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

The MetroHealth System
MetroHealth Board Room K107 - 2500 MetroHealth Dr., Cleveland, OH 44109
2026-09-09 14:00 - 16:00 EDT

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POPULATION AND COMMUNITY HEALTH COMMITTEE

DATE: Wednesday, September 9, 2026
TIME: 2:00pm – 4:00pm
PLACE: Virtual via YouTube Stream
https://www.youtube.com/@metrohealthCLE/streams

AGENDA

I. Approval of Minutes

Committee Meeting Minutes of April 8, 2026

II. Information Items

A. Lown Institute 2026	K. Chagin
B. AEH Presentation: The Most Dangerous Gap	M. Kaufmann
C. Index of Disparity Analysis	N. Khazaal
D. Pillar Lead Updates	
1. Patient-Centered Workforce	C. Moreland, MD
2. Barriers to Health	K. Cook
3. Community Engagement Update	R. Brazile
E. ODM Comparative Data Analysis	M. Kaufmann

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.

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

THE METROHEALTH SYSTEM
Nancy Mendez, Chairperson

MetroHealth

2026 Lown Institute Social Responsibility Rankings

Kevin Chagin, MS

Who is the Lown Institute?

The Lown Institute is an independent, nonpartisan healthcare think tank based in Boston that studies how well hospitals serve their patients and communities. Its Hospitals Index is the first national ranking to grade U.S. hospitals on social responsibility — not reputation.

Evaluating 3,600+ U.S. hospitals

WHAT THEY DO

Conduct research
on equity, value of care, and patient outcomes

Lead conversations
on accountability and human connection in medicine

Rank hospitals
on how well they deliver on that responsibility

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Performance Measures

Since inception, they have evaluated over 3,600 healthcare systems with publicly available data (IRS tax filings, Centers for Medicare & Medicaid Services (CMS), and U.S. Census Bureau data) across a span of time.

Performance measured across:

Equity

Reflects commitment to equity, inclusion, and community Health

Pay Equity

Ratio of executive compensation to worker wages

Community Benefit

Measures the hospitals investment within the community

Inclusivity

Extent to which patients being served are demographically similar based on Income, Race and Education

Value

Reflects the avoidance of use of low-value services and cost efficiency

Avoiding Overuse

Avoidance of inappropriate tests/procedures

Cost Efficiency

Risk-adjusted clinical outcomes over cost per patients adjusted for local cost of living and labor cost at 30 days and 90 days

Outcomes

Reflect performance as it relates to patients' health and experience of care

Clinical Outcome

Measure patient mortality during hospital stay and readmission rates

Patient Safety

Measures patient safety through established indicators on the CMS Care Compare website

Patient Satisfaction

Measures patient satisfaction from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

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2026 Ranking

Social Responsibility

National Ranking: **147** out of **2,689** hospitals who qualify for ranking

Ohio Ranking: **4** out of **104** hospitals who qualify for ranking in Ohio

Top 5 Ohio Hospitals

Rank	Hospital Name	City	2025 Ranking
1	South Pointe Hospital (CCF)	Warrensville Heights	3rd
2	Summa Health System – Akron	Akron	5th
3	East Liverpool City Hospital	East Liverpool	1st
4	The MetroHealth System	Cleveland	2nd
5	Ashtabula Regional Medical Center	Akron	> 5th

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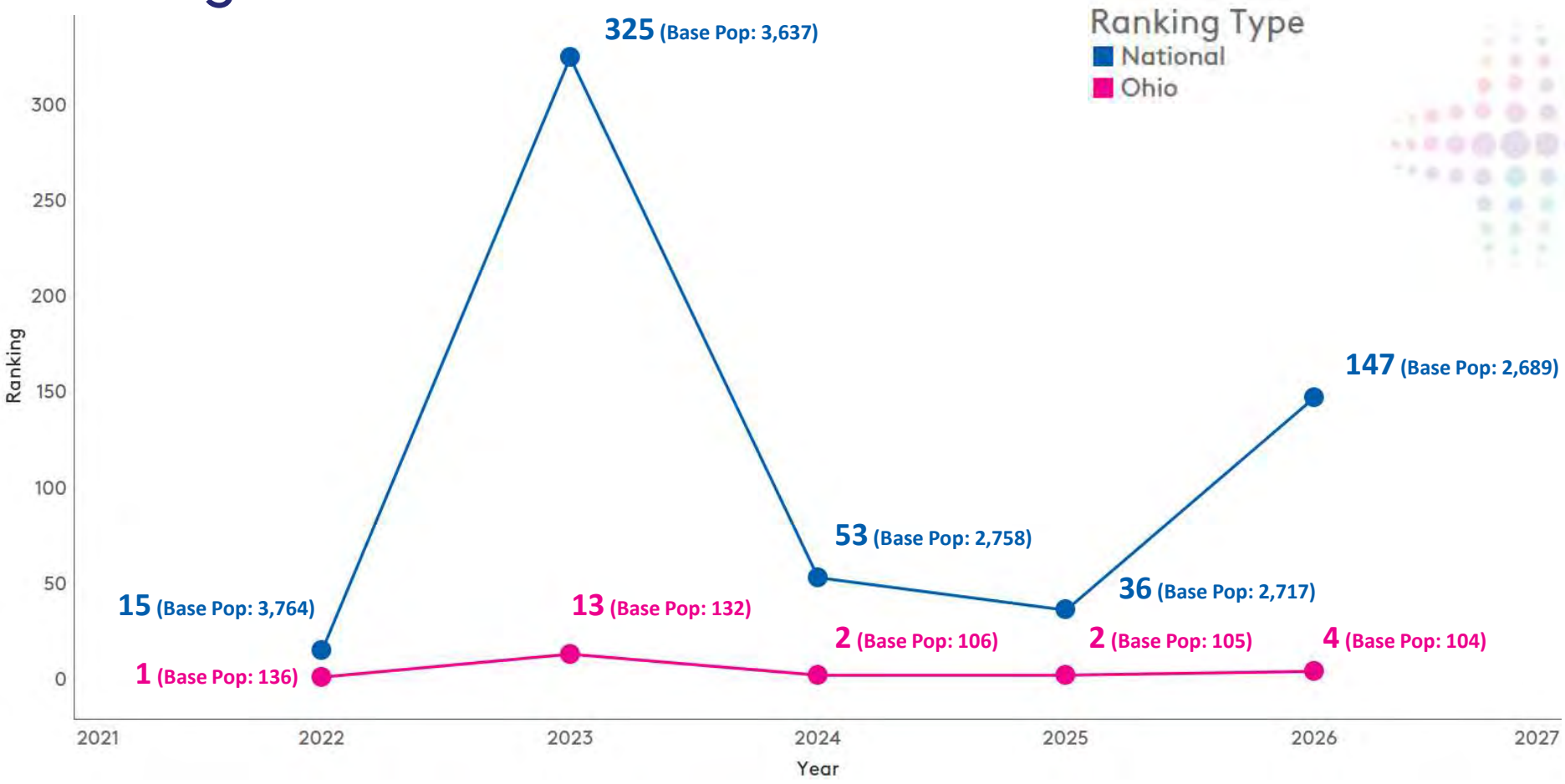
Ranking Over Time



