DESIGN OF OUR ONLINE WORLD

CCSQ WORLD USABILITY DAY 2021

Customer Engagements using Human-Centered Design

Office of Burden Reduction & Health Informatics

Customer-Focused Research Group

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Human-Centered Design Center of Excellence

Visuals are Invaluable when you Get them Right

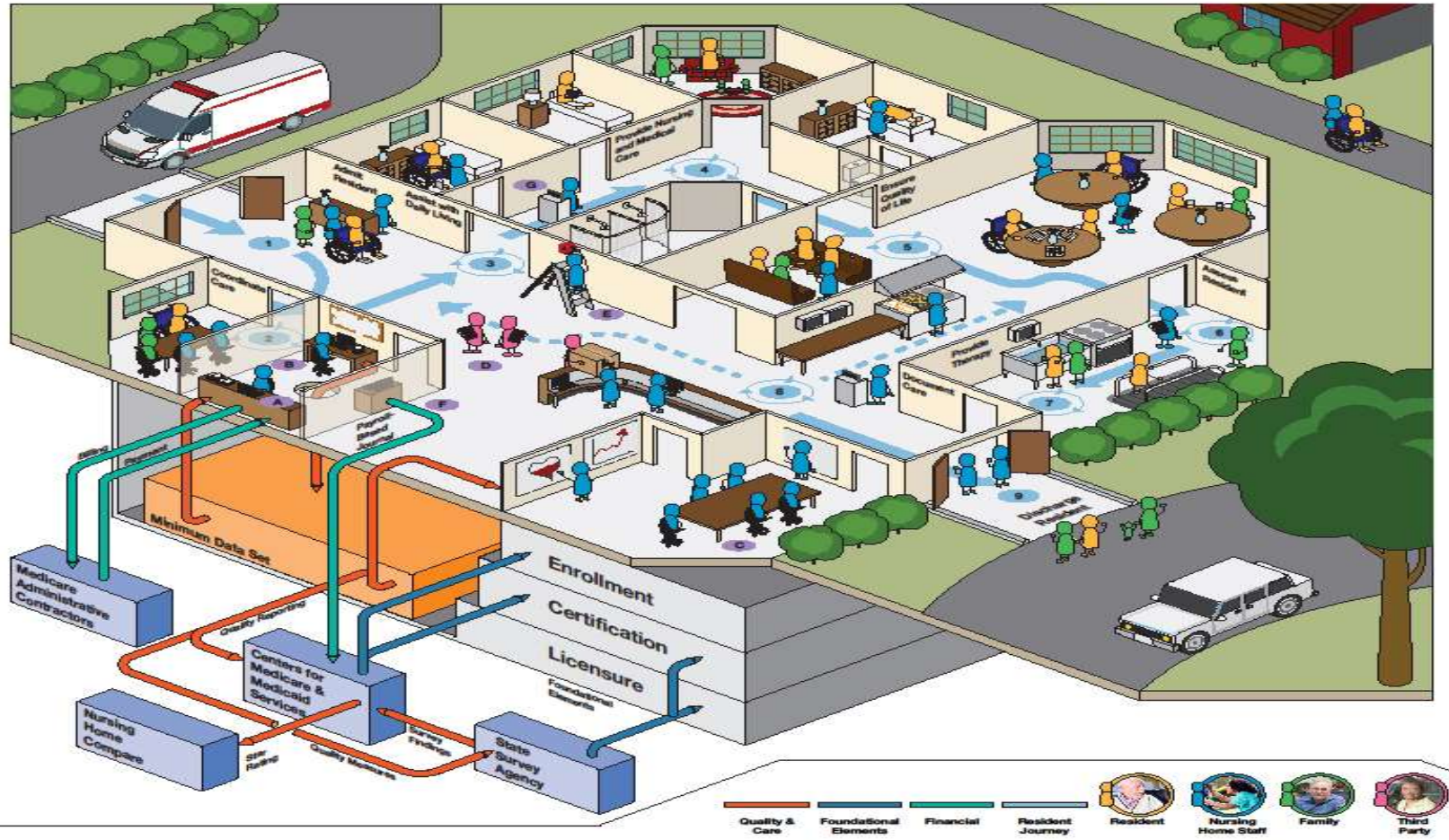
The Nursing Home Journey

Administration & Compliance

- **A Bill for Services** — Submit bills and cost reports to Centers for Medicare & Medicaid Services (CMS). Submit claims to a Medicare Administrative Contractor (MAC), the State, or Medicare Advantage Plans monthly for payment. Bill Residents for care and treatment received outside of Medicare and Medicaid coverage.
- **B Audit** — Provide records for CMS, Office of Inspector General, or the State to audit upon request.
- **C Train Staff** — Provide continuous education, support, feedback, and interpretation of new regulations for staff.
- **D Survey & Recertify** — Admit State Survey Agency (SA) to ensure requirements are met and retain certification.
- **E Correct Deficiencies** — Develop and implement a Plan of Correction if the SA cites deficiencies. SA verifies Nursing Home is in compliance.
- **F Report Quality** — Collect Resident care data through MDS and staffing data through payroll-based journals. Submit data to CMS and SA. Receive a star rating on Nursing Home Compare based on this data and surveys.
- **G Improve Quality** — Improve the quality of care, organizational culture, ethics, processes, and technology with Quality Assurance & Performance Improvement educational material and other resources.

Program Participation

- **Enrollment** — Apply for participation in CMS program. Receive tax ID number. Hire, credential, and enroll staff.
- **Certification** — Complete initial survey and become certified through CMS, the State, and MAC.
- **Licensure** — Apply for a license through the State.



