Decision Point Provider Playbook for Medicare 5-Star Quality Ratings

decisionpoint

Contents

The Decision Point Provider Playbook for Medicare 5-Star Quality Ratings is a set of repeatable steps, actions, and best practices for plans to adopt when engaging providers in member experience improvement efforts. Decision Point compiles specific tactics to guide plans' initial implementation and ongoing management of a provider-centric member experience program. Focus areas include keys to educate and engage providers and the importance of member experience efforts (The 'Why') and keys to success when deploying advanced analytics in an incentive-based program (The 'How').

This Playbook is designed to help plans identify strategies for provider engagement that will lead to true, measurable improvements in member experience and perceptions, as captured in the annual CAHPS and HOS surveys.

Importance & Significance of the Member Experience

Regulation & Market Forces Driving the Need to Improve

The healthcare industry's CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey is a healthcare consumer satisfaction survey that is randomly administered to gauge an individual's perception of healthcare, access to care, and specific areas of satisfaction. Similarly, the (Health Outcomes Survey) HOS looks to characterize members' perceptions of their individual clinical outcomes, as summarized by self-evaluations of their health care conditions and general state of well-being. Health plans are measured, publicly reported, and compensated based upon aggregate responses from a small percentage of randomly selected individuals.

We know that health plans have a big stake in the CAHPS game when it comes to improving members' experiences with their providers, but how do payers engage their contracted providers in the process? What is the provider's incentive to deliver high-quality care that leads to a positive member experience? Furthermore, how can payers help to mold members' perceptions of their healthcare quality, as measured by the HOS?

The stakes may have been raised by the decision by The Centers for Medicare and Medicaid Services (CMS) to substantially increase the weight of member experience measures in the 2021 Medicare Part C and D Star Ratings program, but the concept of member experience as a key healthcare outcome is nothing new.

Research aiming to measure the effect of positive patient experiences on clinical and business outcomes has been underway for decades. This research provided hard evidence that positive patient experiences lead to improved clinical outcomes, within a similar timeframe. Plans that realized the value of the insights found in this line of research began to include patient satisfaction questions as part of provider reimbursement structures.

From the providers' perspectives, to help further satisfy the "but what's in it for me" question, the research also shows that providers with the highest levels of patient satisfaction experience fewer medical malpractice claims, on average.[1] In short, by placing focus on the member/provider experience, there is much to be gained by every entity of the member/provider/plan triad.

[1] Stelfox, Henry & Gandhi, Tejal & Orav, E & Gustafson, Michael. (2005). Relation of patient satisfaction with complaints against physicians and malpractice lawsuits. The American Journal of Medicine. 118. 1126-33. 10.1016/j.amjmed.2005.01.060.

The Role & Potential Impact of Providers on Plan Member Experience Performance

Improving CAHPS and HOS scores is no easy task. Often requiring extensive budgets and coordinated strategies, plans sometimes struggle to maximize their outreaches and pinpoint the target audience who can help to move the needle. Further exacerbating the challenges are the survey design elements that have been put into place by CMS. Not only are these surveys anonymous, based on randomly selected individuals, but the influences on these individuals' survey responses can seem both deeply personal and intangible – in other words, seemingly impossible to impact.

Much of the reported impressions of these members are logically based on their personal experience with their personal doctor and the clinic where they receive regular care.

As CMS continues to apply scrutiny to health plans' CAHPS and HOS ratings, which directly influence plan Stars scores, those plans that wish to compete for payment bonuses and market share are encouraged to dive more deeply into the nuances surrounding CAHPS and HOS, and, more specifically, on helping to orchestrate a positive provider experience for the members.

When we dive into the specific questions asked on the CAHPS and HOS surveys, it becomes apparent that there is a wide breadth of opportunities available to the provider to influence the member experience. The highlighted measures below indicate those that are most impactable by the provider.

CAHPS CATEGORIES ("MEASURES")	HOS CATEGORIES ("MEASURES")
Care Coordination	Improving or Maintaining Physical Health
Customer Service	Improving or Maintaining Mental Health
Getting Appts and Care Quickly	Improving Bladder Control
Getting Needed Care	Monitoring Physical Activity
Getting Needed Prescription Drugs	Reducing Risk of Falling
Rating of Drug Plan	
Rating of Health Care Quality	
Rating of Health Plan	

For both surveys, there are a number of individual survey items that roll into the measures listed above. These measures are subject to change on an annual basis.

