Population and Community Health Committee Meeting

The MetroHealth System
MetroHealth Board Room K107 - 2500 MetroHealth Dr., Cleveland, OH 44109
2025-12-10 13:00 - 15:00 EST

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POPULATION AND COMMUNITY HEALTH COMMITTEE

DATE: Wednesday, December 10, 2025
TIME: 1:00pm – 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 September 17, 2025

II. Information Items

A. 2026 Draft Ambulatory Quality Goals
B. The Index of Disparity
C. Selection for Population and Community Priority Goals
D. Pillar Priorities for 2026

POPULATION AND COMMUNITY HEALTH COMMITTEE
REGULAR MEETING

Wednesday, September 17, 2025
1:30pm – 3:00pm
MetroHealth Board Room (K107) / Virtual

Meeting Minutes

Committee Members:	Nancy Mendez-I, John Corlett-I, Dolores (Lola) Garcia-R
Other Trustees:	E. Harry Walker, MD-I[1]
Staff:	Christine Alexander-Rager, MD-I, Bridget Barrett-I, Peter Benkowski-I, Romona Brazile-I, Robert (Doug) Bruce, MD-I, Lashon Carson-I, Nabil Chehade, MD-I, Karen Cook-I, Joseph Golob, MD-I, Ryan Johnson-I, Matthew Kaufmann-I, Nisrine Khazaal-I, Thomas Minor-I, Connie Moreland, MD-I, Kate Nagel-I, Kathryn Plummer-R, Allison Poulios-I, 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 1:30 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 April 30, 2025, Committee meeting was approved by unanimous vote as presented.

II. Information Items

A. Population and Community Health Strategy

The committee engaged in a robust discussion on the foundational concept of population health and to ensure the population and community health strategy is built into the overall MetroHealth strategic framework. Population health extends beyond clinical care to encompass social, environmental, and economic determinants of health, requiring collaboration among healthcare providers, government agencies, academia, and community organizations. The strategic framework presented aligns with MetroHealth's enterprise-wide goals and addresses systemic challenges such as socioeconomic disparities, resource limitations, and

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

variability in workflows. The overarching aim is to deliver compassionate, holistic care through a unified, accountable system. The strategy outlined several core imperatives: building a patient-centered workforce, developing upstream solutions to reduce health barriers, aligning quality care with rigorous process improvement, and engaging community partners to leverage resources and influence. These imperatives reflect a shift from reactive sick care to proactive wellness promotion, emphasizing data-driven decision-making and patient engagement.

B. **New Operational Structure: 4 Pillar Strategy**

The committee was introduced to MetroHealth's new operational framework for executing population health objectives, structured around four strategic pillars:

(1) **Patient-Centered Workforce**: Dr. Connie Moreland, VP Provider Pipeline Development & Engagement, presented the patient-centered workforce pillar which focuses on understanding the demographic and cultural needs of the patient population. The Committee reviewed data on patient demographics, highlighting opportunities to respond effectively to the needs of the entire patient population. Strategies to address gaps in care include raising awareness and consciousness about the patients served, developing community engagement for dialogue, learning, and trust-building, and focusing on outcomes and performance to improve overall quality of care through data-driven approaches. Data was presented showing improved outcomes when patients are treated by providers who understand their background and needs, highlighting the importance of doctor-patient concordance in healthcare delivery.

(2) **Barriers to Health**: Karen Cook, Director Thriving Communities, presented the second pillar which addresses social determinants of health (SDOH) through the work of the Institute for H.O.P.E. The Committee reviewed screening data and discussed how SDOH factors, such as food insecurity, housing instability, and transportation barriers, impact health outcomes. MetroHealth's approach includes integrating SDOH screening into clinical workflows, leveraging platforms such as Unite Ohio, and deploying community health workers to connect patients with resources. Examples of targeted interventions, such as the Food as Medicine clinic and partnerships with United Way and Benjamin Rose, demonstrated measurable improvements in chronic disease management and healthcare utilization.

(3) **Quality Outcomes and Performance Improvement**: Nisrine Khazaal, Director Clinical Process and Improvement PHII, presented the third pillar which emphasizes aligning system goals with external benchmarks and value-based care models. The Committee reviewed the 2025 ambulatory quality goals and discussed the importance of process improvement education and collaboration across

departments. A key innovation is the use of the Index of Disparity, a tool that identifies gaps in health outcomes across demographic groups. The Committee introduced how this index informs goal selection and prioritization, ensuring that disparities are addressed systematically. Metrics such as diabetes control, cancer screenings, and prenatal care were highlighted as areas of focus.

