Population and Community Health Committee Meeting

The MetroHealth System
Virtual Only
2026-04-08 13:00 - 15:00 EDT

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POPULATION AND COMMUNITY HEALTH COMMITTEE

DATE: Wednesday, April 8, 2026
TIME: 1:00pm – 3:00pm
PLACE: Virtual via YouTube Stream: https://www.youtube.com/@metrohealthCLE/streams

AGENDA

I. Approval of Minutes

Committee Meeting Minutes of December 10, 2025

II. Information Items

A.	Overview of Priority Measures for 2026	M. Kaufmann
B.	Quality and Performance Overview: Pre-Term Birth	N. Khazaal
C.	Barriers to Health: Pre-Term Birth	K. Cook
D.	Community Engagement: Pre-Term Birth	R. Brazile
E.	Patient Centered Workforce: Pre-Term Birth	C. Moreland

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

MetroHealth

Population and Community Health Committee

Date: April 8, 2026

Time: 1:00pm – 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. Review of Minutes

II. Information Items
   A. Overview of Priority Measures for 2026
   B. Quality and Performance Overview: Pre-Term Birth
   C. Barriers to Health: Pre-Term Birth
   D. Community Engagement: Pre-Term Birth
   E. Patient Centered Workforce: Pre-Term Birth

III. Executive Session
   A. No Scheduled Topics

IV. Recommendation/Resolution Approval
   A. No Scheduled Topics

Approval of Minutes

Meeting Objectives

- Provide a more in-depth summary on the four priority measures in 2026
- Complete review of program for Pre-Term Birth across all four pillars of work.
- Discussion with Board members on Pre-Term Birth.

Priority Measures for 2026

Matthew Kaufmann

Focus Measures for Population and Community Health

4 Measures Selected:

- Diabetes: Glycemic Status Assessment greater than 9%
- Controlling Blood Pressure
- 7 day follow up for SUD ED patients
- Preterm Birth

Diabetes: Glycemic Status Assessment greater than 9% (%)

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
- Continuous Glucose Monitoring (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
- 2026 Action Plan: Outreach intervention through Cheers Campaigns to patients due for a PCP visit or have a high BP

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
- Completing nurse visits via telehealth before first prenatal visit
- Express cares making OB appointments for positive pregnancy tests
- 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 (Healthcare Committee) put a list of interventions

Population and Community Health Measures

Population and Community Health Measures		Results												
	Baseline	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Current performanc
PreTerm Birth (%)	10.6%	8.0%	8.0%	7.7%										7.7%
Diabetes: Glycemic Status Assessment >9% (Lower is better) (%)	22%	75%	63%	54%										54%
Controlling Blood Pressure (%)	72%	60%	65%	68%										68%
7 day follow up for SUD ED patients (%)	9%	9%	11%	10%										10%

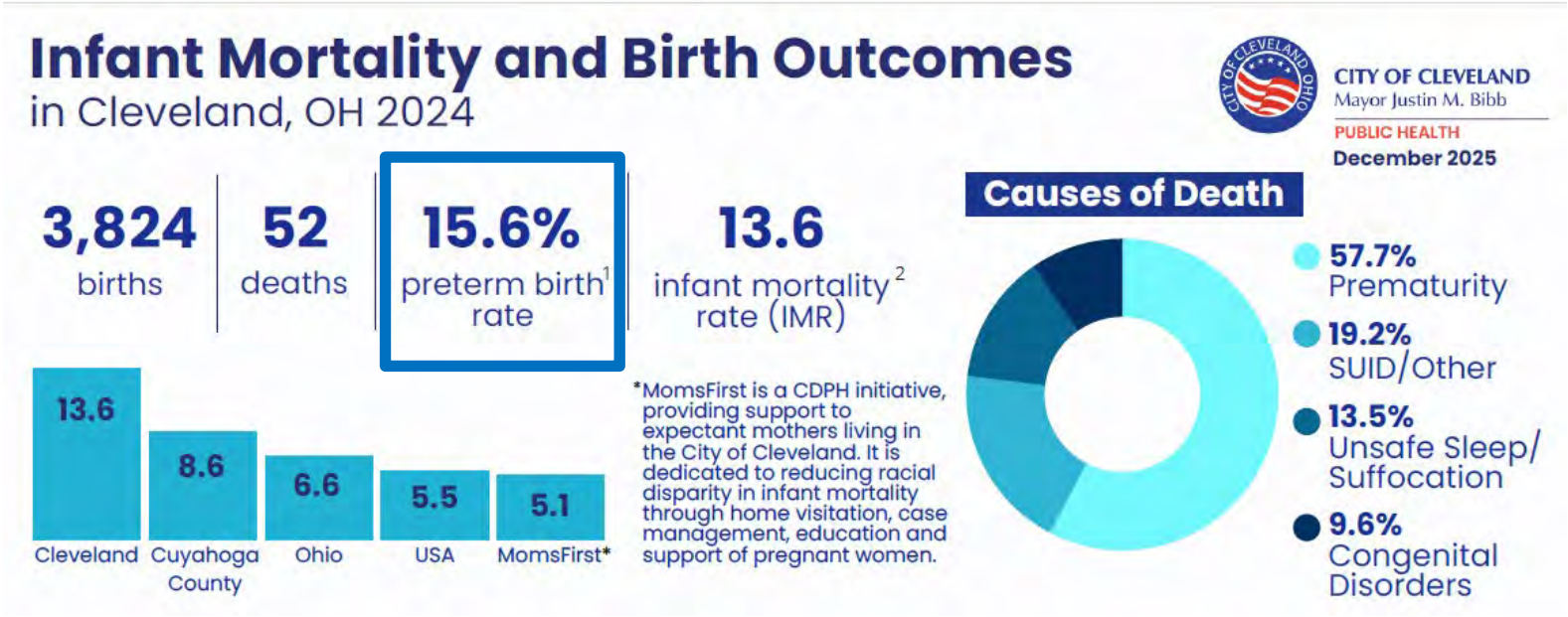
Quality Outcomes and Performance Improvement: Pre-Term Birth

