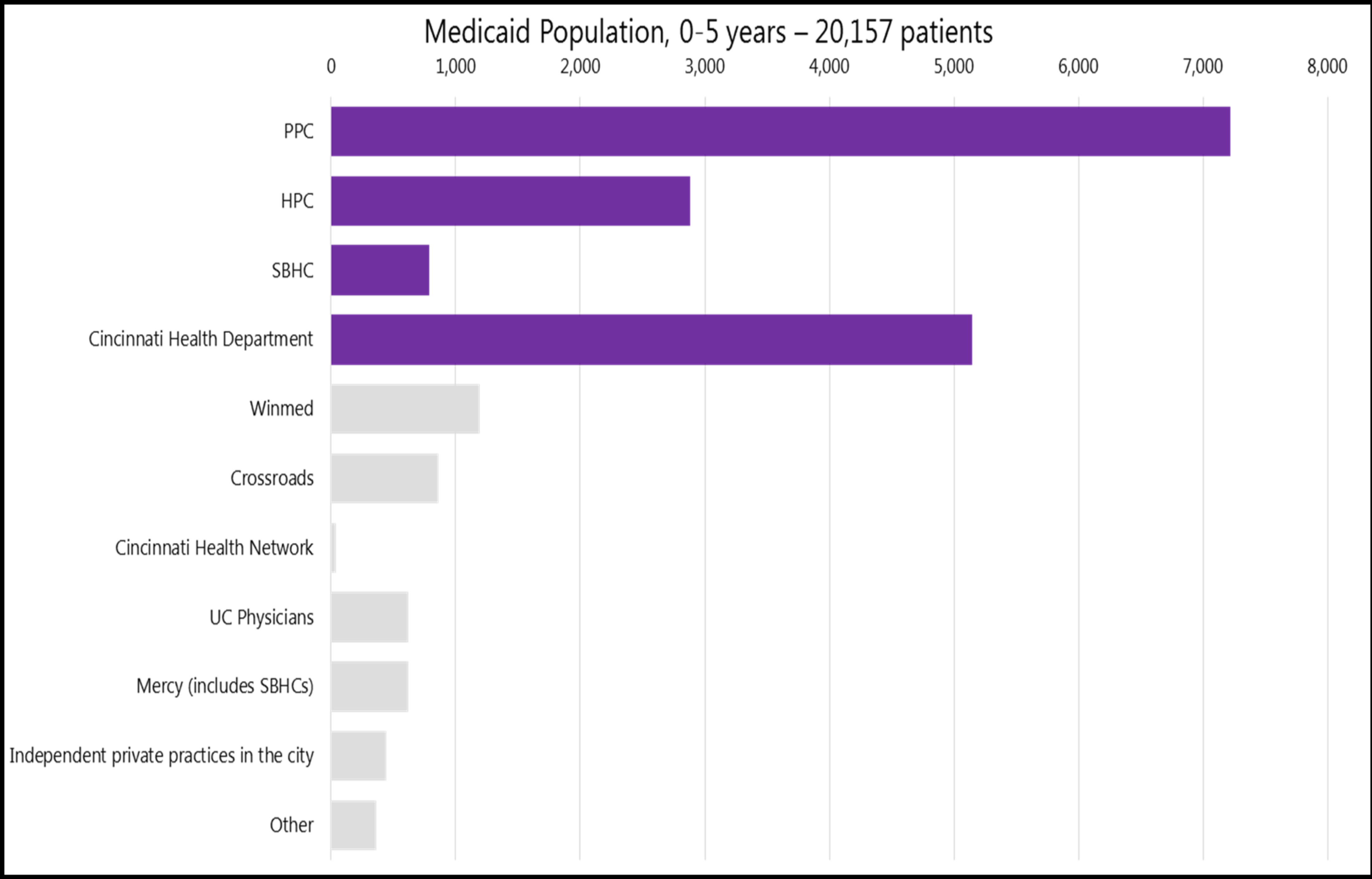
Closing Care Gaps
Across the City of Cincinnati:
Thrive at Five Learning Collaborative

