POPULATION AND COMMUNITY HEALTH COMMITTEE
REGULAR MEETING

Wednesday, December 10, 2025
1:00pm – 3:00pm
MetroHealth Board Room (K107) / Virtual

Meeting Minutes

Committee Members:	Nancy Mendez-I
Other Trustees:	Michael Summers-I, E. Harry Walker, MD-R (late)[1]
Staff:	Christine Alexander-Rager, MD-I, Bridget Barrett-I, Peter Benkowski-I, Romona Brazile-I, Lashon Carson-I, Nabil Chehade, MD-I, Karen Cook-I, Jamie Garay-I, Joseph Golob, MD-I, Ryan Johnson-I, Matthew Kaufmann-I, Nisrine Khazaal-I, Connie Moreland, MD-I, Kate Nagel-I, Kathryn Plummer-R, Allison Poulios-R, Tamiyka Rose-I, David Stepnick, MD-I, James Wellons-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 1:00 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

Approval of the September 17, 2025, minutes was deferred at the start of the meeting due to lack of quorum. Later in the meeting, once a quorum was established, the minutes were approved by unanimous vote.

II. Information Items

A. 2026 Draft Ambulatory Quality Goals

Ms. Mendez introduced Matthew Kaufmann, Executive Director, Population Health and Care Coordination, to discuss the draft 2026 Ambulatory Quality Goals. Mr. Kaufmann presented the proposed 2026 Draft Ambulatory Quality Goals, outlining the population health framework and performance measures intended to guide system improvement efforts in the upcoming year. The goals were developed using a SMART (Specific, Measurable, Achievable, Relevant, Time-based) framework and aligned with the System's mission, strategic plan, and external quality benchmarks, including Centers for Medicare and Medicaid Services (CMS) and Healthcare

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

Effectiveness Data and Information Set (HEDIS) measures. The draft ambulatory goals were organized into several categories. Screening goals were positioned as first-line preventive interventions intended to identify risk early, reduce disease burden, and improve long-term outcomes. Chronic condition goals focused primarily on hypertension and diabetes, with the intent of improving disease detection, management, and equity while reducing costs and improving population-level outcomes. Clinical connection goals emphasized access, continuity, and patient engagement, recognizing the role of sustained primary care relationships in improving adherence, reducing unnecessary emergency department utilization, and supporting whole-person care, including social drivers of health.

Additional quality continuity goals were described as mechanisms to maintain patient engagement once care relationships are established. Examples included pharmacy capture rate measures, which aim to enhance care quality through integrated medication management services, multilingual labeling, medication adherence support, and technology-assisted tools. Mr. Kaufmann also explained a revised structure for 2026, reducing the number of system-level goals from 16 to 13, while continuing to monitor several important quality indicators, such as pediatric immunizations, depression screening, diabetic eye exams, postpartum care, and lead screening. A new monitoring subset, referred to as Ambulatory Quality Indicator Monitoring, was introduced to track historically important measures and introduce emerging priorities. Among these, preterm birth was highlighted as a significant area of concern due to its contribution to infant morbidity and mortality and its disproportionate impact on certain populations. Data presented indicated that while the national preterm birth rate stood at approximately 10.4 percent, Ohio's rate was 11%, and Cuyahoga County's rate was 12.4%, underscoring the need for focused intervention in 2026. The scoring methodology for the ambulatory quality goals was also reviewed. Each goal would be assigned points based on performance thresholds, with cumulative system-level targets defined for minimum, target, and maximum achievement. Mr. Kaufmann noted that final targets may be adjusted based on year-end 2025 performance to ensure continued challenge and relevance.

B. The Index of Disparity

Next, Ms. Mendez introduced Kevin Chagin, Director of Population Health Data and Analytics, to discuss the Index of Disparity and how it is used to identify disparities and gaps within system goals. The Index of Disparity centers on a versatile approach to identifying and monitoring disparities across population health measures. The index was described as a method adapted from work by the National Center for Health Statistics, designed to calculate the average difference in performance between demographic subgroups and the overall population, standardized across group size and number. The intent of the index is to highlight relative gaps within each measure so that areas of underperformance can be identified quickly and

