Contact Center Operations

CCO Transferred Supervisor call:
Capstone Project

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Objective: Deep dive into call reasons that required Senior/Team lead intervention

Introduction:

Our goal in CCO is to keep the Customer Experience "**Easy, Caring and Connected**"

When members are still dissatisfied with the agent's assistance and/or requesting immediate Supervisor, agents' procedure is to reach out to the Supervisor phone line as a last resort. The supervisor on the call will manually enter the information (call reason, action, agent information) through a "Go-Fish" form in SharePoint. The available options on the form is subjective to the Senior or Team Lead decision and whether full information was given to them by the agents . This Go-Fish form is utilized by several departments.

CCO Business Analyst team uses this data to generate several reports to account for the calls made to Seniors/ Team Lead. (Ex: CAHPS Assist Line and CCO Assist Line) The existing reports details the number of calls Seniors and Team lead took. It display the top call reasons and LOBs (line of business), and the current reports are pull from SharePoint and IVR server for accuracy and numbers.

Data Source:

The data I'm utilizing is exclusively from SharePoint:

- Sourced from **CCO Assist Line SharePoint**
- Containing: **17 columns and 232,377 rows**
- Last pull as of **5/22/24**

Objective: Deep dive into call reasons that required Senior/Team lead intervention

Research Questions:

My research question would be on a granular level , focusing on specific call scenarios,

After *agent attempt to resolve the call* ***And*** *member still insist on supervisor intervention*

What is the top reason for member's dissatisfaction and how to improve the member's experience?

Methodology

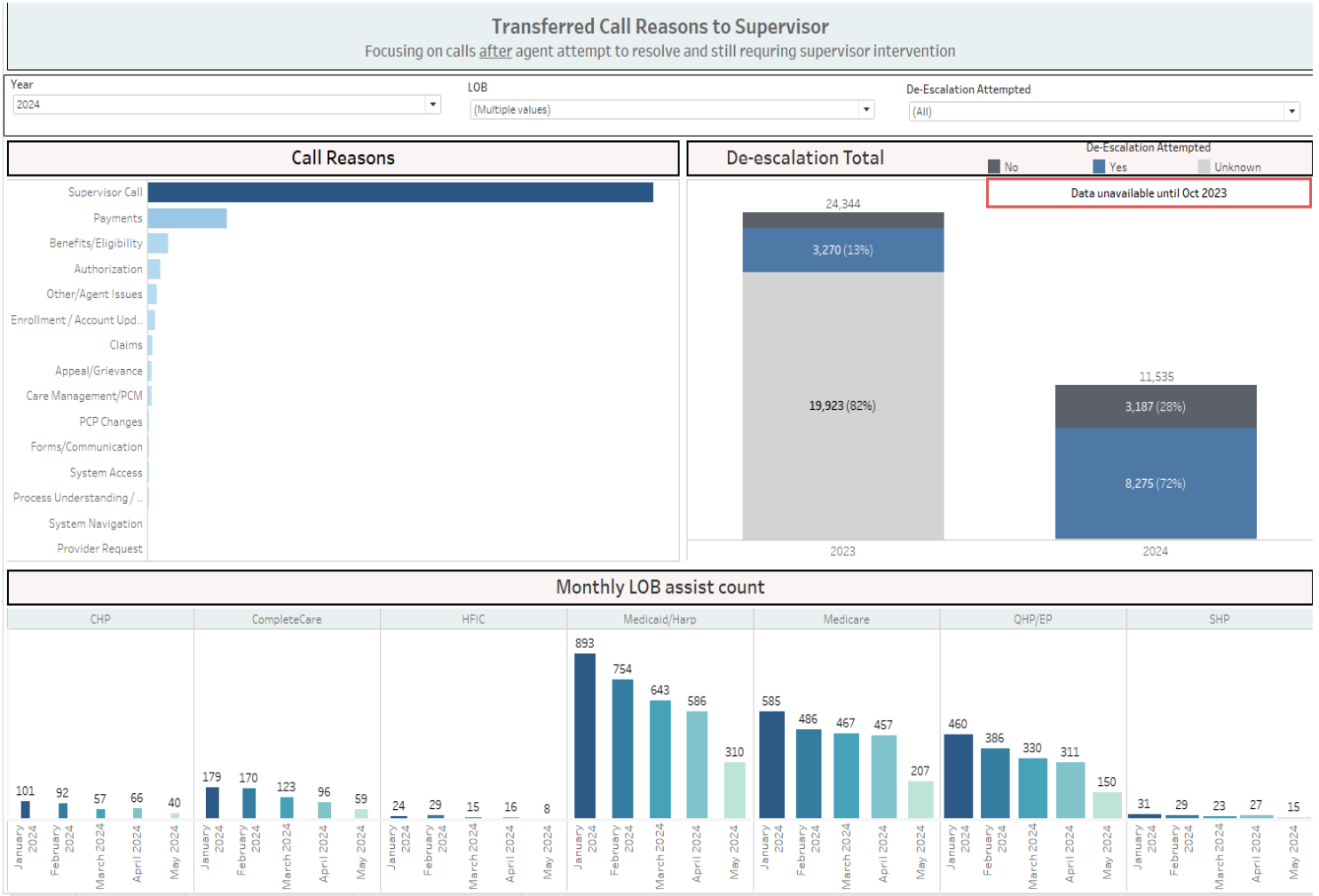
- **Clean with Python :** Import pandas, numpy, nltk
  - **Dates:** replace missing dates from “Orig_created date” with “Created” date and created a new date column labeled , “`InitialCreatedDate”`
  - **LOB:** combine duplicates line of business
  - **De-escalated attempted:** replace null values with “unknown”
  - **Datatypes:** change data types to numeric and categoric
  - **Keyword:** utilize stop word to remove filler words