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Ranking Breakdown of Categories

	2026	Last year (2025)
Equity Ohio: no change	A National Ranking: 616 of 2706 Ohio Ranking: 10 of 104	A National Ranking: 914 of 2728 Ohio Ranking: 10 of 105
Value Ohio: no change	A National Ranking: 56 of 2699 Ohio Ranking: 2 of 104	A National Ranking: 19 of 2725 Ohio Ranking: 2 of 105
Outcomes Ohio: ▼ 17 lower	A National Ranking: 1417 of 2718 Ohio Ranking: 76 of 104	A National Ranking: 962 of 2738 Ohio Ranking: 59 of 105

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Ranking Breakdown of Sub-Categories

Equity

	2026	Last year (2025)
Pay Equity		
Ohio: no change	D — National Ranking: 2407 of 2711; Ohio Ranking: 93 of 104	D — National Ranking: 2398 of 2736; Ohio Ranking: 93 of 105
Community Benefit		
Ohio: no change	A — National Ranking: 230 of 2694; Ohio Ranking: 1 of 104	A — National Ranking: 96 of 2716; Ohio Ranking: 1 of 105
Inclusivity		
Ohio: no change	A — National Ranking: 138 of 2553; Ohio Ranking: 4 of 103	A — National Ranking: 164 of 2563; Ohio Ranking: 4 of 104

MetroHealth

Ranking Breakdown of Sub-Categories

Value

	2026		Last year (2025)	
Avoiding Overuse				
Ohio: no change	A	National Ranking: 21 of 2676 Ohio Ranking: 1 of 103	A	National Ranking: 22 of 2562 Ohio Ranking: 1 of 103
Cost Efficiency				
Ohio: ▼ 9 lower	A	National Ranking: 417 of 2699 Ohio Ranking: 17 of 104	A	National Ranking: 207 of 2725 Ohio Ranking: 8 of 105

Ranking in Cost Efficiency decreases but we still earned 5 stars in both risk-adjusted mortality and cost per Medicare patient30 days and 90 days

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Ranking Breakdown of Sub-Categories

Outcomes

	2026	Last year (2025)
Clinical Outcomes		
Ohio: ▼ 33 lower	A — National Ranking: 1250 of 2718; Ohio Ranking: 68 of 104	A — National Ranking: 582 of 2738; Ohio Ranking: 35 of 105
Patient Safety		
Ohio: no change	D — National Ranking: 1823 of 2091; Ohio Ranking: 70 of 81	C — National Ranking: 1755 of 2127; Ohio Ranking: 70 of 82
Patient Satisfaction		
Ohio: ▲ 17 better	B — National Ranking: 1221 of 2641; Ohio Ranking: 54 of 104	B — National Ranking: 1483 of 2670; Ohio Ranking: 71 of 105

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Decrease in Clinical Outcomes

Between 2025 and 2026 There was a decrease in ranking due to 7-day and 30-day readmission

Note:
Data was obtained from Medicare FFS Claims between 2021 and 2024

MetroHealth

Comparison to South Pointe Hospital

	MetroHealth		South Pointe	
Equity	A	National Ranking: 616 of 2706 Ohio Ranking: 10 of 104	A	National Ranking: 749 of 2706 Ohio Ranking: 14 of 104
Value	A	National Ranking: 56 of 2699 Ohio Ranking: 2 of 104	A	National Ranking: 368 of 2699 Ohio Ranking: 7 of 104
Outcomes	A	National Ranking: 1417 of 2718 Ohio Ranking: 76 of 107	A	National Ranking: 423 of 2718 Ohio Ranking: 23 of 107

Comparison to South Pointe Hospital

EQUITY

MEASURE	METROHEALTH	SOUTH POINTE	OHIO GAP
Pay Equity	93	41	▼ 52 behind
Community Benefit	1	20	▲ 19 ahead
Inclusivity	4	17	▲ 13 ahead

VALUE

MEASURE	METROHEALTH	SOUTH POINTE	OHIO GAP
Avoiding Overuse	1	39	▲ 38 ahead
Cost Efficiency	17	2	▼ 15 behind

Ohio rankings. Avoiding Overuse: avoidance of inappropriate tests and procedures.
Cost Efficiency: risk-adjusted clinical outcomes over cost per patient, adjusted for local cost of living and labor cost at 30 and 90 days.

Comparison to South Pointe Hospital

OUTCOMES

We outperform South Pointe in Patient Satisfaction

MEASURE	METROHEALTH	SOUTH POINTE	OHIO GAP
Clinical Outcomes	68	4	▼ 64 behind
Patient Safety	70	13	▼ 57 behind
Patient Satisfaction	54	87	▲ 33 ahead

PATIENT SATISFACTION DETAIL

- **Ahead of South Pointe** on
  - doctor communication,
  - quietness,
  - overall rating, and
  - likelihood to recommend

Comparison to South Pointe Hospital

OVERVIEW

4
sub-measures ahead

4
sub-measures behind

We outperform South Pointe on **4 of 8 sub-measures**. Equity and Value carry the result, including two first-in-Ohio finishes. Outcomes is the drag — we trail on Clinical Outcomes and Patient Safety.

EQUITY		VALUE		OUTCOMES	
Pay Equity	▼ 52	Avoiding Overuse	▲ 38	Clinical Outcomes	▼ 64
Community Benefit	▲ 19	Cost Efficiency	▼ 15	Patient Safety	▼ 57
Inclusivity	▲ 13			Patient Satisfaction	▲ 33

Where to focus: every loss outside Outcomes is a single measure — Pay Equity and Cost Efficiency. Closing Clinical Outcomes and Patient Safety is what moves the overall standing.

America's Essential Hospitals (VITAL) The Most Dangerous Gap in Health Care

Matthew Kaufmann, MSN RN

Kevin Chagin, MS

VITAL2026
Connect. Inspire. Lead.

