Provider Data Accuracy
Taking Action

PRESENTED BY:
Krista Lehm, MBA
Director, Delivery System Support
Cigna-HealthSpring

Atul Pathiyal
Managing Director, Products & Strategy
CAQH
Cigna-HealthSpring

Krista Lehm, MBA
Director, Delivery System Support
Drivers for Provider Directory Improvement

Promoted by complaints like Hill’s, the California state auditor began evaluating plans... The resulting audit released Tuesday found that provider directories were riddled with errors.

Concerns are increasing about the accuracy of information that insurers share with consumers about the members of their network in the form of "provider directories."

Center for Medicare and Medicaid Services: Provider Directory Survey**

- 45% of provider directory locations are inaccurate.
- 47% of providers have at least one deficiency.
- 66% of errors identified are where the 'Provider is not practicing at location'.
- Majority of Medicare Advantage plans have between 30 and 60% inaccurate locations.

<table>
<thead>
<tr>
<th>Source</th>
<th>Requirement</th>
<th>Effective Date</th>
<th>Key Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage 2016 Advance Notice</td>
<td>MA organizations must maintain “Regular, ongoing communications / contacts (quarterly) with providers…”</td>
<td>January 1, 2016</td>
<td>Penalties up to $25k per day per beneficiary. CMS has begun monitoring plans.</td>
</tr>
<tr>
<td>HHS Final 2016 Letter to Insurers in the Federally-Facilitated Marketplaces</td>
<td>QHP issuers must update their provider directory information at least once a month. Includes field-level requirements for data.</td>
<td>November 1, 2015</td>
<td>Penalties up to $100 per day per individual affected.</td>
</tr>
<tr>
<td>Medicaid and CHIP Proposed Rule</td>
<td>Medicaid MCOs must update electronic provider directories no later than 30 calendar days after updated provider information is received.</td>
<td>July 1, 2017</td>
<td>Machine-readable requirements are now aligning with QHP requirements.</td>
</tr>
<tr>
<td>NCQA Health Plan Accreditation 2016 Proposed Update</td>
<td>Using valid sampling methods, analyze the accuracy of information within provider directories.</td>
<td>July 2016</td>
<td>Must annually identify opportunities to improve accuracy and take action.</td>
</tr>
<tr>
<td>Other state requirements</td>
<td>Twenty-seven states have now enacted rules on provider directories, with about half of the states specifying update frequency.</td>
<td>Varied</td>
<td>Varied</td>
</tr>
</tbody>
</table>
### Overview of CMS Provider Directory Requirements

<table>
<thead>
<tr>
<th>CMS Regulation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Outreach</td>
<td>Plans must complete regular, ongoing communications/contact on a quarterly basis with providers to ascertain their availability and panel status, participation, and demographic data/changes.</td>
</tr>
<tr>
<td>Accurate Provider Data in both Online and Printed Directories</td>
<td>Plans must ensure provider directories are accurate for enrollees and their caregivers who rely on them to make informed decisions regarding their health care and health plan choices.</td>
</tr>
<tr>
<td>Effectively Address Customer Inquires/Complaints in Regards to Access to Providers</td>
<td>Plans must develop and implement a protocol to effectively address inquires/complaints related to enrollees being denied access to a contracted provider with follow through to make corrections to the directory.</td>
</tr>
<tr>
<td>Real Time Update to Online Provider Directories</td>
<td>Real time updates, defined as 30 calendar days, must occur when the plan is notified of changes in a provider’s panel status, participation, and/or demographic data or when the MAO makes contracting changes to its network of providers.</td>
</tr>
</tbody>
</table>
### Overview of CMS Provider Directory Requirements (cont.)

