



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



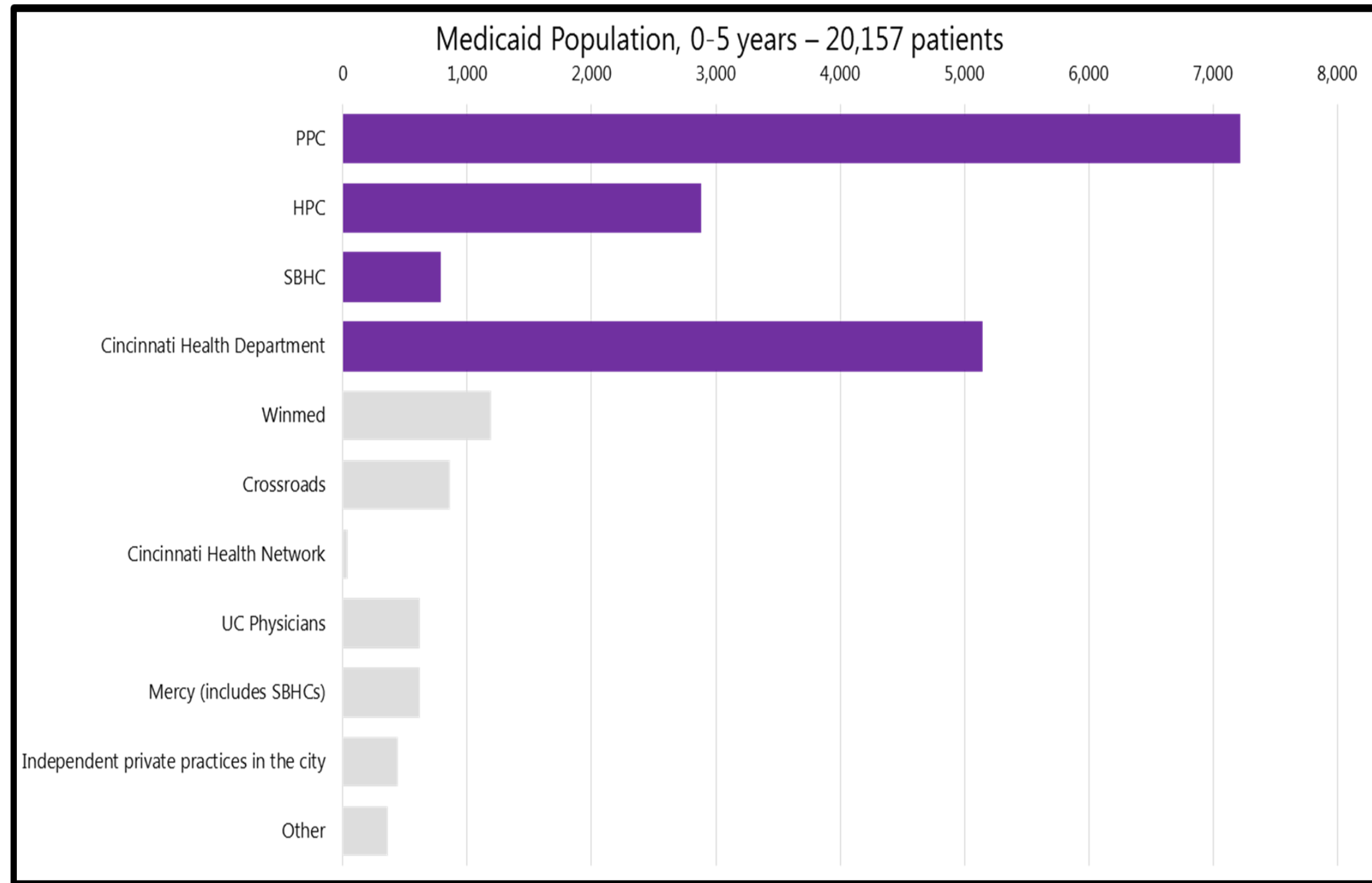
**Mona Mansour, MD**



**Grant Mussman, MD**

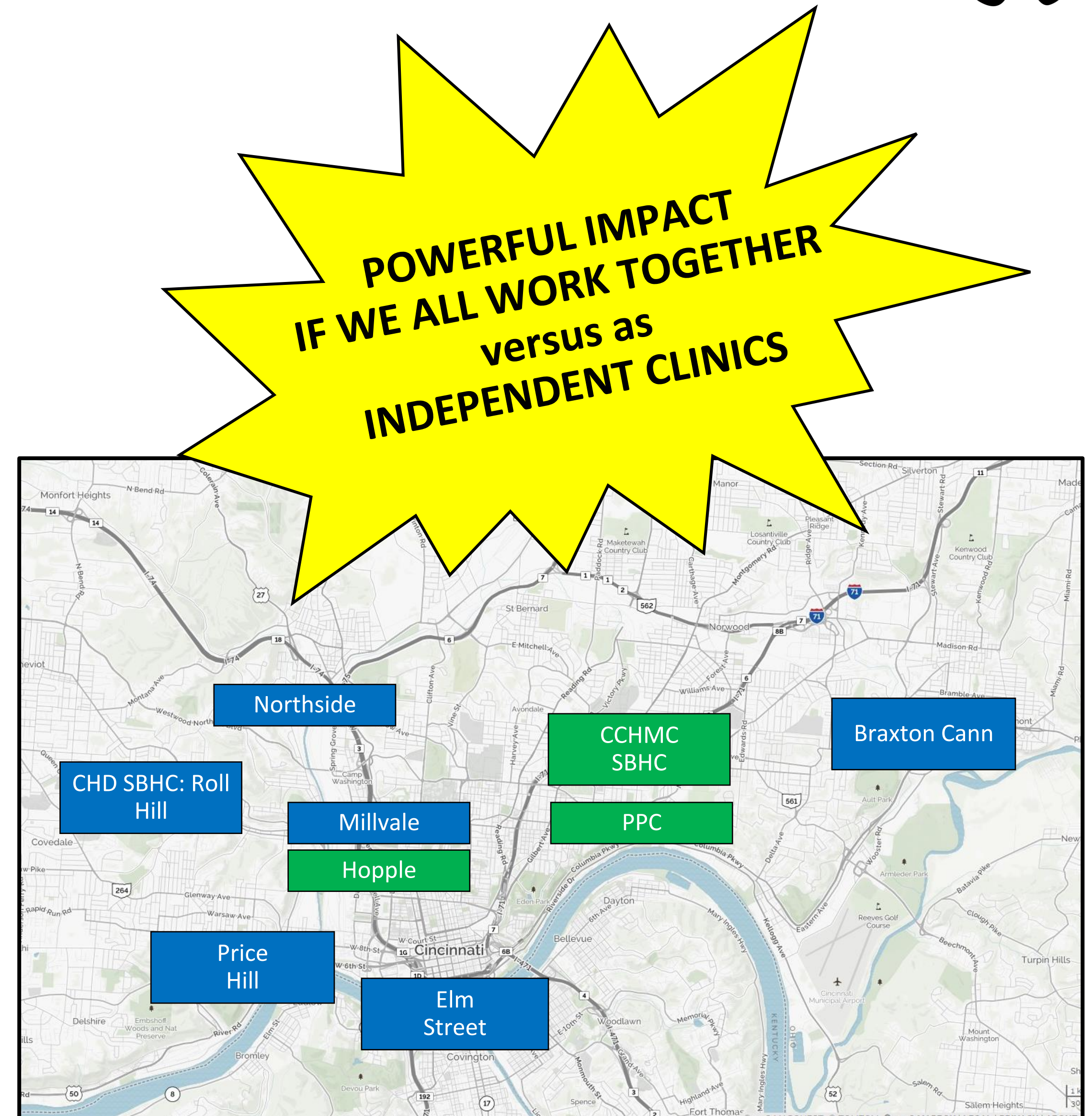


# BACKGROUND

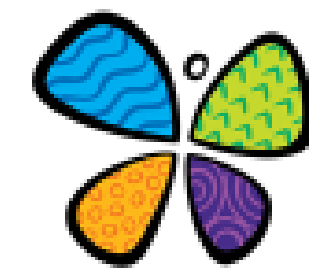


June 2017

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



# System Level KDD: Thrive at Five Collaborative



Revision Date: 05.2019

Champions: Mona Mansour, MD and Grant Mussman, MD

## Vision

Help Cincinnati's 66,000 children be the healthiest in the nation through strong community partnerships

## Mission

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

## What are we trying to accomplish?

FY 20

Thrive at Five Collaborative AIM – increase the percentage of preventive elements given (lead, ASQ, vaccines) from 54% to 65% in 0-27 month children by June 30, 2020.

