The #HCBiz Show! Episode 16
PD06 - How to Tap Existing Processes for Provider Data | Martin Dunn | Gaine Healthcare
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Don Lee: You're listening to the HCBiz Show. The podcast dedicated to unraveling the business of healthcare. I'm your host, Don Lee. Today we are continuing our provider directory series. We are well into problem definition and understanding why this problem exists. Now, we are starting to spend some time talking about the solutions. We are very lucky today to have on a show someone that spends all of their time working on those solutions. We have Martin Dunn who is the CEO of Gaine Healthcare. Martin, welcome to the HCBiz show.

Martin Dunn: Thanks, Don. Very pleased to be with you.

Don Lee: Why don't we start to talk a little bit about Gaine Healthcare and Gaine itself? Because Gaine Healthcare is a subsidiary of the company called Gaine, is that correct?

Martin Dunn: Correct.

Don Lee: What does Gaine do? Where did you guys come from?

Martin Dunn: Gaine Solutions is the parent company. Our background has always been in data management. Working with large enterprises helping them connect internal systems and exchange information and maintain data quality. For once, if a better term, that was all classified way back when as master data management. That whole space has become very verticalized so we ended up with solutions in the healthcare space that we were just repeating time and time again. We pulled some of the solutions together, formed Gaine Healthcare so that we could concentrate all of the industry knowledge, the expertise, the models, the designs, the processes and the people with that experience on that particular problem set. That was the genesis of Gaine Healthcare.

Don Lee: Got it. You were working on custom software solution type issues and that you kept doing the same thing over and over again. Is that what I'm hearing?

Martin Dunn: We've built a platform called MBX master data exchange, which is a master data management platform. That is the background that was founded here in Gaine. We've sold that platform and leveraged that platform as commercial software products and across a number of different industries for a number of viewers. Gaine, the parent company dates back 2007. The Gaine Healthcare is something that only spun out in

kind of 2012, 2013. That range.

Don Lee: Got it. What was it about healthcare that pulled you in? Why did you get interested in a provider directory problem in particular?

Martin Dunn: We were working inside the walls of large healthcare companies, large payers. Helping them rationalize provider information across systems and helping them rationalize patient and member information across systems. We were working with a group called CAPG.They the largest paid association. The largest representative trade association for provider organizations in the United States. They are in 43 states, they represent hundreds and hundreds of APIs, MSOs, ACOs multi-specialty provider groups. We were working with CAPG on a problem around the social-economic modeling of members and patients when a fellow called Bill Barcellona came to us at CAPG and said: "Guys, I understand the underlying capabilities of the platform. We have a far larger problem that's going to affect our groups, our provider organizations." He went into an explanation of some pending legislation in California called SB-137. This was legislation that was going to require more timely and more accurate updating of provider directories of health plans. Bill explained the problem to us from the perspective of the provider organization. I think, historically, the problem of maintaining online provider directories has been seen through the lens of the health plan. They are the regulated [00:03:51] and that's how the problem was defined. Whether you look at it from the other perspective, you look at it from these provider organizations that may be as small as dozen people. They may be as large as 10.000 people with very different levels of sophistication inside their systems. They're all contracted with multiple health plans. If you were to have this outreach of health plans asking for more information on a more frequent basis from provider organizations, provider organizations don't have the ability to support that. We got involved with this problem of provider directory [00:04:30]. From the perspective of the provider organization at the request of CAPG. The more we understood about the business of the multispecialty group, the hospital systems, the APIs, the more we could understand how their existing processes shouldn't possibly keep pace is how the health plans define the problem. We've applied our data management platform, we've applied our knowledge of systems integration across hundreds or thousands of endpoints. To solve the problem, some of the perspective at the provider organizations saw that we can solve the problem for the health plans. I think they're starting the journey from the other side of the fence. That was extremely helpful and helping us understand how best to solve the problem.

Don Lee: Yes, absolutely. I couldn't agree more on that front. For those who are listening that Bill Barcellona of CAPG, that was the same Bill that was on a show just a couple of episodes ago. PD-02 if you want to check that out,

Bill goes into great detail explaining SB-137 and the business need as well from that provider side and from CAPG's perspective. Definitely, check that out, I'll link it up in the show notes. Back to your story, Martin, from your perspective, when you're looking at this and CAPG and those folks are coming along and telling you about this problem, you're looking at the solutions that you've built to solve similar problems in both health care and other industries... What did you see here with the provider directory problem that made you think you can do something about it?