Resident Care

1. **Admit Resident** — Determine capacity to provide care, coordinate Resident transition to the Nursing Home, and create Minimum Data Set (MDS) within two weeks and baseline care plan within 48 hours.
2. **Coordinate Care** — Coordinate Resident care with family and a variety of contracted specialists, internal staff, and other institutional providers.
3. **Assist with Daily Living** — Help Resident bathe, groom, dress, undress, eat, and toilet. Assist with movement.
4. **Provide Medical and Nursing Care** — Provide person-centered medical and nursing services.
5. **Ensure Quality of Life** — Provide quality of life services such as life enrichment programs.
6. **Assess Resident** — Track progress by assessing Resident and entering data into MDS. Coordinate and verify assessments.
7. **Provide Therapy** — Improve or maintain Resident's abilities through physical, occupational, speech, or other therapies.
8. **Document Care** — Track progress of each Resident interaction, documenting a wide variety of measures.
9. **Discharge Resident** — Coordinate, prepare, and discharge Resident to another setting. If Resident passes away, help family with end-of-life arrangements.

End Participation

- **Withdraw** — Stop participating in Medicare and Medicaid voluntarily.
- **Terminate** — Nursing Home is involuntarily excluded from participating in Medicare and Medicaid for violating requirements.

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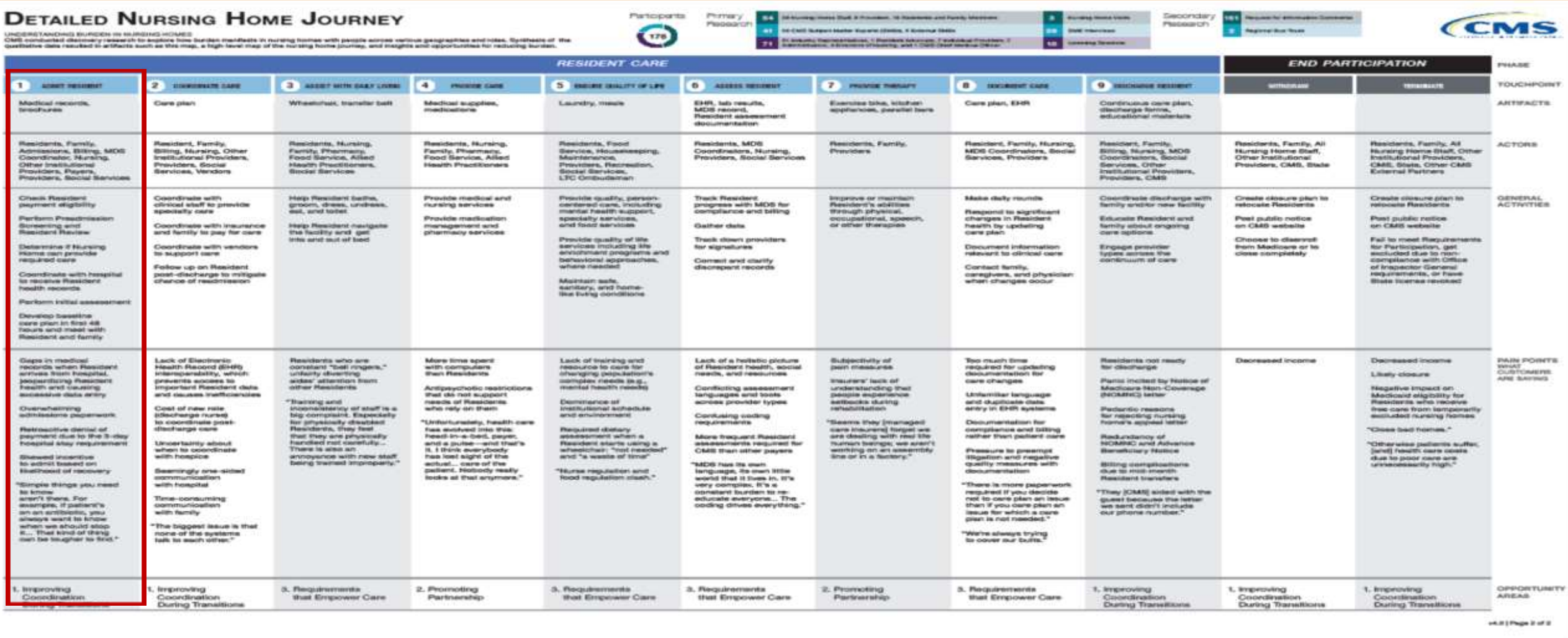
The Details inform Opportunities for Improvement…



Detailed Nursing Home Journey

Understanding burden in nursing homes

CMS conducted discovery research to explore how burden manifests in nursing homes with people across various geographies and roles. Synthesis of the qualitative data resulted in artifacts such as this map, a high-level map of the nursing home journey, and insights and opportunities for reducing burden.