Nisrine Khazaal

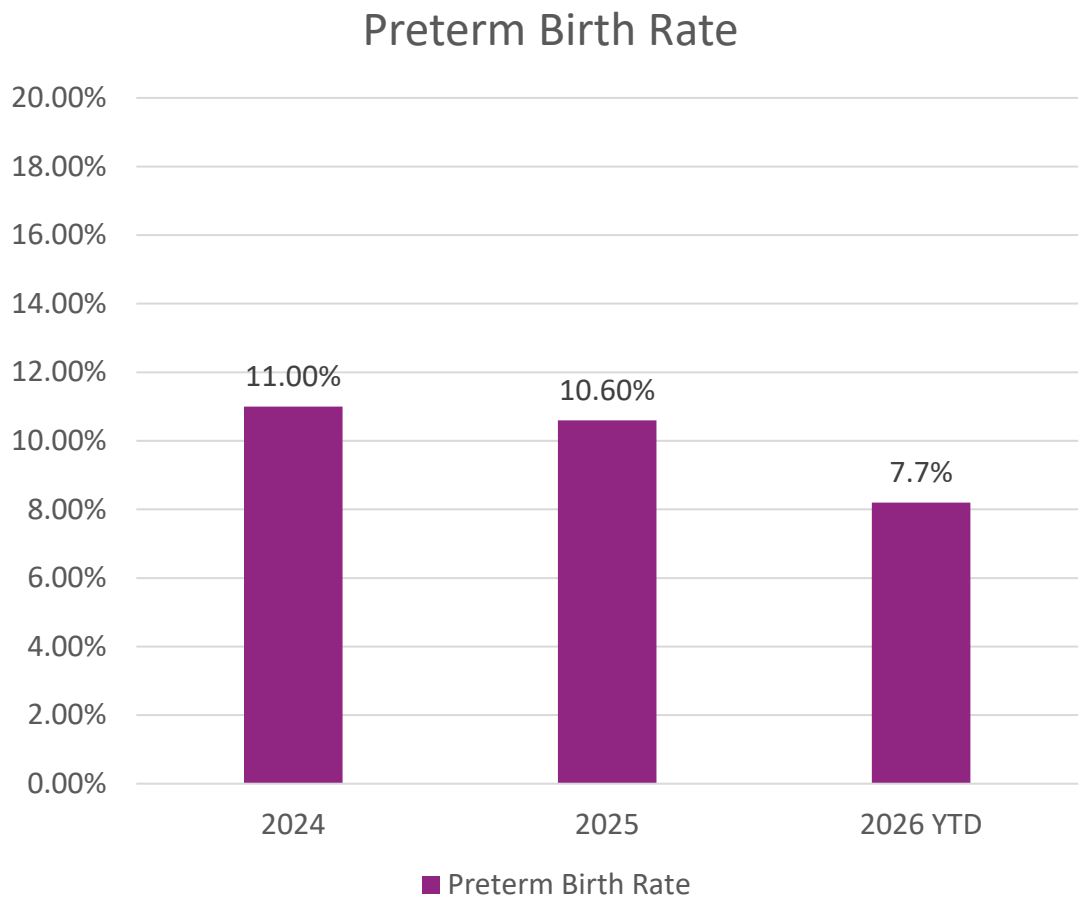
Preterm Birth

Definition: Preterm birth is when a baby is born too early, before 37 weeks of pregnancy have been completed.

In 2022, preterm birth affected about 1 of every 10 infants born in the United States (CDC.gov). National rate is 10.4%



MetroHealth Preterm Birth



- This rate is for all deliveries at MH
- Need to apply index of disparity for further analysis

Preterm birth can never be 0%

- **Spontaneous and Indicated Preterm Birth**
- PTB due to preterm labor with cervical dilation or preterm rupture of membranes is classified as “spontaneous”.
- Labor which is induced or in which the infant is delivered by cesarean section for maternal or fetal illness is classified as “indicated” preterm birth.
- US PTB classification: **2/3 spontaneous preterm and 1/3 medically indicated** (iatrogenic) preterm (**1**).
- Risk factors for indicated PTB include preeclampsia, diabetes complications, intrauterine abnormalities, and placental abnormalities (**2**).
- Maternal Risk factors for PTB include older maternal age, heart disease, hypertension, diabetes, tobacco use, previous preterm delivery, and socioeconomic factors (**3**)
- Spontaneous PTB has no defined set of risk factors, and it is still poorly understood (**1**)
- For MetroHealth, focusing on maternal risk factors even before pregnancy is the direction we will be adopting in 2026.