Martin Dunn: I think when we looked at the current processes and the way health plans were talking about solving the problem, within the provider organization there's a remarkable lack of sophistication. There's a different level of sophistication across the different groups depending upon their size. We have a lot of information we have passed around in spreadsheets which were put together by non-technical people. Often, we're answering questions with a different context. You asked me what locations providers are at and you asked a dozen people. Some may include their billing locations, some may include every location that a group has an office. Some may include every location that a doctor has ever visited or may ever visit. Others may just include the doctor's primary location. The question was poorly phrased. When we look at the way the provider groups were passing this information back, we could see that they were struggling with understanding the context of the question which immediately suggested the benefit of having a clearing house. Somebody who collects all of this information, rationalize it, apply some standards, help the groups that are providing this information with understanding the question and help the counterparty to that discussion. Understanding what was being provided. Then we look at the systems that were in play. When I say systems, that could be anything from literally and Excel Spreadsheet on someone's desktop to a credentialing system and you spied on one of the larger groups. We have all of the characteristics of desperate systems and a heterogeneous environment with different, actors, different stakeholders that would all attach the different meaning to a location, provider, practice, group. These were all the conditions we've been solving for years. Not just in health care but across the industry.

Don Lee: Sure. The perspectives are always different, depending on who's looking at it and they are using that data for different purposes too, so it automatically has a different meaning.

Martin Dunn: Absolutely, we define data quality as fitness for purpose. Unless you understand the purpose, you can't possibly decide whether the data you have is of quality. We get very lazy across the industry. We use these terms lucid the way we understand it. And that's very difficult to coordinate even within an organization where you have some degree of control. Where you can publish a corporate lexicon, and ask people to use

it and understand it. You can't do that across a heterogeneous environment where you have literally millions of endpoints. We could see that some of the characteristics that we'd already solved within the walls of a complex organization. We felt that we could apply those same processes and technics across the provider data management spectrum. We've created a platform called "Sanator". We have the Sanator Provider Registry. Sanator is Latin for Caregiver. We thought that was an appropriate title for it. We've set about plugging in the operational systems. The operational processes. The data dictionary of multiple endpoints. Rationalizing those in the central canonical model with a shared common dictionary and then translating out to any endpoints based upon the data dictionary, the lexicon, the data model and the standards which that other endpoint wanted. That really is the essential function of the Sanator Provider Registry. It means that whenever we add a new endpoint, we have to solve for one more endpoint. We don't have to solve, it was never easy but we save that. We solved for a single endpoint when we had a new organization into the Sanator Provider Registry network. We don't have to solve for every endpoint and have the cartesian product blow-up around us. That approach has been very successful and allowed us to add a lot of organizations into the plan without them having to change their own internal systems. Without them having to rework their internal processes but yet still be able to exchange information successfully with other people with different data standards.

Don Lee: Got it. Can we talk about some specifics here and if you take an example? Has high level, I hear what you're saying and for the audience, I'd like to give them some specific examples and there's a bunch of problems that keep coming up throughout the course of the series here, and one of them is on this context issue, that if you ask a provider for their address, let's say, they might decide to give you all of the addresses for all of the offices that they might work in. If that's the question you ask them, just no context around at what's your address and they say: "Well, here's my primary address. I sometimes work over here. I cover for Joe down the street every once in a while, at their other office." Then, on the payer side, they are trying to put into a provider directory that you as a provider practice at this office and accept patients there. How do you translate that nitty-gritty detail of that basic address element so that provider knows what they're being asked for, specifically? And the payer knows then how to use each of those addresses that are provided through your system?

Martin Dunn: Sure. There are really a couple of large topics that relate to that problem statement. Let’s go to the first and easiest to deal with. If you ask a poor question you will get a poor answer. When the questions are not specific enough, the answers will follow suit. Asking: "Give me your practice locations." how does one answer them? You will get the interpretation of what you actually meant by that. I think that we have to tighten up the

language. When we look forward is what does an eventual end state look like. It's really being a little bit more disciplined around what it is we're trying to achieve and putting much more precise language around that. I think on a broader issue, we have some real challenges around network adequacy and provider directory timeliness and accuracy. From a network adequacy perspective, the plans are under pressure. To make sure they have enough physicians, have enough locations with enough specialties to cover the member base that they have. In order to keep that information up-to-date, they reach out to their providers and ask them to report all of the places where they can see patients for your particular product. But we don't have a good system anywhere of balancing full-time equivalency. If you have a cardiologist that contracts with two or three different plans, each one of those plans is reporting a cardiologist within their network. It's very difficult for them to understand do I have 90% of their time and 10% goes to everyone else? Or is it 25% each? How do I report that person? That brings us into the area of mining claims data, mining encounter data to try and understand how accurate anyone assessed within the full-time equivalency is. By the time have this challenge maintaining this network with enough physicians in it in order to provide service. Then, the plans are required to go to those provider organizations that contracted providers and ask them, demand from them accurate updates when they change their status. Where the plans may have been given some instrument, the stick, to say: "Well, we can withhold some of your payments for a little while", which is certainly one of the provisions in California "if you don't reply to us in time." That's really not a practical measure. The other option that the health plans have is to delist you from my provider directory. If you don't give me accurate information or if we find the information you're giving us is not accurate, I can't take you out of my directory. Now, that throws back the plans into a more awkward situation because they don't have network adequacy any longer.