Participants 175

Primary Research

54	3
41	23
71	18

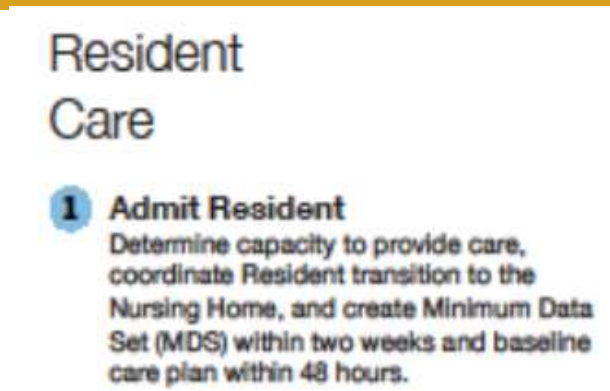
Secondary Research

161	
3	

CMS

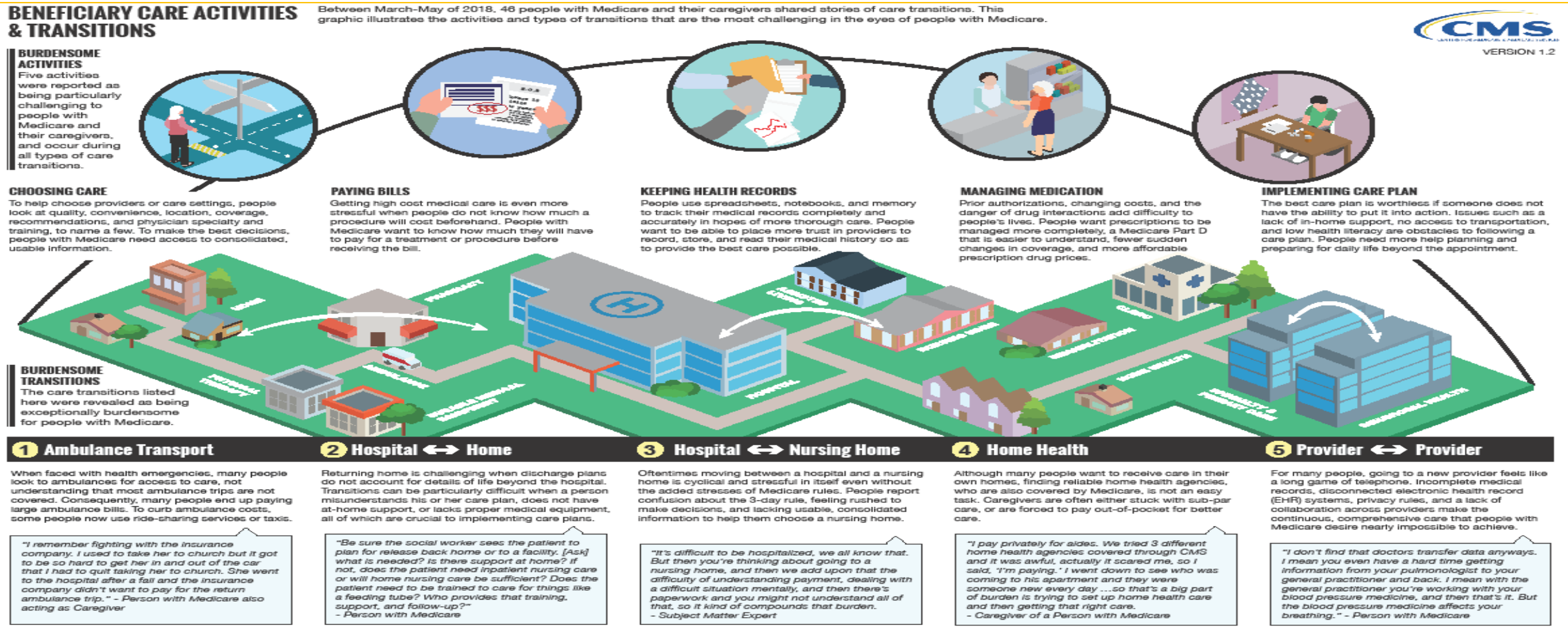
	Resident Care								End Participation		
Phase	1	2	3	4	5	6	7	8	9		
Touchpoint										Withdraws	Terminates
Artifacts	Medical records, brochures	Care plan	Wheelchair, transfer belt	Medical supplies, medications	Laundry, meals	EHR, lab results, MDS record, Resident assessment documentation	Exercise bike, kitchen appliances, parallel bars	Care plan, EHR	Continuous care plan, discharge forms, educational materials		
Actors	Residents, Family, Admissions, Billing, MDS Coordinator, Nursing, Other Institutional Providers, Payers, Providers, Social Services	Resident, Family, Billing, Nursing, Other Institutional Providers, Providers, Social Services, Vendors	Residents, Nursing, Family, Pharmacy, Food Service, Allied Health Practitioners, Social Services	Residents, Nursing, Family, Pharmacy, Food Service, Allied Health Practitioners	Residents, Food Service, Housekeeping, Maintenance, Providers, Recreation, Social Services, LTC Ombudsman	Residents, MDS Coordinators, Nursing, Providers, Social Services	Residents, Family, Providers	Resident, Family, Nursing, MDS Coordinators, Social Services, Providers	Resident, Family, Billing, Nursing, MDS Coordinators, Social Services, Other Institutional Providers, Providers, CMS	Residents, Family, All Nursing Home Staff, Other Institutional Providers, CMS, State	Residents, Family, All Nursing Home Staff, Other Institutional Providers, CMS, State, Other CMS External Partners
General Activities	Check Resident payment eligibility Perform Preadmission Screening and Resident Review Determine if Nursing Home can provide required care Coordinate with hospital to receive Resident health records Perform initial assessment Develop baseline care plan in first 48 hours and meet with Resident and family	Coordinate with clinical staff to provide specialty care Coordinate with insurance and family to pay for care Coordinate with vendors to support care Follow up on Resident post-discharge to mitigate chance of readmission	Help Resident bathe, groom, dress, undress, eat, and toilet Help Resident navigate the facility and get into and out of bed	Provide medical and nursing services Provide medication management and pharmacy services	Provide quality, person-centered care, including mental health support, specialty services, and food services Provide quality of life services including life enrichment programs and behavioral approaches, where needed Maintain safe, sanitary, and home-like living conditions	Track Resident progress with MDS for compliance and billing Gather data Track down providers for signatures Correct and clarify discrepant records	Improve or maintain Resident's abilities through physical, occupational, speech, or other therapies	Make daily rounds Respond to significant changes in Resident health by updating care plan Document information relevant to clinical care Contact family, caregivers, and physician when changes occur	Coordinate discharge with family and/or new facility Educate Resident and family about ongoing care options Engage provider types across the continuum of care	Create closure plan to relocate Residents Post public notice on CMS website Choose to disenroll from Medicare or to close completely	Create closure plan to relocate Residents Post public notice on CMS website Fail to meet Requirements for Participation, get excluded due to non-compliance with Office of Inspector General requirements, or have State license revoked
Pain Points What Customers Are Saying	Gaps in medical records when Resident arrives from hospital, jeopardizing Resident health and causing excessive data entry Overwhelming admissions paperwork Retroactive denial of payment due to the 3-day hospital stay requirement Skewed incentive to admit based on likelihood of recovery "Simple things you need to know aren't there. For example, if patient's on an antibiotic, you always want to know when we should stop it… That kind of thing can be tougher to find."	Lack of Electronic Health Record (EHR) interoperability, which prevents access to important Resident data and causes inefficiencies Cost of new role (discharge nurse) to coordinate post-discharge care Uncertainty about when to coordinate with hospice Seemingly one-sided communication with hospital Time-consuming communication with family "The biggest issue is that none of the systems talk to each other."	Residents who are constant "bell ringers," unfairly diverting aides' attention from other Residents "Training and inconsistency of staff is a big complaint. Especially for physically disabled Residents, they feel that they are physically handled not carefully… There is also an annoyance with new staff being trained improperly."	More time spent with computers than Residents Antipsychotic restrictions that do not support needs of Residents who rely on them "Unfortunately, health care has evolved into this head-in-a-bed, payer, and a pulse—and that's it. I think everybody has lost sight of the actual… care of the patient. Nobody really looks at that anymore."	Lack of training and resource to care for changing population's complex needs (e.g., mental health needs) Dominance of institutional schedule and environment Required dietary assessment when a Resident starts using a wheelchair; "not needed" and "a waste of time" "Nurse regulation and food regulation clash."	Lack of a holistic picture of Resident health, social needs, and resources Conflicting assessment languages and tools across provider types Confusing coding requirements More frequent Resident assessments required for CMS than other payers "MDS has its own language, its own little world that it lives in. It's very complex. It's a constant burden to re-educate everyone… The coding drives everything."	Subjectivity of pain measures Insurers' lack of understanding that people experience setbacks during rehabilitation "Seems they [managed care insurers] forget we are dealing with real life human beings; we aren't working on an assembly line or in a factory."	Too much time required for updating documentation for care changes Unfamiliar language and duplicate data entry in EHR systems Documentation for compliance and billing rather than patient care Pressure to preempt litigation and negative quality measures with documentation "There is more paperwork required if you decide not to care plan an issue than if you care plan an issue for which a care plan is not needed." "We're always trying to cover our butts."	Residents not ready for discharge Panic incited by Notice of Medicare Non-Coverage (NOMNC) letter Pedantic reasons for rejecting nursing home's appeal letter Redundancy of NOMNC and Advance Beneficiary Notice Billing complications due to mid-month Resident transfers "They [CMS] aided with the guest because the letter we sent didn't include our phone number."	Decreased income	Decreased income Likely closure Negative impact on Medicaid eligibility for Residents who receive free care from temporarily excluded nursing homes "Close bad homes." "Otherwise patients suffer, [and] health care costs due to poor care are unnecessarily high."
Opportunity Areas	1. Improving Coordination	1. Improving Coordination During Transitions	3. Requirements that Empower Care	2. Promoting Partnership	3. Requirements that Empower Care	3. Requirements that Empower Care	2. Promoting Partnership	3. Requirements that Empower Care	1. Improving Coordination During Transitions	1. Improving Coordination During Transitions	1. Improving Coordination During Transitions

