Rachel Katz: Thank you so much, Brooke. Thank you everyone, for taking time out of your day to join us. We're really excited to share this offering with you. As Brooke said, my name is Rachel Katz. I'm senior vice president of product development of Health Catalyst, and I formerly served as the CEO of Able Health. We at Able Health are absolutely delighted to join the Heath Catalyst family. Our primary goal in doing this combination is really to bring you the most comprehensive and forward-looking suite of solutions, to help you both drive outcomes and manage your business.

We're going to show you today both what Able Health can do, and also how it fits in with the Health Catalyst platform. We recognize that if you're like us, your attention is still caught between coronavirus and your normal responsibilities. But what we have noticed is that in many ways, and especially in our industry, these two are really becoming one combined reality.

That's because we are all still determining what we need to prepare society for this pandemic, and even for the next. When thinking about preparations, I can't help but think about the importance of high quality outpatient care. I'm talking about high quality outpatient care that tenaciously prevents and controls disease. I say that because there's a strong link between chronic conditions and poor outcomes in coronavirus patients.

Those inpatient outcomes reinforce the importance of outpatient care, and even these quality measures that we're going to talk about today, designed to present and control a chronic condition. Today, we're proud to introduce Able Health, a quality measure solution by Health Catalyst. Specifically, this presentation will highlight what makes this quality measure solution unique and how it can help you drive outcomes in your patient population, and manage your business successfully. Now, I will pass it over to Darren O'Brien, director of marketing and client strategy at Able Health, to walk you through the product. Over to you, Darren.

Darren O'Brien: Thanks, Rachel. Hello everyone, I'm delighted to spend the rest of this hour with you. As Rachel said, I get to explain the uniqueness of the Able Health solution, which as you see there on the screen, is that it's the only solution for provider quality measures that's truly comprehensive. To explain the importance of a truly comprehensive solution for providers and for payers, and for payers supporting providers in quality measurement, I'll first explain the problems that Able Health solves.

That's because you can't define a solution without first defining the problem. I'll explain how provider quality measurement is complicated because it's incomplete. That's the problem. More specifically, I mean that quality measurement is complicated by incomplete data, incomplete quality measure calculations, incomplete visualizations, and incomplete workflows. In quality measurement that depends on an incomplete picture and incomplete

workflows is unnecessarily complex. That's because you can't measure, improve, or submit performance until after you've first filled the holes in data, measures, visualizations, and workflows.

Every hole is one more complex and recurring task. That complexity burdens quality measurement, and the result of those holes is unwanted debate, doubt, and delay that wastes time and decreases quality performance. A truly comprehensive quality measures platform is the only solution to these problems. A comprehensive solution combines complete data measures, visualizations, and workloads into one comprehensive system. The result is a complete quality picture and complete quality workflows.

That completeness eliminates the complexity and the burden of incomplete data measures, visualizations, and workflows. The resulting simplicity and control creates accuracy, certainty, and authority in provider quality measurement and quality improvement. That's the entire webinar in two slides. But every word on these two slides references a world of meaning we'll get into during the rest of our time together.

Here's where we're going today. We're going to first dig much more into the problem of incomplete data measures, visualizations, and workflows. At the end of this section, we'll have clearly established what needs to change. Next, we'll dig much more into the solution, meaning the value of complete data, measures, visualizations, and workflows. During this time, we'll identify necessary interventions. At the end of this section, we'll clearly establish a vision for a comprehensive solution.

Then, we'll do a 20 minute demonstration of Able Health's performance dashboard. Finally, we'll talk about how you can get started with Able Health by discussing those next steps and answers to your questions. With that conclusion in mind, please use the question box during the webinar so that we can group and answer each of those questions during the last 15 minutes.

Speaking of questions, we'd also like to ask you four questions during our time together. As a personal favor to me, please answer each question. Your answers to each question allow me to create more specific and therefore more beneficial resources, whether we post those online or in future webinars. With that, I want to start with an easy question. The first question will start with, related to the fact that we'd love to know what department you support within your organization. To help you answer that question, please select one department from this list when we launch this as a poll question.

Brooke MacCourtney: All right, we're going to go ahead and launch the poll. The question is, what department within your organization do you support? Your options are quality, analytics and IT, finance, executive leadership, or other. We've got some votes coming in. We'll give you a few seconds to get those votes in. It looks like we

still have a few more coming in. We will go ahead and close that poll, and share the results. All right, so it looks like we had 24% respond quality, 26% said analytics and IT. 5% said finance, 10% said executive leadership, and 36% said other. Is that kind of the makeup you were expecting to see, Darren?

Darren O'Brien: Yeah, a little bit. I should probably do a better job of breaking up the other category. That's on me, and I'll get that right. But thank you so much for that feedback. That definitely helps us envision the world that you live in, and also your answers to future poll questions. Thanks so much.

All right, now let's get started by fully defining the problem. This section quantifies and specifies the problem of provider quality measurement. By the way, as you can probably guess, in a presentation like this, the problems highlighted in this section are problems solved by the Able Health solution. For that reason, this section is not just a briefing on the current state of quality measurement. It highlights the problems solved by the Able Health solution.

With that in mind, let's get started. Health Affairs published research in March 2016 that quantified the burden of provider quality measurement at 15.1 hours per provider per week. That's a $15.4 billion burden shared across providers and staff in U.S. medical groups. For a medical group with just 100 providers, that's a burden of 78,000 hours and $4 million per year. Those numbers seem hard to believe, but they're not hard to believe when you write down just a few of the problems of quality measurement.