Don Lee: Yes. Besides that, it's bad business because they are going to be irritating each other on those types of scenarios.

Martin Dunn: They are.

Don Lee: If a doctor accidentally has a typo that leads to a problem, that ultimately leads to them being pulled off from a list somewhere, that's not going to be a good relationship between a health plan and that provider.

Martin Dunn: I think that we got regulations that largely filter down through the health plans, that are the regulated bodies. That is not consistent and not really working well with each other. It's difficult to be a health plan. It's difficult to balance your requirements of maintaining network adequacy, maintaining your online provider directories. Satisfying the regulator that you've got everything in place. And still having to deal with provider

organizations in a way that they can respond. What it really comes down to and this is a lifeboat moment for us when we were looking at this problem from the provider's perspective. It doesn't matter how much you regulate the docs, It doesn't matter how much you've threatened the docs. It doesn't matter how much you incent the docs to pull this information together for you. If you ask questions that are difficult to answer, difficult to understand, impossible to keep up with because the doctors and the physicians and the provider organizations just don't have the systems in order to give you that information, you're not going to get it. You have to look at where the information, right now, is being created. You have to remove the interpretation of data. When we talk, for instance, something like billing information, you've got to go back to the system where the billing is being generated and link up that system to the billing information that can. The billing address and separate that from practice locations. Each health plan is contracted with doctors via contracts signed by two parties. The party could be the individual doctor it might be a medical group or it might be an API. That is the definitive agreement between the provider or the provider organization in the health plan. Asking anyone else in the chain to express an opinion on whether this doctor is at that location with this specialty for this plan and whether they're open for new patients. It's an interpretation of the facts. What we could see, the natural go to play from the health plans was to reach out via phone or fax to the medical office and ask the administrator who answers: "Could you tell us all of this information about the doctors in your office, where they practice? What plans? What groups?" They are so far removed from the contractual relationship which may not even be held within that office, may be held via the third party like an IPA. It's impossible for them to provide the answer provide the accurate information that's required. What we did is, we've been borrowing back and back towards the actual source of truth which varies across the data elements. The system that has the billing information in it is not the system that has a contractual arrangement in it. It's not the system that you would go to validate an MPI or a state license number or a medical board certification. They all have a primary source of data. You have to go back to those primary sources of data and make sure there's nothing between the trusted source, the primary source and the distribution of that data out to multiple parties.

Don Lee: How do you go about identifying what is the proper source for a particular item? How do you know to go to the billing system to get this particular address or this particular item?

Martin Dunn: When you understand the billing process when you understand all of the processes that go into running a medical practice, contracting with a health plan. Negotiating rates, picking up delegated lives, whatever the process is. The place where that information is stored is defined by that process.

Billing information is being generated in different systems within different groups. Billing information has been generated at a particular point in the chain. That is where the 1099 address. There's where the tax ID. That's where the relationship between the doctor and the place where he's practicing, the network he's practicing for and the bill he's sending out. That's where that information exists and that's the only place to go and get it.

Don Lee: Right, because that's the point like operational funnel if you will, where it has to be correct. You're leaning on that example, billing. You're going to find out quickly if there's a problem with billing data because there's going to be a problem with money and that's going to make people ask questions and get a result. If you're looking for a piece of data at the point where it is operationally validated, that's how you can have confidence that it's going to be correct.

Martin Dunn: Correct. Sometimes the data that exist at that primary point is itself factual. But the interpretation that someone may give of it may be different. We see this often times around a panel status whether they're accepting new patients on their particular product. The ruling document is the contract signed by the doctor or the organization and the health plan. There are contracts out there that have all products clauses. They say: "If you sign with us as a health plan you have to accept all of the following products, all of our products." If you then go six months later and ask the doctor: "Hey, are you accepting patients on this product?" The doctor may just say: "No." Tells his front office: "No, I don't want any more of those patients. I don't want the patients from the exchange." It reminds me of the Ron Burgundy quotes from Anchorman years ago: "You can't just declare something and it becomes so. The factual information lives in a place and the health plan may be relying upon that factual expression of that data." Just because somebody else told you: "No, Dr. Smith says he's not doing that any longer." That's not the fact, that's a distortion of the fact. The process that we go through needs to identify those and double them up and send them out for resolution. It's a really important concept when you're building this kind of system to understand element per element, who has the facts? Who may express an opinion on the facts and how do you compare the two to identify where things have got themselves out of sync?