<table>
<thead>
<tr>
<th>CMS Regulation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Panel Status</strong></td>
<td>Online and print directories must notate the provider’s panel status.</td>
</tr>
<tr>
<td><strong>Contract Status</strong></td>
<td>Plans must verify that all providers contained in the directory have a current contract to participate in the plan and should list effective and termination dates of providers where applicable.</td>
</tr>
</tbody>
</table>
| **Directories must provide enrollees with a list of providers from whom the enrollee may reasonably be expected to obtain services and accurately identify any providers that may not be available to enrollees** | - Notate restrictions on provider access:  
  - Providers who are only available to a subset of enrollees  
  - Providers who practice concierge medicine and are available only to patients who pay an annual fee/retainer  
  - Providers who only offer home visits and do not see patients at physical location  
- Only list providers who enrollees can go to for appointments (i.e. exclude hospitalists or on call only providers)  
- If a provider has multiple specialties, only list the specialty the provider is practicing at that particular location  
- NPs and PAs should only be listed if the enrollee is able to call and make an appointment with that provider. They should be notated as a non-physician and should not be listed as a primary care physician  
- For group practices, only list providers at location where they routinely see patients, as opposed to every practice location for that group.  
- Practice names should reflect the name stated when an enrollee call to make an appointment (i.e. name on the door) |
| **Network Adequacy** | - Plans should periodically reassess whether additional providers need to be added to the network to ensure current CMS Network Adequacy standards are met as changes in provider directories may affect enrollee access.  
- When applicable, ensure that HSD tables are updated when changes are received for directories. Updates to provider directories should be synced with updates to the HSD tables. |
<table>
<thead>
<tr>
<th>State Regulation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>California SB137</td>
<td>Plans require affirmative response from providers that information in directories are current and accurate. Must investigate reported errors within 30-days. Providers who do not confirm information must be removed from directories.</td>
</tr>
<tr>
<td>Georgia SB302</td>
<td>Insurer shall audit a reasonable size of its provider directories for accuracy.</td>
</tr>
<tr>
<td>Illinois HB6213</td>
<td>Medicaid Managed Care enrollee shall not be held responsible for costs resulting from a material misrepresentation in the online provider directory.</td>
</tr>
<tr>
<td>Texas MMC</td>
<td>Information must be accurate and MCO must update at least twice a month.</td>
</tr>
</tbody>
</table>
CMS Three-Pronged Approach

Direct Monitoring:
CMS is using an outside vendor to verify the accuracy of online provider directories

Audit protocol:
An audit protocol was developed in 2016 to further enhance our oversight of the validity and accuracy of online directories, accessibility of network providers, and provider network adequacy standards

Compliance and/or enforcement actions:
Civil money penalties or enrollment sanctions
Current State of Health Plans

Plans Have Been Audited
- 54 health plans were audited in 2016.
- Industry pilot reports show mixed results at best.

Plans Have Tried Solutions
- Many plans are performing internal audits.
- Utilizing data analytics is not a complete solution.
- Many plans completing own outreach efforts.

Obtaining Information from Providers is Preferred
Data accuracy increases when a provider offers the information.
Questions CMS is asking

Survey process: Reviewers in the study placed calls to each provider’s office(s), verifying the accuracy of the information listed in the provider directory. During the calls, reviewers asked the following questions, in the following order, to determine directory accuracy:

- Does the provider see patients at this location?
- Does the provider accept the MA-PD plan at this location? *(The provider directory is considered accurate if it correctly indicates if the provider is or is not accepting new patients)*
- Is the provider a (PCP, cardiologist, oncologist, or ophthalmologist)?
- Is the address correct?
- Is the telephone number correct? *(Usually confirmed by dialing the phone number)*
- Is the provider’s name correct?
- Is the practice name correct?
## Deficiency Types and Weights

### Table 2: Deficiency Types and Weight

<table>
<thead>
<tr>
<th>Final Deficiency</th>
<th>Deficiency Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider should not be listed in the directory at this location</td>
<td>3</td>
</tr>
<tr>
<td>Phone number needs to be updated</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Final Deficiency</th>
<th>Deficiency Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider is Not accepting new patients</td>
<td>3</td>
</tr>
<tr>
<td>Address needs to be updated</td>
<td>2</td>
</tr>
<tr>
<td>Address (suite number) needs to be updated</td>
<td>1</td>
</tr>
<tr>
<td>Provider IS accepting new patients</td>
<td>1</td>
</tr>
<tr>
<td>Specialty needs to be updated</td>
<td>1</td>
</tr>
<tr>
<td>Provider name needs to be updated</td>
<td>0</td>
</tr>
</tbody>
</table>
‘Provider not practicing at location’ represents the most significant directory deficiency

* Results reported by CMS Medicare Drug & Health Plan Contract Administration Group on September 8, 2016. N=11,646 practice locations
Provider Challenges in Responding to Health Plan Data Requests

- Several Similar Inquiries
  Providers receive multiple requests from multiple plans on a reoccurring basis.