(4) **Community Engagement**: Romona Brazile, Exec Dir Government & Community Relations, presented the final pillar which centers on building bi-directional relationships with diverse community stakeholders. The Committee explored MetroHealth's community engagement framework, which includes advisory boards, listening sessions, and strategic partnerships. Engagement efforts are guided by public health principles and aim to mobilize resources, influence systems, and catalyze policy change. The committee discussed operational functions such as funding, mini-grants, and special initiatives, as well as enabling functions like participatory research and program design. The benefits of this pillar include clearer focus areas, improved accountability, and enhanced collaboration across the system.

Introduction to the Index of Disparity
A key component of the new strategy is the Index of Disparity, which was formally introduced to the Committee. This analytical tool is designed to quantify disparities in health outcomes across various demographic groups, including age, race, ethnicity, and language. By applying the index to system goals, MetroHealth can identify where gaps exist and prioritize interventions accordingly. The committee reviewed examples of how the index has been used to inform decisions around diabetes management, cancer screenings, and maternal health. The tool supports a data-driven approach to equity and ensures that performance improvement efforts are targeted and impactful. The tool will be discussed at the next Committee meeting.

C. **Review of Restated Committee Charter**
The committee reviewed the restated charter, which reflects the updated strategic direction and operational framework. The charter reaffirms the committee's purpose: to promote compassionate and holistic care through a coordinated population health approach. Responsibilities outlined in the charter include aligning metrics with national benchmarks, developing evidence-based strategies, guiding policy development, reporting progress to the Board, evaluating program effectiveness, and assessing financial impacts. The composition of the committee was also discussed; the committee will be led by a Board member with expertise in population health and include other Trustees appointed by the Chairperson. The committee will meet quarterly and maintain a collaborative relationship with

MetroHealth's administration and community stakeholders. The restated charter reflects the committee's commitment to the four pillars. Committee members expressed support for the revised charter and noted that it aligns well with the four-pillar strategy and the broader goals of MetroHealth.

III. Recommendation / Resolution Approvals

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

Ms. Mendez asked for a motion for the Approval of Amendment to Restate to the Charter of the Population and Community Health 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 2:37 pm.

NEXT MEETING: **Wednesday, December 10, 2025 – 1:00pm - 3:00pm**
MetroHealth Board Room K107 and Virtual

THE METROHEALTH SYSTEM

Nancy Mendez, Chairperson

MetroHealth

Population and Community Health Committee

Date: December 10, 2025

Time: 1:30pm – 3:00pm

Place: MetroHealth Board Room (K107) or via Zoom

Population and Community Health Committee

Agenda for December 10, 2025

I. Approval of Minutes
   A. Committee Meeting Minutes of September 17, 2025

II. Information Items
   A. 2026 Draft Ambulatory Quality Goals (20 Minutes)
   B. The Index of Disparity (30 Minutes)
   C. Selection for Population and Community Priority Goals (20 Minutes)
   D. Pillar Priorities for 2026 (20 Minutes)

III. Executive Session
   A. No Scheduled Topics

IV. Recommendation/Resolution Approval
   A. No Scheduled Topics

Meeting Objectives

- Presentation of draft goals for 2026 to provide understanding and planning context
- Detailed explanation of equity measurement using the Index of Disparity
- Introduce priority goals for 2026 with review of definitions and current performance indicators
- Brief discussions led by pillar leads on initiatives and next steps for work related to priority goals

