POPULATION AND COMMUNITY HEALTH COMMITTEE
REGULAR MEETING

Wednesday, April 8, 2026
1:00pm – 3:00pm
Virtual

Meeting Minutes

Committee Members:	John Corlett, Nancy Mendez, E. Harry Walker, MD
Other Trustees:	Michael Summers
Staff:	Christine Alexander-Rager, MD, Marshall Ashby, Bridget Barrett, Peter Benkowski, Romona Brazile, Nabil Chehade, MD, Karen Cook, Katie Davis-Bellamy, Joseph Golob, MD, Matthew Kaufmann, Nisrine Khazaal, Tony Minor, Connie Moreland, MD, Dr. Candy Mori, Kate Nagel, Kathryn Plummer, Allison Poulios, Rochelle Smith, David Stepnick, MD, John Thornton, MD, James Wellons, Gregory Zucca
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 1:01 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 10, 2025, Committee meeting was approved by unanimous vote as presented.

II. Information Items

A. Overview of Priority Measures for 2026

Ms. Mendez introduced Matthew Kaufmann, Executive Director, Population Health and Care Coordination, to provide an overview of the Population and Community Health priority measures for 2026. Mr. Kaufmann presented four priority measures that will guide the Committee's work during the year: glycemic status assessment among patients with diabetes, controlling hypertension, seven-day follow-up after emergency department encounters involving substance use disorder, and pre-term birth. Mr. Kaufmann explained that diabetes performance is measured by the percentage of patients with a hemoglobin A1C greater than nine percent or without a documented test. Key populations identified through disparity analyses included younger adults, Medicaid and self-pay patients, Hispanic patients and Spanish-speaking patients, and Black or African American patients. Interventions discussed

included expansion of point-of-care A1C testing, pharmacy support for chronic disease management, increased use of continuous glucose monitoring technology, and diabetes self-management education programs. The Committee also received an overview of the hypertension measure, which evaluates blood pressure control among adults diagnosed with hypertension. Disparities were identified among Medicaid beneficiaries and Black or African American patients. Mr. Kaufmann discussed initiatives to support improved outcomes including clinical workflow supports within the electronic health record and patient outreach efforts designed to encourage follow-up care and monitoring. An update was provided regarding the seven-day follow-up measure for patients diagnosed with substance use disorder in the emergency department. Mr. Kaufmann stated that the measure is intended to ensure connection to ongoing services following an emergency department visit and emphasized the importance of continued engagement with addiction treatment and recovery resources. Existing interventions include work by the Office of Opioid Safety, substance use navigators, and enhanced integration with behavioral health services. Disparity analyses for both the substance use disorder and pre-term birth measures are currently under development and are expected to be incorporated into future reporting. Mr. Kaufmann concluded by introducing a recurring performance dashboard that will be brought to future committee meetings to monitor progress on the four priority measures.

B. Quality and Performance Overview: Pre-Term Birth

Ms. Mendez introduced Nisreen Khazaal, Executive Director Population Health, to discuss pre-term birth through the lens of the Committee's four pillars. Pre-term birth is defined as the delivery of a baby before 37 weeks of pregnancy. Nationally, the preterm birth rate was approximately 10.4% based on 2022 CDC data, while the local rate in Cleveland was reported at 15.6%, a measure closely associated with infant mortality outcomes. A pre-term birth dashboard was developed to monitor performance, showing rates of 11.0% in 2024, 10.6% in 2025, and 7.7% in 2026 year-to-date, although the 2026 rate may change as additional deliveries occur. Additionally, plans are underway to develop an index of disparity to better understand differences in outcomes across populations. Ms. Khazaal emphasized that pre-term birth cannot realistically be reduced to zero because it includes both spontaneous and medically indicated deliveries. Spontaneous pre-term births occur due to factors such as pre-term labor or premature rupture of membranes, while medically indicated births may result from conditions including preeclampsia, diabetes complications, fetal abnormalities, or placental issues. Research suggests that approximately two-thirds of pre-term births are spontaneous and one-third are medically indicated. Additional risk factors include advanced maternal age, chronic diseases such as hypertension, diabetes, heart disease, previous preterm births, and socioeconomic conditions.