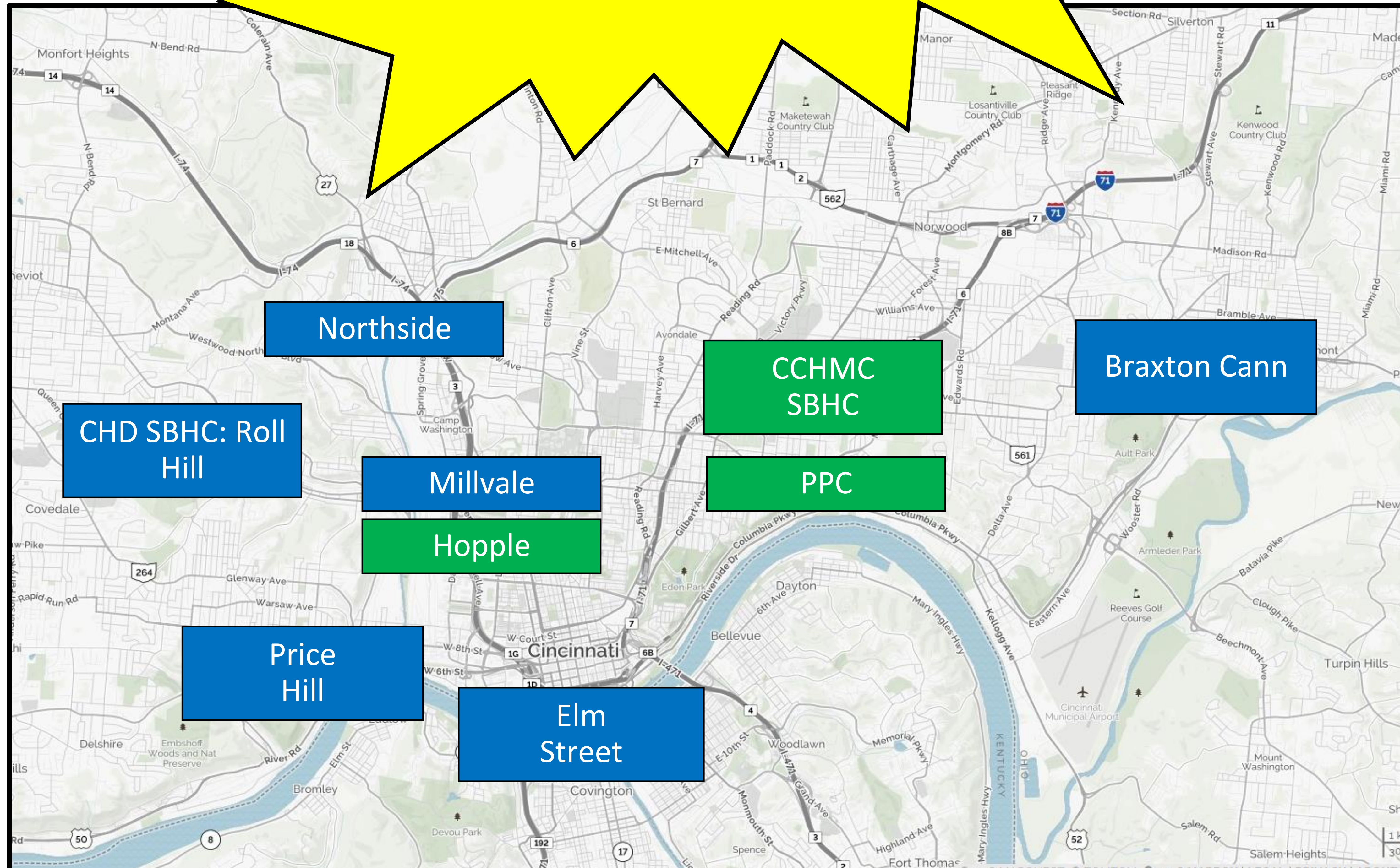
Mona Mansour, MD **Grant Mussman, MD**

BACKGROUND



June 2017

POWERFUL IMPACT IF WE ALL WORK TOGETHER versus as INDEPENDENT CLINICS