## Primary Drivers

The entire health system & community have a shared vision, are engaged and activated, and demonstrate accountability for improving outcomes for families living in poverty

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  
*(System connectivity – communication & info sharing)*

Proactive Population Management

Models of payment support population management

Data availability and transparency

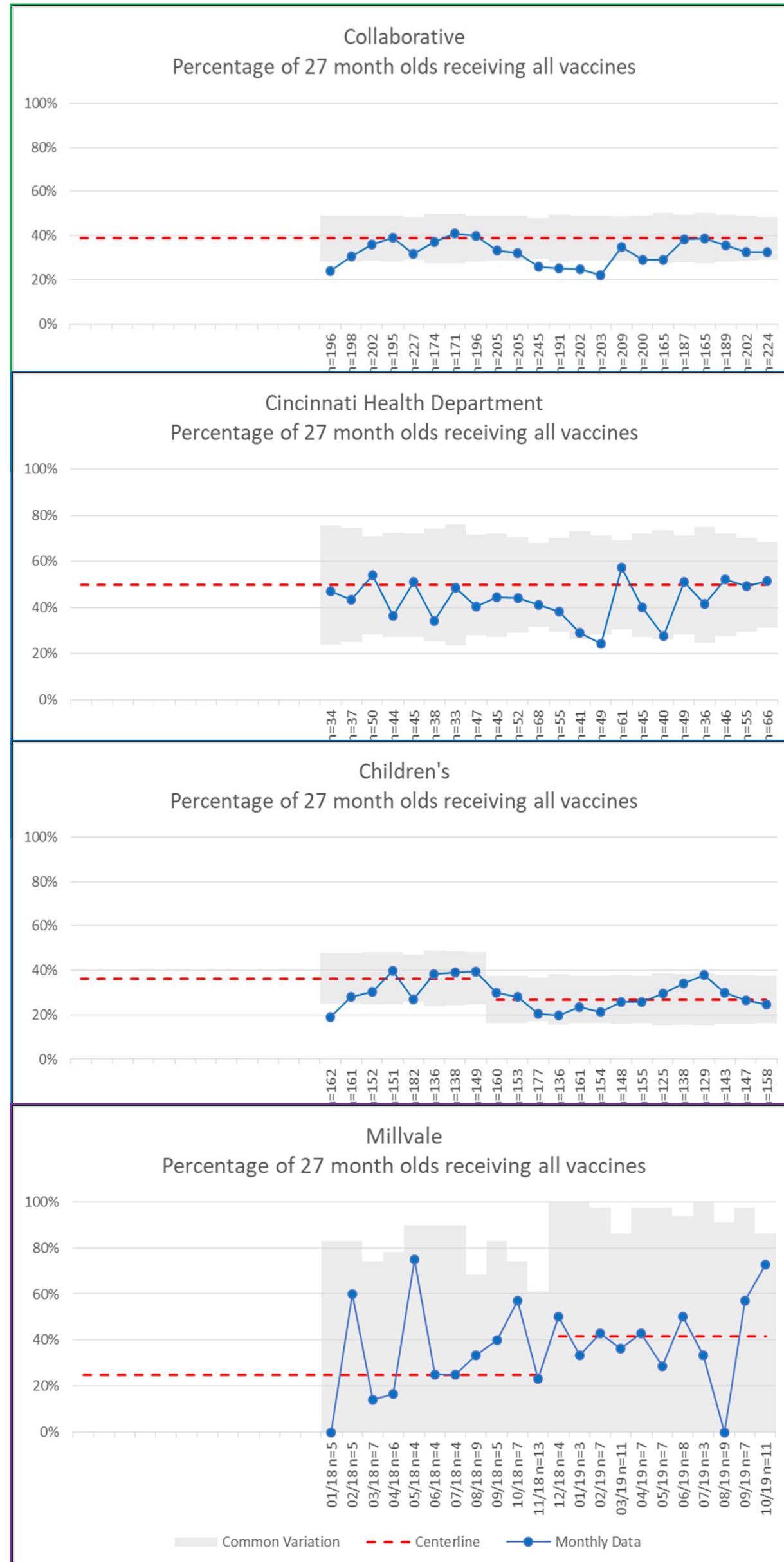
Families, communities, medical systems activated and equipped to support equity

