The #HCBiz Show! Episode 15
PD05 – Approaching Provider Directory as a Data Quality Issue | Andrew Kobylinski | BetterDoctor
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Don Lee: You're listening to the HCBiz Show. The podcast dedicated to unraveling the business that's so complicated, it has to be on purpose. The business of healthcare. I'm Don Lee and first I'd like to welcome my co-host to the show, Shahid Shah. Welcome, sir.

Shahid Shah: Hey, thanks, guys. Good to be here again.

Don Lee: Awesome. We're going to get back into our Provider Directory series after a brief one week break, to talk about the Digital Health Accelerators. We are going to get onto solutioning here. We've kind of beat up what and why of this problem pretty good, would you agree, Shahid?

Shahid Shah: For sure, yeah. As a recap, the way we like to do things is start number one with why something is worth doing, and those we've covered quite a bit. Then, we've talked about what should we do. That starts to move a little bit into solutioning but really talking more about the capabilities that we need more than these specifics of the way they're working. Then we jumped into how things work. That's a good innovation pattern. If somebody hasn't thought about why an innovation is necessary, he never talked about what the innovation is. And never talk about how the innovation works until you talk about what actually it should be doing from the expectations point of view. We're not crossing over into that what and how, so I'm looking forward to it.

Don Lee: Awesome. With that, we're going to talk with someone who's actually out there working on this problem every day. I'd like to welcome our guest, Andrew Kobylinski who's the Head of Platform at "Better Doctor". Andrew, welcome to the HCBiz Show.

Andrew Kobylinski: Hey, Don and Shah. Thank you for having me today. It's great to be here and talk with you. I've been working on this problem for about a decade and solutioning is definitely at that stage, where we need to solve this Provider Data problem. It's really unacceptable that as an industry we haven't solved this yet. We don't know where our doctors are. Where patients can access them. It's one of the fundamental issues that your work here and work of many folks are ... progress is finally happening in the space and we're really excited about that. Thank you for having me.

Don Lee: Yes, you bet. Absolutely. You said you're been at it for a decade. Which I

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think might make you the person who has known about this problem a longest then. Because most people are just getting up to speed here, so that's good to know. Has all that time been with "Better Doctor" or did you do some work before you even got involved there?

Andrew Kobylinski: I did some work previously at another Health IT company that had many consulting types of relationships and unfortunately, at a time I was always on the side of the problem and just presenting the Provider Data and creating user interfaces into the Provider Data, yet never having the control over the data quality. I've just witnessed first hand, many wonderful projects and initiatives and multi-million dollar efforts to bring Provider Data to consumers and evermore consumable formats. All failed because the quality issues would kill user adoption. It's great to finally be on the other side of the problem to actually fix some of the fundamentals that I've witnessed, hold back the industry.

Don Lee: Yes.

Shahid Shah: Hey, Don, just from a messaging perspective that's the interesting way that Andrew put it. I think we thought about this in a variety of different ways but thinking of Provider Directory primarily as a data quality issue rather than core functionality issue. I think Provider Directories exist in a variety of different ways. Some directories are missing data, some data is available but incorrect and a variety of other things. Maybe, as we talked about this, thinking about the Provider Directory, first and foremost are the data quality problem is probably a good way of characterizing it. So, as we move in from the what are we trying to do or what we're trying to do is to improve the quality of provider data. How do we do that? Sometimes we need a new directory. Sometimes we just need to correct the directories that are there. It's a good way to think about that problem, I think.

Don Lee: Yes, I couldn't agree more. It's funny how data quality is always an afterthought. People just think it's a given that... the data quality is going to work itself out. That's the hardest part of all of this. It's true when you're talking about provider directory. It's true when you're talking about population health and healthcare analytics in general. Absolutely, folks on data quality is huge. Andrew, why don't you tell us a little bit about "Better Doctor" from a background standpoint. Is this the company that started to solve this problem or did you evolve to solve this problem?

Andrew Kobylinski: Great question. "Better Doctor" doesn't have a traditional approach. The company really pivoted into this problem from a real-world experience. The company was founded by two former Nokia engineers, Ari and Tapio. They came from Nokia with gaming and mobile app experience. Working in Innovation Lab in Silicon Valley and witnessing some of the difficulties in finding a doctor through their own experiences back in Europe as well