The Most Dangerous Gap in Health Care Isn't Always Clinical

Bridging Governance with Data-Driven Operations to Improve Patient Outcomes

The MetroHealth System

Thursday, June 11, 2026

TODAY'S SPEAKERS

Nabil Chehade MD, MS
Sr EVP Chief Clinical Transformation, Innovation & Strategy Officer

Matthew Kaufmann MSN, RN
VP Population Health and The Institute for H.O.P.E.™

Kevin Chagin MS
Dir. Population Health Data and Analytics

SHIFTING GOVERNANCE FROM OVERSIGHT TO STEWARDSHIP

Oversight: *"Are you compliant?"*

Stewardship: *"Are we improving outcomes equitably?"*

Stewardship behaviors:

1 Setting System-Level Outcomes

A small number of outcomes that define success for the entire system

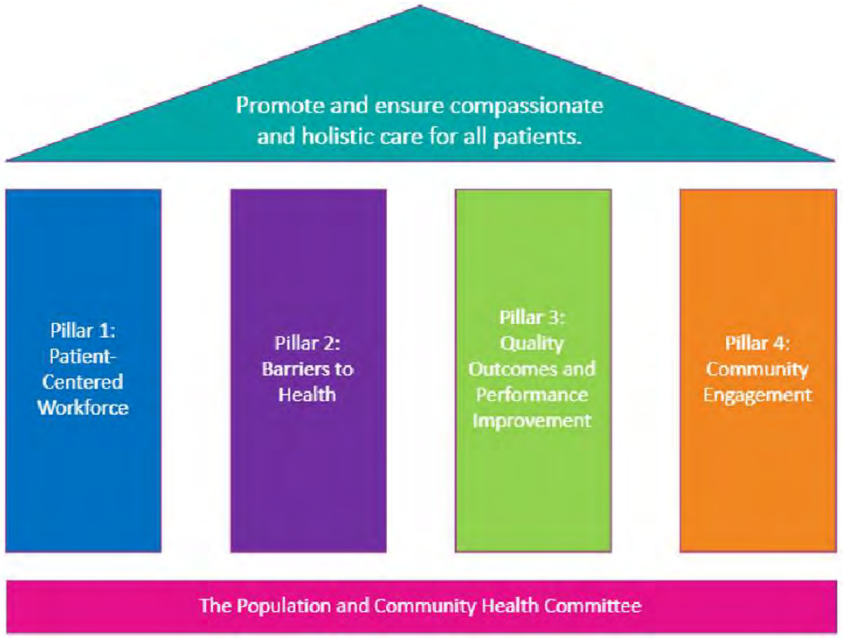
2 Demanding a Measurement Architecture

Without a measurement architecture, equity becomes a slogan. With one, equity becomes a **trackable, improvable outcome.**

3 Creating Accountability Loops

OUR ALIGNMENT MODEL

1. Board aims
2. Operational priorities
3. Metrics cascade
4. Decision rights
5. Learning loops
6. High-need metrics



WHAT LEADERS CAN DO

Replace a Status Update with a Data-Driven Decision Item

- ✓ Shifts meetings from "Update Mode" to "Decision Mode"
- ✓ Requires clarity on the problem, data, owner
- ✓ Turns agendas into engines for progress

Require Aim → Metric → Owner for Every Initiative

- Forces alignment to Board Aims
- Prevents initiative overload
- Gives teams clarity on "*the metric that matters*"



IMPLEMENTING THE INDEX OF DISPARITY

Our measurement framework currently supports system priorities, including Value-Based Contracts, State Directed Payment programs, and government-reported patient experience outcomes.

We will continue to enhance this framework as new measures are introduced.

System Ambulatory goals

19 measures

Including:
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Prenatal Care
- Follow-up After Substance Abuse
- Controlling High Blood Pressure
- Follow-Up after Hospitalization of Acute Chronic Conditions

Patient Experience

110+ measures

Inpatient/Emergency/Outpatient/Pharmacy
Including:
- Timely check-in
- Comfort talking with nurses
- Doctors explained things well
- Doctors listen carefully
- Explained what to do
- etc.

HCAHP Surveys

23 measures

Including:
- Cleanliness of Hospital Environment
- Communication about Medication
- Physician interaction
- Discharge Information
- Nurse interaction

IMPLEMENTING THE INDEX OF DISPARITY

The patient characteristics used in this analysis were intentionally selected based on data availability and evidence of persistent gaps reported across the literature and clinical practice.

Patient Characteristics

- Age Groups
- Gender
- Race
- Ethnicity
- Primary Language
- Median Income*
- Median Percent of Poverty*
- Assigned Primary Care Physician
- Payer Class

* Data is derived from the US Census data based on geocoded addresses.

IMPLEMENTING THE INDEX OF DISPARITY

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

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

How the index works:

- Compares each subgroup to overall health system performance
- Calculates an average difference weighted by subgroup size

Works across multiple categorical variables (race, age, gender, insurance class, etc.)

IMPLEMENTING THE INDEX OF DISPARITY

Why This Method Is Powerful...

1. **Prioritize interventions based on disparity size**
   Focus resources and improvement efforts where gaps are largest.

2. **Use disparity trends as KPIs**
   Track a single, consistent metric over time for dashboards and leadership reporting.

3. **Identify high-disparity areas for deeper analysis**
   Flag where advanced analytics should investigate root causes.

4. **Provide a standardized baseline for modeling**
   Use consistent disparity metrics as inputs or targets for predictive/causal models.

5. **Guide variable selection for advanced analytics**
   Reveal which demographic or social factors matter most for further modeling and risk adjustment.

THE GOVERNANCE VALUE: TURNING EQUITY INTO CHOICES

What the board gets when the index is used well:

- A single view of where the system is widening vs closing gaps
- A "*reason for action*" tied to investments, not just awareness

How operational teams benefit:

- Clear targets
- Reduced churn ("*this is the metric that matters*")

Close with the governance loop:

“SO WHAT?” HOW GOVERNANCE MAKES THIS STICK

Drives Action, Not Just Measurement
- Moves beyond screening to response capacity and outcomes
- Identifies variation to guide targeted interventions

Key Performance Questions
- Are all patients being screened?
- Who is requesting help?
- Are patients connected to services?
- Are outcomes improving?

Governance Impact
- Aligns resources to highest-need units/departments
- Highlights disparities and gaps
- Enables sustained improvement and accountability

THE “SILOS TO COLLABORATION” PLAYBOOK

Playbook

1. Define the system aim (outcomes + equity)

2. Choose the few metrics that travel (board ↔ ops)

3. Build the operating dashboard (actionable, not decorative)

4. Create the response pathway (who acts, by when, with what resources)

5. Run the learning loop (monthly decisions + quarterly re-prioritization)

KEY TAKEAWAYS

Alignment Drives Impact

- Aligning governance and operations reduces fragmentation
- Shared aims, metrics, and expectations create clarity and accountability
- Enables equity to be measured and improved

Data Enables Targeted Action

- Index of Disparity and dashboards highlight variation
- Identify where gaps are widening or narrowing
- Provide leaders visibility and teams focus

Integration Accelerates Value-Based Care

- Embed governance priorities into workflows
- Connect strategy from boardroom to bedside
- Enable consistent and scalable improvement

When governance and operations move together—with shared aims, data, and accountability—organizations move from silos to synergy and deliver better outcomes.