…AND THE PAIN POINTS HELP SET PRIORITIES



Resident Care	PHASE
Admit Resident	TOUCHPOINT
Medical records, brochures	ARTIFACTS
Resident, Family, Admissions, Billing, MDS Coordinator, Nursing, Other Institutional Providers, Payers, Providers, Social Services	ACTORS
Check resident payment eligibility Perform Preadmission Screening and Resident Review Determine if Nursing Home can provide required care Coordinate with hospital to received Resident health records Perform initial assessment Develop baseline care plan in first 48 hours and meet with Resident and family	GENERAL ACTIVITIES
Gaps in medical records when resident arrives from hospital, jeopardizing Resident health and causing excessive data entry Overwhelming admissions paperwork Retroactive denial of payment due to the 3-day hospital stay requirement Skewed incentive to admit based on likelihood of recovery "Simple things you need to know. For example, if patient's on an antibiotic, you always want to know when we should stop it…That kind of thing can be tougher to find."	**PAIN POINTS WHAT CUSTOMERS ARE SAYING**
1. Improving Coordination During Transitions	OPPORTUNITY AREAS

A Journey Map is Not Always the Visual we Need



Various Visuals explain the Customer Perspective

COMMON CHALLENGES FOR BENEFICIARY CARE TRANSITIONS

Wanting to better understand the challenges that people face when undergoing care transitions, the Centers for Medicare & Medicaid Services listened to the stories of 46 people with Medicare and their caregivers. In recounting their experiences, people spoke of a broad range of obstacles they confront. Some of these obstacles were noted as not being unique to care transitions. This graphic depicts 11 insights, informed by this research, on the most commonly shared challenges.