Unlocking the Potential of Plan-Provider Partnerships to Drive Member Experience Improvement

Leveraging inter-measure relationships is key to engaging providers in the member experience effort. Member experience measures are not stand-alone concepts. The concepts of member access and satisfaction can manifest themselves in other measures and can influence the performance of other measures.

For example, it stands to reason that members who have access issues (whether real or perceived) may not get their preventive screenings or fill their prescriptions, and other measures of clinical importance with which providers are familiar.

Providers can positively impact ratings while improving health by focusing on the areas that clinicians and their clinic staff can influence.

- 33% of likely negative CAHPS raters are high risk for non-compliance with evidence-based guidelines (HEDIS)
- 35-40% of likely negative raters of Provider or Access Related CAHPS items are High Risk for HOS issues
- 25-30% of likely negative HOS raters are potentially eligible for care management

Furthermore, a member who is dissatisfied with the plan or their doctor may choose to leave the plan to explore their other options.

- 1/3 of likely negative CAHPS raters are likely negative raters of multiple types of CAHPS issues (provider satisfaction, plan satisfaction, access issues)
- As the number of different types of issues increases (provider satisfaction AND access issues AND plan satisfaction), the likelihood that a member will choose to leave the plan also increases.

> "Patient experience has been found to be associated with clinical outcomes. Patient experience issues indicated on surveys like the CAHPS survey may manifest in adverse outcomes such as lack of engagement in primary care, inappropriate utilization of Emergency Department services, and low adherence to treatments as prescribed."

It's simply not feasible (or affordable) for providers to communicate with members based solely on their projected CAHPS responses.

It is much more compelling to highlight opportunities for providers to combine member communications that include both member experience communications and communications related to other important and related topics (such as getting appropriate preventive screenings and medication adherence).

This integrated clinical and member experience approach makes member experience improvement familiar and approachable to providers and members alike. Providers can reduce over-communication and member abrasion, and also make communications more meaningful to the member.

Recommended Interventions for Improved Performance

Performance on CAHPS and the Health Outcomes Survey is dictated by answers provided by the members randomly selected by the Centers for Medicare and Medicaid Services (CMS) in the annual sample.

Negative responses are driven by actual experiences or perceptions that members have with the plan, with their provider, when attempting to access care, and in their daily life and functioning.

We can break down the drivers of negative responses into two categories: structural drivers and perceived drivers. The utility in breaking down drivers by type is that we can match the right intervention to the driver. System and workflow initiatives (commonly referred to as Quality Improvement/"QI" initiatives) are foundational and help reduce structural barriers for patients. Outbound individual member outreach is the gold standard, most impactful outreach that providers can conduct for members. Ultimately, it is the combination of an individual's perceptions that interact with the system to determine the perceived quality of a member experience.

Overview of Drivers of Experience

Interventions to impact structural drivers of experience

While CAHPS and the Health Outcomes Survey are based on an individual's perception of care, some of these perceptions can be real and pervasive: there are certain providers that have long wait times for appointments. How do we identify these providers, communicate effectively with them, and make positive change across the organization?

Structural drivers include factors related to the systems, people, and processes with which members interact. For example, the extent to which a provider is available to care for a member can be a driver of dissatisfaction, perceived health outcomes, or both. A provider's clinic hours, the degree to which the physical building accommodates members that use wheelchairs, and the user-friendliness of the provider's telemedicine platform are all examples of structural drivers of member experience.

Providers can mitigate structural barriers through system and workflow initiatives. This work is foundational. For example, for members with access issues:

- See your patients within 15 minutes of their scheduled appointment
- At check in ask patients to complete a pre-visit questionnaire while waiting to be seen
- Engage patients by collecting and recording height, weight, BMI, BP prior to the start of each visit
- Review charts for next day appointments and ensure all appropriate documentation is present
- Inform your patients what to do if they need to be seen after hours
- Offer appointments or medicine refill requests via email or text
- Consider offering open access to appointments for a limited time each day for urgent care

Interventions to impact perception-based drivers of experience

Perception-based drivers include factors related to the member that influence member experience for better or worse. For example, a member may be intrinsically highly motivated and engaged in their care, enabling them to actively seek and benefit from a provider's resources. Another member may be similarly motivated but face additional personal barriers, such as stressful family situations or a high caretaker burden, which prevent them from being aware of the provider's resources available to them.