- Varied Data Submission Requirements
  Technology limitations and varied data submission requirements contribute to data latency.

- Lack of Standardized Questions
  Questions health plans use to update their provider directories are not standardized.
Solving Provider Challenges in Data Gathering, Extraction and Validation to Increase Engagement

Streamline the number of requests to update or submit information

Simplify the data submission requirements

Standardize the requested content
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Provider Records</td>
<td>220K</td>
</tr>
<tr>
<td>Active Unique Providers</td>
<td>73K</td>
</tr>
<tr>
<td>Active Unique Service Locations</td>
<td>45K</td>
</tr>
<tr>
<td>Provider Directories Maintained</td>
<td>26</td>
</tr>
<tr>
<td>Average change rate in provider directories per month</td>
<td>&gt;3%</td>
</tr>
<tr>
<td>Average number of adds/terms/changes per month</td>
<td>6800</td>
</tr>
</tbody>
</table>
Direct vs Delegated/Vendor

60% Direct

40% Delegated / Vendor

Delegate and Vendor Providers
Directly Contracted Providers
## Current State

<table>
<thead>
<tr>
<th>CMS Requirement</th>
<th>CMS Requirement Description</th>
<th>Current State</th>
</tr>
</thead>
</table>
| Quarterly Outreach | Regular, ongoing communications/contacts (at least quarterly) with providers to ascertain their current availability, whether they are accepting new patients, street address, phone number, office hours, changes that affect availability | • Utilizing CAQH for approximately 50% of provider outreach  
• Remaining providers receive outreach through:  
  • Direct Mailings  
  • Delegated Entities |
| Real Time Provider Directory Updates | MAOs are expected to update their online provider directories in real-time, which means MAOs are to make updates when they are notified of changes in a provider’s status, or when the MAO itself makes contracting changes to its network of providers within 30 calendar days of receipt. | • Created teams in each market which are dedicated resources to upload provider changes on a daily basis  
• Limited entry point of self reported provider changes  
• Daily (Monday through Friday) updates to the Online Provider Directory  
• Provider Directory printed monthly |
| Customer Inquiries / Complaints in regards to access to providers | Developing and implementing a protocol to effectively address inquiries/complaints related to enrollees being denied access to a contracted provider with follow through to make corrections to the online directory | • Ensuring timely routing of grievances and CTMs related to directory issues to PDV teams  
• Enhanced and strengthened current policies to include CMS mandates |
| Internal Monitoring | CMS expects formal internal monitoring process relative to provider directory data and its accuracy. | • Established centralized team responsible for internal monitoring of:  
  • Provider directory data accuracy  
  • Changes completed timely and accurately  
  • Outreach to providers  
  • Created policies and procedures outlining audit protocols  
  • Created job aids and SOPs to support PDV teams |
Health Plan Challenges

Provider Outreach and Engagement
- Provider compliance/responsiveness.
- Provider abrasion due to numerous plans and vendors completing outreach.

Data Validation
- Provider location verification.
- Data accuracy issues with Delegates.
- No “Source of Truth” for provider data.

Downstream Workflow Integration
- Resource Needs – tools, technology, and people
- Syncing all systems to have the same data
Opportunities for Improvement

1. Provider Outreach and Engagement

• Contacting non-responders.

• Increase educational efforts with providers to help them understand how health plans are using practice location data for directory verification purposes. Increased awareness of health plan use cases will better motivate providers to submit their right information.