MetroHealth

Index of Disparity Analysis

Nisrine Khazaal, MSN RN

Kevin Chagin, MS

Implementing the Index of Disparity

The Challenge

Equity gaps are often "everywhere and nowhere" unless you standardize how they are measured.

To calculate and track disparities within our system's goals, we will use the 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/*

Why Use the Index?

It is a simpler method that allows us to measure gaps and disparities across different subgroups of the population regardless of population size.

It also allows us to easily measure changes over time and to easily interpret the impact of those changes.

Implementing the Index of Disparity

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

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

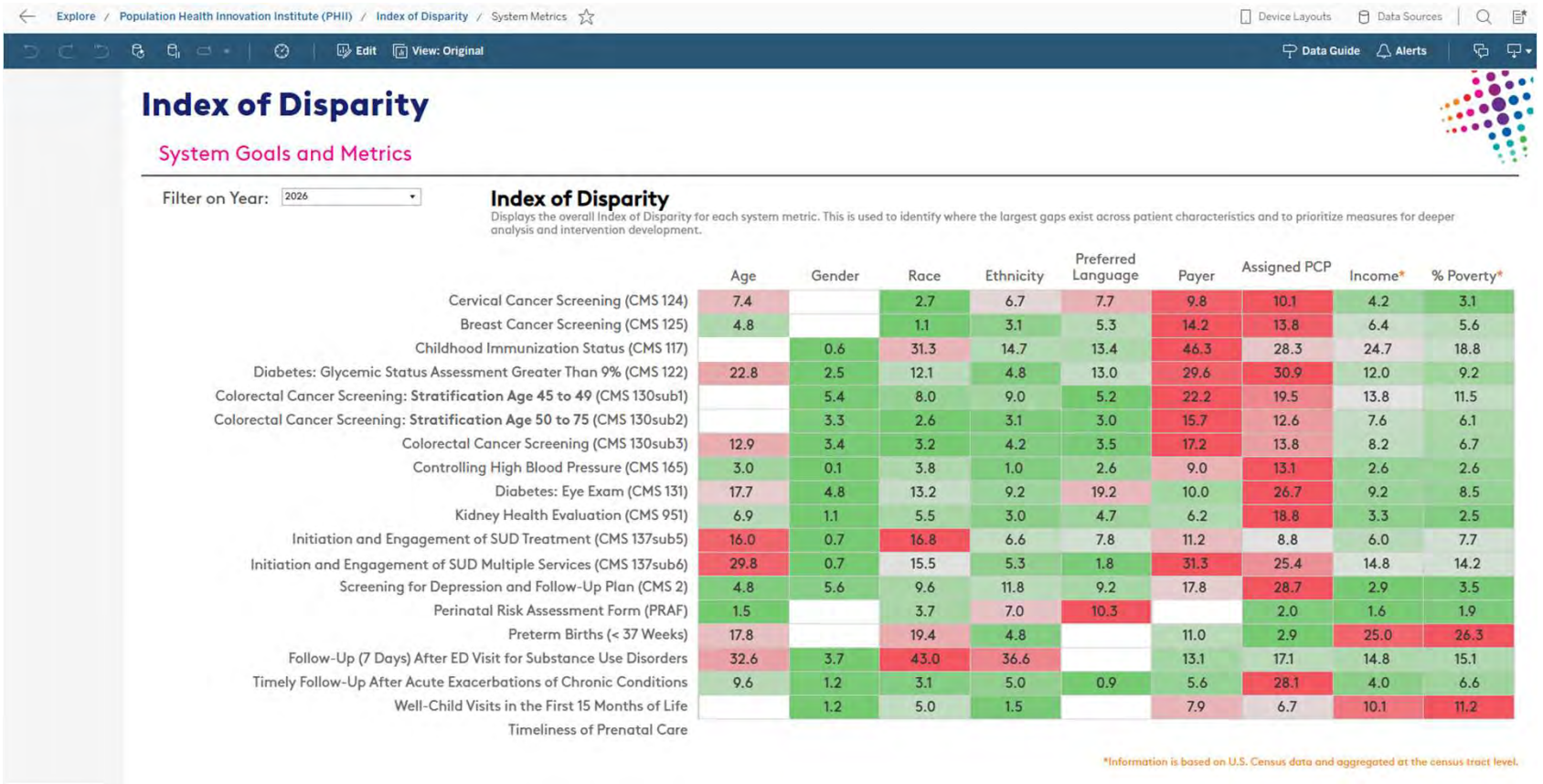
How the index works:

- Compares each subgroup to overall health system performance
- Calculates an average difference weighted by subgroup size

Works across multiple categorical variables (race, age, gender, insurance class, etc.)

Building a Dashboard

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



	Age	Gender	Race	Ethnicity	Preferred Language	Payer	Assigned PCP	Income*	% Poverty*
Cervical Cancer Screening (CMS 124)	7.4		2.7	6.7	7.7	9.8	10.1	4.2	3.1
Breast Cancer Screening (CMS 125)	4.8		1.1	3.1	5.3	14.2	13.8	6.4	5.6
Childhood Immunization Status (CMS 117)		0.6	31.3	14.7	13.4	46.3	28.3	24.7	18.8
Diabetes: Glycemic Status Assessment Greater Than 9% (CMS 122)	22.8	2.5	12.1	4.8	13.0	29.6	30.9	12.0	9.2
Colorectal Cancer Screening: **Stratification Age 45 to 49** (CMS 130sub1)		5.4	8.0	9.0	5.2	22.2	19.5	13.8	11.5
Colorectal Cancer Screening: **Stratification Age 50 to 75** (CMS 130sub2)		3.3	2.6	3.1	3.0	15.7	12.6	7.6	6.1
Colorectal Cancer Screening (CMS 130sub3)	12.9	3.4	3.2	4.2	3.5	17.2	13.8	8.2	6.7
Controlling High Blood Pressure (CMS 165)	3.0	0.1	3.8	1.0	2.6	9.0	13.1	2.6	2.6
Diabetes: Eye Exam (CMS 131)	17.7	4.8	13.2	9.2	19.2	10.0	26.7	9.2	8.5
Kidney Health Evaluation (CMS 951)	6.9	1.1	5.5	3.0	4.7	6.2	18.8	3.3	2.5
Initiation and Engagement of SUD Treatment (CMS 137sub5)	16.0	0.7	16.8	6.6	7.8	11.2	8.8	6.0	7.7
Initiation and Engagement of SUD Multiple Services (CMS 137sub6)	29.8	0.7	15.5	5.3	1.8	31.3	25.4	14.8	14.2
Screening for Depression and Follow-Up Plan (CMS 2)	4.8	5.6	9.6	11.8	9.2	17.8	28.7	2.9	3.5
Perinatal Risk Assessment Form (PRAF)	1.5		3.7	7.0	10.3		2.0	1.6	1.9
Preterm Births (< 37 Weeks)	17.8		19.4	4.8		11.0	2.9	25.0	26.3
Follow-Up (7 Days) After ED Visit for Substance Use Disorders	32.6	3.7	43.0	36.6		13.1	17.1	14.8	15.1
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	9.6	1.2	3.1	5.0	0.9	5.6	28.1	4.0	6.6
Well-Child Visits in the First 15 Months of Life		1.2	5.0	1.5		7.9	6.7	10.1	11.2
Timeliness of Prenatal Care									