Approval of Minutes

2026 Draft Ambulatory Goal Overview

Matthew Kaufmann

2026 Ambulatory Quality Measures

DRAFT Version

At Risk Measures		2026 System Quality Goals			Results														
	Baseline thru Sept	Minimum	Target	Maximum	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Current performance	Points	Index of disparity
Cervical Cancer Screening (%) (Existing Reports)	65%	66%	67%	68%															
Breast Cancer Screening (%) (Existing Reports)	74%	74%	75%	76%															
Colorectal Cancer Screening (%) (Existing Reports)	61%	61%	62%	63%															
Kidney Health Evaluation (%) (Existing Reports)	47%	52%	56%	60%															
Diabetes: Hemoglobin A1c poor (Lower is better) (%)	25%	24%	23%	21%															
Controlling Blood Pressure (%) (Existing Reports)	73%	73%	74%	75%															
7 day follow up for SUD ED patients (Reporting Needs to be Selected) (2024 data for baseline)	41%	42%	43%	44%															
Timeliness of Prenatal Care (%) (Existing Reports)	82%	83%	84%	85%															
Well-Child Visits in the first 15 months of Life (%) (Existing Reports)	61%	61%	62%	63%															
TFU for Inpatient discharges (7 day) (Finalizing Reporting)																			
Pharmacy Capture Rate (Finalizing Reporting																			
Completion of Medicare Wellness Visits (N) (Existing Reports)	12239	15000	15500	16000															
Improving annual assessments of chronic conditions (%) (Existing Reports)	66%	73%	74%	75%															
Composite Points		Min		Target		Max												0	

2026 Ambulatory Quality Measures

Draft Version

- Alignment with System Priorities and Strategy
- Scoring Methodology

At Risk Measures		2026 System Quality Goals		
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Cervical Cancer Screening (%) (Existing Reports)	65%	66%	67%	68%
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2026 Ambulatory Quality Measures

Draft Version

- Alignment with System Priorities and Strategy
- Scoring Methodology
- "Screening Measures"

At Risk Measures		2026 System Quality Goals		
	Baseline thru Sept	Minimum	Target	Maximum
Cervical Cancer Screening (%) (Existing Reports)	65%	66%	67%	68%
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2026 Ambulatory Quality Measures

Draft Version

- Alignment with System Priorities and Strategy
- Scoring Methodology
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- "Chronic Condition Measures"

At Risk Measures		2026 System Quality Goals		
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2026 Ambulatory Quality Measures

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- Chronic Condition Measures
- "Clinical Connection Measures"

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2026 Ambulatory Quality Measures

Draft Version

- Alignment with System Priorities and Strategy
- Scoring Methodology
- Screening Measures
- Chronic Condition Measures
- Clinical Connection Measures
- "Quality Continuity Measures"

At Risk Measures		2026 System Quality Goals		
	Baseline thru Sept	Minimum	Target	Maximum
Cervical Cancer Screening (%) (Existing Reports)	65%	66%	67%	68%
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2026 Ambulatory Monitoring Measures

Draft Version

- New for 2026
- Keeping sight on important measures
- Introduction of new measures
- Prioritize difficult to move measures.

2026 Monitor Measures	
	Baseline thru Sept
Diabetic Eye Exam (%)	40%
Screening for Clinical Depression & Follow Up (%)	59%
Pediatric Immunizations (%)	30%
Pediatric Lead Screening (%)	80%
Preterm Birth	
Postpartum Care visit	83%
Pregnancy Risk Assessment Form (PRAF) submission	

MetroHealth Institute for H.O.P.E. Disparities in Clinical Outcomes

Applying the Index of Disparity

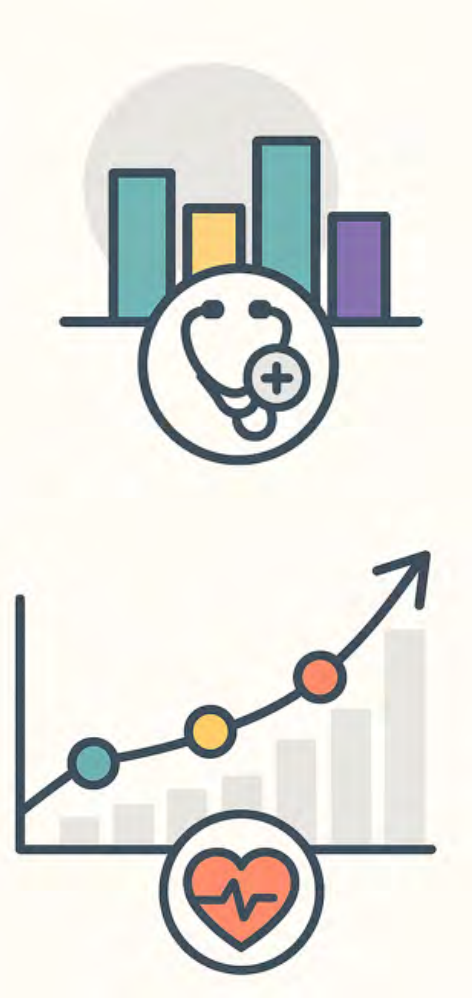
Kevin Chagin

Disparity Tracking

To advance health equity across the MetroHealth System, it is essential to first establish visibility into the existing disparities in health outcomes and our system goals.