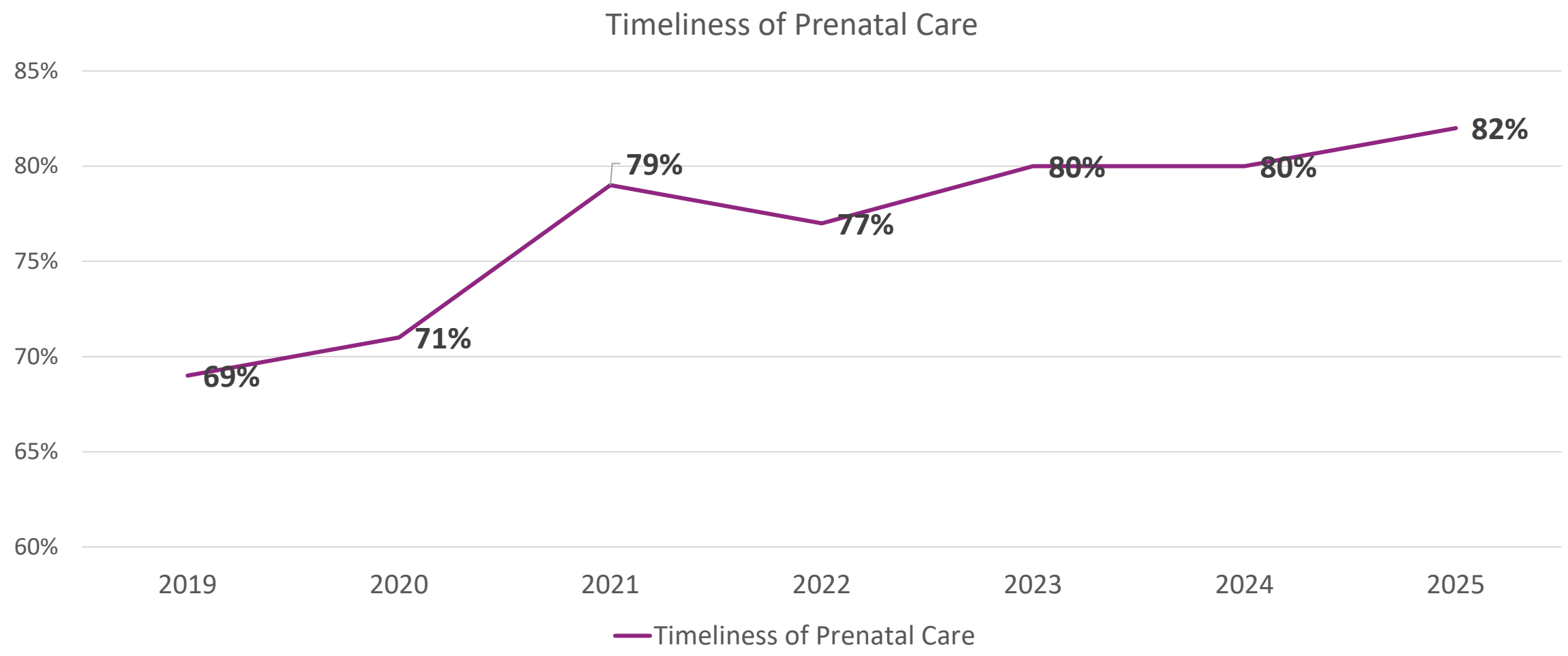
Work that has been done

Timely and frequent prenatal care: Prenatal care and specifically early prenatal care 9-12 weeks has proven to be crucial in preventing preterm birth and in improving neonatal outcomes.

- Consistent completion of Pregnancy Risk Assessment Forms (PRAFs). This is a requirement for Medicaid pregnant patients. Important in identifying risk factors very early in the pregnancy.
- Completing nurse visits via telehealth before first prenatal visit. Those visits include data gathering, education and preparation for the first prenatal visit.
- Express cares making OB appointments for positive pregnancy tests. Making sure we schedule patients as early as possible for prenatal care
- 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. This is a low dose aspirin for preeclampsia prevention and offer aspirin prophylaxis (81mg) to all pregnant patients unless contraindicated.
- First Year Cleveland Initiatives (Healthcare Committee)

Timeliness of Prenatal Care

Definition: The percentage of deliveries of live births that received a prenatal care visit in the first trimester.



Work that needs to be done

Addressing risk factors before pregnancy: Taking care of our childbearing women ages 18-45.

- Screening for pregnancy and referring to pre-conception counselling: Workflows to ask the right questions
- Addressing uncontrolled chronic illnesses in childbearing women. Workflows to connect with patients with uncontrolled diabetes and hypertension, through collaboration with pharmacy and primary care.
- Addressing continuity of care for women with previous preterm birth. Workflows to keep them connected with the system even after their 84 days postpartum.

Data around Preterm birth

Data and data management systems will be needed to help refine and focus our work

- Aspirin administration compliance
- Spontaneous versus Indicated delivers before 37 weeks
- Gestational week delivery data
- Registry for Preterm Birth
- Index of disparity for preterm birth

