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

Mona Mansour, MD
Grant Mussman, MD
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
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?
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.

Primary Drivers
- 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

All Children Thrive Cincinnati
RESULTS

How many Care Gaps are we closing?
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
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

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