Providers can mitigate perception barriers through personalized outbound messaging. This type of outreach is transformative, potentially making or breaking a member's perception of the quality of care they receive, the degree to which their provider is "there" for them, and their perception of the plan's role to enable access to their provider's services. For example, for members with quality of care related issues:

- Outreach to likely negative raters and conduct a warm member experience call
- Consider framing the outreach as a relevant clinical support call (e.g., COVID-19 vaccination support). The message is: "Our office is here for you."
- Inform patients what resources are available to them that help keep their care coordinated (e.g., medical record, patient portal, referral network, communication of test results)
- Inform your patients how their doctor will review all the prescription medications they are taking and ensure they have a next appointment scheduled
- Review patients' chart and offer to help coordinate any outstanding referrals, generally check in on their care with specialists

When focused on impacting member responses on official surveys, a two-pronged approach yields the most significant and lasting impact on members:

Year-round, holistic member engagement: Member experience can be front and center year-round if integrated into other campaigns. Outbound individual member outreach focused on member satisfaction and experience can be affordable if is combined with already planned outreaches, as described in as described in the section above, such as preventive screening reminders or appointment reminders.

Just-in-time member engagement: Plans and providers should also consider targeted outreaches strategically timed just before a survey administration period begins. The close proximity of the outreach to the time that the member may be completing the survey ensures that the outreach itself -- the support to resolve issues, whether actual or perceived -- is salient to potential survey respondents when they go to complete the survey, should they be sampled.

Member-Level Outreaches

The most direct way to impact member perception is via outbound individual member outreach. Reaching members with targeted messaging that addresses their need or gap in information is the gold standard, most impactful outreach that providers can conduct for members, as it is ultimately the combination of an individual's characteristics that interact with the system that determines the perceived member experience.

How to choose the right communication channel for a member?

The communication channel selected for a member should be based on (a) the likelihood that the member will negatively respond to one or more survey items and, (b) where available, their communication preferences. If self-reported communication preferences are available, they should be prioritized, and where no communication preferences are available, advanced analytics can be leveraged to identify the most likely preferred channel for a member.

Members identified to have issues that drive negative ratings on the CAHPS and Health Outcomes Survey (e.g., provider satisfaction issues, access issues, and/or perceived health decline) typically need help resolving those issues. These members can also be less engaged (and therefore less familiar) with the health care system and benefits available to them. Because of the level of complexity of these member issues, the communication channels that best support actively "triaging" members' issues are most effective.

Communication channels that support this dynamic triaging of member needs include:

- Live Calls (outbound calls or "smart" triaging of inbound calls)
- Interactive SMS (text messaging)
- IVR (interactive voice response) phone apps with transfer capabilities
- IVR (interactive voice response) phone apps

Other communication channels can be leveraged as needed, such as engaging emails or mailers. Less interactive channels may have a more modest impact on member perception. When it comes to impacting member perception, any thoughtfully crafted outreach, however low-touch, is better than no outreach.

Who should conduct the member engagement outreach?

There are three main options for administering member outreach campaigns to impact member experience, summarized in the table below. Note that where a provider-administered outreach is not feasible, there are alternative options to still impact the "provider impactable" member experience areas. The best method of administration is determined by the relationship that the plan has with individual IPAs.

1. **Provider-administered:** This method is typically leveraged by strong, highly collaborative plan/provider relationships where providers have high trust in the information that the plan has historically provided, and where providers do not have the resources to administer individual member-level outreach.

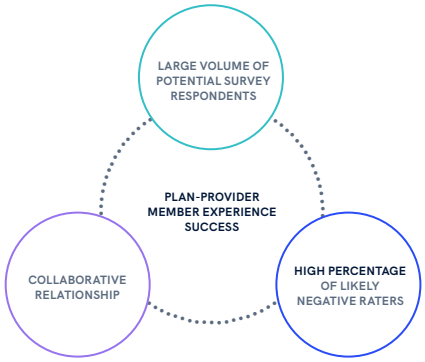
2. **Provider-labeled, Plan-administered:** This method is typically leveraged by strong, highly collaborative plan/provider relationships where providers have high trust in the information that the plan has historically provided, high trust in the plan's ability to execute member outreaches, and where providers do not have the resources to administer individual member-level outreach.

3. **Plan-administered:** This method is typically leveraged by less established plan/provider relationships or by established plan/provider relationships on behalf of members (1) new to or less engaged with the primary care clinic or (2) with plan satisfaction issues and no identified provider satisfaction issues.