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here in the United States. They thought "we have the best user experience in fields and expertise. We know how to build stuff that's responsive, quick and mobile. Let's go ahead and let's do a startup ourselves." They went out and raised a bunch of money and founded a company in 2012. and launched a directory consumer service. It was a service that initially didn't have a definitive business model. It was more as "can we build something that's really useful to consumers? Can we reinvent the wheel on how folks access and look for doctors online?"
The service launched as a website betterdoctor.com; Mobile apps, iOS apps. It was quite successful. Over a million users a month, but something that really became evident in 2013 and 2014 was that there were a lot of data quality issues. The company was licensing some of the best data from the top ranked vendors in industry spending top dollar, multi-million dollars. Millions of dollars from the venture investments that had been put into "Better Doctor" were spent on the best data that the industry could have, could provide. Everyone was just shocked that things were wrong. It was really a bit perplexing. We're hearing a lot of different complaints. Patients and doctors, for example, the claims cleansed, the best golden rule algorithm, confidence data that was available was confidently telling us that patients would go to doctor's home address and call them on their personal cell phone to get an appointment. When things are that fundamentally wrong and actually that fundamentally wrong not as one [00:06:34] but as a few presented points of entire data set, you know that industry has failed. There's something I miss here. The thing that "Better Doctor" started looking at this in more detail and one of the call center team to an initial thought was "we'll go through and we'll evaluate each data vendor and one that has the good quality data we'll keep and this problem will be solved." They went through and every single assumption that they had about data sets from licensing databases, date medical boards to NPPES directories to commercial their party is that to claim drive data sets, all the assumptions proved out wrong. **The underlining seem was that every data set had really unacceptable error rates.** We're talking 30-40% on just the doctor, name, address combinations. That really gave us pause. At the same time that we're doing this analysis, the consumer service was getting a lot of traction from the developer community and doctors asking: "We like the site, we love the usability. Can you build something like this for me? Can you build something like this for my doctor's practice? Can I take a little bit of the data and put it into my mobile app?" Coming from an open source type background, they decided to launch the developer portal. An API. Programmable Interface into our [00:07:59]. While we're looking at this data quality problem, since starting to open up access to data we had to a larger audience, we realized we were becoming a hub of data but the data was not very good. We decided to pivot the business. Exit the consumer business and focus on the data problem entirely.

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Don Lee: Got it. What's the timeline there? Is this year or two after launch or where about?

Andrew Kobylinski: Yes. The decision was really in 2015 to make that pivot. And early 2015 what really sealed the deal for us was AHIP. America's Health Insurance Plan reached out to us and coincidently they had the task force where they were looking at some of the White House frustration around the data quality through the federal exchange rights and the federal exchange QHP plan products. There was a lot of frustration at executive levels at health plans that they have been doing the same old thing for 20 years without making any progress. They felt that the market and the industry was a bit stuck. Something needed to happen disruptively to force everyone to rethink what they're doing and how they're doing it. Basically, a lot has happened in 2015. We worked with AHIP to create the AHIP pilot projects and that resulted by the Fall of 2015 recruiting nine health plans to work with "Better Doctor" in California and Indiana. As you've mentioned and discussed with Availity in one of your previous sessions, Availity was working in Florida, to test out some concepts. One of the main goals of that whole effort was really to try something new. Don't be afraid to sail. Let's see if we can bring different folks together and communicate on provider data and try different ideas and really learn. Learn how to advance. Learn how people are doing it at different health plans. Share that knowledge. As a company kind of went through that pivot and the AHIP pilot really solidified our approach and as of mid-2016 to today, "Better Doctor" has been 100% solely focused on this and it's really, we moved from any previous direct consumer activity.

Don Lee: Got you. That's really interesting. Go ahead, Shah.

Shahid Shah: One quick question. If you think about the data quality issue, sometimes when you know what the right data is supposed to be, data quality is a bit easier, one of the fundamental problems here both for you guys as well as the industry is nobody knows what is the canonical representation of what right data is. What is your strategy of knowing what is correct so you know what data to put in?

Andrew Kobylinski: That's a great point. When we were, if you think of history, we were talking to different doctors about the data coming from various data vendors. One of the most fundamental things that we've discovered is that none of the data sets anyone was working with came with metadata that described when it was collected? Who attested to it? Who provided it? When did they provide it? Which attributes where they providing at that time? There is no context. There was no follow-up information. If you've found something that seems to contradict another data point you had, you didn't know who or where it came from, so you couldn't call that provider to confirm the conflict or resolve the conflict. Without that metadata, the

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industry is effectively flying blind. People are designing confidential algorithms and all this [00:11:24] but at the end of the day, it wasn't getting anyone anywhere. Without the transparency, you wouldn't trust the data set or you'd find a few errors that'd make you not believe it's good, yet a vast bulk of that data was good. What we looked at and we thought "the only way that we can build this is if we did a new data architecture where we're openly and transparently sharing all that metadata so people can actually trust how this information is collected and include all the additional metadata to go so far as to view recordings, screen recordings, audio recordings of the actual data collection process when it happens." Once you get that level of transparency and you start sharing that data openly, things start to magically happen. People start trusting it. They start looking at records and saying: "This information in these rows, that's 8 months old, so I'm going to ignore that. But records from last week. Wow, this is really good. I'm going to focus all my energy on this stuff." If they have a conflict or if that change implies the contract termination, they know that chain, the office manager at 1, 2, 3 main street of this cardiology clinic was the person who contributed the data. Their team can go ahead and quickly talk to chain about that issue or say "Okay, by you reporting this, it means we need to terminate this provider. Can you please confirm this and we'll send the official paperwork to acknowledge that." **Once the data is transparently shared, everyone can start moving forward.**