Starting from the left, when clinical teams deliver care, sometimes they can't identify care gaps, or sometimes they forget to close care gaps. Or if they direct patients to close care gaps, patients don't follow through. When clinical teams do close care gaps, you're not finished. Because if you didn't document it, it didn't happen. This step could result in missed quality criteria in the note when clinical teams don't document quality data correctly, or they don't document quality data or quality care. You're just getting started.

Spreadsheets and EHRs don't always calculate quality performance accurately or timely, or across all measures, meaning they only do some measures, or the measure calculations don't use all the data you've documented so carefully in your source systems. If you can calculate performance across your complete measures list using complete claims and clinical data, you're still not done if you don't like what you see, and need to use the full measurement period to improve your performance.

Now, you have to make the leap from calculating performance to improving performance. Every one of these steps is a giant leap you take with your data. By the way, isn't it frustrating that this is what you feel as you move down this quality measurement pipeline? But this is what it looks like when somebody walks by your office. It would be a lot more rewarding if your leadership and

your family saw you doing this. But instead, this is just what the stress of it all feels like.

Again, the leap from calculating quality to improving quality is not easy. That's because EHRs, in house applications, and spreadsheets don't make it easy to identify the relationship between a measure, a site, a provider, or a patient population. You almost need to measure your performance from 1000 different angles in order to be able to finally identify the highest priority improvement opportunities.

Finally, if you have made performance improvements, calculated across all your measures, using all of the data you documented, you still have one fateful leap to make. That is, you still have to get that data reported. Right at the finish line, you'll run into more constraints and therefore more problems.

This list starts to make sense of the numbers and Health Affairs article we started with. Again, this is just a sample of the problems that emerge in each step of quality measurement. Now, please take note of the name for each step, because I'd now like to ask you a second question. Here it is. Which step in quality measurement creates the most problems for your organization? When we launch this question as a poll question, please select from one of the five steps that we just discussed.

Brooke MacCourtney: All right, we're going to go ahead and launch this poll. Which step in quality measurement creates the most problems for your organization? You can pick delivering care, documenting data, calculating performance, improving performance, or reporting performance. We've got the votes coming in. Thanks everyone for voting and participating. This is really helpful, and hopefully it's interesting to you to see the results as well. We'll go ahead and leave that open for a couple more seconds.

We're going to go ahead and close the poll and share the results. It looks like 5% said delivering care, 38% said documenting data, 25% said calculating performance, 28% said improving performance, and 5% said reporting performance. It looks like we have kind of a split. What are your thoughts on that, Darren?

Darren O'Brien: Yeah, I've done this question before on other webinars, and documenting data took up the greatest share. Much more majority, up into the 60s. Interesting to see that much more spread cross those three middle steps. Very interesting. Again, thank you so much. Just like Brooke said, thanks for your feedback here, because it allows us to start to notice based on your roles and based on organizations where different problems emerge that again, help us do a better job for you. Thank you.

Okay, so these are the practical problems that emerge on the surface of your daily responsibilities. Interestingly, every problem on this list results from either incomplete data, incomplete measures, incomplete visualizations, or incomplete workflows. To eliminate the problems on the previous slide and take control of provider quality measurement, you have to fill the holes in data measure calculations, visualizations, and submissions.

Now, incredibly, your specific situation could multiply the holes you have to fill by five, 10, or 20 times. That's true if you have five, 10, or 20 different data sources. That's because the number of holes you need to fill multiplies by the number of source systems you have. That's because you have to fill those holes over and over again for each of your source systems.

The burden of this complexity is so great that most groups spend most of their time filling those holes. Or in other words, managing constraints rather than improving performance. In other words, if you think about quality improvement in a ready, aim, fire framework, time in the ready column and very little time in the fire column. That's the current state on the bottom left of the screen.

So much time is consumed in the ready column because it's that hard to established accurate performance calculations that reflect reality. Rather than reflecting constraints and their subsequent holes. Once through the ready stage, aiming has its own challenges. Namely that identifying the highest priority improvement opportunities across thousands of patients, hundreds of providers, and many locations is not easy.

Of course, the desired state is to have gross time in the fire column. Everyone wants to get here because that's what moves the needle on performance. That's what moves the needle for patients. Justifiably, that's what moves the needle on our resumes, our careers, and more importantly, our purpose and meaning. You can get to that desired state with Able Health.

Let me show you how. To show you how, let's start filling holes and solving specific problems, starting with the problem summary at the top. That statement is, provider quality measurement is complicated by incomplete data, measures, visualizations, and workflows. In response to this problem, Able Health combines complete data, complete measures, complete visualizations, and complete workflows into one comprehensive solution.

That comprehensive combination of data, measures, visualizations, and workflows reverses the problems in the ready, aim, and fire stages. An incomplete calculation is draining time in this stage. Able Health calculates performance for a complete list of provider quality measures, using complete claims and clinical data.

Instead of unhelpful visualizations and delayed feedback draining time and resources in the aim stage, Able Health visualizes complete performance metrics for daily monitoring and prioritization of high priority improvement opportunities. Finally, to overcome the constraints of unspecified care gaps and incomplete submissions in the fire stage, Able Health specifies care gaps and connects the workflows for performance improvement and submission to payers.

This is how you spend less time managing constraints and more time managing performance. Making all of this possible are three core components that make up the Able Health solution. The measures engine calculates performance, the performance dashboard displays performance, and the submission engine submits performance. The measures engine is a growing measures library that already includes over 240 quality measures across the six quality domains. Because of this centralized measures engine, once a measure is built, it can be accessed and used by anyone with Able Health. When updates are needed, we only have to update the measure once.