• Continue to work with delegates and stress the importance of their provider data accuracy. Possibly convert their providers to CAQH outreach.
Opportunities for Improvement

Data Validation

- Customer service verification of data on provider calls.
- Increase engagement from Network Operations to validate provider data during office visits and phone call contact with provider offices.
- Clean up data using analytics:
  - Claims audits looking at providers who have not submitted claims within the past 6-12 months
  - Hospital based locations
  - Provider with more than 10 locations.
Opportunities for Improvement

3 Downstream Workflow Integration

• Syncing Health Service Delivery (HSD) Tables with directory data.
• Reconciliation with other Cigna-HealthSpring systems.
• SharePoint manual workflows.
• Onboarding new workflow tool to assist with automated workflows and the development of future business rules.
• Consolidated database to be “Source of Truth” for Cigna-HealthSpring.
• Additional automation of provider changes.
Best Practices

• Use of vendors to reduce provider abrasion
  • CAQH for provider outreach.

• Use of vendors for data validation:
  • CAQH, Quest Analytics and Anderson Marketing for provider data verification.

• Craft a dedicated Provider Data Validation (PDV) team to handle provider changes for directories.

• Use CAQH shared best practices on audit scripts and CMS scoring methodology.

• Institute an internal monitoring process.

• Automate the vendor and national ancillary provider changes.

• Frequent updates to online provider directory (OLPD).
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce volume of manual changes needed to the directory database</td>
<td>• Automation of changes, adds, and terminations for providers wherever possible</td>
</tr>
<tr>
<td>Reconciliation with Credentialing Data</td>
<td>• Reconciliation process with Credentialing to automate updates to provider specialty and accreditations or board certifications</td>
</tr>
<tr>
<td>New Provider Data Database</td>
<td>• Incorporate additional data elements into current database in order to potentially extract HSD tables. Currently, the HSD tables are maintained outside of the directory database and this will allow one point of entry for both directories and HSD tables. This will ensure our provider directory data and HSD table data is synced up.</td>
</tr>
</tbody>
</table>
| Implementation of Online Form for Providers to Attest and Provide Any Changes | Create landing pages of provider specific directory data for all providers. This will allow providers to make updates to their provider directory data in an online format which will:  
  • Lighten the administrative burden on providers as changes will no longer need to be faxed, scanned and emailed, or mailed  
  • Allow our team to automate many of the changes we receive  
  • Easily track provider response rates and reach out to those who are not reviewing their directory data  
  • Outreach to providers more easily and effectively |
## Tactics for Provider Directory Improvement (cont’d)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated Entities</td>
<td>• Continue to work with delegates to increase their provider data accuracy&lt;br&gt;• Conduct audits of current delegate rosters&lt;br&gt;• Converting delegates to participate in Cigna-HealthSpring current outreach activities if they cannot demonstrate compliance&lt;br&gt;• Possibly develop an automated roster reconciliation process through a weekly or monthly data feed</td>
</tr>
<tr>
<td>Non-responders to Outreach</td>
<td>• Contacting non-responders to ensure we are validating all provider information</td>
</tr>
<tr>
<td>Claims Analysis</td>
<td>• Reviewing providers who have not submitted a claim within the past 6 to 12 months&lt;br&gt;• Working with Network Operations to research providers to determine if provider and locations listed are still valid&lt;br&gt;• Remove providers from the directory and HSD tables who are no longer participating</td>
</tr>
<tr>
<td>Establish Business Rules for Current Data Elements</td>
<td>• Creating business rules around provider directory data elements&lt;br&gt;• Allows for more control of what is pushed into the directory date&lt;br&gt;• Prevents common data errors&lt;br&gt;• Ex: limiting NPI field to 10 digits, creating a set list for data elements such as special skills and languages spoken, creating derived fields, etc.</td>
</tr>
</tbody>
</table>
### Tactics for Provider Directory Improvement (cont’d)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Use of Quest Analytics Cloud Tool for Data Validation** | • NPI Inspection – determine if we have providers with invalid or deactivated NPIs  
• Address Inspection & Standardization  
  • Determine if we have invalid address per United States Postal Service (USPS) standardization  
  • Analyze and research providers who have an inordinate amount of service locations  
• Specialty Inspection  
  • Determine if the specialty of the providers matches their NPI specialty  
  • Analyze those providers with multiple specialties |
| **Implementation of CAQH DirectAssure 2.0** | • Reconcile health plan’s practice location records  
• Validate plan locations against Cigna-HealthSpring’s database with new enhancements  
• Capture plan-specific responses to ‘Accept New Patients’ questions  
• More efficient loading of changes to plans |
| **Additional Provider Touchpoints for Data Validation** | • Increased engagement from Network Operations to validate provider data during office visits and phone call contact with provider offices  
• Customer Service verification of data on provider calls |
| **Consolidated Provider Data Database** | Moving data from SharePoint into SQL based database. This will allow us to incorporate additional data elements into the database in order to extract HSD Tables at a future date. |
Provider Directory Improvement Process Outcomes