To assess these disparities, we will use the Index of Disparity to identify gaps between our system goals and health outcomes across various patient demographic groups.

This will help us pinpoint where disparities exist and which measures show the greatest gaps—guiding our focus for targeted development.



How will we calculate disparity?

To calculate and track disparities within out systems goals, we will use **Index of Disparity**:

Formula developed by the National Center for Health Statistics

Keppel, K., Pearcy, J. N., & Klein, R. J. (2004). A summary measure of health disparity. Public Health Reports, 119(3), 239– 243. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497430/

Calculates the average difference between demographic groups and the overall population, adjusted for the number of groups within each demographic category and the size of the total population.

$$\text{Index of disparity} = (\Sigma |r_{(1-n)} - R| / n) / R*100$$

- r is the group rate.
- R is the total population rate.
- n is the total number of groups used to calculate disparities.

Current Use for the Index of Disparity

The following analysis breaks out each of these metrics and the groupings for patients included the following categories:

- Age
- Ethnicity
- Race
- Gender (Sex at Birth)
- Primary Language Spoken
- Median Income*
- Poverty Rate*
- Payer Category (Commercial, Medicare, Medicaid, etc.)

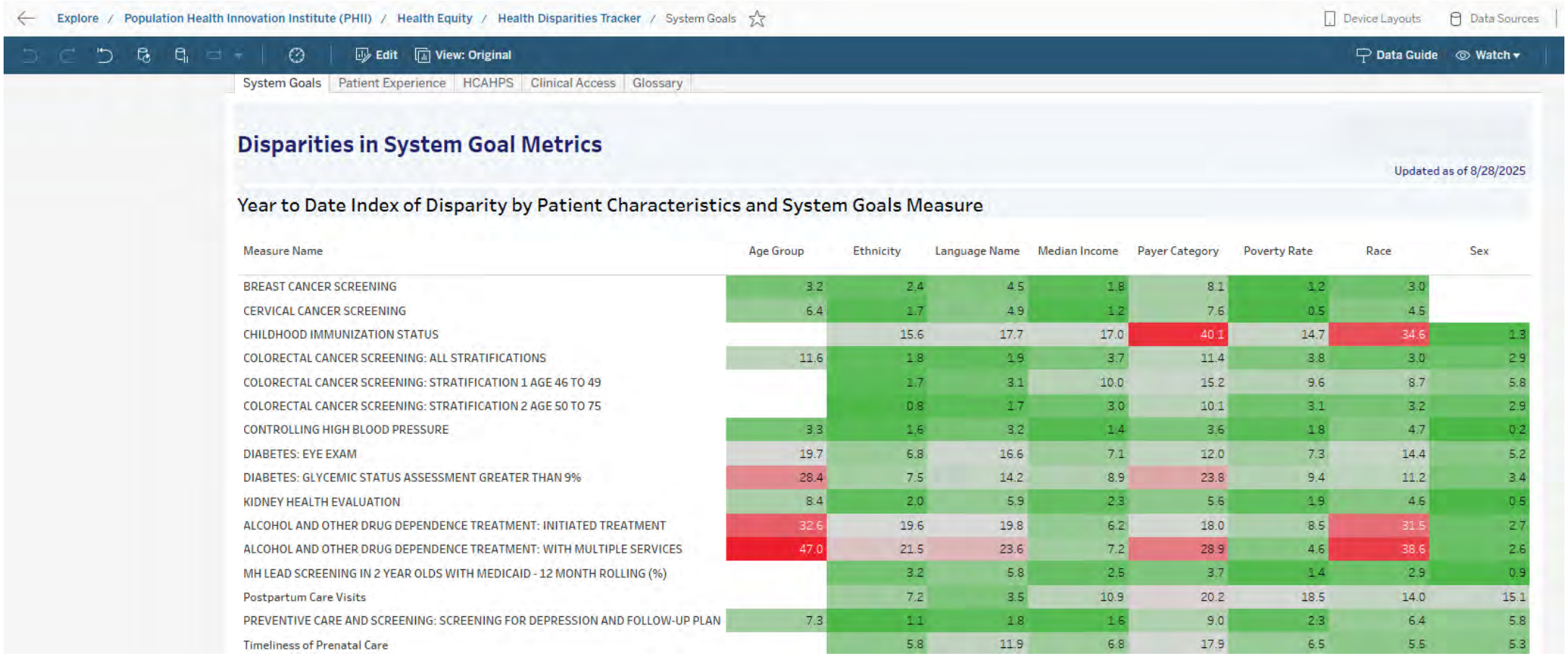
* Calculated from the US Census based on the patient's geocoded address