The performance dashboard is both comprehensive and easy to use. By comprehensive, I mean that the dashboard displays the full breadth, depth, and context of your quality measurement. You'll see that breadth, depth, and context in the demonstration. While the dashboard is comprehensive, it's still incredibly easy to use because you can compare quality performance across the entire enterprise using just five simple screens. You can identify high priority improvement opportunities in just five seconds.

Finally, the submission engine submits complete and compliant data to select payers. Submit clinical data to commercial payers via CSV files to close care gaps at the payer level. Or submit MIPS performance data through an API connection to Medicare for all MIPS categories. By the way, speaking of MIPS, this brings me to my third question for you today. The question is, what percent of your providers do you report for Medicare's MIPS program?

Your answer to this one question provides two insights. It shows the present of providers in MIPS and the percent of providers in more advanced alternative payment models. With that, just let us know what percent of your providers report for MIPS using these options you see on the screen.

Brooke MacCourtney: All right, we're going to go ahead and launch this third poll question. The question is, what percent of your providers do you report for Medicare's MIPS program? Your options are zero to 25%, 25% to 50%, 50% to 75%, and 75% to 100%. Looks like we've got some votes coming in. They're still coming in for a few minutes. A few seconds I guess, not minutes.

We'll give it a few more seconds. We will go ahead and close that poll and share the results. All right, so it looks like 44% answered zero to 25%. 28% answered

25% to 50%. 8% answered 50% to 75%. 20% answered 75% to 100%. We seem to have a majority and a few others. It's kind of split again Darren, between three answers.

Darren O'Brien: Yeah, it definitely is. It definitely represents kind of the shifting over time. I mean, answers to this question, historically we continue to see that trend away from MIPS. Although there's definitely a fluctuation, so very interesting. Thank you again for taking the time to answer these poll questions. They're very helpful for us as we try to do better and better, based on what's changing out there. Thank you.

All right, before that poll question, we had just finished detailing the three core components of the Able Health solution. With these three core components in your mind, let's go back and do one more kind of piecing of the puzzle before we jump into the demonstration. What I want to do is go back and fix the problem of incomplete quality data measures, visualizations, and payer submissions.

The measures engine solves the problem of incomplete quality measures. The performance dashboard solves the problem with incomplete performance visualizations. The submission engine solves the problem of incomplete payer submissions. Of course, the Health Catalyst data operating system solves the problem of incomplete or fragmented quality data.

If you're not familiar, please know that Health Catalyst data operating system, or DOS, is a healthcare specific, cloud based, open, flexible, and scalable data platform that provides customers a single comprehensive environment to integrate and organize data. DOS combines data from many proprietary source systems, breaking it free from a complicated, expensive monolith that locks data away than to provide actionable insights. DOS feeds complete quality data into the Able Health measures engine to start the process of combining complete data, measures, visualizations, and workflows.

With this comprehensive solution in place, Able Heath then creates value with two phases. First, Able Health creates a comprehensive quality picture by combining complete data measures and performance visualizations. Then, Able Health creates a comprehensive quality workflow by combining the work of monitoring, improving, and submitting performance. The dashboard compliments the medical record for quality improvement, and the submission engine submits patient data or performance data to payers. Meaning that what you see in the dashboard is what you get in submission.

With that, I just showed you everything you can't see in demonstration. However, there's a lot you can see during a tour of the Able Health performance dashboard. For that, I'll hand it over to my colleague, Kevin Rockholt.

Kevin Rockholt: Thank you so much, Darren. Thank you all for taking the time today. I want to second what Rachel Katz said about thanking you and balancing our time between our families and our jobs. Whether you're directly supporting the COVID efforts or you're just trying to get back to seeing your orthopedic patients that are bone on bone, ready for their joint replacement. Whatever that case is and your story is, we want to thank you from the bottom of our hearts. I talk to value leaders daily, and it's amazing because these programs haven't stopped.

They're still working from home and focused on churning numbers and helping these practices move forward. Thank you so much. We really appreciate you and we're honored to be sharing this with you today, quite frankly. That poll that we took really caught my attention because it really hones in on a number of areas when you look at it. It's funny because delivering care is not the issue. Typically, practices or high performing practices, they can deliver exceptional care.

The quality is really there, it's just a matter of documenting that quality, right? Documenting and submitting it. You know what the old adage is from CMS, if you didn't document that you did it, that's right, you didn't do it. We have to make sure that you're getting credit. There are so many providers that just say, "Hey, I didn't get credit for what I did."

There's reasons for this. Much of this process and the paradigm that many organizations have with whom I speak is, it's kind of an after the fact process. You're waiting for data, whether it be weeks or up to a quarter later. Once you have the data, there's all this friction in your world because you've got a value based leader who is trying to affect positive change, with a provider who knows their stuff and a care team. Everybody has really good intentions, but they're just, by the nature of being reactive versus proactive and consolidating your value based efforts with the care you provide, there's constant friction.

There's no getting away from that unless you change the way you look at it, or in other words, your paradigm. Hopefully, we do that today. Instead of being a reactive process in which you're constantly behind and trying to catch up and treat patients, for instance, when there's a care gap. You're four weeks beyond, and tragically that person now has suffered further results of something being dropped. We can effectively merge these two. Let's take a peek at how we do that.

This is Able Health. It is a proactive look. It's a wonderful, clean, hundreds of hours we spent on usability studies. If you ever do go to QPP, you might find a few similarities in the look and the feel. Because we were actually a stakeholder in designing that website, so there might be some similarities there that are familiar. But it's nice because we're set up all the way from any size practice.

That's where our DNA is, and really working with providers and closing care gaps, and providing great care, to the fact that we can deal with an enterprise.