Barriers to Health: Pre-Term Birth

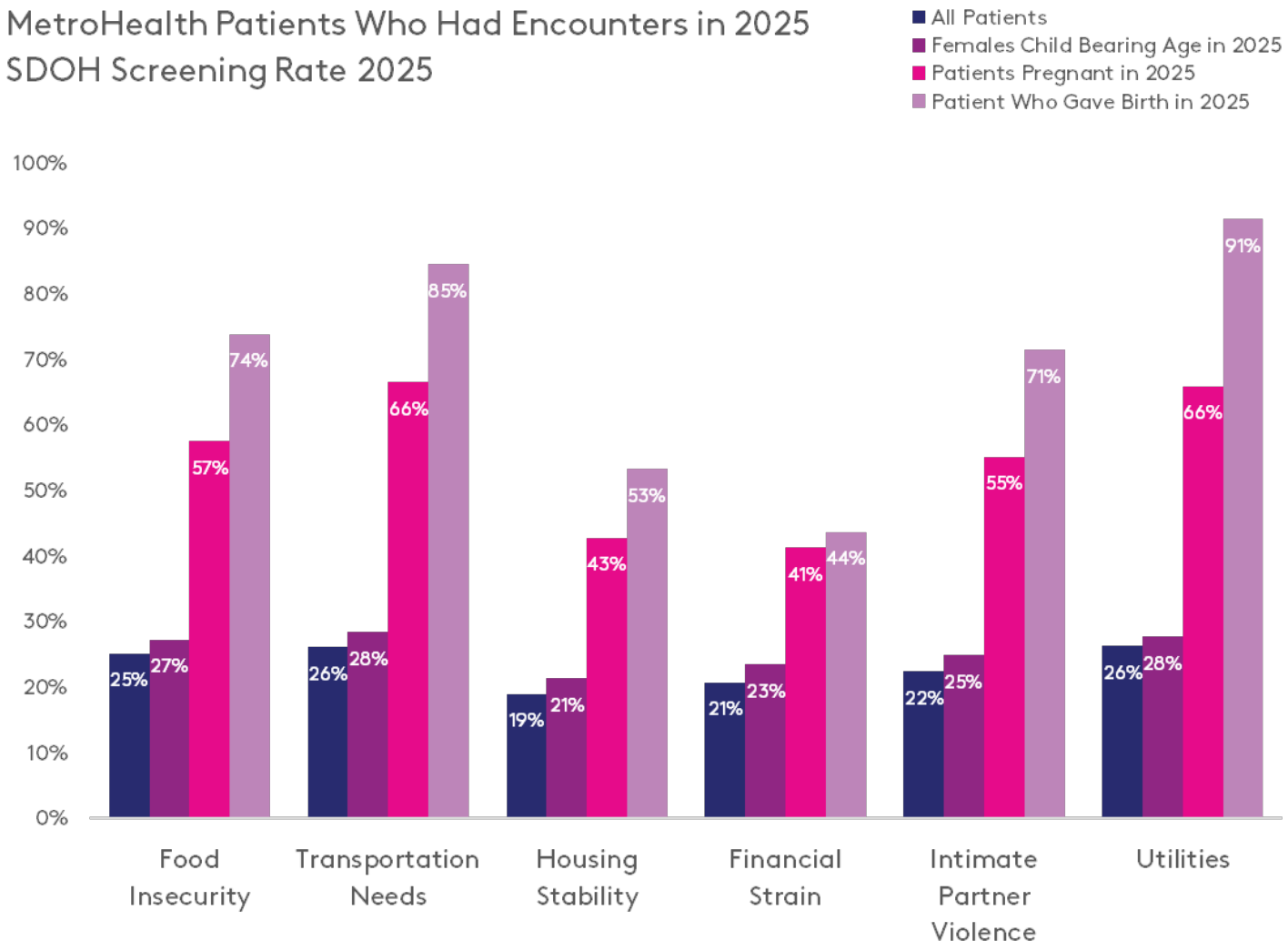
Karen Cook

Pillar #2: Barriers to Health

Preterm Birth and Timeliness of Prenatal Care

- Social Drivers of Health screening of OB population
- Data analysis – Timeliness of Prenatal Care
- Literature Review Findings
- Current SDOH Programs
- Opportunities

SDOH Screening Rates



Pregnant patients and patients who gave birth in 2025 are more likely to have completed SDOH screening questions.