Don Lee: Yes, absolutely. You've made me think of the example I came across where a particular health plan that I was working with did not want to accept from the providers, whether or not they were participating in a particular ACO, because what would happen would be, if you ask them at the beginning of the year at the beginning of the contract: "Then, yes. I was participating in the ACO." For the ones that decided they were no longer going to participate, they made that decision before the end of the contract and if you ask them that question their answer became: "No. I'm

not participating in the ACO." But contractually, if you go to the facts, they were for two or three more months of whatever the timing was on it. What's your perception of the facts, what's your interpretation of the facts is not going to bear out in these situations in every case?

Martin Dunn: The process that you have to have in place, and again this can only be done to a central point that has eyes and ears on multiple endpoints**.** It's where you can create those opportunities to identify the conflicts. "Yes, Dr. Smith. You have, your group has signed old products, old locations. Commit them." But you, yourself don't want to accept the following products. Maybe the following products of the certain location because you're full at that practice. You know that you can't take any more patients on that practice. You have to bubble up and send up a notification to the people that are the signatory to the contract and say: "Here is the problem. You guys have a problem with Dr. Smith and then your normal cause of business. You need to go and have a conversation with Dr. Smith to resolve that issue." Another one of the key concepts of Sanator has been not to introduce additional administrative burden to the doctor or the doctor's office because they're already overburdened. We all know that.

Don Lee: Absolutely.

Martin Dunn: The idea of adding outreach to call or fax in to a doctor's office to try and gather and validate information just seem a burden to the job. I couldn't understand why you would add a process that has no viability of producing accurate up-to-date information. It can only give you somebody's current view of what they think that is. You already have these trusted relationships between doctors and the people they have employed in order to run various aspects of their business. Doctors have outsourced billings, doctors have outsourced network management. They've outsourced credentialing. They've outsourced so many of these back office administrative processes that they don't have the capabilities to perform. They've made a conscious decision of the person or a group they trust in that exchange of information. That's the point that you want to go back and notify. If the data that you have relates to somebody's medical education or specialty or current state license. Maybe an upcoming expiration date on a state license or an expired state license. Go back to the endpoint that is responsible for credentialing the doctor. If you have a query around panel status, go back to the contracting entity. That's been an important part of Sanator has been to connect into existing business processes**,** existing trusted relationships. Get back to their system so that we can gather that new information. When we find a conflict we can report it out to the people. In their normal course of business would want to resolve that conflict. We didn't find the conflict and add it to someone else's "to-do list". We've used the network to identify things that these organizations want to do anyway.

Don Lee: Yes, I love it. It's basically the step one of the whole process. If you're going into a new practice organization or a new health system is pull their vendor list. Go through it and say: "Who is doing billing? Who is doing this thing?" Is that your entry point when you're trying to figure this stuff out?

Martin Dunn: Absolutely. When we go in and we pull a new organization in, we sit down and spend considerable time with the organization. We understand their own business processes. How did you gain credentialing?

Don Lee: That's smart.

Martin Dunn: Were you doing billing? Where are you contracting? Who's responsible for contracting?

Don Lee: Yes, I've been saying for a while that all of these data exist. You laid it out really nicely there, the way that you're talking about the facts versus the interpretation of the facts and that is the issue. The interpretation is the issue because these facts exist and are used all over the place. If you can scale the model if identifying them and pulling the right facts from the right place, then I think you could be on to something for sure.

Martin Dunn: Yes, it can be done. It's a plan that the process and supporting technology supported by a fair amount of education. We spent an awful lot of our time educating different people within that ecosystem about how we can remove administration from their lives. How we can leverage this collective management of the information to everyone's benefit. Often look at the system of these millions of endpoints. Where we get frustrated is when you have one of those endpoints that are the purest working on the way they will solve the problem. There is no endpoint in this interconnected maze that is large enough to steer the entire ship. Anybody that's working on their own process, this is what's going to work for us. If you're not part of the solution, you are part of the problem. Because you're purely working on what you want and nobody else understands it. You have to lift your head up and see the problem for what it is. It is a highly distributed heterogeneous environment with multiple stakeholders. You have to understand there's anyone's endpoint. How can I best participate in this exchange of information which may mean offering connectivity or offering the exchange of information back to some of your core systems where the information exists. They did get sent out to provider organizations today from a health plan typically comes from their provider directory. I know from working behind the scenes in a health plan, provider directory information is rarely in sync with the core plains administration system. Is rarely in sync with the credentialing system. It's rarely in sync with the network management people because they all have

their own contacts and they're all doing their own thing.