When her mom needed a walker, she just went out and spent the $500 because, "She didn't know how to navigate Medicare, and she didn't feel like dealing with the hassle."
- Caregiver of Person with Medicare

Off-Road Options

Not understanding their benefits, high cost, and a lack of convenience push people with Medicare to seek medication and durable medical equipment (DME) through informal and often unregulated channels.

"I had a hospital send me a bill for outpatient surgery [for my late husband] and I said, 'he's never been to this hospital and if he has I want to see a picture because he's been dead for 2 years.'"
- Caregiver of Person with Medicare

Lost in Transfer

Even when people with Medicare go to great lengths to track and document their health data, problems with Electronic Health Records (EHR) systems, privacy policies, provider collaboration, and human error make it difficult to maintain complete, accurate health records.

"Intimately, care-giving has impacted us. Literally every nook and cranny of our lives. Our decisions about where to live, our professional lives, decision not to have children."
- Caregiver of Person with Medicare

A Full-Time Job

Caregivers find themselves sacrificing career and personal aspirations to be readily available to provide care to the person they are supporting and to respond to the demands of insurance.

"I'm both the patient and the caregiver which is very hard."
- Person with Medicare

Surely You Have Someone

Many believe that Medicare is built on the assumption that people with Medicare have large support networks to lean on at all times. In actuality, more and more people today are acting as their own caregiver.

"The snow scared me to death...The State doesn't have a plan for dealing with dialysis patients during the snow...So it's on, it's up to you and your family."
- Person with Medicare

Coordination of Care

People with Medicare feel like providers often under-value the realities of how they live their lives and how these realities affect their ability to follow their care plan.

"But even with Medicare, you never know what things are going to cost... You're never told and you never really find out... Like my husband says, 'you go to buy a car and you know what you're going to be charged, and on medical you don't have a clue.'"
- Person with Medicare

No Clarity in Chaos

Coverage options create multiple decision points for people with Medicare. Even with a growing number of resources meant to help people with Medicare navigate the system, confusion is common, particularly when dealing with complex costs and coverage rules.

"I went home and got on the internet and figured out what I was pretty sure I had...I made the mistake of telling a doctor...He totally dismissed me. He had no interest in what I knew about my body that could have helped accelerate the diagnosis process."
- Person with Medicare

Dr. Google™

Doctors are no longer the single source of information that people with Medicare rely on to understand their medical conditions. Similarly, what the doctor suggests is just one of many opinions that people consider when making health decisions.

"I was a Medicare beneficiary due to disability. I found it rather unusual the way Medicare is administered and why if you are put on disability then you wait two years to qualify for Medicare. Generally, with an ovarian cancer patient, a two year wait is a long, long time."
- Person with Medicare

One Size Fits All?

Medicare often uses a one size fits all approach, and leaves people with specific needs such as people with disabilities and chronic diseases, people who speak English as a second language, or dual-eligible individuals, jumping through additional hoops to get the care they need.

"You know I've seen situations where doctors stand outside a patient's room and they have their meeting...Patients [are thinking], 'What are they talking about?' If a patient is truly part of the team, the meeting should be at the bedside. Then we get engaged patients."
- Person with Medicare

Count Me In

In contrast to the widely held belief that a shared understanding between providers and patients is about priorities, values, and goals as the basis of good care, people with Medicare largely feel like they are not being heard and are excluded from decision-making.

"Treat the whole patient! Treat the whole body and all its side effects. Keep the quality of life going. Don't just pay for the patient to be treated for the [lymphedema]. Buy the pump that will allow the patient to be proactive at home to keep the arm or leg usable." - Person with Medicare

Snapshot Treatment

People with Medicare receive treatment based upon the symptoms they present in the moment, unless the patient or caregiver can advocate for inclusion of important information from the past or desired outcomes for the future.

"I'm on a large amount of opioids and when I was on morphine it numbed my brain, it was too hard to figure out Medicare and Medicaid."
- Person with Medicare

Diminished Ability, Increased Responsibility

During a care transition, the moments that require the most decisions often coincide with the times that people with Medicare have the lowest capacity due to stress, fear, or the side effects of medication.

VERSION 1.2

PERSONAS HIGHLIGHT THE VOICE OF THE CUSTOMER

ROSE'S STORY

Rose is a 76-year-old Medicare beneficiary

INSIGHTS

No Clarity in Chaos

Even though Rose carefully chose a Part D Plan specifically suited to her needs and finances, formulary changes have left her facing greater costs than she planned. Rose also has troubles with Part B. Rose recently was prescribed oxygen. Even though she was told Medicare would cover the cost, she kept receiving bills from the vendor. After several unsuccessful calls with 1-800-Medicare, her vendor, and her provider to solve the issue, she was so frustrated that she returned the oxygen.

Surely You Have Someone

Rose believes that, without the support of her daughter, she would not still be alive. Her daughter helps her with all aspects of coverage and care, from providing her a place to live, applying for coverage, to researching providers, and driving her to doctor's appointments.