Where has the Index of Disparity been applied?

- Ambulatory System Metrics
- Patient Experience Metrics
- HCAHPS Survey Questions
- Clinical Access Metrics (Bump Rate, Completed Visit Rate, Schedule labs, etc.)

Current Use for the Index of Disparity

A dashboard has been developed to visualize disparities across all system goals and health outcomes.



Disparities in System Goal Metrics

Updated as of 8/28/2025

Year to Date Index of Disparity by Patient Characteristics and System Goals Measure

Measure Name	Age Group	Ethnicity	Language Name	Median Income	Payer Category	Poverty Rate	Race	Sex
BREAST CANCER SCREENING	3.2	2.4	4.5	1.8	8.1	1.2	3.0	
CERVICAL CANCER SCREENING	6.4	1.7	4.9	1.2	7.6	0.5	4.5	
CHILDHOOD IMMUNIZATION STATUS		15.6	17.7	17.0	40.1	14.7	34.6	1.3
COLORECTAL CANCER SCREENING: ALL STRATIFICATIONS	11.6	1.8	1.9	3.7	11.4	3.8	3.0	2.9
COLORECTAL CANCER SCREENING: STRATIFICATION 1 AGE 46 TO 49		1.7	3.1	10.0	15.2	9.6	8.7	5.8
COLORECTAL CANCER SCREENING: STRATIFICATION 2 AGE 50 TO 75		0.8	1.7	3.0	10.1	3.1	3.2	2.9
CONTROLLING HIGH BLOOD PRESSURE	3.3	1.6	3.2	1.4	3.6	1.8	4.7	0.2
DIABETES: EYE EXAM	19.7	6.8	16.6	7.1	12.0	7.3	14.4	5.2
DIABETES: GLYCEMIC STATUS ASSESSMENT GREATER THAN 9%	28.4	7.5	14.2	8.9	23.8	9.4	11.2	3.4
KIDNEY HEALTH EVALUATION	8.4	2.0	5.9	2.3	5.6	1.9	4.6	0.5
ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT: INITIATED TREATMENT	32.6	19.6	19.8	6.2	18.0	8.5	31.5	2.7
ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT: WITH MULTIPLE SERVICES	47.0	21.5	23.6	7.2	28.9	4.6	38.6	2.6
MH LEAD SCREENING IN 2 YEAR OLDS WITH MEDICAID - 12 MONTH ROLLING (%)		3.2	5.8	2.5	3.7	1.4	2.9	0.9
Postpartum Care Visits		7.2	3.5	10.9	20.2	18.5	14.0	15.1
PREVENTIVE CARE AND SCREENING: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN	7.3	1.1	1.8	1.6	9.0	2.3	6.4	5.8
Timeliness of Prenatal Care		5.8	11.9	6.8	17.9	6.5	5.5	5.3

Current Use for the Index of Disparity

This view highlights the impact each demographic group has on ambulatory metrics.

Higher values indicate greater disparities within that group.

Measure Name	Age Group	Ethnicity	Language Name	Median Income	Payer Category	Poverty Rate	Race	Sex
BREAST CANCER SCREENING	3.2	2.4	4.5	1.8	8.1	1.2	3.0	
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Well-Child visits in the first 15 months of life		6.8	8.6	9.9	24.8	8.4	8.5	2.1

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Focusing on **breast cancer screening**, we observe that the greatest disparity is associated with

payer category (8.1)

followed by language spoken (4.5) and age (3.2).