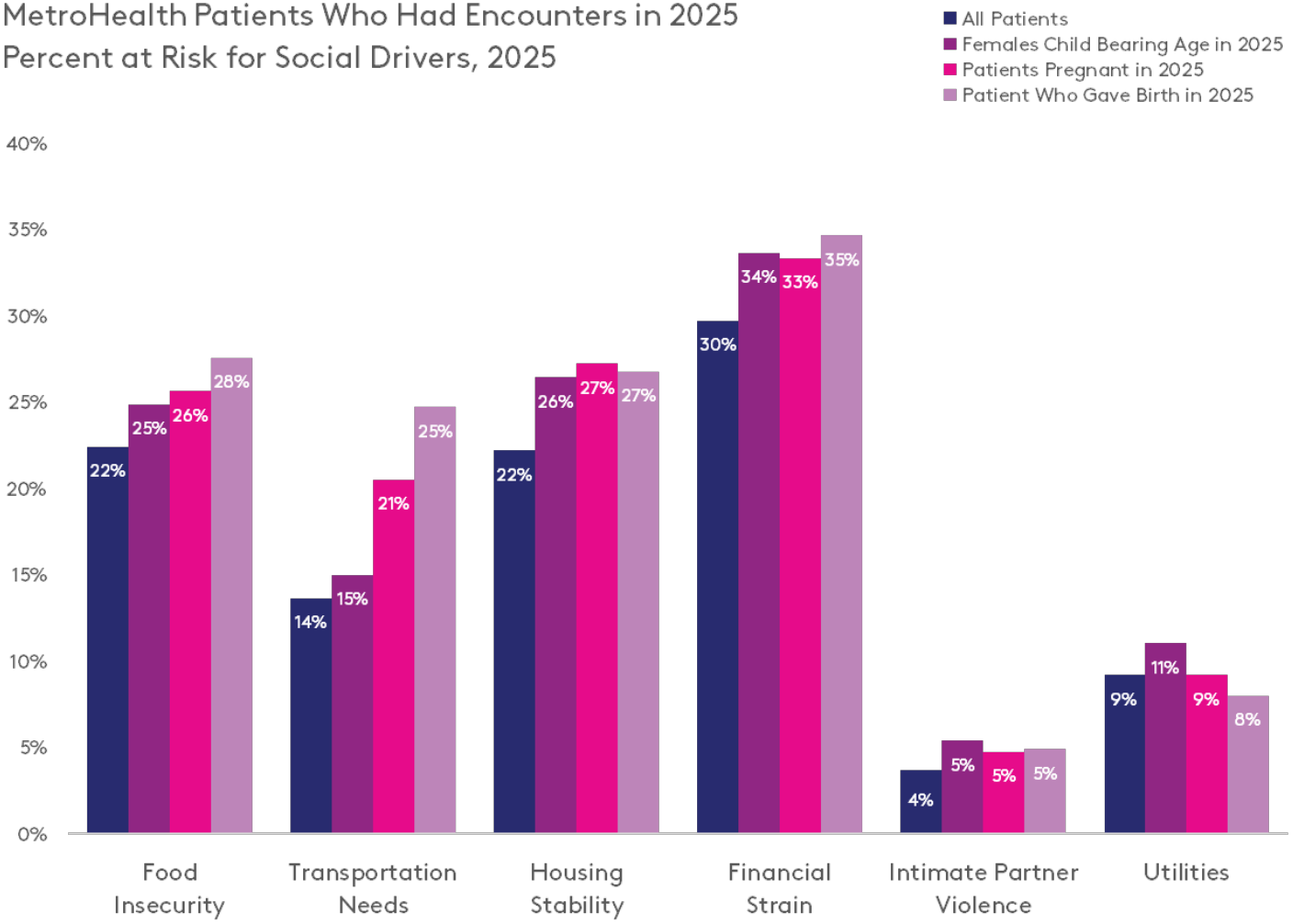
These patients have more touchpoints along the continuum of care to receive SDOH Screening as part of multiple interventions, and those who gave birth are captured in Inpatient SDOH screening.

SDOH Screening can be the first step toward gaining assistance for health-related social needs.

Source MetroHealth Epic Slicer Dicer, retrieved 3.5.2026, Katrina Dubovikova, I4HOPE Change Management & Process Improvement.

SDOH Risks

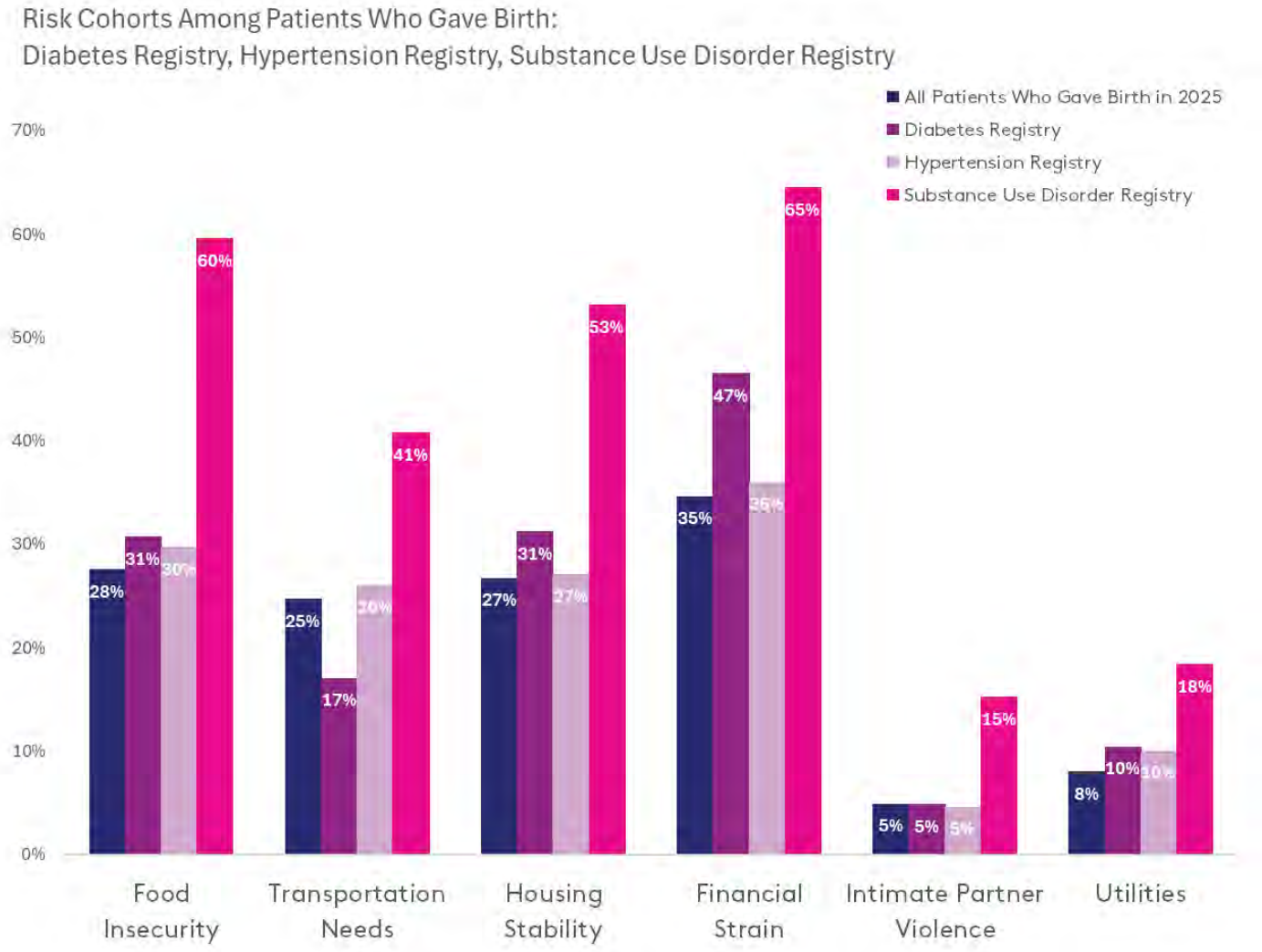
MetroHealth Patients Who Had Encounters in 2025
Percent at Risk for Social Drivers, 2025