## FY19-20 Improvement Teams

### Thrive at Five Collaborative Population Health Focus

- Braxton Cann
- Bobbie Sterne
- Hopple
- Millvale
- Northside
- PPC
- Price Hill
- SBHC CHMC
- SBHC Roll Hill CHD

# DATA ON SEVERAL LEVELS



✓ **Collaborative** - combined CHD and CCHMC data

✓ **By System** – shows the relative contribution of each system to the overall Collaborative

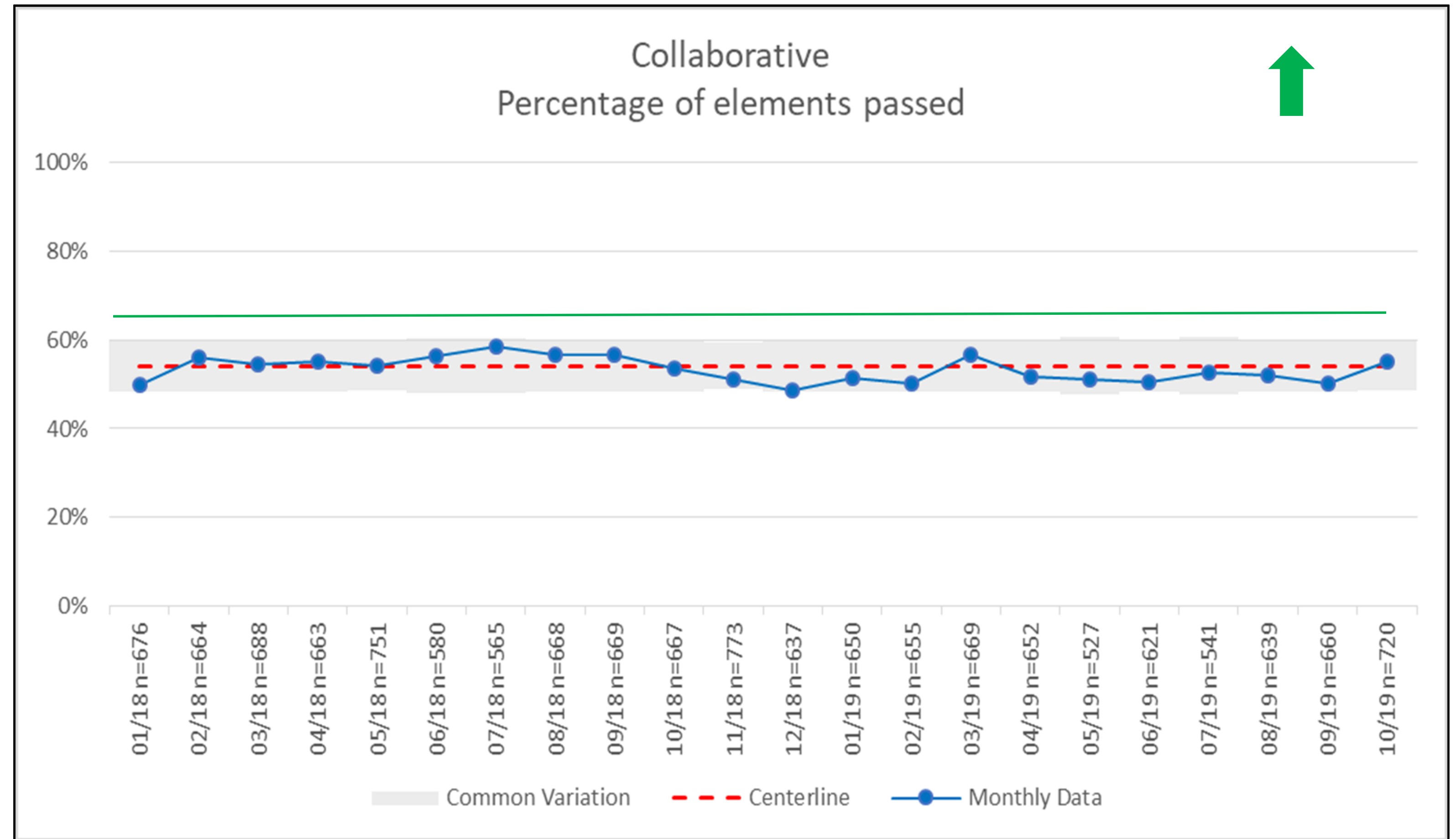
✓ **By Clinic** – each team can chart their work

✓ **Visit Level** – by patient each week

# RESULTS



How many Care Gaps are we closing?