Interpreting the Index of Disparity

- Higher values indicate greater disparities within a patient characteristic.
- An index is calculated only when a patient characteristic has two or more categories.
- The index can be unstable with small denominators or event counts, so it is not calculated when the denominator is under 50 or the numerator is under 20.

Timeliness of Prenatal Care

Age	Gender	Race	Ethnicity	Preferred Language	Payer	Assigned PCP	Income	% Poverty
4.5		5.6	4.5	4.0	13.3	5.4	5.5	4.4

Interpreting the Index of Disparity

The IoD can be filtered by metric and patient characteristic to reveal which groups drive the disparity.

Example: Timeliness of Prenatal Care, by Payer

Uninsured patients complete prenatal care at 60.5%, about 24 points below the population rate of 84.9% — the largest driver of the payer gap.

	Group Numerator	Group Denominator	Group Rate	Population Numerator	Population Denominator	Population Rate	Difference
Commercial	445	486	91.6%	1,434	1,689	84.9%	7
Medicaid	798	976	81.8%	1,434	1,689	84.9%	-3
MH Employee/Other	145	151	96.0%	1,434	1,689	84.9%	11
Uninsured	46	76	60.5%	1,434	1,689	84.9%	-24

Reading the Group Columns

Group Calculations: Timeliness of Prenatal Care

Calculates the number of patients who qualify for the measure (Denominator) and the number who met it (Numerator) within each patient characteristic.

Completion is lowest among **uninsured (60.5%)** and **Medicaid (81.8%)** patients.

	Group Numerator	Group Denominator	Group Rate	Population Numerator	Population Denominator	Population Rate	Difference
Commercial	445	486	91.6%	1,434	1,689	84.9%	7
Medicaid	798	976	81.8%	1,434	1,689	84.9%	-3
MH Employee/Other	145	151	96.0%	1,434	1,689	84.9%	11
Uninsured	46	76	60.5%	1,434	1,689	84.9%	-24

Reading the Population Columns

Population Calculations: Timeliness of Prenatal Care

Calculates the same counts across the entire eligible population rather than a single group: everyone who qualifies for the measure (Denominator) and everyone who met it (Numerator).

The resulting population rate of **84.9%** is the benchmark every group is measured against, and the gap between a group rate and this rate is what the Index of Disparity summarizes.

	Group Numerator	Group Denominator	Group Rate	Population Numerator	Population Denominator	Population Rate	Difference
Commercial	445	486	91.6%	1,434	1,689	84.9%	7
Medicaid	798	976	81.8%	1,434	1,689	84.9%	-3
MH Employee/Other	145	151	96.0%	1,434	1,689	84.9%	11
Uninsured	46	76	60.5%	1,434	1,689	84.9%	-24

Reading the Difference Column

Difference: Timeliness of Prenatal Care

Subtracts the population rate from each group rate, showing how far above or below the benchmark each group falls in percentage points.

Positive values sit above the population rate and negative values below it. Uninsured patients are **24 points below** the benchmark, the largest gap in this measure. These differences are what the Index of Disparity averages into a single value.

	Group Numerator	Group Denominator	Group Rate	Population Numerator	Population Denominator	Population Rate	Difference
Commercial	445	486	91.6%	1,434	1,689	84.9%	7
Medicaid	798	976	81.8%	1,434	1,689	84.9%	-3
MH Employee/Other	145	151	96.0%	1,434	1,689	84.9%	11
Uninsured	46	76	60.5%	1,434	1,689	84.9%	-24

Preterm Birth

Filter on Year: 2026

Index of Disparity

Displays the overall Index of Disparity for each system metric. This is used to identify where the largest gaps exist across patient characteristics and to prioritize measures for deeper analysis and intervention development.

	Age	Gender	Race	Ethnicity	Preferred Language	Payer	Assigned PCP	Income*	% Poverty
Cervical Cancer Screening (CMS 124)	7.4		2.7	6.7	7.7	9.8	10.1	4.2	3.1
Breast Cancer Screening (CMS 125)	4.8		1.1	3.1	5.3	14.2	13.8	6.4	5.6
Childhood Immunization Status (CMS 117)		0.6	31.3	14.7	13.4	46.3	28.3	24.7	18.8
Diabetes: Glycemic Status Assessment Greater Than 9% (CMS 122)	22.8	2.5	12.1	4.8	13.0	29.6	30.9	12.0	9.2
Colorectal Cancer Screening: **Stratification Age 45 to 49** (CMS 130sub1)		5.4	8.0	9.0	5.2	22.2	19.5	13.8	11.5
Colorectal Cancer Screening: **Stratification Age 50 to 75** (CMS 130sub2)		3.3	2.6	3.1	3.0	15.7	12.6	7.6	6.1
Colorectal Cancer Screening (CMS 130sub3)	12.9	3.4	3.2	4.2	3.5	17.2	13.8	8.2	6.7
Controlling High Blood Pressure (CMS 165)	3.0	0.1	3.8	1.0	2.6	9.0	13.1	2.6	2.6
Diabetes: Eye Exam (CMS 131)	17.7	4.8	13.2	9.2	19.2	10.0	26.7	9.2	8.5
Kidney Health Evaluation (CMS 951)	6.9	1.1	5.5	3.0	4.7	6.2	18.8	3.3	2.5
Initiation and Engagement of SUD Treatment (CMS 137sub5)	16.0	0.7	16.8	6.6	7.8	11.2	8.8	6.0	7.7
Initiation and Engagement of SUD Multiple Services (CMS 137sub6)	29.8	0.7	15.5	5.3	1.8	31.3	25.4	14.8	14.2
Screening for Depression and Follow-Up Plan (CMS 2)	4.8	5.6	9.6	11.8	9.2	17.8	28.7	2.9	3.5
Perinatal Risk Assessment Form (PRAF)	1.5		3.7	7.0	10.3		2.0	1.6	1.9
Preterm Births (< 37 Weeks)	17.8		19.4	4.8		11.0	2.9	25.0	26.3
Follow-Up (7 Days) After ED Visit for Substance Use Disorders	32.6	3.7	43.0	36.6		13.1	17.1	14.8	15.1
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	9.6	1.2	3.1	5.0	0.9	5.6	28.1	4.0	6.6
Well-Child Visits in the First 15 Months of Life		1.2	5.0	1.5		7.9	6.7	10.1	11.2
Timeliness of Prenatal Care									