Female patients of child-bearing age overall, pregnant patients, and patients who gave birth at MetroHealth in 2025 report higher rates for various social risks than the general patient population.

Source MetroHealth Epic Slicer Dicer, retrieved 3.5.2026, Katrina Dubovikova, I4HOPE Change Management & Process Improvement.

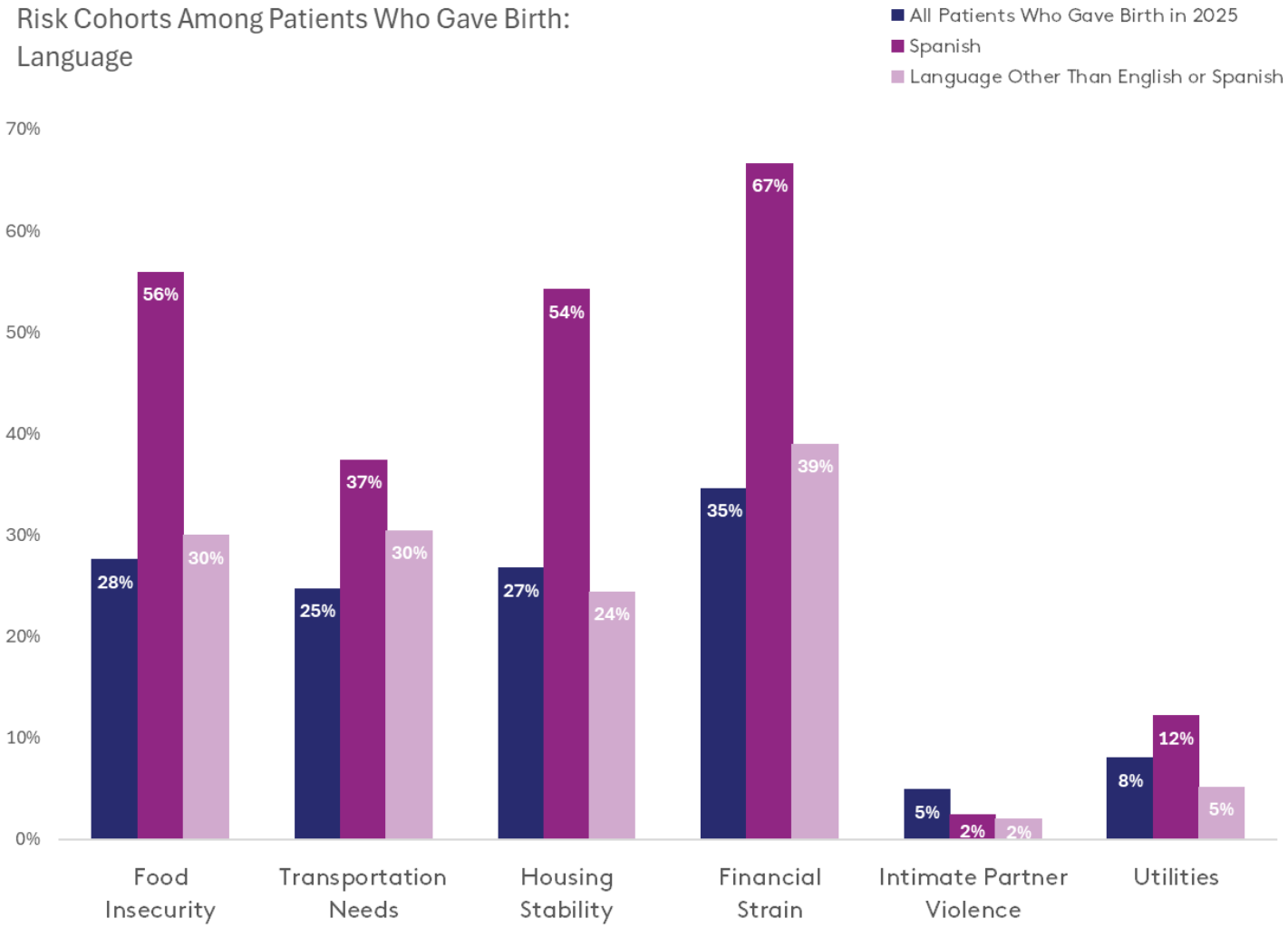
SDOH Risk Cohorts



- Social risk rates vary among different cohorts of patients who gave birth at MetroHealth in 2025.
- This chart compares across cohorts related to conditions reflected in other system goals: diabetes, hypertension and substance use disorder.