- **Create Visualization:** import matplotib, seaborn, wordcloud, utilized Tableau
  - **Matplotib & Seaborn:** bar and line chart
  - **Wordcloud:** common words
  - **Tableau:** combine charts: sheet formatting (color, tooltip, filters, marks, data-ink ratios)

Deep Dive

Findings:

- **Top Call reason**: Supervisor Call
- **72% agents** in YTD attempted to deescalate call before transferring to Supervisor
- Data on de-escalation attempts not available until Oct 2023
- **Top LOB volume**: Medicaid/Harp



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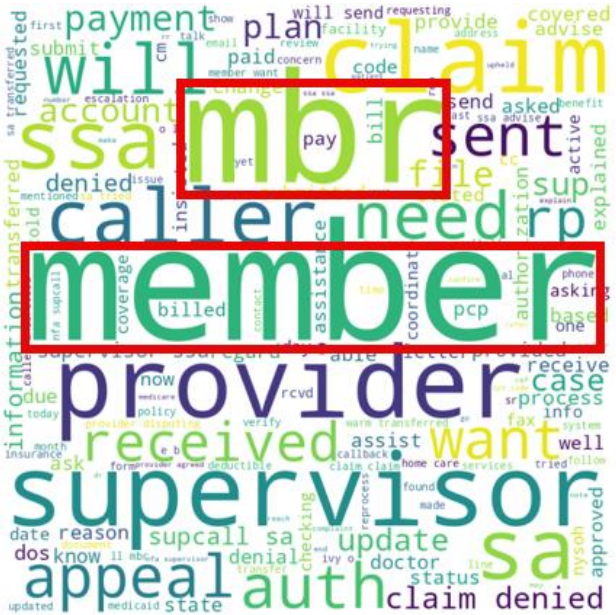
Deep Dive

Finding: Member are the top callers

Surprise Finding: Provider are the 2nd top callers transfer to SGQ line.