prioritized for further analysis. Mr. Chagin explained that the Index of Disparity can be applied across a wide range of domains, including ambulatory quality goals, patient experience, safety measures, access metrics, and utilization patterns. Current applications include stratification by age, race, ethnicity, gender, language, income, poverty level, and payer class. Results are displayed in an interactive dashboard that allows users to identify which demographic characteristics exhibit the greatest gaps for each measure, drill down to individual group performance, and examine trends over time. Examples were provided to illustrate how the index has revealed both expected and unexpected patterns. In some cases, disparities aligned with prior assumptions, such as lower screening rates among Medicaid or uninsured populations. In other cases, findings challenged expectations, such as poorer diabetes control among younger adults compared to older populations. These insights were described as valuable for informing targeted interventions and avoiding reliance on assumptions alone. Mr. Chagin emphasized that the index serves as a starting point, enabling rapid identification of gaps, followed by deeper statistical and qualitative analysis to understand underlying drivers and inform system-wide and community-level responses.

C. Selection for Population and Community Priority Goals

Next, Ms. Mendez introduced Nisreen Khazaal, Director of Clinical Process and Improvement PHII, to discuss the selection for population and community priority goals. Built on the preceding discussions of quality goals and disparity measurement, four priority focus areas were identified for 2026: diabetes control, blood pressure control, seven-day follow-up after emergency department visits for substance use disorder, and preterm birth. These areas were selected based on disease burden, community impact, alignment with strategic priorities, and the presence of measurable disparities. For diabetes, the focus was on improving hemoglobin A1C control, particularly among younger adults, Medicaid and self-pay populations, and certain racial and ethnic groups. Interventions described included point-of-care A1C testing, pharmacy-led disease management programs, expanded use of continuous glucose monitoring, and patient education through nutrition and self-management programs. Blood pressure control efforts emphasized accurate measurement, repeat readings, clinical decision support, follow-up scheduling, and coordination between specialty and primary care settings. The seven-day follow-up goal for substance use disorder addressed the need to connect patients seen in the emergency department with timely outpatient care. The Committee discussed the role of substance use navigators and community partnerships in supporting engagement beyond the hospital setting, noting that follow-up care delivered by external community providers would count toward the measure. The discussion emphasized the importance of cross-sector collaboration and community capacity in addressing substance use.

Preterm birth was identified as a particularly complex priority requiring both clinical and community-based strategies. Key interventions included early prenatal care, pregnancy risk assessment, use of community health workers, universal low-dose aspirin protocols, and coordination with broader community initiatives aimed at addressing social drivers such as stress, housing, food insecurity, and access to care. The committee acknowledged structural challenges associated with the metric, including attribution for patients who present for delivery without prior engagement, reinforcing the need for proactive outreach and community presence.

D. Pillar Priorities for 2026

Next, Ms. Mendez introduced Mr. Kaufmann and team to discuss pillar priorities for 2026, which outlines the strategic framework through which the priority goals would be pursued. Four pillars were reaffirmed: Patient-Centered Workforce; Barriers to Health; Quality Outcomes and Performance Improvement; and Community Engagement. Each pillar lead described planned focus areas and strategies for the coming year. The Patient-Centered Workforce pillar emphasized embedding patient experience and trauma-informed care across all roles within the organization, not limited to clinical staff. The discussion highlighted the importance of service recovery, communication skills, cultural humility, language access, and shared accountability for patient experience. The Barriers to Health pillar focused on leveraging social determinants of health data, community health workers, referral platforms such as Unite Ohio, and targeted programs, including food and pregnancy support initiatives, to reduce non-clinical obstacles to health outcomes.

The Quality Outcomes and Performance Improvement pillar emphasized alignment with value-based contracts, continued process improvement, provider education, and collaboration across ambulatory settings, with an explicit commitment to working in partnership with community engagement efforts. The Community Engagement pillar described ongoing and planned activities such as health fairs, culturally specific community events, point-of-care testing in community settings, sponsorship alignment, and mini-grants to community organizations, all intended to support access, education, and trust-building while contributing to measurable health outcomes.

With no further questions from the Board members in attendance, the meeting was adjourned at approximately 2:21 pm.

NEXT MEETING: **Wednesday, April 8, 2026 – 1:00pm - 3:00pm**
MetroHealth Board Room K107 and Virtual

THE METROHEALTH SYSTEM
Nancy Mendez, Chairperson