	EXAMPLE OUTREACH CAMPAIGNS	ADVANTAGES	CONSIDERATIONS
Provider-administered	• WHAT: Proactive call to inform members that the clinic has available appointments and that the clinic staff can easily help schedule an appointment • WHO: Targeted to members that haven't been into the office or booked a telemedicine appointment with their doctor recently	• Direct outreach from the provider will let members know that they have options available to them to get the care that they need • Establishes or further underlines the availability of clinic staff to support the member	• "Piggybacking" on planned outreach campaigns (e.g., for preventive screenings) will increase the chance that the provider will be able to dedicate resources to individual member outreach
Provider-labeled, Plan-administered	• WHAT: Mailers highlighting various methods for scheduling an appointment, including a direct line to speak to someone in the clinic who can help schedule appointments and help set up virtual visits • WHO: Target to likely negative respondents of Getting Needed Care or Getting Appointments and Care Quickly related CAHPS items	• Gives the plan the opportunity to execute the campaign on the desired timeline • High likelihood that engaged provider partners will see the benefit of a plan-administered outreach	• The plan can coordinate with the provider to ensure that the clinic staff is aware of the campaign and can knowledgeably triage any calls or questions to the clinic from members touched by the plan-administered campaigns
Plan-administered	• WHAT: Live calls to ensure the member has a doctor that they work well with, conduct a brief needs assessment, and ensure member has plans and tools to address their needs together with their doctor • WHO: Likely negative respondents of perceived health decline or management of falls or bladder issues who are not already engaged in plan care management	• Gives the member an opportunity to work with the plan to find a new doctor, should the doctor relationship be a primary driver of satisfaction issues	• Live calls to address members issues, such as find a new PCP, are most impactful • The plan can consider an interactive voice response channel with call transfer or 'smart escalations' to also be responsive to member issues that require resolution

Identifying High Impact Providers

Providers in the plan network with the highest potential to impact the plan's overall member experience performance are those with whom the plan has established a strong collaboration, with a large volume of potential survey respondents, and with a high percentage of members with satisfaction and health outcomes needs.

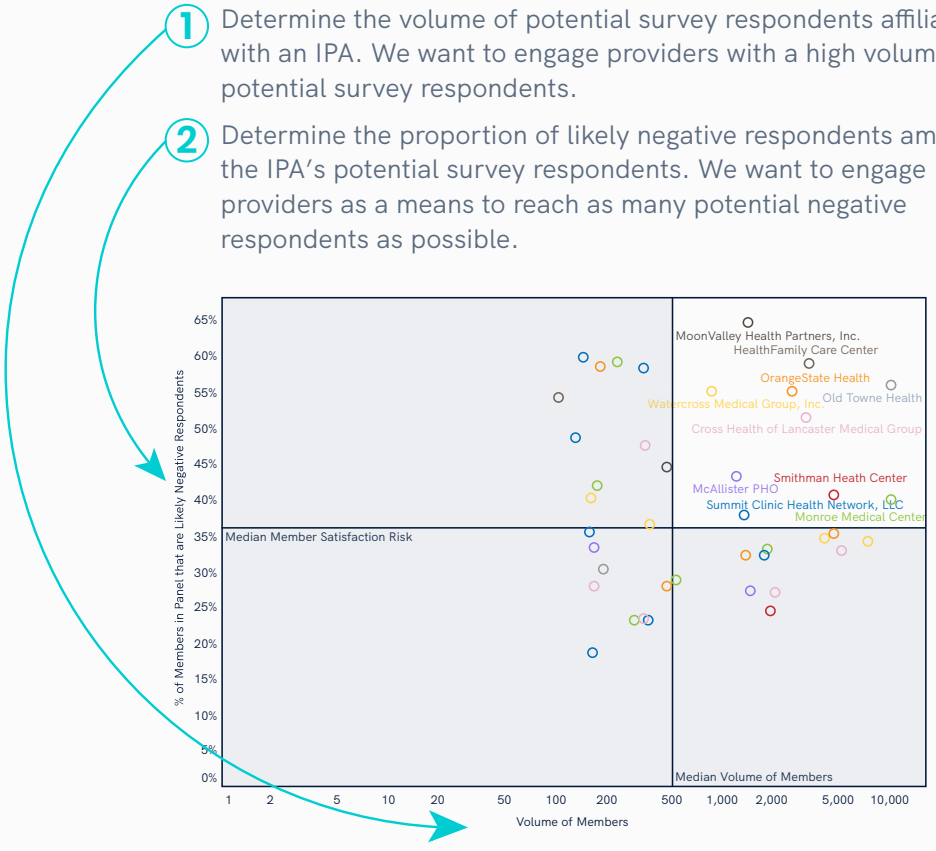


How do we identify the IPAs with whom to engage in member experience efforts?