Preterm Birth

Demographics		Demographic Categories			Population			
		Num.	Den.	Rate	Num.	Den.	Rate	Rate Diff.
Income	<$24,999	49	402	12.2%	136	1,568	8.7%	3.5
	$25,000-$34,999	38	374	10.2%	136	1,568	8.7%	1.5
	$35,000+	27	539	5.0%	136	1,568	8.7%	-3.7
	Unknown	22	253	8.7%	136	1,568	8.7%	0.0

Demographics		Demographic Categories			Population			
		Num.	Den.	Rate	Num.	Den.	Rate	Rate Diff.
% Poverty	0% - 9.9%	20	439	4.6%	136	1,568	8.7%	-4.1
	10% - 29.9%	48	515	9.3%	136	1,568	8.7%	0.6
	30%+	47	366	12.8%	136	1,568	8.7%	4.2
	Unknown	21	248	8.5%	136	1,568	8.7%	-0.2

Demographics		Demographic Categories			Population			
		Num.	Den.	Rate	Num.	Den.	Rate	Rate Diff.
Race	Black / African American	58	550	10.5%	136	1,568	8.7%	1.9
	Other/Unknown	23	227	10.1%	136	1,568	8.7%	1.5
	White	55	791	7.0%	136	1,568	8.7%	-1.7

Demographics		Demographic Categories			Population			
		Num.	Den.	Rate	Num.	Den.	Rate	Rate Diff.
Age	14-24	24	311	7.7%	136	1,568	8.7%	-1.0
	25-34	69	883	7.8%	136	1,568	8.7%	-0.9
	35+	43	374	11.5%	136	1,568	8.7%	2.8

MetroHealth

Follow-up(7 Days) After ED visit for SUD

Filter on Year: 2026

Index of Disparity

Displays the overall Index of Disparity for each system metric. This is used to identify where the largest gaps exist across patient characteristics and to prioritize measures for deeper analysis and intervention development.

	Age	Gender	Race	Ethnicity	Preferred Language	Payer	Assigned PCP	Income*	% Poverty
Cervical Cancer Screening (CMS 124)	7.4		2.7	6.7	7.7	9.8	10.1	4.2	3.1
Breast Cancer Screening (CMS 125)	4.8		1.1	3.1	5.3	14.2	13.8	6.4	5.6
Childhood Immunization Status (CMS 117)		0.6	31.3	14.7	13.4	46.3	28.3	24.7	18.8
Diabetes: Glycemic Status Assessment Greater Than 9% (CMS 122)	22.8	2.5	12.1	4.8	13.0	29.6	30.9	12.0	9.2
Colorectal Cancer Screening: **Stratification Age 45 to 49** (CMS 130sub1)		5.4	8.0	9.0	5.2	22.2	19.5	13.8	11.5
Colorectal Cancer Screening: **Stratification Age 50 to 75** (CMS 130sub2)		3.3	2.6	3.1	3.0	15.7	12.6	7.6	6.1
Colorectal Cancer Screening (CMS 130sub3)	12.9	3.4	3.2	4.2	3.5	17.2	13.8	8.2	6.7
Controlling High Blood Pressure (CMS 165)	3.0	0.1	3.8	1.0	2.6	9.0	13.1	2.6	2.6
Diabetes: Eye Exam (CMS 131)	17.7	4.8	13.2	9.2	19.2	10.0	26.7	9.2	8.5
Kidney Health Evaluation (CMS 951)	6.9	1.1	5.5	3.0	4.7	6.2	18.8	3.3	2.5
Initiation and Engagement of SUD Treatment (CMS 137sub5)	16.0	0.7	16.8	6.6	7.8	11.2	8.8	6.0	7.7
Initiation and Engagement of SUD Multiple Services (CMS 137sub6)	29.8	0.7	15.5	5.3	1.8	31.3	25.4	14.8	14.2
Screening for Depression and Follow-Up Plan (CMS 2)	4.8	5.6	9.6	11.8	9.2	17.8	28.7	2.9	3.5
Perinatal Risk Assessment Form (PRAF)	1.5		3.7	7.0	10.3		2.0	1.6	1.9
Preterm Births (< 37 Weeks)	17.8		19.4	4.8		11.0	2.9	25.0	26.3
Follow-Up (7 Days) After ED Visit for Substance Use Disorders	32.6	3.7	43.0	36.6		13.1	17.1	14.8	15.1
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	9.6	1.2	3.1	5.0	0.9	5.6	28.1	4.0	6.6
Well-Child Visits in the First 15 Months of Life		1.2	5.0	1.5		7.9	6.7	10.1	11.2
Timeliness of Prenatal Care									

MetroHealth

Follow-up(7 Days) After ED visit for SUD

Demographics		Demographic Categories			Population			
		Num.	Den.	Rate	Num.	Den.	Rate	Rate Diff.
Age	18-34	20	240	8.3%	96	816	11.8%	-3.4
	35-54	61	384	15.9%	96	816	11.8%	4.1
	55+	15	192	7.8%	96	816	11.8%	-4.0

Demographics		Demographic Categories			Population			
		Num.	Den.	Rate	Num.	Den.	Rate	Rate Diff.
Race	Black / African American	16	318	5.0%	96	816	11.8%	-6.7
	Other/Unknown	13	82	15.9%	96	816	11.8%	4.1
	White	67	416	16.1%	96	816	11.8%	4.3

Demographics		Demographic Categories			Population			
		Num.	Den.	Rate	Num.	Den.	Rate	Rate Diff.
Ethnicity	Hispanic	16	82	19.5%	96	816	11.8%	7.7
	Non-Hispanic/Unknown	80	734	10.9%	96	816	11.8%	-0.9