Don Lee: Right on. That's problem number one, right there is that even within the health plan we don't have this solved. Even within the health systems, this is true too, from department to department whether you got the group managing the ACO or the group managing a Medicaid redesign or the group doing credentialing, they're not all on the same page internally. You've got two bubbles if you will, a health system and a health plan trying to talk to each other but even within their own organizations, we have a communication problem around this data.

Martin Dunn: Correct. I think the danger and the thing that holds the progress back the most is the internal challenges themselves are not trivial and an organization closes ranks and solves internally. Which may be certainly an important part of the problem but you're solving an internal problem and the solution that you end up with has to play nicely with others. When you're solving internally, you have to look at how am I going to plug this into the rest of the world? Within Sanator, the approach that we took is to have the central registry which is a multi-tenant shared base of information. At each endpoint where you have multiple disparate systems, they also get their own private instance of Sanator which is an integration engine. Master data management would be the best way of describing these fundamental techniques of this integration engine but each endpoint that has multiple internal systems has its own, let's call it a "staging area", where it can plug multiple internal systems together, resolved internally the view of the provider in a context that allows it to share it with other endpoints. Then it can send over that cleaned up contextual view of the provider into the registry where it's easier for us to compare it to other cleaned up contextual views of the registry and send it out to other endpoints. Again, it splits apart and maybe goes to different systems of that endpoint. That works really well for the larger, more sophisticated organizations that have to deal with multiple views internally. Of course, not everyone's in that category. We have some of our endpoints suggest us small doctor's practice that really can still only exchange a file and go onto the online portal and manage its profile. That is its system of records. That's okay too. You have to have the realization that all these things exist and will continue to exist. You cannot design a system-wide solution without taking into consideration all of these different views of the problem. All of these different contextual views of the problem.

Don Lee: Absolutely. Let's walk through a few scenarios here just to make sure that I understand this centralized model a little bit better. Why don't we talk about it from the standpoint of not so small provider but let's say a five ten doc. practice that is they're independent but they participate in an ACO? They have contracts with 15 different health plans. Within those health plans, they're working on a couple of value based models. They're

obviously gonna be participating in MIPS and MACRA and things like that. They have 25 different places where they're going to be sending some level of this information out, this provider directory information. For that office's perspective, walk us through how you go in and put this solution in place for them.

Martin Dunn: That group, we'll have a conversation with them. It's about whether it had this information in one or more different systems internally which I don't understand how are they going about some of the core processes like contracting, like credentialing, like billing. Understanding what they have internally often found such a practice management system and their EHR and then supported by a couple of smaller, maybe spreadsheet based internal systems. We import that information, we map that information imported into the registry. They in that part of scenario probably don't need the sophistication of their own integration engine at their side. That tends to kick in with the organization that has got commercial software products or home run software products for different business processes. That group would choose to either exchange files with us on a regular basis. Requirements for participating in the registry is your exchanging information at least every week. Or they would choose to maintain their provider directory profile through the Sanator portal which has all of the elements well-structured in a way that allows us to meet all of the regulations and report out to the different health plans. We then gather from the group which health plans they're contracted with. We try to understand those contractual relationships that they have and some of the key causes that they exist on those contracts. We ask them what is their current process for exchanging information with these health plans. And that varies dramatically. We have health plans that send out, call them roster files but sometimes that in itself is the poor description of the file. A health plan sends out on a regular basis information to the group that says "Is this information correct?" All the health plans do it in the different formats, some don't do it. Some do it sporadically, some do it every quarter. But everyone has got some profiles of the way it's exchanging information. We understand here what plans are, what that cycle is, what that frequency is. We ask to see the way they're currently communicating that information. More often than not we've dealt with the health plan before. We already understand its preferences in terms of the way it would like the information. We plug in what the group can do, what the group has with what the health plan needs in a format that a health plan needs. Those mappings by and large are already taken care of within the Sanator Shared Registry.

Don Lee: Meaning that you've created them already for another relationship and now you can more or less reuse them because you understand the context of the question? Okay.