Don Lee: Got it. That's interesting. You're adding that context to it as well, as you're getting the data from the source. That's one of the issues that came up on a couple of the podcast recently as this lack of context between the person who was asking the question and the person who is receiving that, who is being asked. They're not on the same page as to what that data is going to be used for. The example was, the difference between I need this information so that we can make sure we process your claims properly versus we need this information for our provider directory. Are you ever going to bill from this office? Yes or no versus would you accept a new patient at this office? Yes or no? It sounds like you guys are adding that context after the fact and reconfirming, is that right?

Andrew Kobylinski: It is correct. There's one interesting point when we talk about contexts here. I don't think... some people confuse context of the problem, have you asked the wrong question in the wrong way to the wrong person? **I feel like the industry still, uses a little bit as an excuse to mask bad user interface designs.** Things that are just not intuitive or easy to use. As an industry health care tends to be riddled with jargon and really horrible old-school technology and tools. When you think of yourself or your parents as consumer and user, it could be a family member of yours that's a practice manager at a clinic. We want to use things that are intuitive, easy to use, that really explain what's been collected. **I would say this problem**

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is less about forming the right way to phrase a specific question for a user at one time. It's more about this really good interfaces, really good product design. Bringing modern functionalities and how everyday people look at and expect to use products. **Bringing that thinking into this process and context may become more intuitive.**

Don Lee: Got it. Let's go down that path a little bit and talk about what specifically you guys are doing to facilitate that. You've mentioned audio recordings and video recordings and it sounds like there is a bunch of different ways you might collect data. Let's talk about that. What is "Better Doctor's" approach to collecting high-quality provider data and verifying the high quality is there?

Shahid Shah: And if you can add to that, Andrew, the ability that, do you guys ever connect with existing sources that are collecting that data today, so for example, Electronic Health Record Systems have some kind of provider data. The Revenue Cycle Management Systems. Lab System, Imaging System... these all have doctor data of one [00:15:36] or another. Or do you go somewhere else? Talk to us about the existing data. Where that might be? Would you be able to pull from in the future? Maybe not even today. Is that worth it? What are your resources and which ones seem to work best for you?

Andrew Kobylinski: Absolutely. Let's start with that and I'll work back to the first part of your question. If you think back to our early story when we were evaluating a lot of different data sets, we've really learned to be skeptical of data sets and data sources and we learned that the hard way. We trusted things and just to get burned about them time and time again. Today, we apply that approach when we look at data sets and workflow integrations and information contributed by our API developers. If the provider groups send us the roster or marking department for a chain of dental practices since it's the roster adoption that works there. We take everything with the grain of salt and say: **"Okay, this is good information but is there metadata to provide us context why we should trust it?" If there isn't, what can we do to get that metadata? What can we do to build confidence in this information and validate that what we're working with is in fact what we're assuming to be?** As we're looking at different data sets, today we don't say they are sources of truth for any attributes. What we say is that there are sources that are useful in helping the user complete form responses and attestation. To give you an example for this, **in our process today our focus is to perform outreach to providers and put in front of them a form with all of the data from health plans, systems that are on record and ask them to go through and verify if that information is correct.** When the user goes through these forms, we can use the NPI directory to help us check that data inputs for NPI numbers are valid or active. We can use licensing databases to help the