Diabetes: Glycemic Status Assessment

Filter on Year: 2026

Index of Disparity

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	Age	Gender	Race	Ethnicity	Preferred Language	Payer	Assigned PCP	Income*	% Poverty
Cervical Cancer Screening (CMS 124)	7.4		2.7	6.7	7.7	9.8	10.1	4.2	3.1
Breast Cancer Screening (CMS 125)	4.8		1.1	3.1	5.3	14.2	13.8	6.4	5.6
Childhood Immunization Status (CMS 117)		0.6	31.3	14.7	13.4	46.3	28.3	24.7	18.8
Diabetes: Glycemic Status Assessment Greater Than 9% (CMS 122)	22.8	2.5	12.1	4.8	13.0	29.6	30.9	12.0	9.2
Colorectal Cancer Screening: Stratification Age 45 to 49 (CMS 130sub1)		3.4	6.0	9.0	5.2	22.2	19.5	13.6	11.3
Colorectal Cancer Screening: **Stratification Age 50 to 75** (CMS 130sub2)		3.3	2.6	3.1	3.0	15.7	12.6	7.6	6.1
Colorectal Cancer Screening (CMS 130sub3)	12.9	3.4	3.2	4.2	3.5	17.2	13.8	8.2	6.7
Controlling High Blood Pressure (CMS 165)	3.0	0.1	3.8	1.0	2.6	9.0	13.1	2.6	2.6
Diabetes: Eye Exam (CMS 131)	17.7	4.8	13.2	9.2	19.2	10.0	26.7	9.2	8.5
Kidney Health Evaluation (CMS 951)	6.9	1.1	5.5	3.0	4.7	6.2	18.8	3.3	2.5
Initiation and Engagement of SUD Treatment (CMS 137sub5)	16.0	0.7	16.8	6.6	7.8	11.2	8.8	6.0	7.7
Initiation and Engagement of SUD Multiple Services (CMS 137sub6)	29.8	0.7	15.5	5.3	1.8	31.3	25.4	14.8	14.2
Screening for Depression and Follow-Up Plan (CMS 2)	4.8	5.6	9.6	11.8	9.2	17.8	28.7	2.9	3.5
Perinatal Risk Assessment Form (PRAF)	1.5		3.7	7.0	10.3		2.0	1.6	1.9
Preterm Births (< 37 Weeks)	17.8		19.4	4.8		11.0	2.9	25.0	26.3
Follow-Up (7 Days) After ED Visit for Substance Use Disorders	32.6	3.7	43.0	36.6		13.1	17.1	14.8	15.1
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	9.6	1.2	3.1	5.0	0.9	5.6	28.1	4.0	6.6
Well-Child Visits in the First 15 Months of Life		1.2	5.0	1.5		7.9	6.7	10.1	11.2
Timeliness of Prenatal Care									

MetroHealth

Diabetes: Glycemic Status Assessment

Demographics		Demographic Categories			Population			Rate Diff.
		Num.	Den.	Rate	Num.	Den.	Rate	
Age	18-34	491	1,241	39.6%	6,903	24,814	27.8%	11.7
	35-54	2,354	6,851	34.4%	6,903	24,814	27.8%	6.5
	55-64	2,233	8,353	26.7%	6,903	24,814	27.8%	-1.1
	65-75	1,825	8,369	21.8%	6,903	24,814	27.8%	-6.0

Demographics		Demographic Categories			Population			Rate Diff.
		Num.	Den.	Rate	Num.	Den.	Rate	
Payer	Commercial	1,958	7,328	26.7%	6,903	24,814	27.8%	-1.1
	Medicaid	1,780	5,310	33.5%	6,903	24,814	27.8%	5.7
	Medicare	2,053	9,016	22.8%	6,903	24,814	27.8%	-5.0
	MH Employee	150	780	19.2%	6,903	24,814	27.8%	-8.6
	Other	65	146	44.5%	6,903	24,814	27.8%	16.7
	Uninsured	897	2,234	40.2%	6,903	24,814	27.8%	12.3

Demographics		Demographic Categories			Population			Rate Diff.
		Num.	Den.	Rate	Num.	Den.	Rate	
Assigned PCP	No	1,385	3,238	42.8%	6,903	24,814	27.8%	15.0
	Yes	5,518	21,576	25.6%	6,903	24,814	27.8%	-2.2

Controlling High Blood Pressure

Filter on Year: 2026

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	Age	Gender	Race	Ethnicity	Preferred Language	Payer	Assigned PCP	Income*	% Poverty
Cervical Cancer Screening (CMS 124)	7.4		2.7	6.7	7.7	9.8	10.1	4.2	3.1
Breast Cancer Screening (CMS 125)	4.8		1.1	3.1	5.3	14.2	13.8	6.4	5.6
Childhood Immunization Status (CMS 117)		0.6	31.3	14.7	13.4	46.3	28.3	24.7	18.8
Diabetes: Glycemic Status Assessment Greater Than 9% (CMS 122)	22.8	2.5	12.1	4.8	13.0	29.6	30.9	12.0	9.2
Colorectal Cancer Screening: **Stratification Age 45 to 49** (CMS 130sub1)		5.4	8.0	9.0	5.2	22.2	19.5	13.8	11.5
Colorectal Cancer Screening: **Stratification Age 50 to 75** (CMS 130sub2)		3.3	2.6	3.1	3.0	15.7	12.6	7.6	6.1
Colorectal Cancer Screening (CMS 130sub3)	12.9	3.4	3.2	4.2	3.5	17.2	13.8	8.2	6.7
Controlling High Blood Pressure (CMS 165)	3.0	0.1	3.8	1.0	2.6	9.0	13.1	2.6	2.6
Diabetes: Eye Exam (CMS 131)	17.7	4.8	13.2	9.2	19.2	10.0	26.7	9.2	8.5
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Initiation and Engagement of SUD Treatment (CMS 137sub5)	16.0	0.7	16.8	6.6	7.8	11.2	8.8	6.0	7.7
Initiation and Engagement of SUD Multiple Services (CMS 137sub6)	29.8	0.7	15.5	5.3	1.8	31.3	25.4	14.8	14.2
Screening for Depression and Follow-Up Plan (CMS 2)	4.8	5.6	9.6	11.8	9.2	17.8	28.7	2.9	3.5
Perinatal Risk Assessment Form (PRAF)	1.5		3.7	7.0	10.3		2.0	1.6	1.9
Preterm Births (< 37 Weeks)	17.8		19.4	4.8		11.0	2.9	25.0	26.3
Follow-Up (7 Days) After ED Visit for Substance Use Disorders	32.6	3.7	43.0	36.6		13.1	17.1	14.8	15.1
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	9.6	1.2	3.1	5.0	0.9	5.6	28.1	4.0	6.6
Well-Child Visits in the First 15 Months of Life		1.2	5.0	1.5		7.9	6.7	10.1	11.2
Timeliness of Prenatal Care									