It's funny because so many payers and enterprises, and especially when I say payers, I want to focus on that, want to be working from the same sheet of music as the people that provide care. It's just not happening traditionally out there. But if we can bridge that gap between payer and provider and health system, it's a beautiful place. That's really what HEDIS is. HEDIS is a place, because that's the commonality between payer and provider. Much of it is the same, and the goals are really the same.

Let's find a common nomenclature to talk about this between the two. If you're just a health system or provider group, that's great too. Because we're set up here on the left hand side to actually give every stakeholder, no matter what their role is in providing care, the appropriate information at the right time.

Now, when I said data, the biggest thing you can do, and Darren really did a great job covering this, is plug your holes and gaps in data. Instead of starting on the care side, you want to really start with that data and having one source of truth, or what we would think of as an enterprise record for quality. Everybody is trying to do an EMPI for patient clinical matters.

Well, we kind of need to pull in all the different data sources in appropriate areas for that to be true within quality. We can do that here at Health Catalyst. These are all the programs you would have. We're going to pull in data as frequently as daily, so you are near real time. Let me repeat, not a quarter, not a week, not 48 hours. When you come in as a value leader, you will login and have refreshed data daily.

Now, guess what you just did? You matched right from the cusp, the beginning, your patient care with your value based efforts. That's the first step. All of your different programs contained on one enterprise platform, whether it's MIPS, whether it's an APM, whether it's a commercial. We know that payers want to have that provider take on more risk, and they're willing to reward for that.

The provider has got to have the right set of tools given to them by the payer. If you're a payer and you provide them with the right set of tools to make more through your plan, guess what you just did? You created stickiness and you grew your business. Because the word is going to get around, "Hey, that's who I want to do business with." Life is simple. You want to make yourself easier to do business with, okay?

That's what we're going to do here. All of these different programs or cards, these boxes are called cards, represent a different program. I'm going to drill into a couple just to kind of get that wow factor. Here's a wow factor, that's

what happens if you don't login for about five minutes. You say, "Wow, that guy is really good." Here, this is your MIPS based program.

It's a composite screen with all of the elements of MIPS built into it. I'm not going to spend a lot of time here, but I wanted to show you that we represent the MIPS program as it's written. In other words, all the subcategories and all the measures weighted on the relative weight within the program bubble up daily. Boom, there you have it. You can come in, you can go to the group level, the provider level, patient level. All kinds of wonderful things.

I just wanted to show you that. Now, we're going to jump over for quality. Program number two. Can you see in your world value based leaders? Because so many times, it's like I call a health system and they've got one person working on MIPS. That's one workflow. Then they've got this commercial process, which is almost always with their commercial contract. It's all these manual spreadsheets as well, and manual effort.

It's amazing the work you all are going through to gleam even the most basic insight within performance. Here, we've got performance about the program. Or I'm sorry, information about the program, it's commercial. We've got the measurement period, measurement version. The steward or risk model. We can encapsulate or contain or offer you any steward, any program you want. In this particular case, we're using HCC 2019, but it could be anything. Even custom measures, which is a big thing.

You can even decide on standards of care, which combine measures from multiple programs. In other words, your providers, who are already providing exceptional care, most of you know this. That was reflected in the survey we took. They don't need three HbA1c scores to manage in front of a patient. They need one, which is your standard.

Just look at the three different ones from your payers, and come down with the lowest denominator, and offer that as an alert. We're going to be very weary of alerts by the way. Because I know that in the EHR market. Man, those providers have had enough alert fatigue to last a lifetime. Just to make this clear, your providers are not ever going to touch this dashboard or this product.

This is for management. This is for the enterprise level. This is for the quality level. This is for the office manager and the care team for that morning huddle, when we get to that point. Providers, don't worry. You're not going to have another piece of technology to deal with, you've had enough. We get that. Measures, these are all the different measures within the program. We'll probably jump back and take a quick peek at MIPS in a few minutes, because it's beautiful the way we handle it with deciles and baked in visual cues on how to improve performance.

In the matter of HEDIS, instead of being deciles, okay? Those buckets of performance within that program, it's actually the STAR program. Whatever it is based on the steward of the program, we can work that into your visualization here. This is wonderful, look at all these measures you're doing. With MIPS, of course you do six that are standard and probably an additional six.

With HEDIS, it's whatever you want to do. Maybe some custom measures. Now, if it's red, that's not so hot obviously. We know what red means, that's put on the breaks, take a peek here. If it's blue, there's actually no actual measurement going on. Here, we actually have it baked in and you can see the deciles, okay?

Basically, you have the measure listed. Annual monitoring on ACE inhibitors or ARBs. You've got the HEDIS description or measure identifier here as well. You've got the visualization, and then we've got the percentage. Then we've got your numerator, your denominator. Then at the end here, we have an arrow you can click on which is going to give us all kinds of great tools to affect performance ideally.

What do I see here? What do I glean as an administrator? I'm going to show you how to navigate a program in about four screens. We're already on screen one, so this is actually going to be amazing. Let's look at here. What I can tell is that there are some issues with diabetes, whether it be given the HbA1c, whether it be resulting the HbA1c, or the eye effects of the disease and getting that eye exam. Which may be referred out or internal to the organization.

For some reason, we have issues, okay? Now, you might look at these and say, "Wow, this is a tough one too. Look at those deciles are way up here. How did we ever get there?" Actually, it means the exact opposite. Most people do really, really, really well with this, and so can you. Let's put our chest up and do well because you can do it. This is telling you that most people are doing it based on the performance and the historic.

Anyway, I've got my measurement here. I'm going to go to the arrow, I'm going to click that here. This is where the power comes in. I can look at all patients. I can actually look at the specification. This is the point where my value leaders go, "Wow, can I have that?" They look over to the CEO or whoever they report to, because they're so used to going to an external source. Whoever the steward is for the program.