Martin Dunn: Correct. We understand across the different health plans what they mean by location, by the panel, by limits. What they mean by text ID and how it applies where it sits in their model. We understand the good, the bad and the ugly. There are many files that have been exchanged by health plans right now but make it impossible to actually answer the question. The file is so poorly structured. There is no way of differentiating product's location, billing org, and a group at a doctoral specialty level. Their file doesn't allow you to do that. Again, we have the conversation back to the plans to say: "Hey, this is what we can give you in order to support your current process but here are your options for us to give you what do you really need to know." That's just the conversation. That is creating a level of sophistication and reporting out to plans. That has not previously existed. The responsibility was always on the plan. We know, acting as a proxy to all of these groups I get the information into the Sanator model. Model it correctly, use the multiple views of the single doctor's information across groups, across plans to self-validate some of those data elements. Rationalize it all. Now, with all the power of our underlying data management engine, we consider data routed the most sophisticated formats imaginable. I can give you change by change, field by field, doctor by doctor, by location, by product, by a group. However, you want it. That's now a one-sided conversation between Sanator and the health plan in order to give the health plan what it really needs. As opposed to the health plan having to settle for what it could get. There are some significant paradigm shifts that the model that we're employing enables.

Don Lee: Got it. It sounds like, basically, right now, you're selling this expertise, obviously you have the system to back it up but the big thing that I'm hearing from you, you have this expertise in this know-how, you know who to ask, you know what systems to ask. You have a process for going and identifying. Where can I get the operationally validated data? Then you have the expertise on the other side to translate back out to the health plans. At least on the health plan's side, there's a ton of them but there's more of a finite set of health plans so over time you could understand all of those languages. Ultimately, that's what we're talking about here, you're translating English to Spanish and Spanish to French and on and on, making everything match up. There is a lot of languages on the provider's side. Everybody has their own way of doing things. They use their EMRs differently, they utilize the fields with their EMRs differently. It sounds like a manual process still, today. For today that's great. Sounds like you guys are doing great work today, but my question for you is how do you scale that from here? How do you take that process that you've employed? I don't know your numbers, if you want to share the number of practices or plans or whatever that you're working with, that's fine. How do you take it from where you are today and then scale that so that you can ultimately like you said earlier "there are millions of endpoints and we want to solve

this problem globally", how can a solution like your scale to a more global level?

Martin Dunn: That's a great question and this is something that I think that often gets overlooked in the conversation. What the group sees in Sanator goes way beyond just maintaining provider directory. We're a provide data management platform for groups. If you have your own systems for some of the business processes that you've got such as credentialing, such as billing recent plugins to those, we can find ways plugging your existing systems that you're happy with into Sanator. Typically, what happens at the larger groups as you get down to the smaller groups. Some of these groups can be still fairly large, tens of physicians. Sometimes hundreds of physicians. They're saying to us: "You know what? We just want to use Sanator. I just want to use that as my internal repository. I want to manage my information in Sanator. I want to extend the model to add these additional data fields that we manage internally." Then they get their own Sanator instance, their own private instance in Sanator which communicate seamlessly with the shared registry and it provides a system. Think of it is as an ERP system that plugs into the existing, we're not trying to be the EMR we don't touch clinical information at all. It says ERP from provider data management within the provider organizations. That's what Sanator is. At that endpoint, you have to always look at the problem in the context of the endpoint. Through the lens of the endpoint that we're talking about. Within the health plan, Sanator looks different today. Sanator looks like a mechanism to exchange information with multiple different providers and provider organizations. It's a nice way to exchange files or whatever form that you need internally. From a provider organization, they look at it as it is "this is my provider data management platform."

Don Lee: Yes, right on. I'm glad you went down this path because we've been talking about this and I didn't get into it today because we've done a bunch of shows on the topic but this is so important is that from a provider's standpoint, having good provider data and being able to manage that, yes it will help you to get the payers off your back on this provider directory problem. So much more important than that is, especially as the business of health care continues to get more and more competitive and you need to understand your referral patterns and you need to understand how patient flow is working and everything else. It all starts with good foundational provider data set. If you don't have that, all of those activities are going to suffer. You will also have a bad provider directory but all of these things that are going to make you more competitive in the market are all going to suffer as well. I'm really glad you went down this path.

Martin Dunn: Yes, I think that health care as you move away from fee for service and as soon as you get away from fee for service, it's very difficult to be an

independent author. How do you participate unless there's some level of control around the network in which you're participating and [00:40:20] coordination process in which you're participating? We see more and more from a macro perspective, we can see more and more groups whether you're an ACO or IPA or hospital system, whatever the term is. It ends up managing these groups of providers and providers the individual themselves may participate in multiple of these vehicles and get the best bang for your buck and time. In those groups themselves, they have this provider data management challenge that previously has really been the... it's only been done within the health plans. The health plans have had systems to help them manage the provider data management. Unfortunately, their weakness is that the systems that they have although the systems are great, they're only as good as the data that's coming into them. You go back to the point of weakness in the overall system. The data that's coming into them is poor. It's poor because the guys that are providing you the data, they don't have great systems. That's the problem that we're solving for.