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Controlling High Blood Pressure

Demographics		Demographic Categories			Population			Rate Diff.
		Num.	Den.	Rate	Num.	Den.	Rate	
Assigned PCP	No	3,684	6,539	56.3%	38,558	52,720	73.1%	-16.8
	Yes	34,874	46,181	75.5%	38,558	52,720	73.1%	2.4

Demographics		Demographic Categories			Population			Rate Diff.
		Num.	Den.	Rate	Num.	Den.	Rate	
Payer	Commercial	11,133	14,864	74.9%	38,558	52,720	73.1%	1.8
	Medicaid	6,216	9,080	68.5%	38,558	52,720	73.1%	-4.7
	Medicare	16,690	22,360	74.6%	38,558	52,720	73.1%	1.5
	MH Employee	1,394	1,749	79.7%	38,558	52,720	73.1%	6.6
	Other	213	403	52.9%	38,558	52,720	73.1%	-20.3
	Uninsured	2,912	4,264	68.3%	38,558	52,720	73.1%	-4.8

MetroHealth

Pillar Lead Updates:
Patient-Centered Workforce
Barriers to Health
Community Engagement

Dr. Connie Moreland
Karen Cook
Romona Brazile

MetroHealth

Patient-Centered Workforce

Connie Moreland, MD, MMSc, FACOG
VP, Provider Pipeline Development and Engagement

Maternal Health Symposium

SEPTEMBER 18, 2026 • SCOTT AUDITORIUM

Beyond Birth: Advancing Maternal Health from Preconception to the Fourth Trimester

WHY IT MATTERS

A shared forum to understand our current state, elevate MetroHealth programs and community voices, and build trust across the maternal health journey.

1 **Convene**

Bring leadership, clinicians, caregivers and community partners into one conversation.

2 **Learn**

Highlight strengths, gaps and opportunities across preconception through postpartum care.

3 **Act**

Translate the discussion into priorities for trust, access and patient experience.

NEXT: Use symposium insights to shape the maternal health improvement roadmap.

Rx Kids

Building workforce awareness and connection to a new family-centered resource

01

Build awareness

Equip staff with a clear understanding of the program and its relevance to pregnant patients and families.

02

Support conversations

Help care teams introduce Rx Kids consistently, respectfully and at the right point in the care journey.

03

Strengthen connection

Make it easier for eligible families to receive program information and connect with available resources.

NEXT: Continue staff education and clarify a reliable pathway from awareness to family connection.

Improving the Maternal Birthing Experience

Starting with the experiences of Black women and patients who do not speak English

INITIAL FOCUS

Language access as a foundational patient-experience and safety priority

01	**Listen and assess**	Use patient stories, experience data and frontline insight to identify the variables shaping care.
02	**Improve access and workflows**	Strengthen interpreter access, bilingual/bicultural support and reliable escalation pathways in real time.
03	**Build cultural responsiveness**	Partner with community organizations and prepare the workforce to deliver respectful, trauma-informed care.

NEXT: Establish shared measures, owners and a phased improvement plan.

MetroHealth

Barriers to Health

Karen Cook
Executive Director, Social and Community Health

Pillar #2: Barriers to Health

Preterm Birth and Timeliness of Prenatal Care

New:

- **Finalizing workflow for universal Social Drivers of Health screening of pregnant patients; automated follow-up for patients with needs who want assistance**
- **Onboarded new bi-lingual Financial Coach; promoting Financial Coaching services for pregnant patients**
- **Submitted federal HRSA grant application for Maternal Produce Prescription Program, to provide a monthly reloadable grocery debit card**

Continuing:

- **Community Advocacy Program (Medical-Legal Partnership)**
- **Nourishing Tomorrow**
- **Resource Days**

Pillar #2: Barriers to Health

Chronic Conditions

New:

- **Completed data review of SDOH needs of MetroHealth patients with uncontrolled diabetes.**
- **Launched new SDOH Resource Guide for MetroHealth caregivers assisting patients with addressing health-related social needs**
- **Developing program with MetroHealth Pharmacy to provide shelf-stable healthy food package with monthly medication delivery for women of child-bearing age with uncontrolled chronic conditions**
- **Finalizing contract with Medicaid MCO for medically tailored home delivered meals program pilot for patients with uncontrolled chronic conditions**

Continuing:

- **Food as Medicine clinics**
- **Mobile pantries**

MetroHealth

Community Engagement Update

Romona Brazile
Executive Director, Government & Community Relations

MetroHealth

ODM Comparative Data Analysis

Matthew Kaufmann
Vice President, I4HOPE & Population Health

Appendix

Time Frames Data Sources

Metric	2022	2023	2024	2025	2026	Current Data Sources
Pay Equity	2019	2020	2021	2022	2023	IRS Form 990, SEC Filings, Healthcare Cost Report Information System (HCRIS) hospital data, state databases with public employee salaries
Community Benefit	2019	2020	2021	2022	2023	IRS Form 990, HCRIS hospital data
Inclusivity	2020	2021	2021-2022	2022-2023	2023-2024	Census Bureau Data , CMS Hospital Service Area files, CDC Facility ID data set
Avoiding Overuse	2018-2020	2019-2021	2019-2022	2020-2023	2021-2024	Medicare FFS claims and Medicare Advantage encounter files inpatient, outpatient, and carrier
Cost Efficiency	2018-2020	2019-2021	2020-2022	2021-2023	2022-2024	Medicare FFS inpatient, outpatient, and carrier claims data
Clinical Outcomes	2018-2020	2019-2021	2019-2022	2020-2023	2021-2024	Medicare FFS claims and Medicare Advantage encounter files inpatient, outpatient, and carrier with 1-year lookback
Patient Safety	July 2018 – March 2021	July 2019- March 2022	July 2020- March 2023	July 2021 – March 2024	July 2022 – March 2025	CMS Patient Safety Indicators and Health care Associated Infections from Care Compare
Patient Satisfaction	July 2020 – March 2021	July 2012- March 2022	April 2022- March 2023	April 2023 – March 2024	April 2024 – March 2025	CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey

MetroHealth
Devoted to Hope, Health, and Humanity

ABOUT METROHEALTH

Founded in 1837, MetroHealth is leading the way to a healthier you and a healthier community through service, teaching, discovery, and teamwork. Cuyahoga County's public, safety-net hospital csystem, MetroHealth meets people where they are, providing care through five hospitals, four emergency departments, and more than 20 health enters and 40 additional sites. Each day, our almost 9,000 employees focus on providing our community with equitable healthcare—through patient-focused research, access to care, and support services—that seeks to eradicate health disparities rooted in systematic barriers. **For more information, visit metrohealth.org**

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MyChart
metrohealth.org/mychart