If it's QPP, they're going to that website. It's this constant back and forth to review measures because you can't memorize everything about a measure. But what you can do is bake it in. This is not just a typical help section, this is the full, comprehensive support of the program, not just the product. I've got the description, the denominator, the different SNOWMEDCT codes and ICVs, diagnoses. Encounters procedure information codes, it counts, SNOWMEDCT. I

can go on and on, but all of the different data that is pertinent as you're doing your homework, and making sure that things are right.

This is just an example of transparency. We want you to understand the conclusions we're coming to. Now, we've got data coming into the system real-time. We've got support so that you understand what you're doing without leaving the program, that gives you focus. We can also notice things in the population. As I make observations and we're in different times where we're trying to get the practice rolling again, and kind of categorize, who do we get in first? Who has to get in the soonest based on those comorbidities and how sick they truly are?

There's different things that I can put in as an administrator, based on different measures or diagnoses. For instance, here, be sure to register if appropriate for continuity of care. When they've got diabetes or some comorbidities, they're probably a great person. Some of you all have that special clinical environment just for those cases and will flow them through there.

This is just great because instead of reacting, you're being proactive based on things you noticed with that data that's up to date. It's daily, not quarterly, monthly, or whatever. You're making observations. This will actually go with the actual documentation to close care gaps and or make phone calls, which I'm going to show you. That's a powerful tool without even going into your EHR, where we're pulling the data from perhaps. It's one of the sources you can actually do to change your trajectory here. View all gaps.

Now, I don't know if you all are in the office, if you're still at your cottage because we're coming up the holiday weekend. You probably should have sat in the car because then you can put your seatbelt on, because this is a big differentiator. This is where we leave the competition in the dust. This is where the rubber truly meets the road. Are you ready for this? Expose view all care gaps.

My system just auto sorted to the appropriate section it needs to go to. It put the criteria of the measure that I'm looking at and visualizing, and the fact that there's a gap, and there's all kinds of filters in here. Which program we're looking at, and all of my patients. Not only do I have care gaps, but I've got associated risk based on that commercial contract. If you're a payer and you start giving your providers these types of tools, they won't leave you.

They'll be loyal and they will run with you long-term. It'll be beneficial for both of you. You'll both be working from the same page of music. Imagine if you could actually deal with, as a payer, with your particular view. Then push these car gaps in order to monitor their closure with risk to your providers. It's amazing. Let's go ahead and look at aiming.

This is my patient facing, my phase sheet. This is my quality phase sheet. You all have a clinical phase sheet, this is your quality phase sheet. I've got all of the demographics coming in from the EHR. I've got my risk suspects, which we actually generate relatively conservatively. What we're doing is looking at diagnosis and then bill, if there was a claim.

What's really neat here though is the foresight or the insight we had to give you the things that are right, not just wrong, to do an apples to apples comparison. It gives you more of a holistic view of what's been coded and billed appropriately, in conjunction with what didn't. This care gap was actually generated. It makes logical sense because it's in the suite of comorbidities that would go with these. And I've got the code and when it was last built. We didn't find the bill.

We had a diagnosis with no bill, so it generated a risk suspect. In addition, if we find a bill from last year but not this year, do the same thing, risk suspect. We also look at the CMS MOR file, M-O-R, MOR, to look at data and make these conclusions as well. I've got there last and next appointment. This is critical.

If you're dealing with patients, I don't want to have to go back to my EHR and figure out if and when they're coming in again. I need to know that now to make a decision, to generate the appropriate action. This is going to tell me. I know we're going to get a question that says, "How do you do that?" When we're done with the webinar, they're going to say, "How do you get that information?"

I don't know if it's going to be Eric or Rachel, but they're going to answer that and you're going to like the answer. Risk course, CMS, HCC. I can't tell you, if I had a dollar for every provider that said, "In the commercial plan that I'm with, I can't tell before I do that yearly physical, that first visit, how sick they are. I don't know who to get in, when to get them in. I can't affect how I'm reimbursed with equality." You've got real-time information, you've got risk.

I've even got my scoring breakdown that we're calculating based on demographics, comorbidities, and even combining different types of information. It can affect the score. I forgot the actual term for that, but it's part of the equation. We have it all right here, all the comorbidities that have to do with that patient flowing from over here. You couple that with these care gaps, these are probably more care gaps than you'd have honestly, because it's a demo database. But I mean, I can look at these care gaps. By having, again, that factor of things we're successful in and where there's gaps.

I can glean, first of all, just from scrolling here, I can tell already we're doing great in their practices. Where the issue is when they had to either go get a test, go get an eye exam, go get a screening, do something. Now, this gives me direction. This is that breadcrumb trail to a resolution you don't have right now.

This is that manual effort. This is that friction. This is going back to the providers, asking them what they've documented.

It doesn't have to be that way. Here, I've got a breadcrumb trail. First of all, I can make that observation. Okay, I see some tendencies here just based on the information I'm presented with. No hemoglobin A1C was found. No test was found, no eye exam was given. More than likely, these things just fell through the cracks legitimately, that's possible.

This is a big deal because when they do, and if you don't catch it and you're dealing with data that's four weeks behind, that can affect a person. That person may end up in the frequent flyer program, God forbid, to the ED. All they needed was a change in script, a foot exam, a modification, some patient education, a phone call, a tele consult. This is a big challenge, so having that information real-time is absolutely golden.

Now, if you don't have the information to make the decision you need on the front end, another big moment here. We were at a large health system recently, and the incumbent vendor is going bye-bye because they're not transparent. Everything is black box. Well, you have no control to have a conversation with us as a vendor if you don't know how we're coming to the conclusions that we are.