• Using the data from CAQH and Quest to target providers who have more than 10 practice locations has allowed us to suppress inaccurate addressed from our directories and improved accuracy scores.

• Have seen an increase of 20% in provider directory data accuracy since new regulations were released and we continue to improve every quarter.

• Increased automation which has lightened the load for our PDV teams and helps to prevent errors made during manual entry.

• Daily (Monday through Friday) updates to our OLPD and monthly production of printed directories allowing for quicker updates available to enrollees.
Lessons Learned

• Capturing provider responses is an essential part of provider directory quality improvement.
• The only sustainable way to do that in the long run is a provider one stop shop.
• Measure the quality of your data, and determine which approaches make the most difference.
• Get started early and small, to understand how everything works end-to-end, prove that it works at a small scale, then invest in additional IT resources after you’ve proven that it works.
• Automation is necessary when receiving such large amounts of data so automate wherever possible.
CAQH, a non-profit alliance, is the leader in creating shared initiatives to streamline the business of healthcare. Through collaboration and innovation, CAQH accelerates the transformation of business processes, delivering value to providers, patients and health plans.

Member Organizations:
For more than 15 years, CAQH has delivered solutions that solve industry-level challenges in provider data management.

- **UPD**: Industry standard self-reported provider database.
- **SanctionsTrack**: Tracking and reporting of disciplinary actions.
- **DirectAssure**: Provider outreach and reporting to meet Medicare Advantage and other provider directory data validation requirements.
- **VeriFide**: Centralized verification of provider credentialing applications to meet NCQA and other standards.
- **CAQH ProView**: Next generation of UPD system.
- **EnrollHub**: Electronic payment and remittance advice information for providers.

Timeline:
- **2002**: CAQH Provider Data Initiatives
- **2004**: CAQH Provider Data Initiatives
- **2013**: CAQH Provider Data Initiatives
- **2015**: CAQH Provider Data Initiatives
- **2016**: DirectAssure
- **2017**: VeriFide
<table>
<thead>
<tr>
<th>Number of Provider Locations</th>
<th>Providers</th>
<th>Percentage of Providers</th>
<th>Providers with at Least One Deficiency</th>
<th>Percentage of Providers with x Locations with at Least One Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3,322</td>
<td>56.96%</td>
<td>1,001</td>
<td>30.13%</td>
</tr>
<tr>
<td>2</td>
<td>1,287</td>
<td>22.07%</td>
<td>730</td>
<td>56.72%</td>
</tr>
<tr>
<td>3</td>
<td>515</td>
<td>8.83%</td>
<td>360</td>
<td>69.90%</td>
</tr>
<tr>
<td>4</td>
<td>259</td>
<td>4.44%</td>
<td>220</td>
<td>84.94%</td>
</tr>
<tr>
<td>5</td>
<td>155</td>
<td>2.66%</td>
<td>139</td>
<td>89.68%</td>
</tr>
<tr>
<td>6</td>
<td>121</td>
<td>2.07%</td>
<td>117</td>
<td>96.69%</td>
</tr>
<tr>
<td>7 or more</td>
<td>173</td>
<td>2.97%</td>
<td>170</td>
<td>98.27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,832</strong></td>
<td><strong>100%</strong></td>
<td><strong>2,737</strong></td>
<td><strong>46.93%</strong></td>
</tr>
</tbody>
</table>

Provider Data Foundation: CAQH ProView

- Trusted and used by healthcare providers and organizations for more than 15 years.
- 1.4 million unique participating providers, including allied providers (+8,000 each month).
- Over 900 participating health plans, hospitals, provider groups, state Medicaid agencies and other organizations.
- Twelve states and DC have adopted the CAQH Standard Provider Credentialing Application.
- Contains more than 225 self-reported and attested data elements, including those required for provider directories.
- Providers reminded to re-attest every 120 days. One million providers have re-attested in the past 120 days.
- 25K unique users per day.
DirectAssure

Multi-Payer Collaborative to Meet Directory Requirements

- Consolidates multiple potential health plan outreaches into a single outreach for each provider.
- Easy-to-use, web-based confirmation process.
- Leverages data already entered by providers into CAQH ProView.