Because effective provider engagement hinges on the unique relationship between the plan and the IPA, we recommend a combination of a data-driven and relationship-driven approach to identifying the right IPAs with whom to engage in member experience strategies. First, let the data guide an initial list of potentially high-impact IPAs. Second, refine the initial list based on the current relationship that the plan has with IPAs on the list.

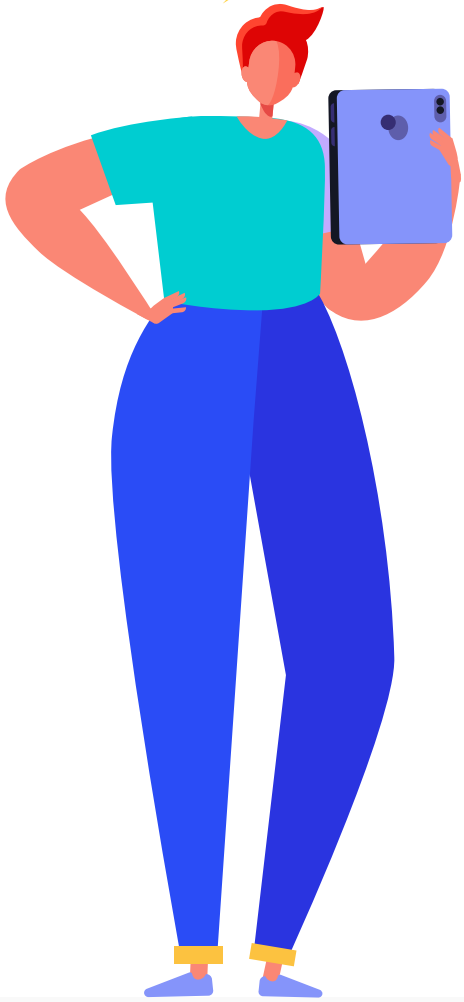
Data-driven identification of high impact IPAs

1. Determine the volume of potential survey respondents affiliated with an IPA. We want to engage providers with a high volume of potential survey respondents.
2. Determine the proportion of likely negative respondents among the IPA's potential survey respondents. We want to engage providers as a means to reach as many potential negative respondents as possible.



Don't let concerns about provider attribution data be a showstopper. If there are concerns from the plan or provider side about the accuracy of member-PCP relationships available in the data, consider stratifying the member population by who the plan can verify has engaged with the PCP recently, and focusing on those members. This approach addresses any provider attribution concerns and helps to strengthen provider buy-in by enabling the plan to say: "These members have been into the clinic and likely need your support."

You've done the work to identify high impact IPAs. How can the plan meaningfully incorporate this information into network management and PCP auto-assignment workflows?



Relationship-driven modifications to initial list of high impact IPAs

Network teams are the experts to consult once there is an initial data-informed list of potential high-impact providers. Network teams can help inform which type of outreach would be best for members associated with providers on the initial list, based on the established relationship and history. Review of the initial list by the Network team should address some of the following questions:

- What is our contractual relationship with this IPA?
- Is this an established, collaborative partnership that would mean the provider is open to this conversation?
- Are there certain clinics we should be focusing on for an initial pilot?
- Is this a good time to have this conversation with the provider?
- Is this group amenable to provider-labeled, plan-administered member-level outreaches?

The Glidepath to Establishing Greater Accountability for Member Experience with Provider Partners

The plan can establish a "glidepath" to establishing greater accountability among providers for member experience. Although the weight of member experience measures in star ratings has spiked quickly, necessitating quick and decisive action among Medicare Advantage plans, the increased weight is not going away anytime soon. Engaging providers in CAHPS and HOS improvement should be approached as a marathon, not a sprint. Plans should plan to thoughtfully engage providers from the beginning, knowing that providers will remain a key strategic partner in achieving high quality member experience in the years to come. We recommend a series of phases to follow from the beginning.

ENGAGEMENT AND AWARENESS: Following the recommended guiding principles below, provide education about the significance and importance of member experience and build awareness of opportunities for providers to engage their panel and address likely negative survey ratings. This phase may last anywhere from 3-6 months, depending on the level of sophistication of the provider. Reporting at this stage should be informational, helping providers to recognize the value of positive member experience and reframe interactions with members as opportunities to impact the perception of their health and the provider's role in supporting their health. The plan may choose to highlight higher priority areas of member experience (e.g., access-related CAHPS areas or perception of health status) during this initial phase.