Source MetroHealth Epic Slicer Dicer, retrieved 3.11.2026, Katrina Dubovikova, I4HOPE Change Management & Process Improvement.

SDOH Risks by Primary Language



- Among patients who gave birth at MetroHealth in 2025, there are notably higher SDOH risk rates for those reporting Spanish as their primary language.
- The Index of Disparity highlights Language as an area where disparities in Timeliness of Prenatal Care outcomes exist.

Source MetroHealth Epic Slicer Dicer, retrieved 3.11.2026, Katrina Dubovikova, I4HOPE Change Management & Process Improvement.

Data Analysis: Timeliness of Prenatal Care

Prenatal and Postpartum Metrics & SDOH

- Data analysis of predictors of completion of Prenatal Care Appointments
- Metric = Percentage of deliveries in which women had a prenatal care visit in the first trimester
- Goal= Run a multivariate logistic regression analysis to identify what data elements are statistically associated with the unsuccessful completion of the metric
- Data Elements= demographics, utilization of primary care at MetroHealth, OB history, social drivers of health screening risk factors and more

Summary of Findings

Prenatal Intervention Opportunities

- *No Show Rate* (QCSD)
- Transportation
- Number of Children
- PCP History at MetroHealth
- Financial Resource Strain
- Food Insecurity

Literature Review: SDOH and Preterm Birth

Sociodemographic factors associated with Preterm Birth:

- Extremes of maternal age (very young or very old)
- Black, Native American, or Hispanic race/ethnicity
- Lower educational attainment
- Living in a disadvantaged area
- Exposure to air pollution, heat waves
- Physically demanding job
- Lack of prenatal care
- Cigarette smoking
- Alcohol use
- Substance use
- Undernutrition
- Stress/lack of social support

Potentially Effective Interventions:

Enhance prenatal care – specialized, multidisciplinary care for high-risk pregnant women

Address unhealthy behaviors – emphasis on cigarette smoking, alcohol use, and misuse of prescription and nonprescription drugs

Optimize nutritional status – to address low pre-pregnancy BMI

Provide social support and stress reduction – limited evidence on effective interventions

- Literature review conducted by Dr. Ash Sehgal, Director, Research & Evaluation, Institute for H.O.P.E.
- Based on a review of over 300 articles published in the last 25 years. Articles were identified through PubMed and Google Scholar. Material was also reviewed in UpToDate, an online medical textbook, and OpenEvidence, an artificial intelligence platform created by leading medical journals.

Current SDOH Programs for OB Population

SDOH Screening

SDOH screener available to patient through MyChart in advance of primary care appointments. If patient requests assistance, they are routed to care team member for follow-up

Unite Ohio

An electronic referral network to connect health care and social services on behalf of patients in need

OB Lead Safe Housing

Making homes lead-safe before a newborn arrives, with funding support from Ohio Dept. of Health

Opportunity Center at Buckeye

Services and programming on-site, including mobile pantry, Resource Closet, financial coaching, and social services

Community Advocacy Program

A medical-legal partnership to address civil legal issues that impact health, in partnership with the Legal Aid Society of Cleveland

Food as Medicine

A nutrition intervention for patients who are food insecure with chronic conditions impacted by diet

Nourishing Tomorrow

An NIH- funded study led by CWRU and Greater Cleveland Food Bank , providing medically-tailored groceries to patients who are pregnant and food insecure

Other

Representation on FYC Housing Committee; SDOH Resource Guides; Mobile pantries; patient assistance

SDOH Opportunities

Fresh Connect

A medically-tailored grocery card program providing a reloadable, prepaid card, programmed with spend parameters for eligible items. Demonstrated impact with OB population. Exploring pilot with women of child-bearing age who have chronic conditions.

Financial Coaching

Targeted outreach to provide financial coaching services to OB patients at risk for financial instability, and particularly those whose primary language is Spanish. In process of hiring bi-lingual Financial Coach. Aim to work with OB staff, Social Workers and Community Health Workers to make Epic referral for financial coaching.

Opportunity Centers at Buckeye and Via Sana

Expand Resource Closet with items needed by pregnant women, identify new partners to bring on-site for essential social services, use community space at Via Sana for community baby showers or other group services .

Unite Ohio

Refresher training for referrers serving OB population, engage CBO partners to meet needs of OB population.

SDOH Screening

Quality improvement project to increase consistent SDOH screening rate; identify other high-risk cohorts; enhanced risk stratification to automatically route to appropriate staff person for follow-up.

Community Engagement: Pre-Term Birth

Romona Brazile

Align System Preterm Efforts with Community Health Improvement Initiatives

Community Engagement

- **Public Health Assessment and Improvement Planning**
  - Cleveland Department of Public Health and Cuyahoga County Board of Health
    - 2026 Cuyahoga County Health Needs Assessment

- **First Year Cleveland Partners for Change Initiative Focused on Preterm Delivery**
  - Healthcare Collaborative Committee (MH, CCF, UH, NFP)
    - Quality improvement efforts
    - Best practice sharing
    - Queen's Village Community Engagement
    - Collaborate on Community Communication Campaign

- **Maternal Health Partnerships**

Convene Community Conversations & Listening Sessions

Community Engagement

- **Partner with Patient Experience and OB/GYN to host Community Conversations & Listening Sessions.**
- **Goals:**
  - Hear lived experiences of women who experienced Pre-term births
  - Host educational sessions with MH providers on key topics that contribute to Pre-term birth
  - Gather input and feedback on proposed MH Preterm Interventions