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user. Auto-populate the license from one system or another and send it to check to see, to help ensure that they don't fat finger a value and they input a valid value. But at the same time not restrict them to not inputting data. Saying that there are some other licensing entities out there for other specialties in focus areas that may not be through the standard licensing bodies that someone might not need as a trusted source of truth for that attribute. Understanding that health care is a little bit more complex and whenever you might make an assumption about a data set, you often find a lot of edge cases to disprove your assumption and if you code up tools that are too strict to those assumptions, on truth, adoption dies. Because users can't complete the form. They can't actually put their real license in there because you don't allow for that. Because you made an assumption about one licensing data set as being the source of truth. The lesson here is, be skeptical, make assumptions, but be happy to sail on it and as providers provide input to you, one thing I can say about doctors and practice managers, they want to give you the right information. **They work really hard to give you the right information. If they can't use your form properly, they will email you and call you to tell you the correct information.** You have to have a really good ear to that. You have to adapt and reassess your assumptions constantly. Basically, fail quickly and iterate. Getting back to the first part of the actual workflow share. "Better Doctor" takes in data files from multiple health plans. We aggregate information together into a single profile. We filter out of that profile information a provider may have already attested to. If they indicated that a phone number is no longer in service or an email address is invalid, this doctor doesn't have this specialty and has the specialty. We blend into a profile that had previous responses so they're not repeating work that they've done previously. Yes, the provider to basically complete that and at the end of it, the data is submitted to the health plans. We do some fancy data work to match that data back and calculate unique differences for each health plan. This is one unique difference in our process than a lot of folks. We're actually in our systems, we effectively have the contract database. We have the health plans database. We have it updated at a high frequency. At any given point, I can calculate differences and updates that health plans need to process into their systems. We're on this long path of continuing to integrate more update workflows within the health plan to actually process changes. There's an important point here that just collecting the data is one-half of the problem. It's actually easier half. The other half of the problem is taking the data that you've collected and sharing it with all the stakeholders that need it in the format they can actually consume and trust. The output side of what's collected is a long path that today "Better Doctor" has real-time APIs into it. We have multiple standard export formats to sign for machine processing and human processing and whatever needs to be. We also have complete custom exports that match unique processes to specific health plans. I see over time this will evolve and this will change and how we communicate

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data will improve and there will be other methods. There will be other integration points. As we look at the process and what we're doing on the API side of the world, that would be in the long term another vehicle for integration with more stakeholders in healthcare.

Shahid Shah: Andrew, one of the things that we hear fairly often is what is the provider's incentive to keep their information up-to-date, that somehow, they are not really responsive. That you send them things over and over again and some of them don't respond or they take a long time. That doesn't sound like... I love your thoughtful response because it makes it very real and it's a big problem, it's not easy to solve because there are a lot of nuances but the thing that struck me most is you saying that when you send a form to them, they do try to fill it up meaning that providers are trying to get it back to you quickly because it does behoove them to keep that data up-to-date. Comment and elaborate a little bit more on this idea that somehow providers don't care about the data and they are not willing to correct it when they find out an error.

Andrew Kobylinski: Yes. It's a very common misunderstanding about this. Providers are very busy and they do miss a lot. Them missing something or forgetting to respond to a health plan, it's a very common thing, it happens. When you speak to the provider, it's not their intent. They say: "Oh, no. I responded to a form the other day. I thought that was your form. Sorry, I got that confused. I'll go ahead and do this now." Providers want to get this done. They are busy. They are human beings. Their office staff has a lot of things on their plate and they are very distracted. We've deployed a methodology of multi-model, lots of modifications, lots of reminders, just to make sure that people get it. We get some of our best response rates on the second or third notice, notifications to a provider. People put it on a desk. Maybe put it on a desk of an office manager. We don't hear a response for few weeks and we go and remind them and they say: "Oh, sorry. Jane was on a vacation." and they jump on the task and get it done. There is a problem, though, in a market that we have a lot of health plans and provider’s contracts with groups and health plans and it's just a complex structure of responsibility and different scenarios and different contract types. All that complexity just includes a workload. The long-term industry really needs to consolidate this together. It needs to provide providers with shared utilities to complete the work so that the burden becomes less onerous, It's easier to complete at once on behalf of multiple entities. That adds value to the provider community. One thing that's been really interesting and really not part of this conversation, in general, is the consumer aspect of this problem and what providers want to see on consumer's side. There are many hospital organizations, there are many providers who pay a lot of money each month to get their data out into the healthcare ecosystem. There are many physicians that pay to update their profiles on Yelp on regular basis. There are many physicians that pay

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services and their marketing department pays services like Yext to get the directories of providers updated on consumer services. At the end of the day, the long-term solution to this and a value prop to the provider community is the organization who can come in and do this work for them and get their data syndicated out to a larger ecosystem of stakeholders that need it. The first hurdle, we have to stage step and take baby steps. The first hurdle is getting all the doctors data to all of the health plans. Solve that use case. That's very critical to - day in/day out - operation and patient flow. And then start moving upstream to the other stakeholders and really enable them with the good data that providers today are paying the marketplace to update and it's happening very inefficiently.

Don Lee: Awesome. Is that where you're going with the APIs? I know that you've mentioned them earlier and that seems to be from, what I've read on the website and out there about you guys, the APIs seems to be the big part of this. Is that where it starts to really play in?

Andrew Kobylinski: That's definitely where the potential is and it's not our near-term focus to roll that out, there's a lot to really work on and stay hyper-focused on the health plan, provider relationships, provider groups. Getting those narrow set stakeholders, communicating and working really well together on data before we open that up fully. Absolutely, that is part of our greater vision.

Don Lee: Got you. What is the API being used for today? As largely for those primary stakeholders? I think it lists 1800 developer partners that are using the API today. Who are those folks and what are they using it for?