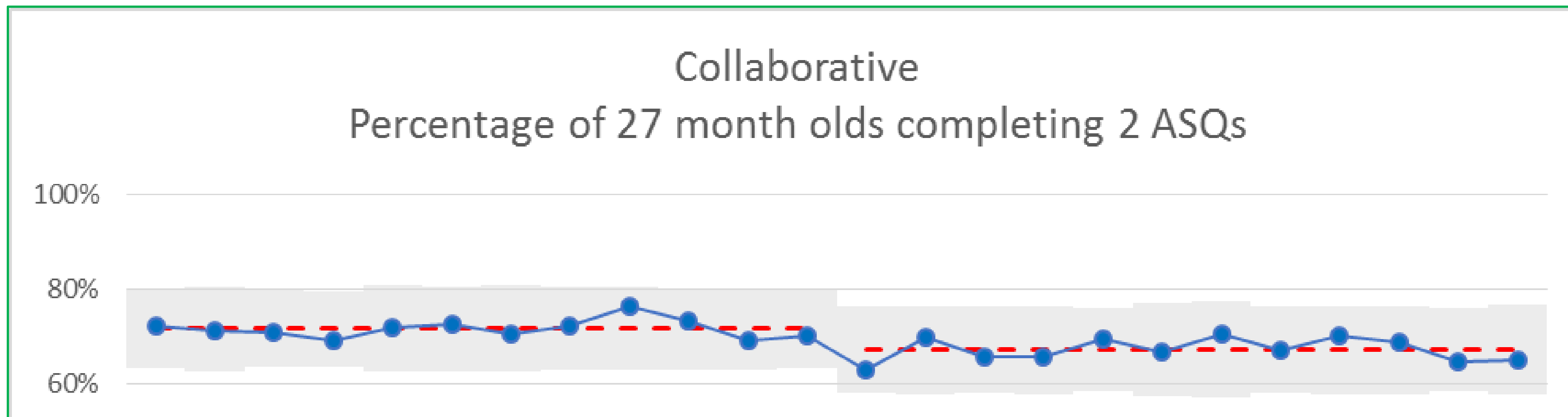


Together CCHMC and Cincinnati Health Department represent ~75% of the 0-5 years of age Medicaid population in City of Cincinnati