IDENTIFYING ACTIONABLE INSIGHTS FROM REPORTING: Identify opportunities to address expected negative ratings, establish goals, and identify possible strategies to reach those goals. Walk providers through reporting on their patient panel. Ensure that reporting is available on a high enough volume of members to ensure that conclusions are statistically valid. Prepare to walk providers through their panel's likely experience and answer questions about the data supporting the metrics included in the report. Reporting may be based on actual survey responses or on profiles of the provider's panel.

REWARDING PROCESS IMPROVEMENT MEASURES: Where actual survey results are available for measurement, the plan can evaluate member satisfaction and provide feedback to provider groups and/or individual providers. Where actual survey results are not available for measurement, plans can consider recognizing provider efforts through attestation of initiatives. See page 16 for more details about how and when to best leverage different types of member-level member experience data.

EXPAND PROGRAM TO INCLUDE ADDITIONAL PRIORITY AREAS OR DEEPER ACCOUNTABILITY WITHIN EXISTING PRIORITY AREAS: The plan can consider focusing providers on member experience issues that are of strategic importance to contract performance in initial program rollout. For example, the plan may choose to focus on CAHPS related issues in Program Year 1. Future program years can expand the breadth of member experience issues. For example, the plan may choose to expand the focus to also include HOS in Program Year 2.

PROVIDER-SIDE IMPLEMENTATION PERIOD: Ensure providers have time to digest reporting and recommended strategies to meet member experience goals. Providers will need to socialize, plan, and implement any new initiatives. This is where having brief, polished reporting with specific recommendations from the plan can help to expedite buy-in and implementation from providers.

a. NOTE: Planning needs to account for the time it will take for members to be "touched" by implemented provider-side initiatives: Once providers have implemented new initiatives, it will take several months for members to experience the benefit of these new initiatives.
    i. Here is where direct member outreach will impact the panel more quickly, compared to structural or workflow improvements that require interaction with the clinic to experience firsthand. For example, if a provider implements broader telehealth options for their patients, awareness of those expanded telehealth options will reach members that are more engaged with the clinic first. For less engaged members, additional outreach and communication about the new telehealth options will be necessary.
    ii. To shorten the cycle, the plan should encourage providers to execute a communication plan alongside any structural improvements to raise awareness among the panel sooner.

PROVIDER-SIDE YEAR-ROUND ENGAGEMENT WITH THEIR PANEL: Ideally, providers identify opportunities to integrate member experience with other quality initiatives that touch members. Providers can address likely negative ratings via communications related to other important clinical topics (such as getting appropriate preventive screenings and medication adherence), or "piggybacking" on planned communications and already dedicated resources.

Key Steps in Initially Approaching High Impact Providers

As with any new initiative, providing clear, targeted education and building the business case is key to successfully engaging participation from providers.

Useful Awareness Building Material to Distribute

Provide a brief explainer, directed to providers, highlighting the following pieces of information:

- Member experience has never been weighted more heavily in your Star quality rating
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Health Outcomes Survey (HOS) results make-or-break quality ratings
- CAHPS and HOS will now contribute more to your Star quality rating than the Healthcare Effectiveness Data and Information Set (HEDIS)
- These two surveys measure perception of access to care, quality of care, perceived health status, and perception of the plan (Tip: Consider including a table that highlights which measures are included under each survey and the weight it will carry indirectly impacting the experience rating. The plan may choose to focus on a subset of measures initially, based on current contract performance.)
- You are uniquely poised to influence your patients' perception of their well-being and the care they receive (Tip: Consider including a table that specifies the definition of each measure and tips for addressing negative ratings)

EXAMPLE

Getting Appointments & Care Quickly

(1) Empower your patients to be health care system navigators, not powerless patients, by pointing out the best days or times to schedule appointments

(2) "It's all relative" Providing brief explanations for long wait times has demonstrated marked improvement in patient satisfaction

GUIDING PRINCIPLES TO FOLLOW

Consider these guiding principles when initially engaging providers in member experience improvement:

