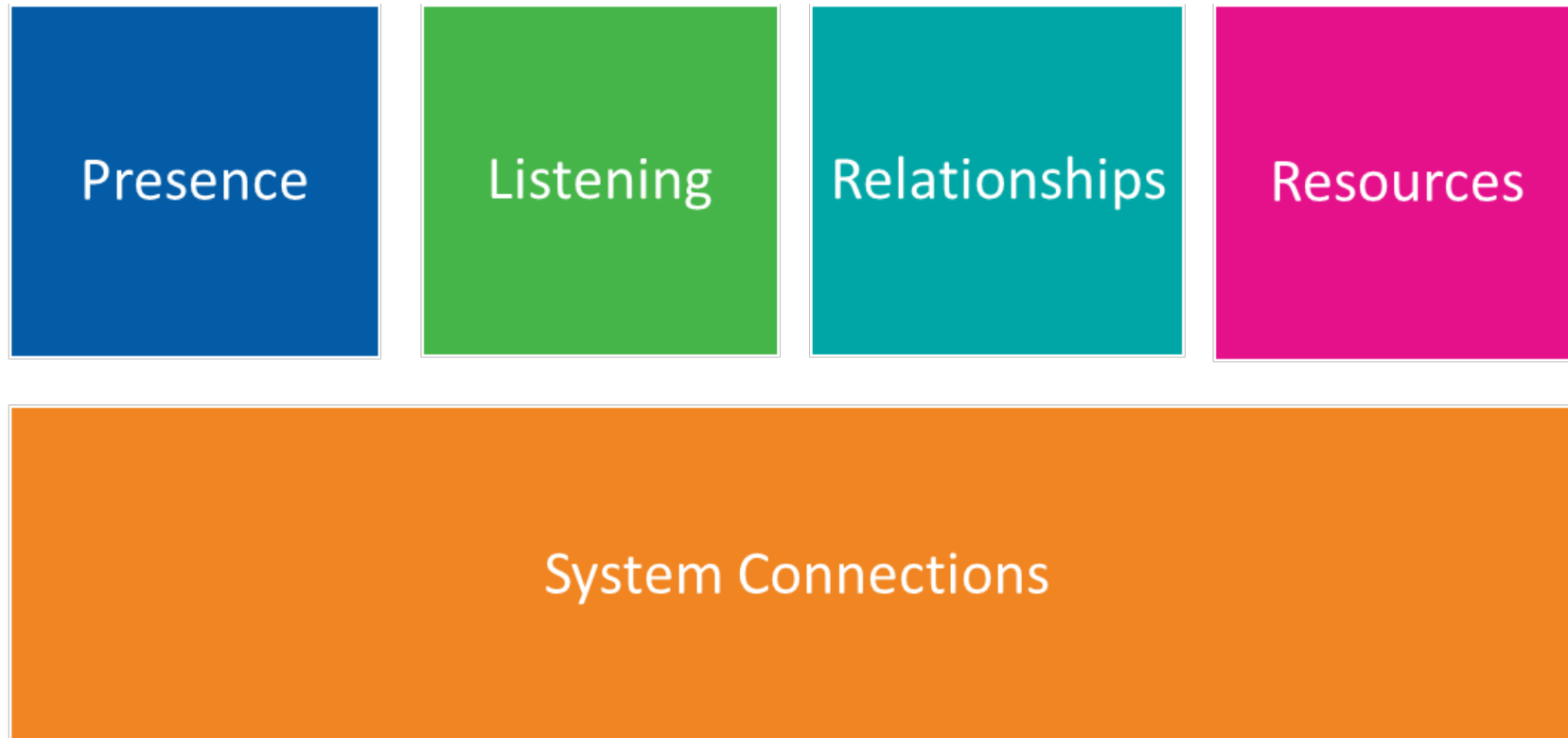- Strategic Community Partnerships and Collaborations

Outcomes & Impact

- Metrics
- Data Analysis
- Reporting

MetroHealth

Strategic Tactical Areas

Presence · Listening · Relationships · Resources

System Connections

35

Community Engagement

Operational Function

- Funding
  - Community sponsorships
  - Mini-grants
  - Initiatives

- Community Events
  - Conduit for external requests
  - Coordination
  - Attendance

- Community Engagement Advisory Committee

- Listening Sessions & Community Talks

- Special Project Initiatives (grief cohorts, maternal health, violence, behavioral health, Windows of Health)

System Enabling Function

- Consultations
  - Community Participatory Research Support
  - Program design and evaluation