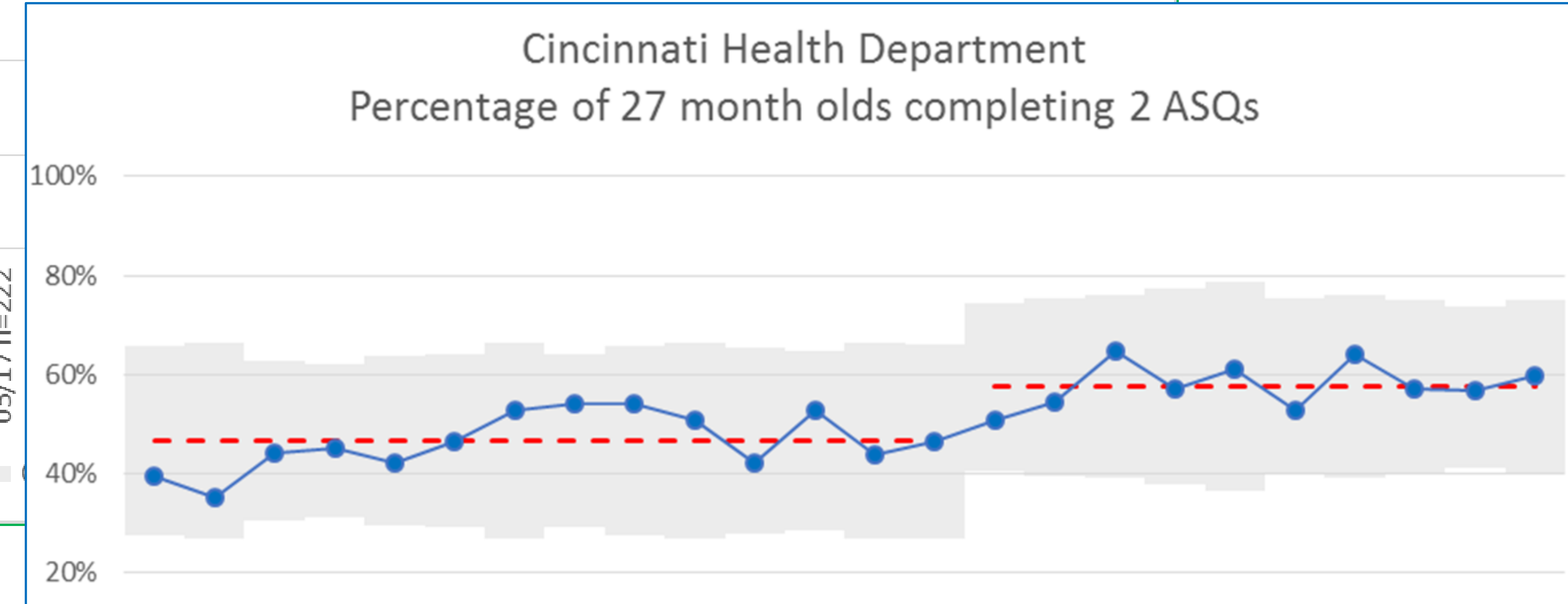
Key Driver Diagram
Community Connected Primary Care

Mission	**What are we trying to accomplish?**	**Primary Drivers**
Attain community connected primary care (CCPC) in the Greater Cincinnati Area CCPC is a community driven primary care system that proactively identifies patient's health and wellness needs, effectively connects the patients and their caregivers to the right resources when and where they need them, and ensures every child is not only free from harm, but thriving, and system reduces cost of care	Thrive by 5 Collaborative AIM – increase the percentage of preventive elements given/care gaps closed (lead, ASQ, vaccines) from 60% to 70% in 0-27 month children by June 30, 2019.	The entire health system and community have a shared vision, are engaged and activated and demonstrate accountability for improving outcomes
		Trust and respect exists between community members and the providers that serve them
		There are no economic and psychosocial obstacles to care
		Caregivers are healthy
		Children and families receive the right care at the right time in the right place (System is capable)
		Optimal Clinical Functioning
		Care is easy to navigate for families
		Proactive Population Management
		Models of payment support population management
		Data availability and transparency