# SUCCESSSES



- ❖ 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 CHALLENGES



- ❖ **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

# NEXT STEPS



- ❖ Will look at the measure as a “bundle”
- ❖ Will enhance the use of Visit Level data
- ❖ Create Change Package on Immunizations and spread
- ❖ Continue to build QI capability through ImpactU attendees

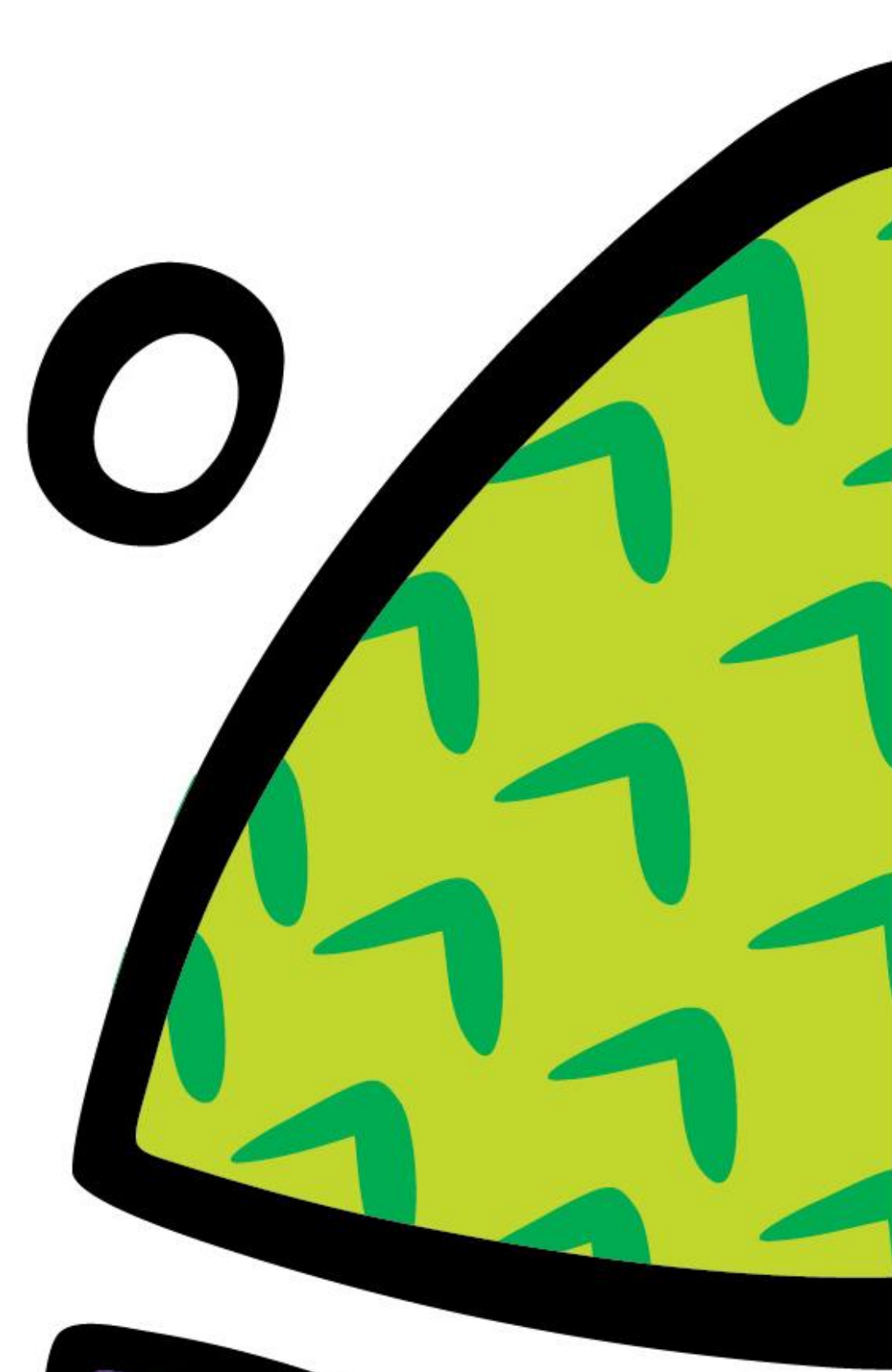
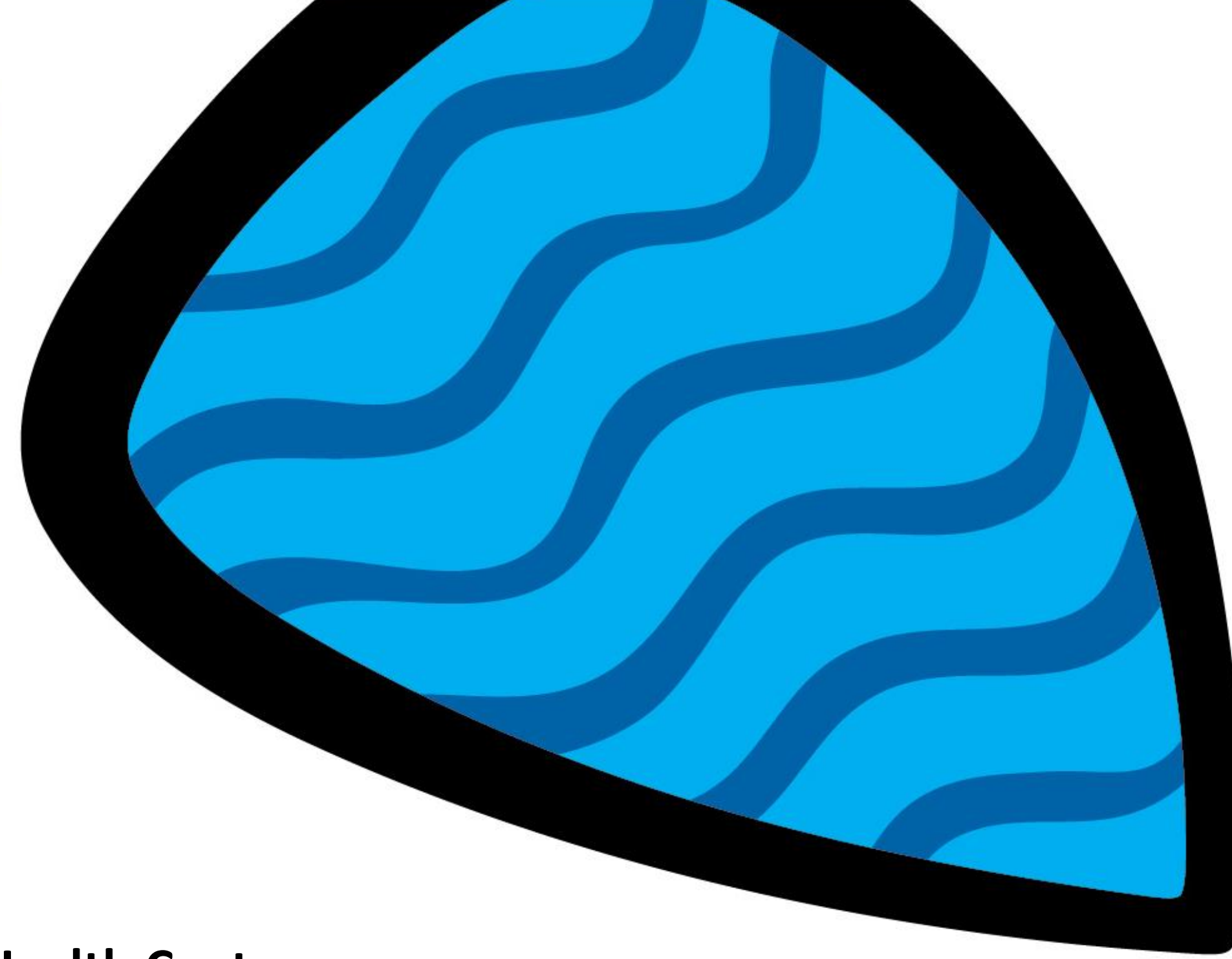