- Clearly describe the business case and the provider's unique role in influencing member perception and satisfaction
- Place the importance of member experience into clinical context, highlighting opportunities to piggyback on planned clinical outreaches to signal that the plan understands this is a new undertaking
- Highlight any activities that the plan is doing on behalf of the provider. For example, if the plan is handling outreach to members that have not been to see the provider in over a year, thereby reducing the volume of members on the provider's outreach list
- Identify where there are opportunities for engagement (e.g., provider has a panel with a high percentage of members likely to negatively rate Care Coordination related CAHPS survey items) and help establish feasible goals tied to those opportunities
- If providing recommendations for targeted interventions, indicate the complexity, level of effort, and expense of any recommended intervention. This accomplishes two things: (1) Signals that the plan is mindful of the provider's capacity, (2) Highlights opportunities for the plan to provide administrative support of interventions (in exchange for the influential provider letterhead, for example)
- Align new programs with existing programs: Where feasible, use the same 'look and feel' as existing programs, such as HEDIS programs. This ranges from leveraging the usual health plan point of contact (e.g., Network manager) to ensuring that methodologies for established reporting programs are similar

Advanced Analytics as the Key to Successful Plan–Provider Partnership Structures

Regardless of the relationship with the provider, the plan should consider starting to include member experience information in established reporting for all providers as part of the new 'business as usual'. Reporting should highlight areas of the provider's panels' needs (ability to get appointments for routine care, perception of care coordination, etc.). The plan is uniquely positioned to offer a holistic view of the member experience and to highlight the value of this information for a provider.

Reporting should start as purely informational as part of the plan's initial engagement and awareness building of the provider's role in impacting member experience. Even when reporting is purely informational, reporting should be directed and actionable, with specific recommendations for how the provider can address likely future negative ratings from their panel.

We have an established quality incentive program built on a pay-for-performance model. What do we need to consider before adding CAHPS or HOS into the mix?

It is important that providers know that the plan is approaching the plan/provider collaboration as an opportunity for both organizations to enhance member experience.

Pay-for-performance in healthcare is defined as "the use of payment methods and other incentives to encourage quality improvement and patient-focused high value care."

Because it is well established that individual characteristics heavily influence how a member will respond to a survey, providers must know that the plan is approaching the plan/provider collaboration as an opportunity for both organizations to enhance member experience. It is strongly advised that incentive programs tied to member experience are reward based (non-punitive) and based on actual survey responses.

Your organization may be ready to develop a pay-for-performance (P4P) member experience initiative if:

- ✔ The organization has experience in the design and implementation of P4P programs
- ✔ The organization has access to the appropriate type data required to support measurement of provider performance (see table below)
- ✔ The organization can establish data collection processes that ensure a sufficient volume of data can be collected to report statistically valid metrics related to member experience
- ✔ Other organizational considerations

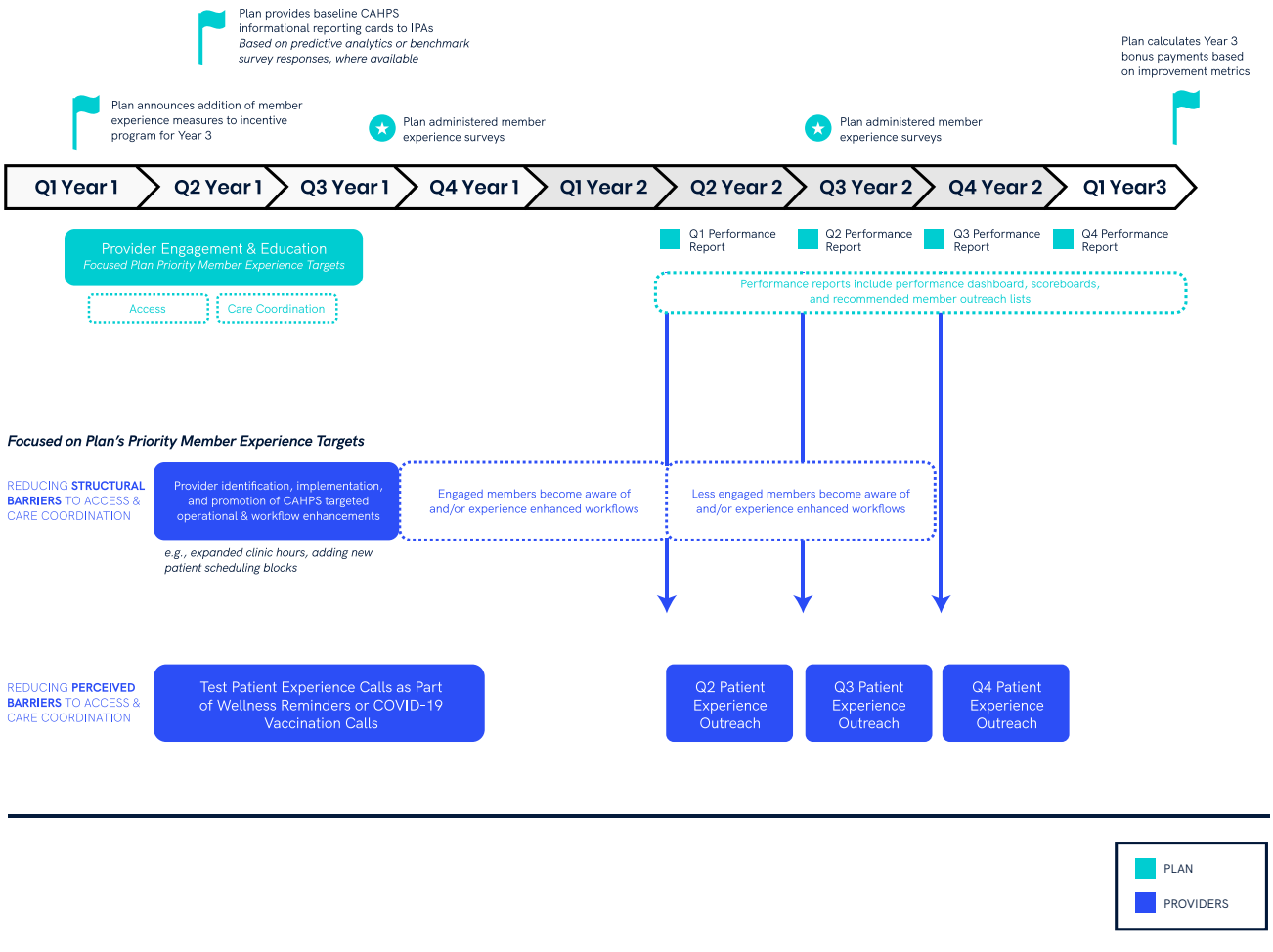
Consult established resources when assessing the operational and potential stakeholder issues involved in specific P4P programs, such as those included in the Resource Guide (Appendix).