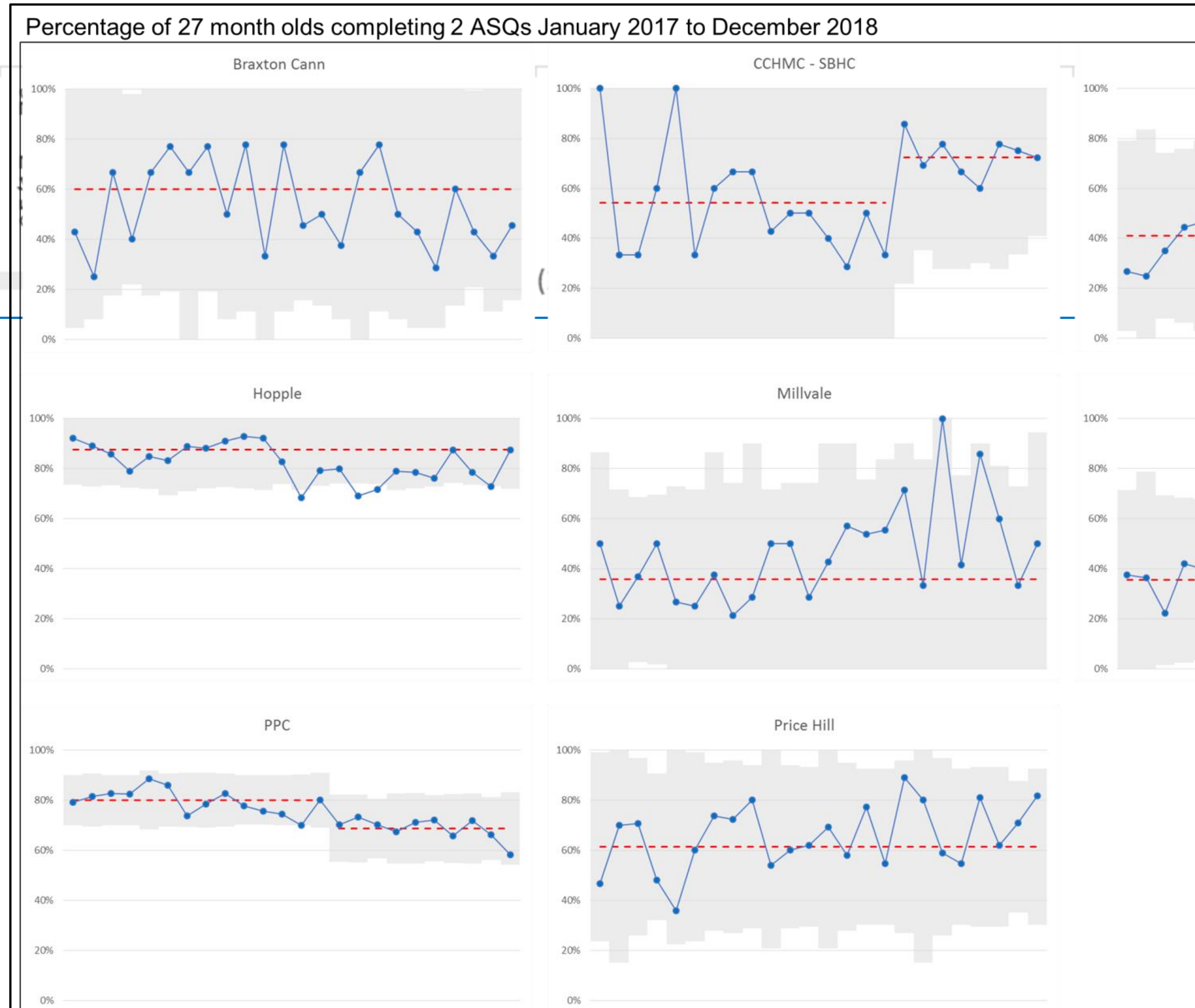
DATA ON SEVERAL LEVELS

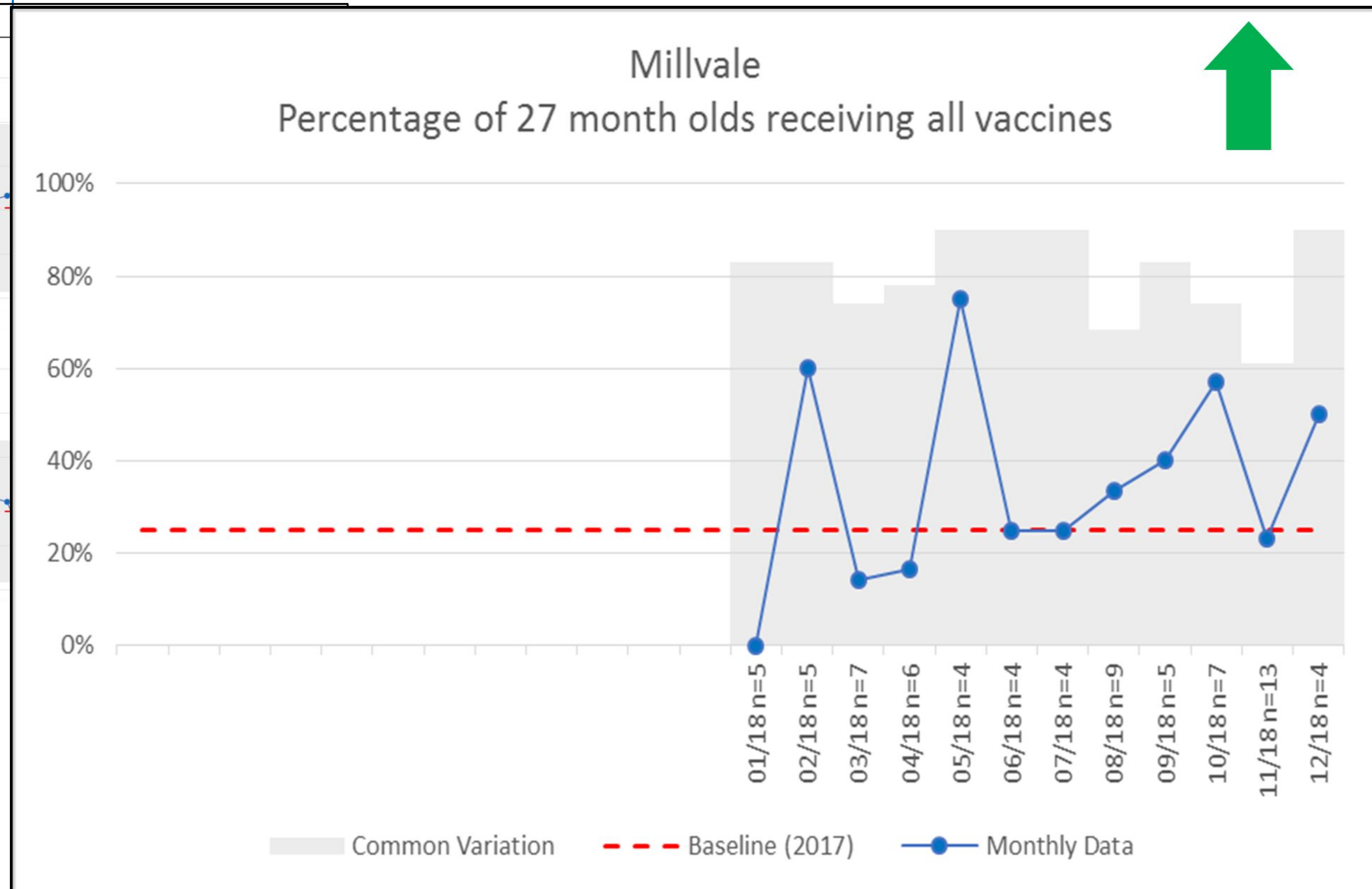


Collaborative



System





Clinic

RESULTS

How many Care Gaps are we closing?

Collaborative
Percentage of elements passed

100%
80%
60%
40%
20%
0%

01/18 n=676
02/18 n=664
03/18 n=688
04/18 n=663
05/18 n=751
06/18 n=583
07/18 n=565
08/18 n=668
09/18 n=669
10/18 n=667
11/18 n=773
12/18 n=637
01/19 n=650
02/19 n=655
03/19 n=669
04/19 n=481

Common Variation
Baseline (2017)
Monthly Data

SUCCESSES

- Power of **improvement science** to help teams test small and learn quickly
- Transparency of the data plus availability at collaborative, system, and clinic level allowed more **effective learning** from each other
- Data sharing agreement allowed opportunity to take a broader **population level view** of preventive services care gaps

GREATEST CHALLENGE

- **Pace of testing** challenging within systems with limited resources and personnel

- Population level data not as helpful for improvement. Visit level will help accelerate our testing/learning moving forward.