Andrew Kobylinski: Absolutely. The growth has been pretty amazing. Very organic. We are constantly surprised by what's been happening there on API. When I look at the list of the type of folks, we have surprisingly a lot of students. What's interesting is quite a few coding schools have used our APIs as a demonstration project under curriculum. Our APIs are so user-friendly, so easy to use. It actually used to teach people how to work with APIs. A lot of interesting stuff happening from these types of organizations. We constantly and probably every other week we're getting some innovation team from Fortune 500 company trying to build something. I've had many countless health plan innovation teams wanting to demonstrate new PCP selection tools for open enrollment and demonstrate new concepts of what could be done with the health plans data and the members experience. **This innovation teams can't get access to their own data internally, so they reach out to us and start using the public free version of "Better Doctor" API to demonstrate this concept back to their organization and justifying doing something new and innovative and making an improvement.** We have a lot of activity like that. We have a lot of users to the API that are workflow solutions, so to speak, for the industry. If you look at EMR systems and EHR systems like Elation EMR, dr chrono and

all these other really cool tools and there are tons of referral apps out there now and patient patching tools. A lot of them are using our API to help facilitate those workflows and those functions for doctor lookup within the services. API community is really this great thing using our public data and data that providers have authorized for public use. It's showing us the greater stakeholder community. The greater range of companies that need access to high-quality provider data and regular updates. The scale at which they need it. It's really opened our eyes to how broad this problem is for the industry and how big the opportunity is to fix it for everyone.

Shahid Shah: When you think about the broad nature of this problem, do you think that there is a strategy and which, if we combine credentialing which is basically an extension of what we're talking about here with provider directory data, does that make sense that trying to think about the broader aspects now so that we get more people jumping in and keeping them up-to-date. Imagine if we had all the credentialers who were sitting at the variety of these practices and health system. If there could be a central capacity to do both provider directories which have one problem associated with network plans, products and network identification on that side. If we add the ability to do deeper credentialing, does that make sense to do as part of this process or should it be kept separate?

Andrew Kobylinski: I would say, at this stage, it really should be kept separate. The reason why is there are tens if not few hundred different organizations and vendors doing credentialing of some sort today across different types of providers. There have been some efforts in the industry to do common credentialing solutions for different states and things like that. We're still a way out for that. Those processes and workflows to mature and be adopted by large enough numbers of providers for them to be significant. I view them as, yes, in a near term from this perspective. Near term to prove the concept that some of this data attributes can be verified in the credentialing workflow. That in certain cases you are speaking with the correct individual who pins a test to specific attributes at a high degree of quality. That these people are giving you the right information, they're giving you the right metadata and it's a great data point that you can use. We need to prove that concept and we need to make sure that our assumptions there are checked. Now, long-term, that can scale up. I think it will scale up as more common credentialing and those workflows are adopted more broadly. However, today as we look at a typical provider practice they may credential through multiple organizations with the same practitioner. They credential through multiple different services for different practitioner types. It's still a very fractured market and when we look at various workflows such as eligibility and those sorts of things, it's still a very fractured market. One practice could be using multiple systems to check eligibility across multiple payers still today. There's no Holy Grail

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yet. A lot of those processes and workflow are definitely going to be critical pieces of the future solution, but our perspective and experience have been that there's no single vendor there that can do it all. They can all contribute to the solution, but they cannot be the solution. It has to be done at a higher level.

Shahid Shah: Yes. In a minute, Don is going to ask you a little bit about the AHIP side as far as the pilot program, but I was thinking if you're thinking about this other industry, why absolution? Based on the pilot that you've done, what would you go back to AHIP or other industry providers? Because we can bring in the folks from HIMSS, AHIP. Does this require a multi-association kind of model where people come together? Or think that AHIP and the plan and insurance side credentialing handled it?

Andrew Kobylinski: Yes, that's a great observation about the pilot. In the pilot formally, we ended up publicly working with nine health plans on "Better Doctor's" side and "Availity" had a few more so we had just 14 in total or something like that. One of the biggest disappointments of the pilot is we actually had two very large providers, organizations, provider communities, societies, set up to actually participate and be a co-stakeholder in the pilot. Where they would participate, bring their membership to the table. Evaluate the vendors and approaches and help co-develop the solution. We've been doing that bridge for some time. We've been opening the doors to the broader provider community. Due to some of the political issues and this problem namely that regulators regulate health plans, they don't regulate providers and provider groups on the data quality issues. It's been very tough to bring the provider community to the table the same level commitments on the solutions. It's been much harder to do that than with the health plans. The health plans think of very much, we have to solve it, we have to get it done. Saying that there are provider groups that have, since the start of the pilot, reached out and connected with "Better Doctor" and really engaged and gotten into the process in our critical to us developing better ways that delegated groups can be included in the process and get this work done and get their rosters done. After you think about it, a large health system or provider group, they're just like the health plan from this data problem. They have numerous feeds of data coming-in to them from their offices and clinics and facilities. They have to aggregate it together to make sense of it and report it back out to multiple stakeholders, regulatory and health plan alike. They actually have the same fundamental issue. Typically, you have one or two people at that system working with Excel spreadsheets, trying to do their best with that on thousands and thousands of rows and hundreds of columns of data. We need to enable them to do their job better. As we look at the next year, I'm seeing a lot of new pilots possibly emerging around this and engaged the provider community. Politically it would be helpful if both parties who need to communicate on the provider data were sitting on the same