ROSE'S ADVICE TO OTHERS

If you do not know how to use a computer, find someone who can help you. When choosing a new Part D Plan, Rose's daughter helped her by printing information about each choice out and sitting down with her to do the cross-comparisons. After Rose made her decisions, her daughter would go back to the computer and select what she had chosen.

ROSE'S JOURNEY

new care need · preparation action · challenge · need fulfilled · good experience · bad experience

Facing new health issues, chooses a new Part D Plan based on copays for specific prescriptions

6 months later, receives notification that Part D will no longer cover her prescriptions

Resulting financial strain impacts her decision to delay oxygen treatment even when her doctor prescribes it

Provider tells her Part B will cover the cost, so she goes ahead and orders oxygen

Receives unexpectedly high bill for oxygen

Calls vendor about the cost, and is told that it is a billing error

A month later, receives a second costly bill

Frustrated, she returns oxygen

"We went through the list [of prescriptions] and we accepted one based on what the deductible was gonna be and the copays... then 3 months/6 months in they decided, 'no, we don't cover those anymore.' So instead of paying 90 bucks a month you're now paying 400 a month."

"When I called the man that was in charge, it was like it was only gonna be like 20 bucks. But then why are you sending me a bill for a couple hundred bucks... it didn't make any sense..."

"... they told me it would cost this amount. And I kept getting bills that were much greater than that. And I'll call him and he'd say, 'no no your insurance paid for it, you're only paying this much.' And then I'd get another bill for hundreds of dollars and I finally said, 'I'm done with this. You don't know what you're doing.'"

Our On-site Visits are Energizing CMS Staff

CMS Volunteer	From Thank You Notes
OFM (Home Health)	"… I came away from the day **feeling uplifted and exhilarated** … one of the **best experiences** I've had while at CMS… so good to **finally humanize the work** we do here at CMS, to **hear the impact it has first-hand**, good and bad."
OC (Dialysis)	… a **powerful experience**…offered a **unique chance** to gain insights into both the processes and experiences of dialysis patients and providers… As I sit here this afternoon working on creating partner training materials…I will **never view this material or deliver the training in the same way again…amazing how one day can completely change your perspective**.
OIT (Hospice)	…talked with the [hospice] patients and the families, and the volunteers … **volunteers are amazing**…careful to explain why they volunteer … yet have to be careful …some of the comfort needed can only be given by a clinician…welcomed documenting everything…so that there is a record. I will **never forget this**… **meeting with the beneficiaries gives me a completely new perspective on how and why I do my job**.
CCSQ (Nursing Home/Hospital)	After reviewing the work from the Nursing Home team, I wasn't sure what this was about, but now I get it. This is **very important work**, and I want to be involved in more going forward. **Now, each time I look at our policies and rules, I see things differently.** Please keep including me.

Prior Authorization Infographic

Improve transparency, efficiency, and standardization of the prior authorization process

People Reached:

5 OBSERVATIONAL VISITS

331 CUSTOMERS INTERVIEWED

17 SME INTERVIEWS

CCSQ | CM | CMCS | CPI
CCIIO | FCHCO

35 LISTENING SESSIONS

Synthesis: From Data to Opportunity Areas

2,439 Data Points
direct observations and quotes

93 Themes
patterns in human behavior

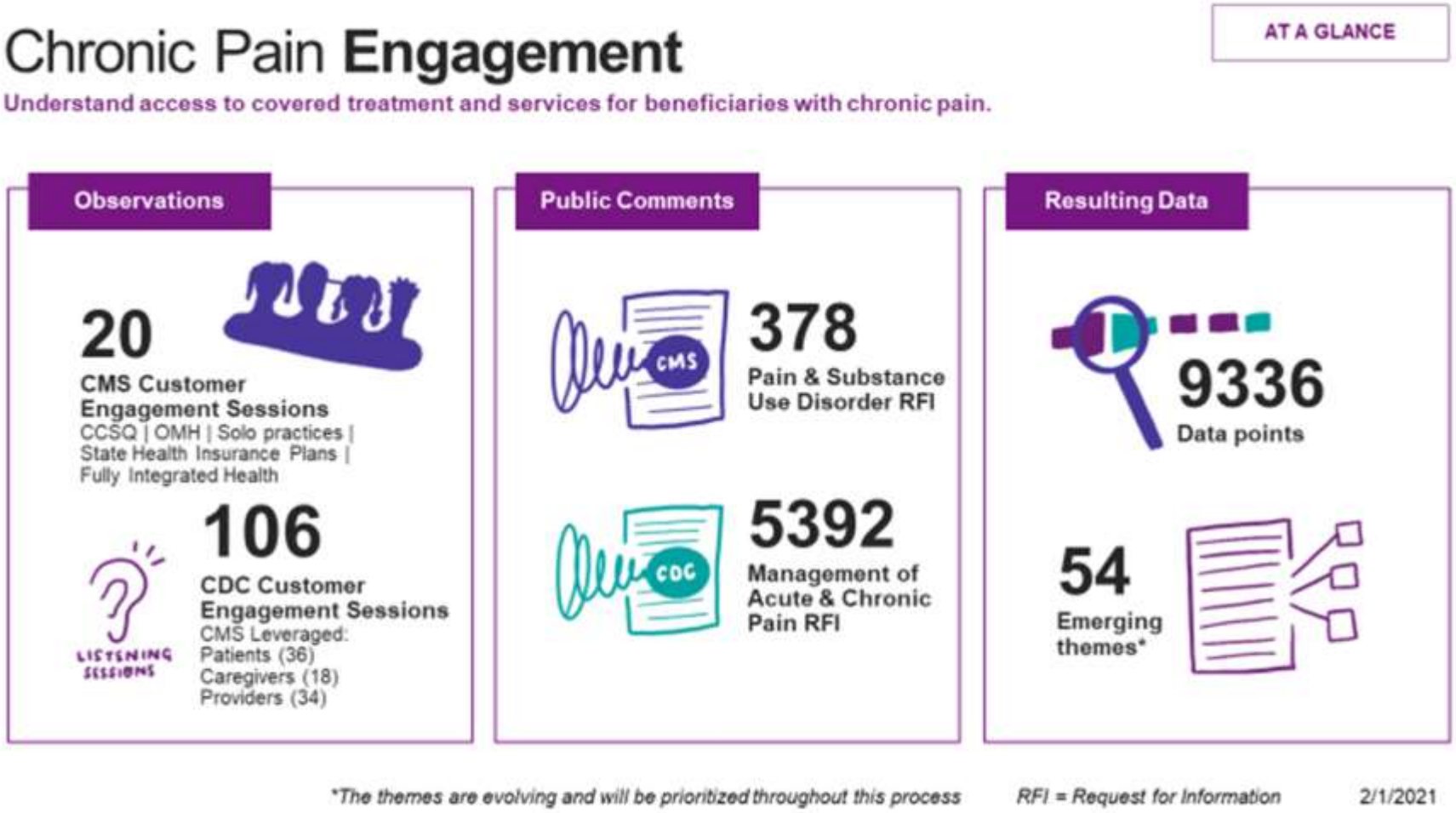
18 Prioritized Themes
selected based on instances of occurrence