Receive Updated Directory Information via CAQH

Health Plan 1
Health Plan 2
Health Plan 3
Health Plan 4
Provider-Attested Data for Practice Locations

Please add practice location information for each practice at which you currently, or will in the near future, see patients, fill in for other providers, read tests, or provide other services. If you do not practice at a location that appears in the list, please click Edit to update your status.

Make sure to enter all group/practice information in the Employment Information section of your profile.

<table>
<thead>
<tr>
<th>Physician Group/Practice Name</th>
<th>Tax ID</th>
<th>Location</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oakton Family Practice</td>
<td>20-4234234</td>
<td>5321 Hunter Mill Road</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oakton, VA 22124-1231</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: 342-923-4879</td>
<td></td>
</tr>
<tr>
<td>Vienna Family Practice</td>
<td>23-7480234</td>
<td>1234 Main Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vienna, VA 22124-1231</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: 703-123-1231</td>
<td></td>
</tr>
</tbody>
</table>

Please indicate if you will see patients at this location. Keeping this information is important for your participating health plans/organizations.

- **Type of Practice**
  - Group

- **Do you have an organization (Type 2) NPI?**
  - Yes
  - No

- **Organization (Type 2) NPI**
  - 1698531679

- **Practice Name as it appears on the W-9**
  - Fairfax Family Medicine

- **Tax ID**
  - 20-4234234

- **Type of Tax ID**
  - Group

- **Provider’s Start Date**
  - Select date that you started practicing or will be practicing at this location in the near future
  - 10/2/2017
2016 CAQH Provider Survey

How do you believe health plans use practice location information?

- 40% To update acceptable service locations in their claims systems
- 48% To publish in their provider directory used by patients/beneficiaries
- 33% To determine the adequacy of their provider network
- 57% To verify practice locations as part of the credentialing process
- 38% To know where to send mail correspondence to practitioners
- 24% I don't think health plans use practice location information at all
What are the reasons for submitting locations at which the provider is not frequently practicing?

Percentage of providers in who gave specific reasons for submitting non-frequent practice locations

- Provider occasionally takes appointments at that location: 32%
- Provider may render care at that location, and will need to submit a claim: 43%
- As a standard practice, the same locations are submitted for all providers at my group: 35%
- These are old practice locations that have not yet been removed from ProView: 3%
- These are new practice locations where the provider is not yet practicing: 8%
- Provider is no longer practicing there, but may have outstanding claims: 11%
- Not Applicable: 24%
Be More Precise When Asking Providers for Information

A simple question was added to elicit the proper context for why each location was entered by the provider.

Providers are requested to answer as part of the normal 120-day reattestation cycle.
January 2017 Pilot Results

Total practice locations with detailed responses to ‘do you practice?’

- I never practiced here and have no affiliation with this location: 378
- I do not practice here, but the location is within my group: 12,051
- I no longer practice at this location: 10,893
- I read tests or provide other services but do not see patients: 8,927
- I cover or fill-in for colleagues within the same group: 35,374
- I see patients here at least one day per month: 16,149
- I see patients here at least one day per week: 115,687

30% of legitimate practice locations are not suitable for provider directories.
720k practice locations that should be suppressed from directories identified to date (and growing)
National Results since July 2017

Impact of Asking More Precise Questions about Practice Locations

Note: Visual limited to providers with large numbers of locations.
Lessons Learned

• Understand the data
• Ask questions in the correct context
• Leverage existing methods of provider engagement to drive high response
Thank You

Questions?
Please complete the survey for this session!

1. On the main menu, select the schedule icon

2. Find and select this session in the schedule

3. Scroll down and select “Surveys”