You certainly can't have a dialogue between payer and provider if there's no common sheet of music. Applicable records, this is the data we're using. Whether it be in a matter of [PETUS 00:43:37], more of a claims nature. If it's MIPS and it's clinical data, we pull from all the sources we need to make the appropriate calculations. We run every measure through 150 test patients to make sure it's accurate before we ever release it to a customer.

We use the latest technologies in order to test and write the measures. In other words, we can turn out custom measures and we can write measures much more quickly. Ask us about that, you'll love what you hear. This shows me that last lab was done, there it is, 2018. I've got the appropriate visits, all kinds of activity. But I know the dates of service now, so now I don't have to go search through Epic, or Cerner, or ECW, or whatever it is. I can go to one succinct date.

If for some reason there was a verbal order, I can come in and say, "Okay, this actually was ordered." In this case, we know that's not the case because there would have been a result. I probably don't even have to go back and look at all that. But if I have one or the other, I could go back and fill in the blanks with documentation that wasn't captured.

A lot of the times, the problem with the documentation being captured is if you use an EHR for instance, for MIPS, there's one prescribed field. It can be very obscure, and your providers are just missing it. We're a registry here at Able

Health. We can open up your entire database and put it anywhere you want. As a matter of fact, if you said, "I want to know every fruit and vegetable they eat and call it fruit and vegetables." You show me within the soap notes, objective, objective, assessment plans.

You tell me the MA is going to gather that information, so we'll put it in objective. We'll put in fruits and vegetables. We'll have a dropdown. Bananas, bananas and pears, pears only, whatever you want it to be. We'll show them and have them agree where they want that box, because that's crucial to your organization. They will get the data for you no problem. It's just a matter of being in agreement.

Here again, and I didn't mean to divert there with my fruits and vegetables analogy. But all the data that I need and have for resolution is here. Now, the power comes in, again, when I go back and I say, "Okay, well what do I do? I made a decision. I've got great information. I want to recall some patients or I want to make phone calls." I can generate a call list based on the fact that they don't have an appointment on the schedule. It will generate a list, send it to my front desk. Then they can go through and schedule everybody, or use titrated text messaging based on who you think will actually respond to a text message, and get them back in the practice or do a tele consult if that's appropriate.

If you generate your visit checklist, that's going to give me all the care gaps as well for point of care. Our customers, what they do is they just literally print this thing off. They'll review it in the morning huddle, print it off for a day or two at a time. As a value leader, this was a stop on our journey today. But this could be your starting place, especially as the manager of a practice. You'll come in, pick your practice, pick your provider, run these for the next couple of days or the week. Put them out there, have your staff review and your front desk.

You're running, you're at the races now. You're improving care. The reason this is not going to cause the friction that you typically have is because the doctor doesn't even know what's going on. You're working around the provider to enhance their performance, not forcing a bunch of mundane workflows upon them, and they love it. It makes a lot more sense using technology and matching the cadence of patients in the practice with your value based efforts. I can't preface that enough.

Let's see what that report looks like. We'll come back here. I just want to make sure I'm staying with... I've got about 80 seconds here, I'm timing myself everyone. We've got about 80 seconds. Here, when we go back and we look at the checklist, this is my visit checklist with care gaps.

You can print this off, you can attach it. Eventually, if you really wanted to push this to help maintenance and use native reminders to remind people, you could

do that as well. Our customers print it off and attach it after the fact if it's appropriate, and have great success with this. They close gaps.

Here's what's neat, this is the other one, the other version of this, which is really just meant for the front desk to have this and refer to them. Then actually have the risk suspects as well. You can actually talk through those and review things with them as well, which they're going to do other processes within the HR, like review meds and things possibly. But anyway, wonderful tool. This is our clinical intelligence tool.

Let me just go back to the provider section or go here. Just to wrap up, regardless of program, the insights that you need are going to be offered. This I MIPS. I've got an average MIPS score I can filter through here. I can go to any provider that I want to and look at any program they're participating in, and isolate their performance and compare it within programs.

I can come and print just the MIPS. See that same original dashboard, go into quality. Remember the HEDIS? Look at the MIPS. See the beauty of that? We're bouncing percentages off of deciles and calculating points real-time. You will know down to the points, to the decimal points, how you are literally performing in MIPS all the time, real-time.

If we go back to providers, another thing you could do is say, "Okay, so I went to..." Let's go back to Angela. I come in, I look at that provider in MIPS. Instead of just looking at the quality, I can say, "Okay, they're doing great. Let's actually have a conversation with this provider at the meeting and show what a great example they are."

I can print their score card, I can email their score card. You know what they say. I don't know about you all, if you have those providers that are competitive. They say some are. The MGMA says if you give it some top providers to kind of show their stuff, the others will come up to them after the meeting basically and say, "Hey, can you help me?"

One last thing, audit. We match the audit process, for instance, within MIPS, identically to them. You wouldn't believe what a time saver that is if Medicare says, "We're going to run an audit." You've got a generated, randomly generated report that matches their process. A workflow where they can come in, view my specification without going to QPP. View the applicable records, have the transparency at my fingertips within this process. Then even attach a screenshot that proves my case. That's it, thank you so much for your time and attention. Have a fantastic day.

Darren O'Brien: Thanks, Kevin.

Brooke MacCourtney: All right, Darren. You should have the power to present now.

Darren O'Brien: Perfect. All right. I appreciate that demonstration, Kevin. As you were walking through the demonstration, I couldn't help but wonder, what payer programs for provider quality are most important to everybody's organization? That leads us right into our next poll question. The question is, again, what payer programs for provider quality are most important to your organization?