- Partnerships/Collaborations
  - System representatives

- Connectors
  - Connect community to internal stakeholders

- Relationship Builders

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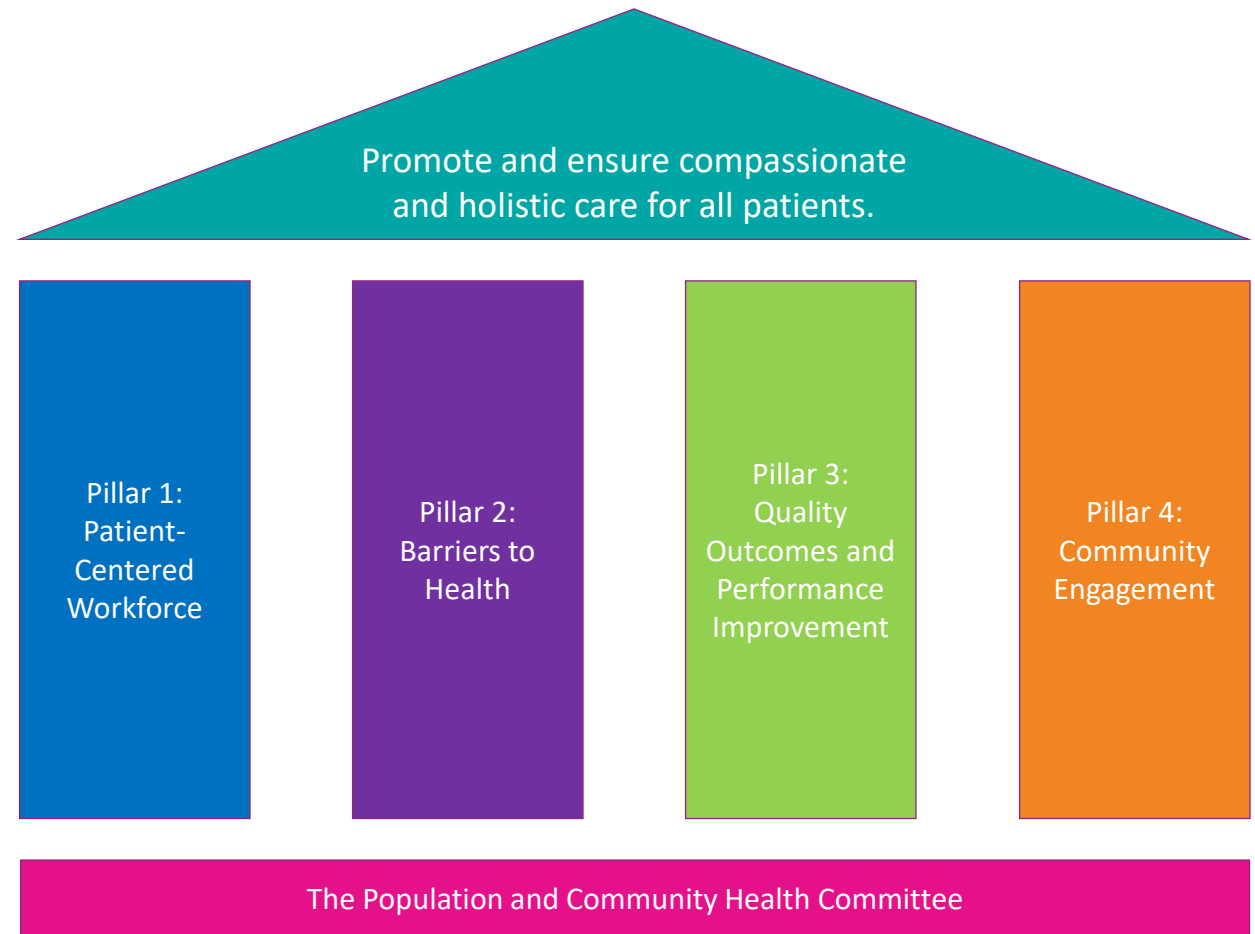
Benefits of the 4-Pillar Strategy

- Clearer areas of focus and aligned expertise
- Improved accountability
- Enhanced collaboration across pillars
- Better alignment with strategic goals

Promote and ensure compassionate and holistic care for all patients.

