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 **Community Care Network Program**

**Region 1**

**Provider Satisfaction Survey**

**OMB No. 2900-0770
Estimated Burden: 10 minutes**

**Expiration Date: 9/30/2020**

**The Paperwork Reduction Act of 1995:** This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this survey will average 10 minutes. This includes the time it will take to follow instructions, gather the necessary facts and respond to questions asked. Customer satisfaction is used to gauge customer perceptions of VA services as well as customer expectations and desires. The results of this online/mail survey will lead to improvements in the quality of service delivery to community providers from Department of Veterans Affairs (VA) Medical Center staff and from health care networks staff through the Community Care Network Program. Participation in this survey is voluntary and failure to respond will have no impact on benefits to which you may be entitled.



**Privacy Act Statement:** This survey is not a collection of personal information; please do not enter any personal information in the open text fields. By voluntarily providing information on **<\_\_\_\_\_TPA PROVIDERS SURVEY WEB ADDRESS\_\_\_\_>**, you are consenting to VA’s use and disclosure of that information in the manner described in this limited policy. The VA general Web privacy policy is available at [www.va.gov/privacy](http://www.va.gov/privacy).

**TPA** will add text introducing themselves, the survey, etc.

 **Unique Identifier Code (UIC)**

Please enter the UIC that is printed under your business name on the survey invitation letter (7-8 characters): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The statements and questions in this survey are regarding your experience in the last three months as a Provider within the Community Care Network (CCN) Program in Region 1.**

**Please respond to this survey from the perspective of your relationship and experiences when providing care to Veterans under your contractual relationship with us, (insert name of TPA).**

**The following questions are regarding your interactions with the Community Care Network Contractor’s *customer service* department when providing care to Veterans under your contractual relations with <insert name of TPA>.**

The majority of the interactions with customer service were questions around:

|  |
| --- |
| Ο Referral Ο Payment status Ο ADD OTHER Ο Other  |

Interactions with the customer service department were courteous.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

Customer service department had the knowledge to answer CCN Program related questions.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

Customer service department was adequately accessible for advice and assistance.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

What is your level of satisfaction or dissatisfaction for responses to inquiries using ***telephone customer service***?

|  |
| --- |
| Ο Very Ο Satisfied Ο Somewhat Ο Somewhat Ο Dissatisfied Ο Very  Satisfied Satisfied Dissatisfied Dissatisfied |

What is your level of satisfaction or dissatisfactions for response to inquiries using ***website customer service***.

|  |
| --- |
| Ο Very Ο Satisfied Ο Somewhat Ο Somewhat Ο Dissatisfied Ο Very  Satisfied Satisfied Dissatisfied Dissatisfied |

**The following questions are regarding transfer of documentation and Billing and Payments with the Community Care Network Contractor when providing care to Veterans under your contractual relations with <insert name of TPA>.**

**Clinical Documentation**

Do you use the HealthShare Referral Manager (HSRM)?

|  |
| --- |
| Ο Yes Ο No Ο Unsure (If No or Not Applicable, please skip to **Billing and Payments**)   |

It was easy to use the HSRM.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

If HSRM ease of use was ***Rarely*** or ***Never***, please describe issue(s) you had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Billing and Payments**

I understand the billing process to submit claims to the CCN Contractor.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

Payments by the CCN Contractor for “clean claims” were issued within 30 days of receipt.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

The EOB I receive from the CCN Contractor fully explains the adjudication of the claim(s).

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

The EOB I receive from the CCN Contractor is easy to understand.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never |

The EOB I receive from the CCN Contractor provides what I need to reconcile my Accounts Receivables.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

 **The next questions are regarding any Problems and Complaints you may have encountered with the Community Care Network Contractor when providing care to Veterans under your contractual relations with <insert name of TPA>.**

Have you experienced a problem with, or had a complaint about, the CCN Contractor?

|  |
| --- |
| Ο Yes Ο No (Please skip to the next section, **Overall Satisfaction**)  |

Problems or complaints with the CCN Contractor were resolved quickly.

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

Problems or complaints were resolved within:

|  |
| --- |
| Ο 0 to 3 day Ο 4 to 7 days Ο 7 to 10 days Ο 10 days or longer Ο Never  |

Problems with the CCN Contractor were resolved with minimal effort on your part?

|  |
| --- |
| Ο Always Ο Most of the Time Ο Sometimes Ο Rarely Ο Never  |

Describe the problem(s) and how the problem(s) was resolved. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**The following questions are about your overall experience with the Community Care Network Contractor when providing care to Veterans under your contractual relations with <insert name of TPA>.**

Please tell us how you feel about the following statements:

I received the service I needed.

|  |
| --- |
| Ο Strongly Ο Agree Ο Neither Agree Ο Disagree Ο Strongly  Agree nor Disagree Disagree  |

It was easy to get the service I needed.

|  |
| --- |
| Ο Strongly Ο Agree Ο Neither Agree Ο Disagree Ο Strongly  Agree nor Disagree Disagree  |

I felt like a valued customer.

|  |
| --- |
| Ο Strongly Ο Agree Ο Neither Agree Ο Disagree Ο Strongly  Agree nor Disagree Disagree  |

I trust the CCN Contractor to fulfill our country’s commitment to Veterans.

|  |
| --- |
| Ο Strongly Ο Agree Ο Neither Agree Ο Disagree Ο Strongly  Agree nor Disagree Disagree  |

**The following questions are about your overall satisfaction with the Community Care Network Contractor.**

Overall, how satisfied are you with your interaction with CCN Contractor regarding the CCN Program?

|  |
| --- |
| Ο Very Ο Satisfied Ο Somewhat Ο Somewhat Ο Dissatisfied Ο Very  Satisfied Satisfied Dissatisfied Dissatisfied |

Will you continue to provide care to Veterans on behalf of VA using the CCN program?

|  |
| --- |
| Ο Definitely Yes Ο Probably Yes Ο Probably No Ο Definitely No Ο Not Sure  |

Is there anything you would like to share about your experience with the CCN Program or the CCN Contractor?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Miscellaneous questions follow.**

I receive adequate training.

|  |
| --- |
| Ο Strongly Ο Agree Ο Neither Agree Ο Disagree Ο Strongly  Agree nor Disagree Disagree  |

If your answer is “Disagree” or “Strongly Disagree” what could be clarified:

|  |
| --- |
| Ο Payment Process Ο Referral/Authorization Ο Veteran Culture Ο Other Process  |

Is other please state what training could be clarified:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Please tell us about you.**

Where do you work?

|  |
| --- |
|  Ο Independent Medical Office Ο Private Hospital Ο University Hospital Ο Other – please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

What is your occupation?

|  |
| --- |
| Ο Clinician Ο Billing and Accounts Receivable PersonnelΟ Office Manager or Office Staff Ο Other – please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Within the last 3 months how many Veterans did you provide care for?

|  |
| --- |
| Ο Fewer than 10 Ο 10-39 Ο 40-69 Ο 70-99 Ο 100 or more Ο Do not know |

How would you describe the geographic area where you provide care?

|  |
| --- |
| Ο Rural Ο Urban Ο Highly Rural |

**END OF SURVEY Thank you for your time!**