MetroHealth

Current Use for the Index of Disparity

Looking at **Breast Cancer Screen** for the month of August

- The disparity is 10.2
- 35,456 eligible for the metric
- 26,051 completing a breast cancer screen

A population rate of 73.5% completion

Measure Name	Dimension	Patient Group	Group Numerator	Group Denominator	Population Numerator	Population Denominator	Group Measure Value	Population Measure Value	Disparity	Index Of Disparity
BREAST CANCER SCREENING	Payer Category	Employee	1,368	1,566	26,051	35,456	87.4%	73.5%	13.9%	10.2
		Medicaid	3,550	5,546	26,051	35,456	64.0%	73.5%	9.5%	10.2
		Self-Pay	1,569	2,419	26,051	35,456	64.9%	73.5%	8.6%	10.2
		Commercial	7,075	9,220	26,051	35,456	76.7%	73.5%	3.3%	10.2
		Not Available	2,271	3,230	26,051	35,456	70.3%	73.5%	3.2%	10.2
		Medicare	10,218	13,475	26,051	35,456	75.8%	73.5%	2.4%	10.2

Current Use for the Index of Disparity

Looking at **Breast Cancer Screen** for the month of August

Question: Where do we do well? And where does the disparity exist?

Measure Name	Dimension	Patient Group	Group Numerator	Group Denominator	Population Numerator	Population Denominator	Group Measure Value	Population Measure Value	Disparity	Index Of Disparity
BREAST CANCER SCREENING	Payer Category	Employee	1,368	1,566	26,051	35,456	87.4%	73.5%	13.9%	10.2
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		Medicare	10,218	13,475	26,051	35,456	75.8%	73.5%	2.4%	10.2

Helps identify where disparity exists and where to focus our attention to improve care across our entire patient population

The Index of Disparity

What Makes the Index of Disparity Impactful?

Clarity – Provides a straightforward, interpretable measure to identify where disparities exist.

Efficiency – Enables quick and consistent calculations across metrics.

Versatility – Applicable across a wide range of healthcare areas and topics.

Measure Name	Dimension	Patient Group	Group Numerator	Group Denominator	Population Numerator	Population Denominator	Group Measure Value	Population Measure Value	Disparity	Index Of Disparity
BREAST CANCER SCREENING	Payer Category	Employee	1,368	1,566	26,051	35,456	87.4%	73.5%	13.9%	10.2
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MetroHealth Institute for H.O.P.E. Priority Goals and Indicators for 2026

Nisrine Khazaal and Matthew Kaufmann

Focus Measures for Population and Community Health

4 Measures Selected:

- Diabetes: Hemoglobin A1c Poor
- Controlling Blood Pressure
- 7 day follow up for SUD ED patients
- Preterm Birth

Diabetes: Hemoglobin A1c Poor (%)

Definition: This metric shows the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% or no hemoglobin A1c test during the measurement period. A lower score is better for this metric.

Index of Disparity

- Age groups: 18-35yrs and 35-55yrs
- Payor groups: Medicaid and self-pay
- Language and Ethnicity: Spanish and Hispanic
- Race: Black/African-American

Current Interventions

- Completed POCT at multiple locations
- Pharmacy Department initiated a program in collaboration with primary care to manage patients with high A1c
- CGM ongoing work on reporting it in Epic and transmitting to payors via claims
- Nutrition Department implemented DSME program

Controlling Blood Pressure (%)

Definition: This metric shows the percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mmHg) during the most recent qualifying visit.

Index of Disparity

- Age groups: 18-35 yrs
- Payor groups: Medicaid
- Race: Black/African-American

Current Interventions

- BPA for BP repeat enhanced to include a 2nd and 3rd alerts for the MA that includes follow up if BP is still high and informing RN or MD if higher than 180 SBP
- 2025 Action Plan: Address taking BP in specialty clinics and decision tree for high BP in specialty clinics that will take BP readings
- Tableau dashboard created for BP repeat and follow up per site and department primary and specialty

7 Day Follow Up for SUD ED patients (%)

The percentage of emergency department (ED) visits for which the person received follow-up within 7 days of the ED visit (8 total days). The percentage of ED visits among persons age 18 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up in 7 days (8 total days).