Pillar 1: Patient-Centered Workforce

Pillar 2: Barriers to Health

Pillar 3: Quality Outcomes and Performance Improvement

Pillar 4: Community Engagement

The Population and Community Health Committee

MetroHealth
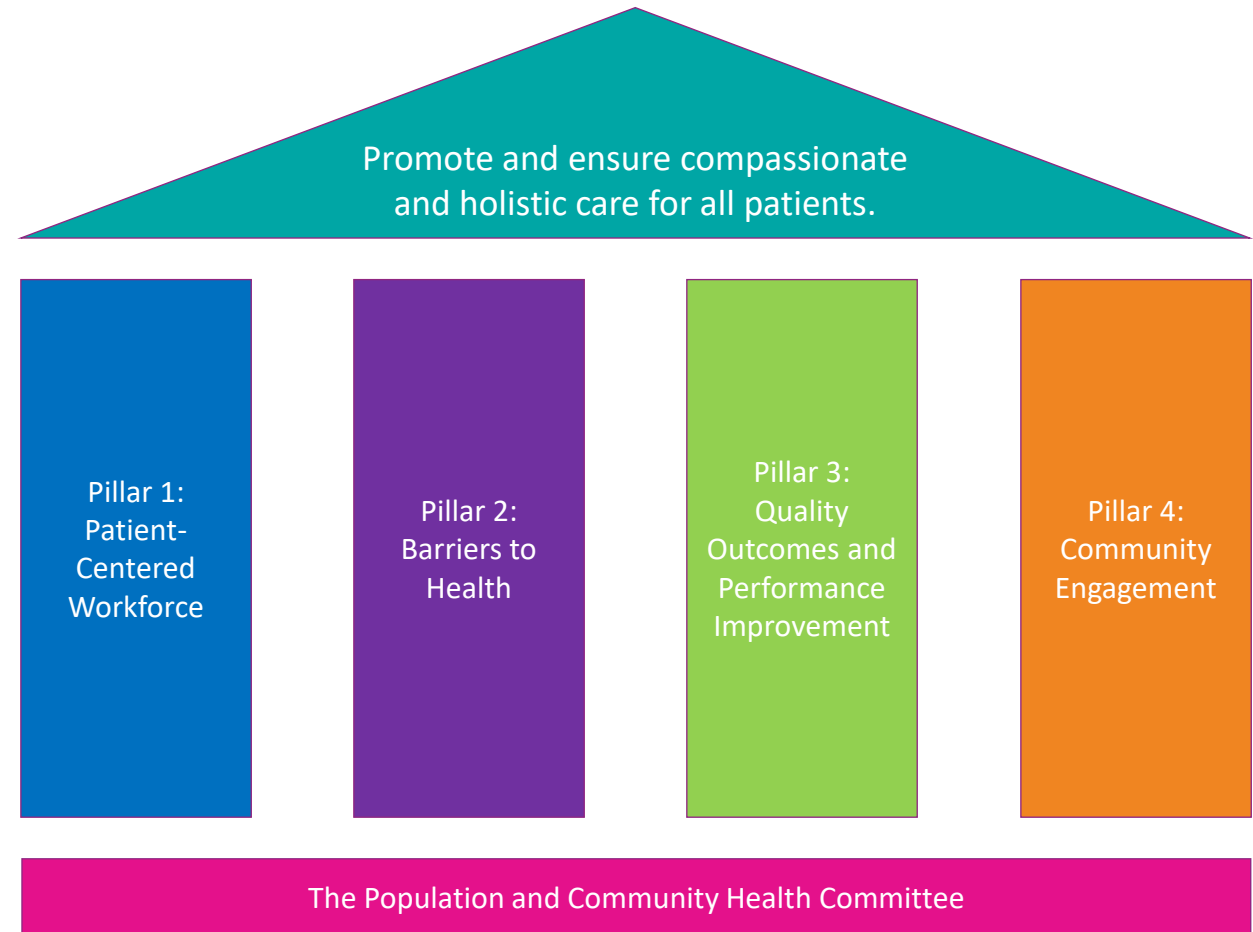
Benefits of the 4-Pillar Strategy

Collaboration Across Pillars

- Interaction mechanisms between pillars
  - ➢ Shared goal setting and strategic priorities
- Cross-pillar communication strategies
  - ➢ Regular meetings between pillar owners
- Examples of shared initiatives or goals
  - ➢ Regular meetings between pillar owners
- Incorporating disparity and quality into operations

Promote and ensure compassionate and holistic care for all patients.