Don Lee: Got it. Again, speaking on that larger scale solution where you've got centralized database. You're starting to build up a pretty good view of what the world looks like in terms of provider data across all of your customers in the health plans that you're working with. How do you take that or do you take that? I guess the better question is what's your view on all of these other collaborations and all of these other solutions that are out there where you have groups coming together and trying to build this centralized model? Do you think that we go down a path where these things come together and you've got a bunch of big hubs? Like you've got AMA and Lexus Nexus out there. You've got CAQH doing work. We've talked with Availity and Better Doctor and you guys. There's a lot of different groups that are trying to attack this problem in a lot of different ways. As we scale up and out and we start banging into each other a lot more, how do you envision that play out? How would you like to see that play out? I guess from your perspective, towards solving this on a national level.

Martin Dunn: I think you need to understand the differences in approach and the differences in what people are actually solving for. Lexus Nexus and ourselves and not solving the same problem. We are both collecting in our own way provider information. We're both working diligently and hard on the quality of that information and distributing it out to different people. The process that an organization like LN or Better Doctor uses in reaching out and gathering the data is different to the one that we have of connecting systems. Folks like Availity are doing a tremendous job at mining out value from claims information. This tremendous value and understanding what happened but its very difficult actually. Impossible to maintain provider data accuracy. Provider directory accuracy. Provide

claims information. It's out of date and it tells you what happeed not what was requested. I think when people stand these things up along side of each other and say: "Oh, you'll have three of these things and if they could all talk to each other, maybe that's the way the world tends out." I don't believe so. I think we're all doing different things that need to co-exist. CAQH is another classic example. CAQH is a great place for an individual doctor. To store his credentialing information. It's not a place for him to maintain his current contractual commitment to cross multiple health plans. Credentialing information is important. The claims and encounter data is important. Organizations that are aggregating public domain data sources are important. So too is the interconnectivity of operational systems and processes. We're all doing different things and I think that eventually, all of these things will find the area where they're at the most value and they get on with providing that.

Don Lee: Got it. Very good. I guess if I can put it in another way, this might sound redundant but I think it is a different question, what do you think is the ultimate solution? What is the path from where we are today where we've got health plans struggling with this problem? You said it earlier, it's really difficult to be a health plan and deal with this problem. We know it's very difficult to be the provider and deal with this problem and all of the requests that they're getting. You've had some success and ironing that out with some of the groups that you're working with, what's the ultimate solution there? Take us down the road five to ten years and what do you see happening with this? Is this the problem that's always going to need to be dealt with at this nitty-gritty level like this? Or is this the problem that more or less... I don't know how to say "goes away" because it never goes away, but does it become commoditized and it's not an issue anymore, five, ten, fifteen years down the road?

Martin Dunn: I think there's point of intersection between all of the things that happened to manage the business of health care. That is important for the consumers to know and for the health plan to advertise and that's called at this provider directories. This is the public online. You can understand my products, you can choose your products and you can use my products and I promise you it will be up-to-date. That kind of piece in the middle. That is the intersection of many other processes that are going on within the health care. I think that the exchange of that information is something that when organizations realize that this is the shared system wide problem and not something that can be solved for internally. That's when we start getting down the path of meaningful standards, better language. I think the language needs to be more precise. I think the requests for information need to be more precise in terms of what's being asked for and how it will be provided. I think the regulators need to get together and understand the realities of where we are. You can't beg to the health plan to delist the providers that they are unable to validate or don't want to participate or