Index of Disparity

- TBD
- Analysis being developed for 7-day SUD follow ups

Current Interventions

- Creation of the Substance Use Navigator (SUN) program by Dr. Papp and the Office of Opioid Safety
- Initiation of Treatment workflows for Alcohol Use Disorder (AUD) in the ED

Preterm Birth

Definition: The percent of members with a live birth before 37 weeks of gestation during the measurement year.

Index of Disparity

- TBD
- Analysis being developed for Preterm Birth

Current Interventions

- Completion of Pregnancy Risk Assessment Forms
- Re-educated OB team on telehealth OB coding
- Completing nurse visits via telehealth before first prenatal visit
- Express cares making OB appointments for positive pregnancy tests 167 appts made YTD
- Community Health Workers providing outreach, support, scheduling and help with SDOH needs through postpartum period
- Implementing universal Aspirin protocol at MH for all pregnant women starting at 12 weeks.
- First Year Cleveland Initiatives

Initiatives and Next Steps for Committee Pillars

Matthew Kaufmann (Review Pillars)

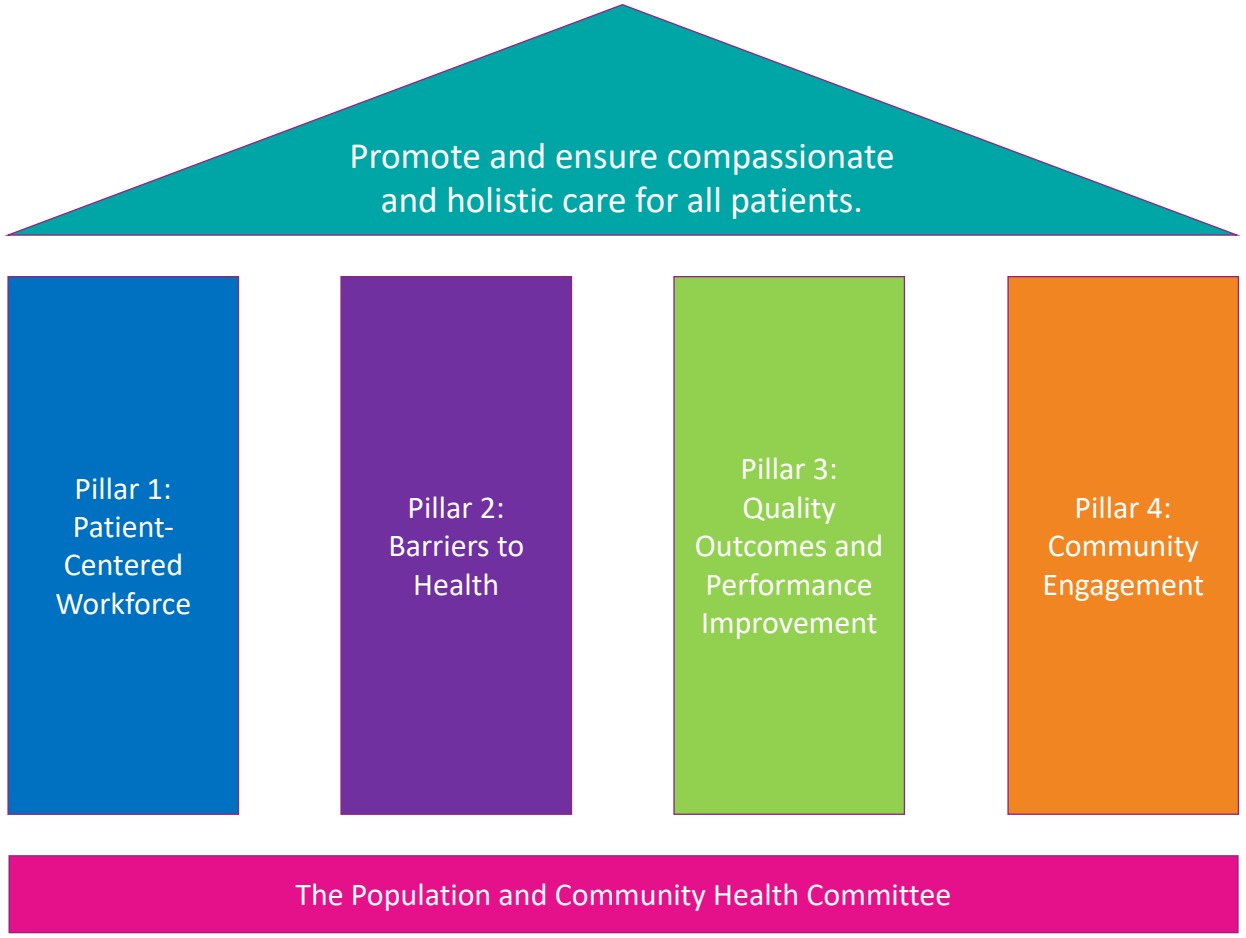
Dr. Connie Moreland (Patient-Centered Workforce)