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**Bobbie Sterne Health Center**

**Braxton Cann Health Center**

**CCHMC School Based Health Centers**

**Hopple Street Clinic**

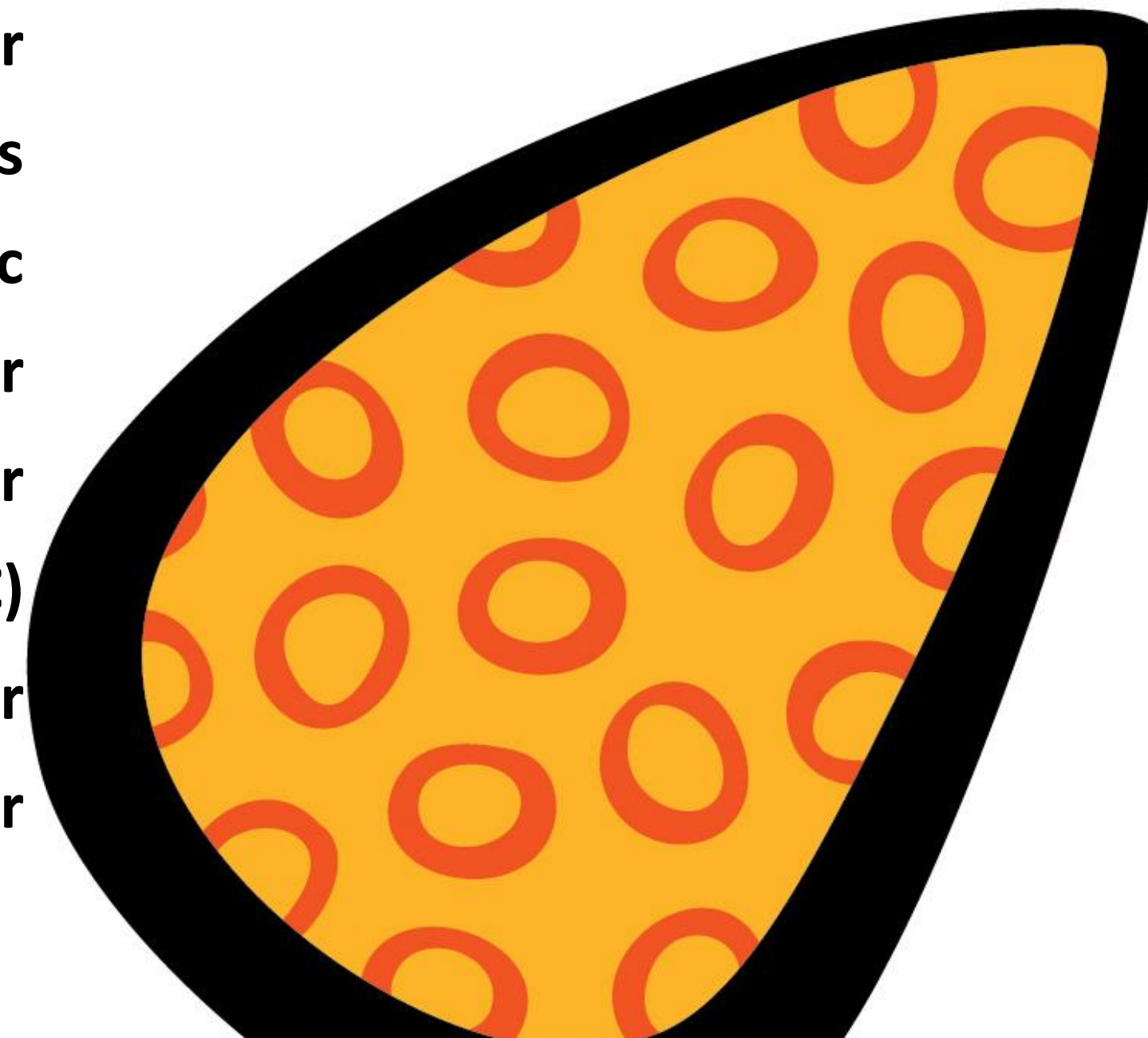
**Millvale Health Center**

**Northside Health Center**

**Pediatric Primary Care (PPC)**

**Price Hill Health Center**

**Roll Hill School Based Health Center**



**Thrive at Five Collaborative Teams**