Patient Centered Workforce: Pre-Term Birth

Dr. Connie Moreland

Building a Patient-Centered Workforce

- A Strategic Framework for The MetroHealth System
- Cleveland, Ohio
- Focus: Patient Experience, Workforce Engagement, and Health Equity

Vision and Goals

- Create a culture of compassionate, culturally responsive care
- Improve patient trust and satisfaction
- Align workforce with system health goals
- Reduce disparities and improve outcomes such as preterm birth

Strategic Pillars

- Patient Experience Leadership
- Provider Education for Health Outcomes
- Cultural Competency and Empathy Training
- Patient and Family Advisory Councils
- Customer-Friendly Culture
- Employee Engagement and Recognition

Patient Experience Leadership

- Led by the Patient Experience Team
- Establish Patient Experience Steering Committee
- Align departments around HCAHPS improvement
- Integrate patient experience metrics into leadership dashboards

Provider Education for System Health Goals

- Clinical education aligned with system priorities
- Focus on reducing preterm birth and improving maternal outcomes
- Quarterly learning sessions and grand rounds
- Use clinical dashboards to track outcomes

Cultural Competency and Empathy Training

- Mandatory empathy and communication training
- Education on implicit bias and trauma-informed care
- Simulation and patient storytelling
- Focus on culturally responsive care for diverse communities

Patient and Family Advisory Panels

- Establish Patient and Family Advisory Councils (PFAC)
- Represent diverse patient populations
- Engage patients in quality improvement and policy design
- Provide direct feedback to leadership

Customer-Friendly Culture

- Launch service excellence initiative: 'Every Patient, Every Encounter'
- Standardize service behaviors across staff
- Patient journey mapping to identify barriers
- Service recovery training to address patient concerns

Employee Engagement and Recognition

- Patient Experience Champion Awards
- Frontline staff improvement teams
- Leadership rounding and staff listening sessions
- Recognition programs that celebrate compassionate care

Implementation and Expected Outcomes

- Phase 1: Governance, training launch, PFAC formation
- Phase 2: Provider education and service culture implementation
- Phase 3: Measurement and expansion
- Expected outcomes: improved HCAHPS, reduced preterm birth, stronger workforce engagement

Community-Integrated Care: Doulas + CHWs

- Embed doulas and community health workers into maternity care teams
- Continuous, culturally concordant support improves trust and engagement
- Reduces preterm birth and cesarean rates
- Reduces racial disparities in outcomes
- Recruit from community and train in trauma-informed care
- Supported through Medicaid and value-based care models

Relationship-Based Care: Group Prenatal Care

- Implement group prenatal care (e.g., CenteringPregnancy)
- Longer visits and peer support strengthen relationships
- Reduces preterm birth up to 30–40% in high-risk populations
- Improves attendance, satisfaction, and health literacy
- Use interdisciplinary teams (OB, midwives, behavioral health)
- Train workforce in facilitation and shared decision-making

Risk Stratification + Targeted Support

- Identify highest-risk patients early
- Focus on prior preterm birth and short interpregnancy interval
- Provide targeted education and intensified support pathways
- Use care navigators and patient educators
- Reduce missed visits and improve coordination
- Deliver clinical interventions within coordinated care plans

Appendix

References

- 1. Goldenberg RL, Culhane JF, Iams JD, Romero R. Epidemiology and causes of preterm birth. Lancet. 2008;371(9606):75–84. https://doi.org/10.1016/S0140-6736(08)60074-4.

- 2. American College of Obstetricians and Gynecologists Committee Opinion. Medically indicated late-preterm and early-term deliveries [Internet]. Washington DC: ACOG; 2021. Cited 15 June 2023. Available from: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/07/medically-indicated-late-preterm-and-early-term-deliveries.

- 3. Purisch SE, Gyamfi-Bannerman C. Epidemiology of preterm birth. Semin Perinatol. 2017;41(7):387–91. https://doi.org/10.1053/j.semperi.2017.07.009.

Universal Protocol for Aspirin

Background

- Preeclampsia is a significant cause of maternal and neonatal morbidity and mortality worldwide and is thought to affect 2-8% of pregnancies.[1] From 2005 to 2014, the rate of preeclampsia or eclampsia among delivery hospitalizations increased by 21%. Deliveries with severe preeclampsia increased by 50% over this time span.[2] Multiple trials and metanalyses have demonstrated that prophylactic low dose aspirin in certain high-risk populations reduces preeclampsia by 10-62%.[3,4,5] Over the years, several academic bodies have released recommendations for prescribing low dose aspirin to prevent preeclampsia. In 2013, the American College of Obstetricians and Gynecologists (ACOG) Task force on Hypertension recommended that women with a history of early-onset preeclampsia and a preterm delivery less than 34 0/7 weeks or preeclampsia in more than one prior pregnancy initiate low dose aspirin (60-80mg) in the late first trimester.[6] The United States Preventative Task Force (USPSTF) released their first recommendation in 2014 to prescribe low dose aspirin for patients at high risk of developing preeclampsia, which included those with a history of preeclampsia, multifetal gestation, chronic hypertension, Type 1 or 2 diabetes, renal disease, or autoimmune diseases such as SLE or antiphospholipid syndrome.[7] By 2021, ACOG recommended aspirin prophylaxis in patients that had at least two moderate risk factors. As with any preventative therapy, the benefits of aspirin in preeclampsia prophylaxis are reliant on provider guideline adherence. On evaluation of our institutional prescription rates, only 26% of eligible patients received a prescription in 2022.