Finding: Claim is the top issue

Related keywords: claim denied, file appeal, auth, dos, bill, letter

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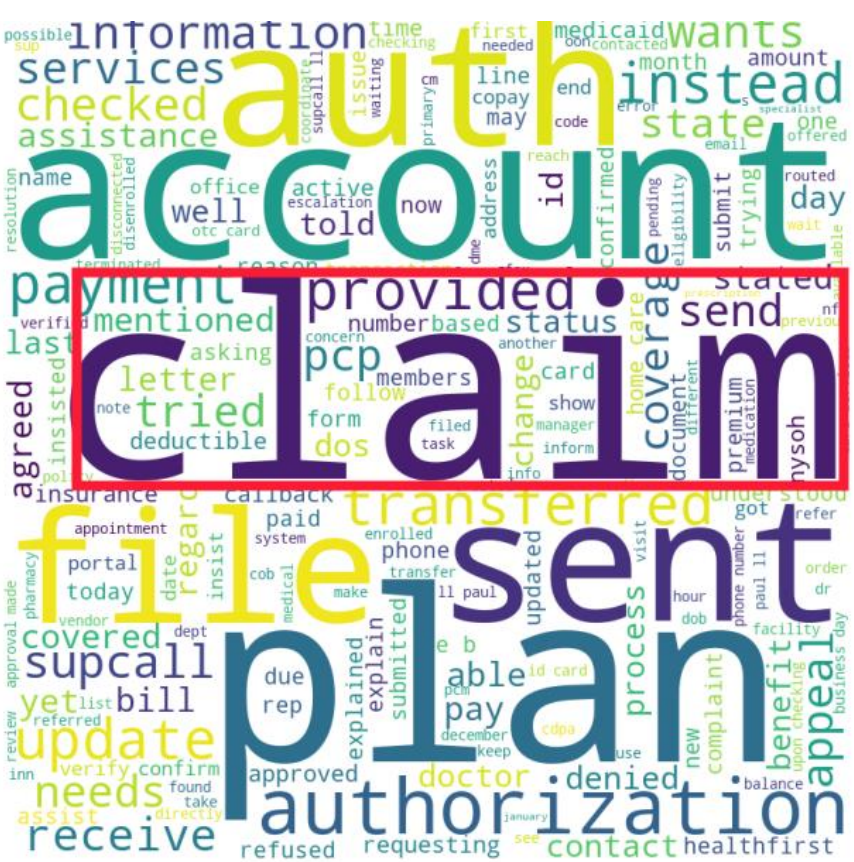
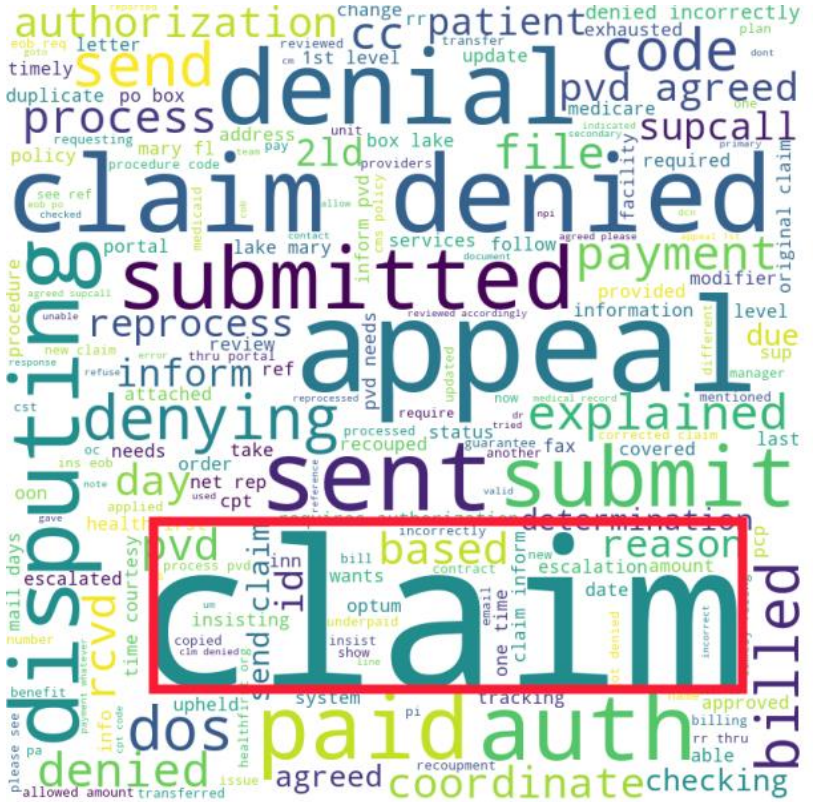
Deep Dive

Finding: Member's call reason



Finding: Provider's call reason



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Conclusion

- **Descriptive statistics:**
  - Supervisor calls are the top reason Senior/ Team Leads handles
  - Member are the top callers
  - Claims is top dissatisfaction
  - Medicaid is top LOB call volume

- **Inferential statistics:**

From the findings, claim is the top issue. A possible reason Medicaid claims are denied is the assumption that Medicaid can cover all services at no cost. However, hf may **denied** for reasons including member's coverage was not in effect at the day of service (**DOS**), untimely **claim** submission, and/or no **auth**orization obtained for service. Members will then receive a **letter** of adverse determination advising them of their **appeal** rights and provider will also have the option for appeal

From the findings, member are the top callers. A possible reason is Medicaid members inquiring about their **account/ plan/ authorization** status. Medicaid plans renewal anniversary is based on when the member signs up. (no set OEP date) If renewal is not completed, Medicaid members loses their insurance and most member are unaware until they see a doctor, refill a medication, or if their home health service is terminated.

Conclusion

Recommendation/ Actionable items:

1. **Documentation opportunity**:
   - "Supervisor Call" is a general reason and does not give insight into the call. There are other selections that best fit the call inquiry but not utilized as often (ex: "claim" or "authorization") In addition, since there is already a question that is identical , "Supervisor Requested" (Y/N)
   - Replace the selection "caller with customer" (Y/N) on Go-Fish form, with a dropdown selection (member, provider, internal, unauth, RP, auth w/ mbr permission) to give more insight who the caller is. This data can be used to further deduct the reason inquiry.

2. **Add feature in SF coverage to indicate if prior authorization is needed**
   - Currently SF benefit indicates for Medicaid plan, service is "cover in full at $0"

3. **Further analysis is need to determine main reason for medicaid denied claim to ensure no other impact**.
   - Look into claims cases sent back for processing

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Reference List

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