15 Insights
learnings about patterns of behavior that are surprising or unexpected

6 Opportunity Areas
places to explore solution areas

Chronic Pain Infographic

Access to covered treatment and services for beneficiaries with chronic pain



Duals Infographic

Understanding the experience of eligibility determination and redetermination processes for the Medicare Savings Programs

Dually Eligible Individuals

Understanding the experience of eligibility determination and redetermination processes for the Medicare Savings Programs (MSP).

9
SME Interviews

ASPE | ACL | MMCO | OHI | Legal Services | Vendor

46
Customers Reached

Synthesis Overview

2,525
Data Points
verbatim quotes

75
Themes
patterns in human behavior

37
Prioritized Themes
higher-level customer truths learned through immersion activities

11
Insights
learnings about patterns of behavior that are surprising or unexpected

6
Opportunities
spaces to explore solution ideas

Data as of 09-21-2021

Past Customer Engagements

Past Customer Engagements	Scope	Customers	Subject Matter Experts
Nursing Home (Executive Sponsor: CM)	Understand the fee-for-service (FFS) Medicare skilled nursing facility (SNF) customer experience and identify burdens the SNF customer faces	Conducted one-on-one interviews, 22 listening sessions, 3 observational visits, 1 RFI Total 64 including administrators, billing staff, family members, MDS staff, nurses, providers, residents, social services, other staff	Total 41 including CM, CCSQ, CPI, CMCS, OMH, OPOLE, ONC, MAC, consultants, associations
Beneficiary (Executive Sponsor: CCSQ & OC)	Understand the Beneficiary burden with transitions of care between all settings	Conducted one-on-one interviews, 2 listening sessions, 1 RFI Total 46 including beneficiaries, professional caregivers, personal caregivers	Total 22 including CCSQ, CM, CMCS, OC, OMH, OPOLE, FCHCO
Hospital (Executive Sponsor: CM)	Understand the Hospital burden relevant to reporting including: quality reporting, conditions of participation, certification and accreditation, billing and cost reporting, and clinician documentation and health records	Conducted one-on-one interviews, 21 listening sessions, 7 observational visits, 1 RFI Total 151 including clinical, case management, billing & coding, administration, registration, quality, informatics, emergency department, finance, and compliance staff	Total 26 including CM, CCSQ, CMCS, CPI, OMH, OFM, OPOLE, vendors, associations
Clinician (Executive Sponsor: CCSQ)	Create concepts to improve the Clinician experience within the documentation burden	Conducted one-on-one interviews, 28 listening sessions, 1 RFI Total 32 including physicians, nurse practitioners, pharmacists, nurses, billing staff, practice managers	Total 8 including CCSQ, CM, CPI, CMMI, OMH, OPOLE, associations

Past Customer Engagements (continued)

Past Customer Engagements	Scope	Customers	Subject Matter Experts
Home Health (Executive Sponsor: FCHCO)	Understand the overall experience of Home Health care delivery from the perspective of home health agencies and beneficiaries	Conducted one-on-one interviews, 3 listening sessions, 5 observational visits, 1 RFI Total 70 including clients, client support network, billing, clinical, compliance, leadership, marketing, policy, quality, referral & intake, and field staff	Total 24 including FCHCO, CCSQ, CM, CMMI, CPI, OMH, OPOLE, associations
Hospice (Executive Sponsor: CCSQ)	Understand the unmet needs and intertwined journeys of all stakeholders who interact with or administer the Hospice benefit from the first discussion of advanced terminal illness through the provision of bereavement services	Conducted one-on-one interviews, 5 observational visits, 1 RFI Total 96 including beneficiaries, admissions, billing & financial, clinical care, clinical leadership, compliance, coordination & navigation, counseling & therapy, health information management, administration leadership, social & spiritual services, support network, volunteers	Total 18 including CCSQ, CM, CMMI, CPI, OMH, OPOLE, academic institutions, associations, contractors, palliative care programs at a private payer, Veterans Affairs
Dialysis Facilities (Executive Sponsor: CCSQ)	Understand the range of patient and provider experiences from early care for Chronic Kidney Disease (CKD); transition into dialysis, and continuous care including coordination between settings	Conducted one-on-one interviews, 4 observational visits, 1 RFI Total 66 including patients, care partners, social workers, dialysis patient care technicians, nurses, nurse care coordinators, nephrologists, medical directors, home dialysis nurses, biomedical technicians, dieticians, dialysis nurses, administrative assistants, facility administrators, dialysis facility leadership	Total 14 including CCSQ, CM, CMMI, OMH, HHS, NIH, foundations