I ask the question now because I always try to picture if you were using Able Health's performance dashboard, what measures would be included in your dashboard? If you would let us know which of these programs are most important to you.

Brooke MacCourtney: All right, we'll launch this poll. The question is, which payer programs for provider quality are most important to your organization? Your options are Medicare ACO, commercial ACO, other Medicare shared savings or loss, other commercial shared savings or loss, and Medicare's MIPS program or commercial FFS, with the link to quality and value. I'll give you a minute to answer that. We've got some votes coming in. Thanks again everyone for voting. We really appreciate the feedback, and we'll go ahead and close that and share the results.

Again, Darren, it looks like there's kind of a split. We have 25% said Medicare ACO, 0% said commercial ACO, 8% said other Medicare shared savings and loss, 25% said other commercial shared savings or loss, and 42% said Medicare's MIPS program or commercial FFS with a link to quality and value. What are your thoughts on that spread?

Darren O'Brien: Yeah, no. It's different than other times I've asked it, but again, I think I'm still learning a lot about the different combinations. Once again, everybody, I appreciate it. After the webinar, I'll definitely sit down and start to piece together the big picture myself. Thanks again. Brooke, did it come back to my screen on your side?

Brooke MacCourtney: Yeah, you should have control now. Yep.

Darren O'Brien: Perfect. Well, wonderful. I just want to summarize the webinar at this point before we move into questions. Here's what we've talked about today. We talked about the fact that Able Health combines a complete picture and complete workflow to create a truly comprehensive solution for provider quality measurement. Unlike alternatives that claim to be comprehensive, Able Health is the only quality measures solution that's truly comprehensive.

I say that because without complete data, complete quality measure calculations, complete visualizations, and a complete workflow, you don't have a comprehensive solution. But that's exactly what Able Health solution offers. If you're interested in learning more about the Able Health solution, we'd love to

learn more about your work in quality measurement. To do that, let us know that you are interested in learning more.

You can do that in our final poll question that'll launch in just a second. We'll reach out to you and then we'll have a discussion. The discussion will allow us to discuss your goals and priorities related to measures, ask more about specific programs and measures of interest, and then definitely answer any questions that you have about what we do. Following this discussion then, we'll provide an implementation approach and pricing information as well.

Once again, if you're interested in learning more, let us know in our upcoming and final poll question. That for me concludes the presentation portion of today's webinar. If you have not been able to ask your question, go ahead and make sure you input that. But for now, Brooke, I'll turn it back over to you. Thank you so much.

Brooke MacCourtney: Great. Thanks Darren and thanks Kevin for that great demonstration and presentation. We're going to jump into our Q and A session now. We have one final poll question before we do that, so I'll go ahead and launch that. Some of you might want to learn more about Able Health or even other Health Catalyst products and services. If you'd like to learn more, please answer this poll question. We'll go ahead and leave that open for a few minutes, and we'll start with our Q and A session. If you have a question, please just ask it in the questions pane and we'll go ahead and get as many as we can answered. We may go a little bit over the top of the hour. If you're able to stay on, we'll be happy to answer your questions. If not, we can follow-up with an email after the webinar. I will now turn the time over to Eric to lead our A and A discussion.

Eric Just: All right. Thank you Brooke, and thank you Darren, Kevin, and Rachel. Before we go into questions, I just want to say how thrilled we are to have Able Health joining the Health Catalyst family and joining our application suite. We've got some great questions. Let's start with the first one here is, are the measures in your system CMS MIPS measures, or are they unique to the Able Health system?

Rachel Katz: Sure, so this is Rachel Katz again. I'll be taking the questions. We have a variety of different types of measures in our system, both standard and custom. For programs that have standard measures such as MIPS or HEDIS or ETQMs, we have measures built out in our library that can serve those programs to stack. Then we also have clients who want to define specific measures or tweak measures as part of other programs. Those can be achieved in the Able Health system as well.

Eric Just: Perfect. Thank you, Rachel. Next question, what type of multi-program views can you drill down for review? Can you see all programs in one view?

Rachel Katz: Yeah. There are quite a few different ways to look at the data. Kevin showed a number of them. I think it may be helpful for your specific use case to follow-up if you're interested, and look through the views in more depth, because we didn't have that much time today. We do have the ability for you to look across your entire patient population, if you want to apply certain measures that way.

We also have views where you can look at program by program for specific patient populations and specific measures. I'm not sure if I'm addressing the use case you are looking for exactly. The kind of short answer is you can look at it quite a few ways. We'd be happy to jump on another demo to personalize it a bit for you, and look at your use case.

Eric Just: Thanks, Rachel. Thanks for that question. Next question, for MIPS, are you a QR or QCDR?

Rachel Katz: Yes, we are a qualified registry or QR. That means that we do submit data directly to CMS on behalf of providers.

Eric Just: All right, thanks again. Okay, here's another one. Of the 4000 plus quality measures across the quality programs, which ones do you support?

Rachel Katz: We have a number of measures across multiple different programs. The standard measures are what we primarily have in our library. HEDIS, MIPS, ambulatory measures mostly. But the really nice thing about the platform is that it enables the implementation of measures easily. Not just the implementation, but the maintenance and the annual updates of those measures. The way we expand our library often is by request from customers who want measures that are not in our library. That's how we add to an extend our library. If you are interested in measures that are outside of our library because we don't have all 4000 or however many thousand there are today, we can implement those into the system for your use and others' use as well.

Eric Just: Wonderful. Okay, next question. Does your patient view look at cohorts for true population health, or is it by practice, group, etcetera?