- **Multiple transitions** in leadership within clinics at both CHD and CCHMC including personnel who received QI training

- Better engagement of families in designing and testing interventions

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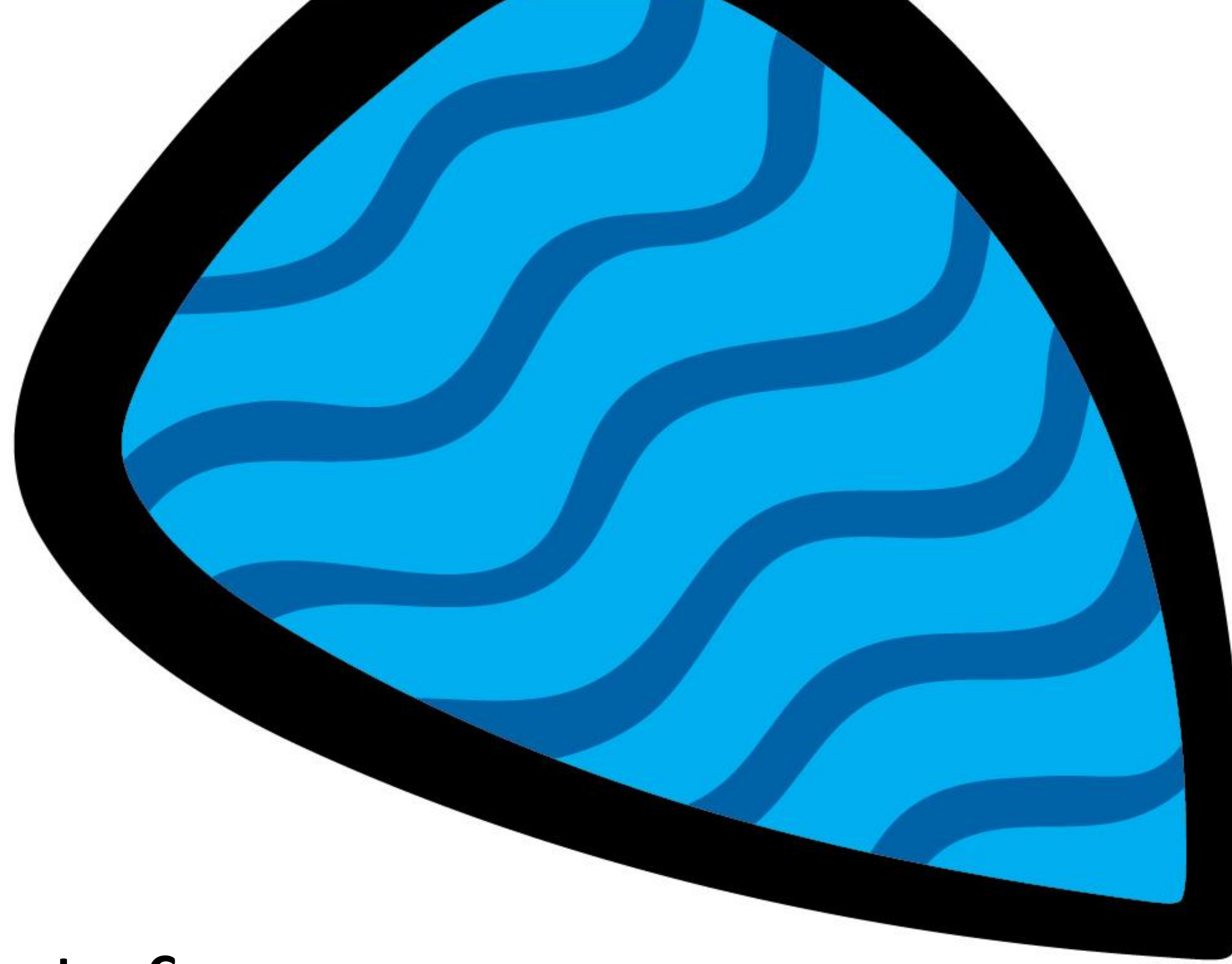