Past Internal CMS HCD Projects

Past Internal CMS HCD Projects	Scope	Customers
eXpedited Life Cycle (XLC) (Executive Sponsor: CIO)	Understand the CMS component and OIT experience with the system development life cycle (XLC)	**(1) OIT**: Conducted 10 one-on-one interviews and 5 observations, 37 participants including the CTO, COR, GTL, manager, contractor, developer, CIRT, project lead, CDA data architect, budget lead, CRA, privacy SME, Tech Advisor, infrastructure, Cloud & DevOps, TRB **(2) CMS XLC customer**: Conducted 9 one-on-one interviews and 2 observations, 30 participants from OPOLE, CM, OEDA, CMMI, OSSO, CCIIO, CCSQ, CISPS, OC
Employee Onboarding (Executive Sponsor: OHC)	Understand the experience of SES, manager, staff, and student interns new to CMS (application through first 6 months)	Conducted 16 interviews – 8 from pre-2018 and 8 from post-2018 (indicated due to hiring freeze midway in the engagement) 12 staff, 2 managers, 1 SES, 1 intern CMS components: OIT, CMMI, OA, CPI, OAGM, CCSQ, OHC
Hiring Process (Executive Sponsor: OA)	Understand the CMS hiring process with a view toward finding efficiencies and reducing the timeline (creating Position Description through making the offer)	Conducted 29 interviews - 3 classifiers, 10 staffers, 12 business operations staff, 4 hiring managers CMS components: OHC, OIT, OPOLE, CCSQ, CM, OFM
Information Security & Privacy Group (ISPG) (Executive Sponsor: CIO)	Understand the CMS customer experience with security and privacy and understand ISPG's view of CMS security and privacy	**(1) CMS Privacy and Security customer**: Conducted 26 interviews CMS components: CCIIO, CCSQ, CM, CMMI, CPI, OFM, OIT, OSSO **(2) ISPG staff**: Conducted 17 interviews; 3 managers and 14 staff

Past Internal CMS HCD Consultations

Past Internal CMS HCD Consultations	Scope	Customers
Risk Adjustment Processing System (RAPS) (Executive Sponsors: OIT and CM)	Assist OIT and CM to apply HCD to "Improve the operational data sharing experience in the Part D reconciliation, risk adjustment, plan payments and premiums, enrollment and eligibility processes for Parts C and D plan sponsors and their functional designees"	Conducted 12 listening sessions with MAOs and third-party submitters
Retiree Drug Subsidy System Modernization (RDSS) (Executive Sponsor: CM)	Assist CM's RDSS contractor with applying HCD to learn the customer experience as they begin planning for major system upgrades	Conducted 6 listening sessions with Part C health plans and third-party contractors that utilize the RDSS
Infuse HCD throughout the Agency (Executive Sponsor: OA)	Create the CMS HCD Definition and Framework*	CMS senior leadership, managers, staff, contractors

**Approved by the SPMC May 2018*

Current Customer Engagements

Current Customer Engagements	Scope	Customers	Subject Matter Experts
Prior Authorization (Executive Sponsor: OA)	Improve transparency, efficiency, and standardization of the prior authorization process	Conducted 35 listening sessions, 5 observational visits, 1 RFI Total 331 including compliance, legal, beneficiaries, caregivers, clinic staff, health systems, clinicians, health plans, associations, societies, health IT staff, SHIPs, billing staff, hospitals, pharmacies, administrators, CEOs	Total 17 including OA,CM, CMCS, CCIIO, CCSQ, CPI, OMH, FCHCO, OPOLE
Chronic Pain (Executive Sponsor: CCSQ)	Understand access to covered treatment and services for beneficiaries with chronic pain	Conducted one-on-one interviews, 2 observational visits, 3 RFIs* Total 120 including beneficiaries, caregivers, clinicians	Total 20 including CCSQ, CM, CMMI, OA, OMH, OC,FCHCO, OPOLE, CDC, State Health Insurance Plans, solo practices, health systems
Duals (Executive Sponsor: FCHCO)	Understand the experience of eligibility determination and redetermination processes for the Medicare Savings Program	Conducted one-on-one interviews, prompted diaries Total 46 including beneficiaries, caregivers, advocates, eligibility staff (from 4 States)	Total 9 including FCHCO, CM, CMCS, CCSQ, CPI, OMH, OHI, OC, OPOLE, ASFR, ASPE, ACL
Minority Health (Executive Sponsor: OMH)	TBD (Fall, 2021)	TBD	TBD
ACO (Executive Sponsor: CM & CCSQ)	TBD (Fall, 2021)	TBD	TBD

Office of Burden Reduction & Health Informatics Customer-Focused Research Group

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