Rachel Katz: Sure. In Able Health, the default is to be able to look at the levels you mentioned, by practice group, etcetera. However, and this was one of the reasons that we're really excited to join up with the rest of the Health Catalyst platform, because Health Catalyst has a world class cohorting tool that we have integrated with several different products. And is in the future going to be integrated with Able Health so that you can push cohorts from that tool into the measures system, and look at your measures that way as well. It's a great question, and it definitely gets to where we are going with this combination and what we're so excited about over here.

Eric Just: Perfect. Thanks, Rachel. Next question, what commercial payer quality programs besides NCQA and HEDIS do you support? ID, BCBS, Humana, etcetera?

Rachel Katz: Sure. All of our programs are configurable. For commercial programs, what we do is we basically configure programs based on any given provider's needs in that program. If you're engaged with say blue, for example, most of those programs are based on HEDIS or they may use HEDIS like measures that need a little bit of tweaking. Then we configure a program that matches your specific contract or set of measure requirements with that payer. Based on the measures in our library, or if needed, adjusted or new measures that are specific to that contract.

But because most of the programs are based on HEDIS, we're typically pulling measures from our library to configure those. Then as Kevin showed, you can also configure benchmarks in each program. If there are certain targets for that specific payer, we can add those in for you so that you can look at your performance relative to those targets as well.

Eric Just: Perfect. This next question came in when Kevin was demonstrating the dashboarding capabilities. The question is, can you automate or batch these reports?

Rachel Katz: Yeah, so I think that was about the output reports. There is a couple ways to batch those and automate them. The first is, we can automate the output of Excel or CSD files containing measure result information on a daily basis. If you want to receive those measure results on an ongoing basis, in an automated way, that's something we can provide. In addition, you can, through the filtering view, you can multi-select patients. Maybe all of the patients coming in on a given day, for example.

You can export all of those kind of huddle care summaries with the care gaps and so on. You can bulk export those and they'll be sent to your email. Then you could print that whole file if you wanted to. Let's say print all of the summaries for all the patients coming in that day, which is a workflow that some of our clients use.

Eric Just: Excellent. Well, we're up against time. We have a handful of questions left, but I think we're happy to go. I think we'll have enough time in the next 10 minutes. We'll extend the webinar by 10 minutes to address the rest of the questions here. Next question, it says, can you estimate cost?

Rachel Katz: Great question. In Able Health, we don't do cost estimation, but we have another excellent cost tool within the Health Catalyst platform called Quora. That is where you would do your cost analytics. As we continue down this path

of integration, you'll see more and more side by side cost and quality type analytics across the entire suite of products that Health Catalyst offers.

Eric Just: Excellent, thank you. One of the reasons why we're so excited about the combination is just bringing together the Catalyst toolkit with the Able Health toolkit. Lots of, lots of future value we can create there. Next question, I think this was in reference to a poll question. They said, "Why didn't you ask about the state Medicaid provider quality program?"

Rachel Katz: Yeah, good point. I think that that would have been a good one to add to the list. Maybe that was why there was such a big bucket in other. Like with commercial programs, where state programs were often configuring measures to match the state requirements, some states are using ECQMs. Some states are using HEDIS measures. Some states have developed sort of alternative types of measures for folks. That's definitely something we put forward, and I think that's a really good point. We should add it to the poll.

Eric Just: Great. Next question, how are your HCC suspects developed?

Rachel Katz: Sure. We use a couple of different risk models. You can choose which model you want to use. We have HHS HCC, CMS HCC. Then the suspects themselves, we do through a relatively conservative identification where we're looking at two... we're looking at two things. One is diagnoses that have been billed in the previous year that are HCC eligible, that were not billed in the current year. You can re-bill if that condition is still active and get that counted towards your risk score.

The second way is if we're getting clinical data in the system, we would look at the problem list and look to see if there are any codes in that list that have not been filled. We are basically looking for codes that indicate that there is a condition I place that is HCC eligible, and that hasn't been filled. So that you can more accurately reflect the health of the population.

In Able Health today, we are not doing additional predictive analytics based on medications that may indicate a certain condition, and so on. But that is something that, again, is done in other parts of the Health Catalyst application suite. We are working toward that unified set of HCC suspects as well.

Eric Just: Awesome. Okay, next question. Are there any financial analytics in the management view?

Rachel Katz: Again, there are not financial analytics in Able Health. But Corus is a world class financial analytics product that we would be happy to explore with you. And also to share how the two tools work side by side and will further be integrated as we go forward.

Eric Just: Okay, next question. Can you distribute incentive based on provider performance?

Rachel Katz: Can we distribute incentive based on provider performance? Was that the question?

Eric Just: Yeah, sorry. I think it maybe could have been worded a little bit better.

Rachel Katz: That's okay. I may not hit the nail on the head here. I'm not quite sure what the question is, but... We don't distribute the actual incentive payments. However, we do in programs like MIPS enable scoring in the product. So that you could see how many points, or in other cases dollars, would be attached to a given level of performance. I guess what I'll say is our tool can be used to facilitate the distribution of incentive payments. It's certainly used to based incentive payments on, but we don't actually do the distribution of incentive payments today.

Eric Just: Got it, thanks. Okay, this is the last question. Can you provide quality bonus payment as financial factor in the report?

Rachel Katz: Yeah, it's a related question.

Eric Just: Yeah.

Rachel Katz: If you have a certain program that has associated dollar, we could explore putting your dollar logic basically into the report. The analogy that we have today is points for standard programs that have points. The dollars for a given, let's say commercial program, would have to be customized to that program's specific payout logic and so on. But it's certainly within the framework of what we currently provide and could be a potential customization.

Eric Just: Wonderful, thank you so much Able Health team. Thank you so much to the audience, and especially those folks who submitted questions. They were great questions and fun to go through. Thank you.