Karen Cook (Barriers to Health)

Nisrine Khazaal (Quality Outcomes and Performance Improvement)

Romona Brazile (Community Engagement)

Four Pillars to Support our Population and Community



Pillar 1: Patient-Centered Workforce

Dr. Connie Moreland

Pillar 2: Barriers to Health

Karen Cook

Pillar 3: Quality Outcomes and Performance Improvement

Nisrine Khazaal

Pillar 4: Community Engagement

Romona Brazile

Appendix

2026 Ambulatory Quality Measures- Definitions

DRAFT Version

2026 At Risk Measures	Defintions
Cervical Cancer Screening (%)	This metric shows the percentage of women 23-64 years of age with one or more pap tests during the measurement period or the two years prior to the measurement period.
Breast Cancer Screening (%)	This metric shows the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
Colorectal Cancer Screening (%)	This metric shows the percentage of patients 46 to 75 years of age who had appropriate screening for colorectal cancer.
Kidney Health Evaluation (%)	This metric shows the percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
Diabetes: Hemoglobin A1c poor (Lower is better) (%)	This metric shows the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% or no hemoglobin A1c test during the measurement period. A lower score is better for this metric.
Controlling Blood Pressure (%)	This metric shows the percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the most recent qualifying visit.

2026 Ambulatory Quality Measures- Definitions

DRAFT Version

2026 At Risk Measures	Defintions
7 day follow up for SUD ED patients (Reporting Needs to be Selected) (2024 data for baseline)	The percentage of ED visits for which the person received follow-up within 7 days of the ED visit (8 total days). The percentage of emergency department (ED) visits among persons age 18 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up in 7 days (8 total days).
Timeliness of Prenatal Care	The percentage of deliveries at MHS that received a prenatal care visit in the first trimester (280–176 days prior to delivery (or EDD).
Well-Child Visits in the first 15 months of life	Children who turned 15 months old during the measurement year: Six or more well-child visits.
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	The percentage of acute events related to one of six chronic conditions where follow-up care was received within the time frame recommended by clinical practice guidelines in a non- emergency outpatient setting. Acute events are those that required either an emergency department visit or hospitalization. The six chronic conditions include hypertension (HTN), asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and diabetes
Pharmacy Capture Rate	The percentage of MetroHealth prescriptions filled at MetroHealth pharmacies
Completion of Medicare Wellness Visits (N)	This measure shows the percentage of patients who had a completed Medicare Wellness Visit in the calendar year.
Improving annual comprehensive assessments of care conditions (%)	This measure shows the percentage of HCC acted upon in Epic. The BPA indicates when chronic and acute conditions need to be evaluated and addressed.

2026 Ambulatory Monitoring Measures - Definitions

DRAFT Version

2026 Monitor Measures	Definitions
Diabetic Eye Exam (%)	This metric shows the percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.
Screening for Clinical Depression & Follow Up (%)	This metric shows the percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized screening tool and, if positive, a follow-up plan is documented.
Pediatric Immunizations (%)	This metric shows the percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines before 730 days of age.
Pediatric Lead Screening (%)	Percentage of patients in the last 12 months that had a lead screening on or before 2nd birthday. This percentage includes results from Care Everywhere / External Claims if available. Provider attribution is based on the patient's current PCP. Department and Location attribution are based upon the provider's primary department.
Preterm Birth	The percent of members with a live birth before 37 weeks of gestation during the measurement year.
Postpartum Care Visit	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Perinatal Risk Assessment Form (PRAF) submission	Percent of Medicaid Managed Care members with a prenatal visit and at least one PRAF submitted during the measurement period into NurtureOhio