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regulatory expectations on data quality. The fact that the predominant weight is on the health plans is creating some imbalance in the ecosystems, just making this a little bit harder to us all...

Shahid Shah: One thing to look at... I love that point that you just made. We're trying to figure out how to get them to be a bit more engaged. So they have the incentive but they're not engaging. What I've seen is that some of the new regulations around Comprehensive Primary Care Plus (CP+) program. When you look at the CPC+ program while the requirements is that a provider, CMS says "If you want to join that CPC+ program, you have to take a provider, toss a pair, bring them together and then you get approved for a pilot program for that." A part of the both MACRA as well as CPC program is that these networks, these new networks of providers may not be able to get their reimbursement payments if their network data is inaccurate. I wonder whether that gives us a little bit of payment here or plans, of course, are fully aligned because they have the provider data that's incorrect. It means that they have somehow given bad contract data to their members which are basically a bait and switch where you sign up for a contract and you tell them you have a thousand doctors and then once they find out you have a hundred or a zero because there's nobody nearby. That is not fully understandable from the insurance funds perspective. They have rules and regulations because, basically, giving bad contract data. On the provider's side, they have no such thing. They don't have the contract with the member until the member shows up to them as a patient. That's the business problem that we have here. With the alignment here coming up with MACRA as well as with the CPC+ program, it's possible that we could drive that through NAACOS (National Association of ACO's) and they re-evaluate care from CAPG. That might be the way for us to be able to get the two sides connected. It's not through AHIP and AAKA. Might seem that those that are trying to sign up for this value-based care programs might see that incentive a little differently over the next couple of years than they have in the past few years. Do you know enough about that program to comment on that? Because I'm trying to find somebody who will.

Andrew Kobylinski: I can't comment on these specific details there, but I have heard some of the teams and I have seen those efforts are starting to make things. People think about this in different ways and that is helpful. It is productive. What has been probably the best way to engage the provider community today have been the health systems that are starting to offer their own products, their own insurance plans. They, suddenly are now in shoes of health plan while also being a health system and contracting providers to round up their networks. Those organizations have become a really nice bridge between these two worlds. They have these issues internally. Then, they're putting us in a health plan shoes to experience externally. They are really, I think in a near-term going to be our bridge to a sustainable solution

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between these two entities and providers and health plans and how do we communicate better. They're doing a lot of really interesting work internally within their organizations too. Kind of improve upon this. Absolutely, the ACO networks, at risk and capitated models and all that kind of stuff, it relies on high-quality information. **In addition, we're seeing some movement as well in the medical records in our operate building space where the fact that we need to know where the providers are currently so that we don't incorrectly send PHI to the wrong office.** It's becoming a larger issue that the folks need to tackle as well. All of these efforts are strengthening everyone's understanding and the provider's community understanding of their role in this problem.

Don Lee: Yes, right on. One of the things that I've noticed throughout the course of this, and you talked about it a little bit today is that there definitely seems to be the desire at least. The doctors want to put the correct data out there. They want the patients to be able to find them in the appropriate place. Of course, they want the health plans, they have it so all of the administrative stuff rolls real smoothly. What it looks like, as an industry, we just haven't given them the right set of tools. We can incentivize them to do the hard work of satisfying this problem, for sure with some of these programs. It sounds to me if we give them the right set of tools that makes it not a huge burden for them to do the thing that they want to do anyway, that might be the best way to move things along here. We're jumping around a little bit here. It makes me think back to earlier in our conversation. Basically, what you've said is you're putting a for out there in front of the providers. I could see what you're doing to make that form really well and the idea of being able to share it out. On the surface, I can see a provider saying: "That sounds like more work. That sounds like a new thing. A new system login to. A new work effort for somebody on my team." How do you deal with that sort of reaction to the platform? How do you ensure them or assure them that it seems on a surface like an extra step but this is going to be good for you in a long way and this is actually going to take work away? How do you deal with that message?