just makes it difficult to do business with. You can't penalize them for having them in the directory or penalize them for not having them in the directory under two different sets of legislations. I think you have to realize that there are some problems. I think we do have some network adequacy problem in the system. I think that we have provider organizations that have given up trying to participate. I think we have health plans that have no interest in working with provider groups and we've created this standoff between the regulators, the plan, and the provider organization. I think we need to look at ways step by step**.** How to eat an elephant… one bite at a time. We have to go step by step and solve everybody's administrative burdens and in a sequence that makes sense. I do believe we will get there. I think that the problems that we've got are not insurmountable. They really come down to communication inside of framework that everyone can live with. When you understand what's on the other side of the fence you have a little bit more empathy in terms of how hard these organizations are working. One of the things that we've found most enlightening as we went into this process and you'd hear so much dialog, so much noise about how bad provider information was. How difficult it is to deal with the plans or from a plan how difficult it is to deal with the organizations. We were blown away with the amount and the levels of diligence within these provider organizations. Of these administrative to a working so hard to maintain provider data accuracy and get it out to multiple different endpoints. Multiple different plans. They would get dismayed that the information they've sent out didn't make it to the directory for one reason or another. They don't have an understanding of why. They don't have a view into that so they start and they work hard again to pull the information together. It's not the lack of effort. The data quality problems we have is not the lack of effort. If we don't have systems that can exchange information in a way that is able to co-exist with the other systems. Data comes in from my system and it's wrong or I can't accept it I have to be able to tell you why. Your system has to be smart enough to say: "Oh, got it. I'll either answer the question differently next time or I'll correct my data." When you just send data to a black hole and nothing happens and then you get asked to do the same thing a quarter later That's never going to get you anywhere.

Don Lee: Right. Especially when it's...

Martin Dunn: We've been doing that as an industry...

Don Lee: Especially when it’s prioritized behind 50 other requests that are coming in. There's this constant triage going on amongst all of these administrative duties and if you keep asking me a question and I don't feel like you're doing anything with that data, your questions will become a lower priority for me as an administrator, for sure.

Martin Dunn: Correct. It's not an imperfection from the other side of that table that they don't have or they don't want to talk with us. No, they really do care. But they answer the question enough times that it doesn't seem to move the needle so they've moved on to other problems that they care about.

Don Lee: Yes, absolutely.

Martin Dunn: I think that everyone sees this problem through their own lens. When we understand as the system how it all hangs together and how it works together I think that's how we eventually get to an end solution. We need education across the different groups. They all need to understand what it's like to walk around in someone else's shoes. That's the way we get there. That's the way we get there. We end up ourselves brokering conversations between provider organizations and a plans that they've been contracted with the ten years. The guys from Sanator who are now collecting and passing the information and let's have a sit-down. After a three-week conversation about it and we resolved problems. It requires that clearing house that intermediary with some sophistication and to be able to pull all the straws together.

Don Lee: Yes, I think that makes sense. I couldn't agree more that there is no way this is for lack of effort. You see that pick an administrative or pick any problem in health care and no matter what it looks like behind the scenes, you're going to find some really good people working really hard trying to make sense of it all. You're going to find them struggling with bad tools, bad context, bad questions and all kinds of hurdles to get over that are causing some of these problems and everybody's pointing fingers at each other saying: "Wow, you clearly don't care about this." I think that's true and in provider directory case I think that's true in a lot of different areas of health care. I think you summed that up beautifully as we need dialogue, we need context, we need really good tools to help us do all of this work so that we're not falling all over ourselves all the time. I think that's a great way to look at it. There are so many more questions I'd like to ask you Martin but we are just running over on time here. I wanna give you an opportunity to share with the audience where can they learn more about you, GAIN Health Care, Sanator etc. Anywhere you want to send them on the web or otherwise.

Martin Dunn: Sure. Providerregistry.com is where you'll find the information about Sanator and the work we're doing around provider registry, provider directory management. Gainehealthcare.com has got a broader view of the work that we're doing across other aspects of health care. I encourage people to go there and learn a little bit more, reach out, talk to us. We have a tremendous amount of experience from all of these different aspects and angles. We're helping organizations solve the problem without having to change their own internal systems and processes. Just helping systems co-

exist with each other.

Don Lee: Right on. I invite you all to check out that episode with Bill Barcellona of CAPG as well. He's not talking about GAINE the entire podcast by any means but it certainly comes up in a context of the problem that he is trying to solve there from the provider's side. These two episodes put together I think will give you a pretty good context. So, definitely check that out. Again, I'll link it up in a show notes. Martin, it's been a pleasure. Keep fighting the good fight and hopefully, the good work that you're doing will help them form some of these standards that we need down the road. I look forward to keeping in touch with you and watching you guys grow.

Martin Dunn: Thanks, Don. I appreciate the chat.

Don Lee: All right, everybody else check us out on thehcbiz.com there you can sign up for our newsletter. Just need an email and you'll get a weekly note straight from me. All just straight text, no spammy images or any of that kind of stuff. Just what's going on with the show, new shows, new blog post... Things that we've found interesting throughout our travels. You can check that out, again thehcbiz.com and you can find this show on iTunes and all other podcast networks so check it out there, subscribe if you haven't already. We will talk to you again next week with some more provider directory insights. Thanks so much everyone. Have a great day.