Pillar 1: Patient-Centered Workforce

Pillar 2: Barriers to Health

Pillar 3: Quality Outcomes and Performance Improvement

Pillar 4: Community Engagement

The Population and Community Health Committee

MetroHealth

Benefits of the 4-Pillar Strategy

Preterm Birth Example

Pillar 1: Patient-Centered Workforce	- Identify/implement provider competency modules for related to preterm birth - Develop a patient-centeredness program for OB staff
Pillar 2: Barriers to Health	- Develop screening and analysis on social contributors to preterm birth rates - Incorporate Index of Disparity in analysis - Design and implement social programs targeted at preterm issues
Pillar 3: Quality Outcome and PI	- Identify appropriate quality metric and performance benchmarking standards - Provider or facilitate improvement process improvement activities related to quality metric
Pillar 4: Community Engagement	- Identify populations where intervention is most needed - Establish community connections and outreach programs related to preterm birth

MetroHealth

Proposed Population and Community Health Committee Charter

MetroHealth

The Population and Community Health Committee
of The MetroHealth System Board of Trustees

Charter

Purpose

The purpose of the Population and Community Health Committee ("Committee") is to promote and ensure compassionate and holistic care for all patients within The MetroHealth System ("MetroHealth") and the communities it serves, through a strong, coordinated and effective population and community health approach. The Committee will work collaboratively with MetroHealth's Board of Trustees ("Board"), administration, staff, and community stakeholders to identify and address population health outcomes, develop strategies to improve health outcomes, and provide healthcare access and delivery for all.

Responsibilities

- Align clinical and non-clinical metrics while working towards national and industry benchmarks and monitor performance, disparities and improvement initiatives related to population and community outcomes.
- Provide input into the development of evidence-based and time-proven strategies in the areas of caregiver education, community health literacy education, health related social needs solutions including community partnerships, care quality, community engagement, and research and academic programs aimed at improving population health.
- Provide guidance to MetroHealth and the broader community by developing policies and practices promoting population and community health. Provide regular reports to the Board, summarizing progress, initiatives, and outcomes related to population health including feedback from patients and community stakeholders, and to inform decision-making processes and ensure transparency and accountability for population health programming.
- Regularly evaluate the effectiveness of population and community health initiatives of MetroHealth and recommend adjustments as necessary to the Board and the President & CEO of MetroHealth.
- Provide periodic assessment of the financial impact of population and community health delivery models.

MetroHealth

Composition

The Committee will be led by a member of the Board with an interest or background in population health and consist of additional members of the Board identified by the Board's Chairperson.

The Committee will be staffed by the President & CEO of MetroHealth, and other relevant leaders of the executive team; including, but not limited to representatives from the Institute of Patient Centered Excellence, nursing, finance, philanthropy, legal, the Institute for H.O.P.E.™, the Population Health Innovation Institute, community outreach, patient advocates, and other representatives as permitted by the Board.

Meeting Schedule

The Committee shall meet at least quarterly.

40

MetroHealth

The Population and Community Health Committee
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1

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The Committee shall meet at least quarterly.

2

RECOMMENDATION FOR THE APPROVAL OF
RESTATEMENT OF THE CHARTER OF THE POPULATION AND COMMUNITY HEALTH COMMITTEE

<u>Recommendation</u>

The Population and Community Health Committee ("<u>**Committee**</u>") of the Board of Trustees ("<u>**Board**</u>") for The MetroHealth System ("<u>**System**</u>") recommends that the Board and the Governance Committee of the Board approve restating the charter of the Committee as set forth in **Exhibit A**.

<u>Background</u>

The Committee has reviewed and created an updated strategy to drive the initiatives of the Committee. The restated charter aligns with that updated strategy. The purpose of the Committee remains to promote and ensure compassionate and holistic care for all patients within the System and the communities it serves by identifying and addressing health outcomes, develop strategies to improve health outcomes across all sub-groups within the population served, and providing healthcare access and delivery for all.

September 2025

APPROVAL OF AMENDMENT TO RESTATE TO THE CHARTER OF THE POPULATION AND COMMUNITY HEALTH COMMITTEE

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RESOLUTION XXXXX

WHEREAS, the Board of Trustees ("**Board**") of The MetroHealth System ("**System**") and the Governance Committee of the Board have been presented a recommendation by the Population and Community Health Committee of the Board ("**Committee**") for the approval of a restatement to its name;

WHEREAS, the Committee desires to restate the charter of the Population and Community Health Committee;

WHEREAS, both the Governance Committee of the Board and the Committee have reviewed this recommendation and now recommends its approval to the Board.

NOW, THEREFORE, BE IT RESOLVED, the Board hereby approves restating the charter of the Committee as outlined in **Exhibit A**.

AYES:

NAYS:

ABSENT:

ABSTAINED:

DATE:

September 2025

EXHIBIT A

The Population and Community Health Committee
of The MetroHealth System Board of Trustees

Charter

Purpose

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September 2025

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September 2025