Andrew Kobylinski: Really simple. You put in extra effort to call that provider that's resistive. If the email with the question why do I need to do this or they contact the provider relations team at the health plan, why are you asking me to do it in another system. You educate them that long-term solution is for a centralized approach. This form, this process is being done once on behalf of multiple organizations that you contract with so if you respond to this one, all of us are going to stop harassing you if all these other communications are currently receiving today. The first time a provider or practice manager says: "Oh, ok. They give it a try. It's a lot to form." They suddenly adopt it, they see that reduction and it nuisance to their office. That's a true solution to them, they actually trust us what's happening is going to work. In addition, our process provides feedback to the provider

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so we acknowledge that they've sent something. We acknowledge that a health plan received it. That health plans will process the change that they've submitted. We're actually engaging a provider in a two-way dialog on the data that they've submitted so they feel like they're part of the process. This is not just some "I fill out the form and it goes to a black box, maybe something happened 12 months later but I don't have the time to check every health plan website to see if my change actually got there." You actually proactively need to get them feedback and then they adopt.

Don Lee: Yes, that's huge. I've actually heard that.

Andrew Kobylinski: We've had many...

Don Lee: Sorry, go ahead. I was going to say I actually heard that from providers: "I get all these requests, one health plan and I get six different requests in a month and I take my time and I fill them out and I send them and nothing happens. Why am I going to continue to spend my time filling out these responses if it doesn't actually end up going anywhere?" I agree with you, that's a huge one.

Andrew Kobylinski: Yes, at the end of the day it's about that feedback and really making it easier to complete. I have a lot of provider groups right now, systems and small practices referring health plans to "Better Doctor" to work with "Better Doctor" saying: "We really like this process. It's quick, it's easy. My updates are always reflected there. I never have to repeatedly correct the phone number. Can you please just get the data from them? They have it right now." As we close this funding round and announce that yesterday, "Better Doctor" is growing. We're expanding nationally and we hope to be an all market serving as a hub for providers, trusted resource just getting this task done and reducing the volume of these communications to their offices.

Don Lee: Yes, right on. Do you find in that sense that you have a bit of a chicken/egg problem too because if you are one system that can share: "I'm a provider, you can share all of my data out to all of my health plans." But only four of my 12 health plans care to pull it from you, then from my perspective, you haven't quite solved my problem all the way yet. Do you find that at all that you have providers that are willing but they say: "Come back and talk to me when you get all 12 of my payers on there"?

Andrew Kobylinski: It does happen. Yes, there are some. Most, though, see the value that we're already doing it on behalf of several. We're already reducing the workload. That means they want from 12 to now 8.

Don Lee: Right. Exactly.

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Andrew Kobylinski: One "Better Doctor" one and 8 other ones and that's already a big win and when you look at and talk to an overworked busy office manager, they're going to take any win they can get. I don't really see a huge problem there, what's actually emerged more so as a problem for us on our product roadmap and it's a really good opportunity to see this upon is that once a provider and a group has worked with us on a roster they say: "Oh, this is amazing. You guys help me get my stuff in order and you gut it out to three of my health plans. Can I now delegate my roster to you and tell everyone to go to you from now on to go get that at scale?" What we're saying is that there's a huge opportunity to really set up and provide the provider community with a proper utility that they can delegate the responsibility to an IT platform, a system that people can integrate with a multitude of different ways. That knows how to communicate with a health plan systems. That knows how to process various data scheme that's in format to cross different carriers and different architecture in IT systems that knows how to communicate that data back into the health plans since we're processing. Today, we're asking a lot of group managers to do by themselves in spreadsheets and responding to requests and roster abuse or logging to third party systems multiple of which. It's just broken. It doesn't work. As providers engage with this and they start to see the potential of what we're doing, they're helping us grow further.

Don Lee: Yes, that's awesome. Basically, you're enabling them to go back to the payer and say: "Yes, sure. I'll answer all of your questions. Here is how you get this information from me. Go here." Yes, that's a great way to go. One last thing, I just want to double back to really quickly, you've mentioned somewhere along the way here about the information being shared amongst the APIs and you said: "A things that the providers allowed for public use, identified for the public use." Something along those lines. Can you talk about that a little bit because that certainly is an area of concern for lots of providers is once this data is out there, what's going to happen with it? What problems is it going to solve for me but where else might it go? Can you talk a little bit about that data governance and policy and all of that?

Andrew Kobylinski: Absolutely. It's a great question and it's a complex topic to look at. To be super clear, at the current state of affairs what you get in the "Better Doctor" API if someone wanted to register it's not the health plans data that health plans are submitting to "Better Doctor" for data verification. Those things are sandboxed away. They're different worlds. The health plans data is still proprietary, same with group rosters and things like that. It's sandboxed away. What's in that dataset that's publicly available is effectively stuff that's already publicly available. Some of it comes from government resources entities. Some of it is provided by providers in a public form so health systems and provider groups say: "Hey, here's our 3000 doctors. Can you please publish that more broadly?" The roots of

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that activity of providers contributing data to "Better Doctor" and asking us to publish it on their behalf in a larger sense came from when we were running betterdoctor.com. We had floods of people coming to our website asking us to update information and publish their information publicly.