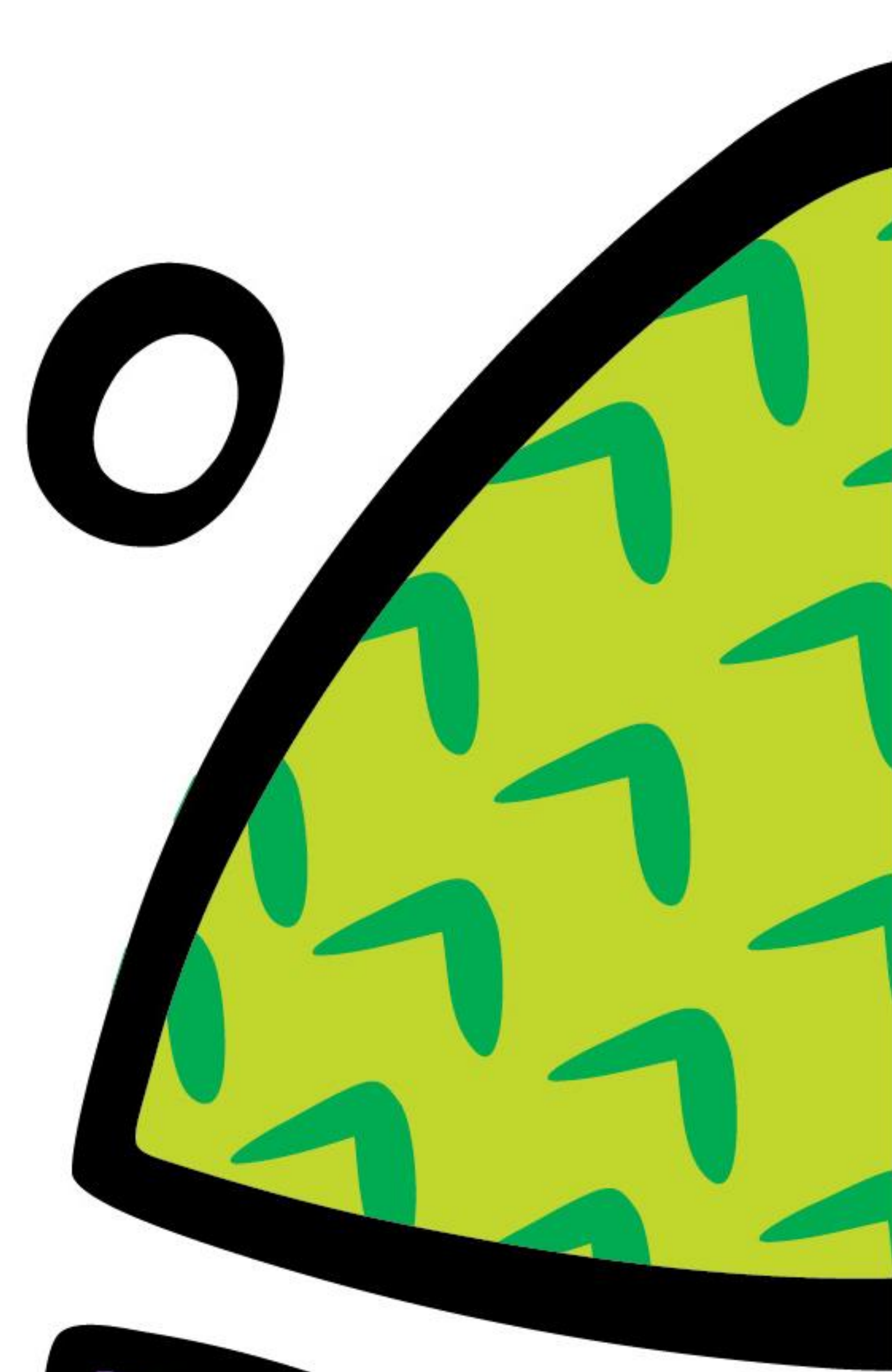

Thrive at Five Collaborative Teams

Braxton Cann

CCHMC School Based Health Centers

Elm Street Health Center

Hopple Street Clinic

Millvale Health Center

Northside Health Center

Pediatric Primary Care (PPC)

Price Hill Health Center

Roll Hill School Based Health Center