[2] Center for Medicaid and State Operations, Centers for Medicaid and Medicare Services. State Health Official Letter #06-003. April 6, 2006

TYPE OF DATA	TYPE OF REPORTING SUPPORTED
Member-level survey responses	• Performance reporting (recommended for P4P) • Responses to "mock", "simulation", "off-cycle" surveys that include CAHPS and HOS questions • Results must be identifiable at the member-level (must be able to tie survey responses back to the individual member that provided the response)
Member-level advanced predictive analytics	• Informational reporting (not recommended for P4P) • Advanced predictive analytics (machine learning and artificial intelligence based technologies) that can identify the likelihood that a member will negatively respond to specific CAHPS and HOS survey questions. It is not recommended that less sophisticated predictive analytics, such as simple linear regression models, are used due to their less significant degree of precision • Raise awareness among providers of potential negative responses • Help providers target resources and interventions • Can potentially be tied to an attestation model, whereby providers attest that they have completed certain interventions to address areas of potential negative responses • Can help identify panels most likely to negatively contribute to CAHPS and HOS performance • Can help inform the plan where to increase survey data collection (to support eventual P4P program on high impact IPAs)
Hybrid (member-level survey responses for a portion of the population)	• Informational reporting (potentially appropriate for P4P depending on volume of actual survey responses) • A hybrid combination of member-level survey responses and member-level advanced predictive analytics • Where recent survey responses for a member are available, they are used in reporting calculations. Where survey responses from a member are not available, advanced predictive analytics are used in reporting calculations

Recommended Provider Member Experience Engagement Plan

Decision Point Recommended Best Practices



Checklist

Track your organization's journey to engaging providers in the effort to drive measurable improvements in member experience and perceptions, as captured in the annual CAHPS and HOS surveys.

- ☑ Communicate the imperative for providers to focus on member experience
- ☑ Highlight the provider's highly influential role in member experience
- ☑ Focus on high impact providers who have collaborative relationships, a large volume of potential survey respondents, and a high percentage of likely negative raters
- ☑ Provide regular, actionable member experience reporting to guide providers' efforts
- ☑ Couple reporting with specific tactics for where providers can focus resources
- ☑ Account for the amount of time it will take providers to identify and implement member engagement initiatives
- ☑ Start measurement focused on process improvement measures
- ☑ Move measurement from process to outcomes measures when the plan can implement a robust data collection program
- ☑ Synthesize best practices from around the network and share back to providers

Resource Guide

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