Don Lee: Got it. That makes sense.

Andrew Kobylinski: When you look at the whole permissions issue and rights to use data and everything I would say that "Better Doctor" is probably one of the few companies in the space right now working health plans that actually understand and work and operationalize those permissions with the provider community at large and understand these issues and the intents. **Nothing's ever perfect and there are edge cases everywhere. There are conflicting responsibilities where one specialist in a hospital wants to build a website and get their profile updated on every website yet the credentialing department at that hospital doesn't want to advertise that provider as a part of that hospital.** There are some issues that the industry still needs to work out but that's the topic for another day.

Don Lee: Yes, got it. It's very complex. I wanted to jump back to a little bit of big news there somewhere along the lines about the round that you just recently closed. I just noticed that myself yesterday that you guys closed an 11-million-dollar round to help with your expansion. Let's talk about that a little bit.

Andrew Kobylinski: Absolutely. We've been running at a very lean startup, small team iterating rapidly. We took on nine health plan clients with about 30 full-time employees in San Francisco office and a team of part-time staff doing phone calls and work elsewhere. It's been a very efficient operation, but looking at this problem on a national scale and our ambitions of new method validation and getting deeper into pinpoint workflows that have good data points, means that we need to grow. We plan this year to double our staff, we're hiring. Anyone listening to this if interested in helping us on the mission, we have a bunch of postings open on our careers page, just go to betterdoctor.com. That's really what the funding is about. Our late investor the funds basically from them come from health plans. It's very strategic. We are looking at this as an industry solution. Everything in our business is now aligned to solving this problem for the industry. Our company, our staff, our product roadmap, our investors, our board... everything is laser focused on this. We're expanding work nationally to all 50 states. We're already doing that. The new funding also helps us bridge some of the cost that we incur in that expansion. As you scale up outreach and you do more faxes, emails, paper mailings etc. there's a certain cost of the operations and making sure that you have the support in for structure to communicate effectively with all these providers.

Don Lee: Yes, that's really exciting. Congratulations to you and the team. I'm sure everyone there is very excited.

Andrew Kobylinski: Yes, we are.

Don Lee: Yes, I bet. With that, is there anything else? Where else can people go to learn about? Obviously, you've mentioned of the job postings. I'll make sure that I link those up in the show notes. Where else would you send people to find more about you, about "Better Doctor" about what's next?

Andrew Kobylinski: [00:49:11] quite a few things, obviously, there is the website. But we also run a monthly webinar series where we bring provider groups and health plans together in a collaborative form to discuss a state of the art. We have guest speakers. If there's a health plan doing something really creative, has figured out a tip or a tidbit in this process that they would like to share with a larger audience, we put them on the agenda and your speaking presents. It's not a sales call. We facilitate collaborative learning on this topic. Those monthly webinars are opened to health plans, provider groups, and systems. If you want to join that just reach out to us hello@betterdoctor.com and we'll get you in the process there. On the developer's side, we do quarterly meetups and sessions where we actually fill the office of about 50 people and healthcare data scientists and engineers and we talk about healthcare data and we have a whole series there. If you're interested in that sign up through our developer portal and you'll receive these communications. Yes, there are easy ways to get started with us.

Don Lee: Awesome. You mentioned earlier that a lot of [00:50:16] camps and learning activities around the API and the developer platform there. That's open and free for people to get started with?

Andrew Kobylinski: Yes, the developer portal, anyone can come there, sign up, take a look at stuff, play around. It's free. As I said earlier though, we're not hyper focused on that we're not really aggressively selling any data there or trying to expand that. We're just opening up their [00:50:39] there for that kind of later-term vision than long-term vision. Our focus today is really more narrowly on the health plans segments and the provider groups and health systems. Let's get the data cleaned up, let's clean up that scale and then we'll start looking up the broader ecosystem through that channel.

Don Lee: Yes, right on. Finish up. We will finish up where we've started and that's all about the data quality. You can bring all of the stuff together but if you don't have that you've still got nothing and you've just wasted a bunch of time. I'm with you a 100% on that.

Andrew Kobylinski: Exactly.

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Don Lee: All right, awesome. Andrew, thank you so much for coming. Everybody, as I said, all of those things that Andrew mentioned will be linked up in the show notes. As always, you can check us out on thehcbiz.com. Links to all our podcast, videos, show notes, blog post, you name it. You can also sign up for our weekly newsletter there. All we need is your email address. I hope to check it out. Again, I'm Don Lee. I want to say, thank you again, Andrew, we really appreciate it and you have a great day.

Andrew Kobylinski: Thanks, guys. It was great to speak today. Thank you.

Don Lee: All right, man.

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