Several strategies have been implemented to reduce pre-term birth, including timely prenatal care, comprehensive pregnancy risk assessments, telehealth nursing visits, rapid scheduling of prenatal appointments for newly identified pregnancies, community health worker support, and universal low-dose aspirin protocols for eligible patients to help prevent preeclampsia. Ms. Khazaal reported improved first-trimester prenatal care access, from 69% in 2019 to 82% in 2025. Looking ahead, MetroHealth's 2026 focus will emphasize preconception and preventive care by screening women of childbearing age for pregnancy intentions, providing preconception counseling, improving management of chronic conditions, and strengthening continuity of care for women with previous preterm births. Future monitoring will include aspirin compliance, analysis of spontaneous versus indicated preterm births, development of a preterm birth registry, and measurement of disparities in outcomes.

C. Barriers to Health: Pre-Term Birth

Ms. Mendez introduced Karen Cook, Executive Director Social & Community Health, to discuss barriers to health related to pre-term birth. Ms. Cook presented an overview of how social drivers of health (SDOH) influence prenatal care and preterm birth outcomes among MetroHealth's obstetric population. Screening data from 2025 showed that pregnant patients and those who delivered at MetroHealth had higher screening rates for social needs and generally higher levels of risk across domains such as food insecurity, transportation challenges, and financial strain compared with the broader patient population. Analysis of prenatal care access identified several factors associated with failure to complete a first-trimester prenatal visit, including transportation barriers, food insecurity, financial strain, number of children, and prior no-show patterns. A literature review found links between preterm birth and demographic, environmental, behavioral, and social factors. MetroHealth currently addresses these needs through programs including SDOH screening, community resource referrals, lead-safe housing initiatives, food-as-medicine programs, legal aid services, and community-based support centers. Proposed opportunities include expanding culturally responsive services, strengthening language-specific support, piloting healthy food purchasing programs, enhancing community partnerships, and improving screening and referral processes for at-risk patients.

D. Community Engagement: Pre-Term Birth

Ms. Mendez introduced Romona Brazile, Executive Director Government & Community Relations, to discuss community engagement strategies related to pre-term birth. Ms. Brazile emphasized the importance of integrating community engagement into the design and implementation of pre-term birth initiatives rather than involving community partners only after decisions have been made.

MetroHealth is aligning its efforts with broader community health improvement priorities, including county and city maternal and child health initiatives and the First-Year Cleveland Partners for Change program, which brings together health systems and community organizations to address pre-term birth. Shared interventions across participating organizations include timely prenatal care, universal aspirin therapy for eligible patients, remote blood pressure monitoring, and quality improvement collaboration. The discussion highlighted the value of community input in understanding patient experiences, evaluating proposed interventions, and improving program effectiveness. Feedback from community groups, including the Queens Village initiative, has identified themes that align with concerns expressed by MetroHealth patients and can help guide future strategies. Planned activities include community conversations, educational sessions on maternal health risk factors, gathering feedback on proposed programs, and developing more intentional referral pathways and collaborations to better connect patients with care, resources, and support services.

E. Patient Centered Workforce: Pre-Term Birth

Ms. Mendez introduced Dr. Connie Moreland, VP, Provider Pipeline Development & Engagement, to discuss the patient centered workforce pillar in relation to pre-term birth. Dr. Moreland presented a strategic framework for building a patient-centered workforce focused on improving patient experience, workforce engagement, and health equity, with a particular emphasis on reducing pre-term births and associated disparities. The framework includes leadership accountability for patient experience metrics, provider education aligned with system priorities, cultural competency and empathy training, patient and family advisory councils, a customer-friendly service culture, and employee engagement initiatives. Implementation will occur through phased governance, education, culture change, measurement, and expansion efforts. To address pre-term birth specifically, MetroHealth utilizes community-based approaches such as integrating doulas and community health workers, recruiting from the communities it serves, offering group prenatal care models like Centering Pregnancy, and applying risk stratification to identify and support high-risk patients. During discussion, leaders acknowledged resource limitations but emphasized targeted, data-driven interventions, strong community partnerships, care coordination, trust-building, and collaboration with organizations such as Birthing Beautiful Communities, First Year Cleveland, and statewide maternal health initiatives to maximize impact and improve outcomes.

With no further questions from the Board members in attendance, the meeting was adjourned at approximately 2:22 pm.

The MetroHealth System Board of Trustees

NEXT MEETING: **Wednesday, September 16, 2026 – 3:00pm - 5:00pm**
MetroHealth Board Room K107 and Virtual

THE METROHEALTH SYSTEM
Nancy Mendez, Chairperson

MetroHealth