COLLABORATIVE VENTURES NETWORK

Overview of CMO Breakout Session at CVN/AAHCH Annual Conference

The CVN CMO breakout session (at the AACHC/CVN Annual Meeting) a couple of Monday's ago generated meaningful conversation that centered on how we all can push Collaborative Ventures Network to be true to its name. The turnout was impressive and a large proportion of centers were represented. Here is a brief synopsis of the meeting:.

CVN QI Manager Sean Clendaniel reviewed themes taken from the recent CMO survey:

1. CVN's efforts have improved CHC quality improvement and care processes
2. Across all centers, there are still variable levels of CVN engagement
3. Not all centers have implemented standing orders, though if they have not, they are planning to develop them this year
4. Dissemination of best practices is appreciated, though respondents would like to see more CVN quality-related communications
5. Members would like to see clinically integrated services including telehealth and HIT and Health Risk Assessments.

Sean then summarized the CVN Quality Improvement Plan which includes four Network-level priorities. The first one to be addressed by the Network is Colorectal Cancer Screening (2018 baseline 47%, goal 65%). Other targets will include DM control/HgBA1C worse than 9% (2018 baseline 32%, goal 16%);
Child and Adolescent Weight Assessment and Counseling (2018 baseline 67%, goal 70%)
Childhood Immunizations for children less than 2 years old (2018 baseline 32%, goal 60%).

Bob Elk, CVN CMO, then facilitated conversation about CVN what efforts would be most useful to the centers and the conversation took off. What followed were a variety of battle-tested strategies, barriers, and ideas for future efforts, mostly around colorectal cancer screening. I have summarized comments into three categories: Solutions, Barriers, and Future Projects, and did not credit the contributors to protect the integrity of the meeting.

Solutions:

1. A physician secret shopper strategy discovered multiple fixable barriers FIT test completion. The brand of FIT provided by the center was not user friendly, the process for completion was confusing and no single medical team member was accountability for ensuring return of the kit.
2. MA-provided verbally summary of visit information in the patient's native language ensured full understanding of the plan
3. Lowered visit FIT test copay
4. Financial incentives to the entire care team
5. Targeting patients who age-up at fifty into the colorectal screening (Cologuard has a program to assist with this strategy)

6. Ensuring a variety of screening options are offered that included FIT and colonoscopy

7. Good care coordination to solve high colonoscopy no-show rates
8. Standing orders for FIT and colonoscopy screening
9. Direct colonoscopy referral by arrangement with local consultant (avoiding the GI consult expense)

Barriers (unresolved):

1. What to do with the physician who refuses to believe—despite best evidence—that FIT testing is an acceptable screening method
2. Surprise patient bills for services and procedures that are supposed to be free under current insurance law (including screening colonoscopy)
3. Colonoscopy not available in rural communities

Future Projects:

1. Quarterly face-to-face CMO meetings with inclusion of quality team staff
2. "Speed dating" meeting format to allow maximal interaction leading to improved collaboration
3. CVN leadership communication to Center CEOs regarding the need for protected time for furture CMO CVN.
4. Patient engagement through automated texting facilitated/managed by CVN
5. Improved quality data sharing unmasked performance of each center.
6. Network scholarly activity, grant writing, around QI efforts including colorectal cancer screening.

The room was alive with ideas. Let's continue future meetings in that spirit as we move from ideas to action. I look forward to seeing you at the next meeting.