Big Idea Podcast - transcription

MARTIN WHITE: Welcome to the Big Idea with ZS. I'm your host, Martin White. Those of you who know me know that I'm not one for excessive jibber jabber. So let's get right to it.

MW: We're starting to get a lot of questions from our clients about provider organizations. There seems to be a general lack of understanding about this customer group and how we can best engage them and best serve them.

MW: I caught up with ZS Principal Joe Stevens to find out more. And along the way, we even talked about this:

JOE STEVENS: Do you realize there's an ICD-10 code for people getting sucked into a jet engine?

MW: But more of that later. Let's hear from Joe.

[Transition music]

MW: Joe, why don't you tell us a little about yourself.

JS: Sure. My name is Joe Stevens. I'm a principal at ZS. The common theme of my work has been a focus on pipeline and launch strategy. For the last three or four years, that focus has been primarily on market access and how to engage better with payers and large organized provider institutions.

MW: Alright, so what's the big idea?

JS: Pharma needs to change the way it engages with customers. From the physician-centric model that we've been focused on for as long as I've been in the industry to a model that's more about a business-to-business transaction where we engage with large organized providers, where we partner with them in a way that brings them value, brings us value and ultimately leads to better care for patients.

MW: So when you say "provider organizations," what exactly do you mean?

JS: I'm generally referring to a large group of healthcare providers—so physicians and the various supporting staff, nurse practitioners, nurses, medical assistants, et cetera—that have organized in such a way as to create a professional management structure. So they have people that aren't just doing some administration part time in addition to their patient care, but they actually have professional management (finance staff, operations staff) and make decisions as an organization.

The most important kind of provider organization is the integrated delivery network. We commonly define these as a healthcare provider organization that has integrated primary and acute care under the same management structure. There are about little more than 600 of these in the United States.

MW: Where are we with thinking about provider organizations and what we can do with them?

JS: I think it's pretty nascent. There's a lot that's being piloted right now by people across the industry and ZS is helping with some of those pilots, but I don't think we've cracked the nut, as it were. I think it's going to be critical, as the healthcare ecosystem evolves, that we figure it out.

MW: OK, but what's the burning platform here? Why do we need to sit up and take notice of this right now?

JS: We've had this trend of larger provider organizations merging with each other and becoming even larger. This has been happening for many years now and doesn't show any sign of abating. So we have continually growing providers through horizontal organization. Of course, the payers tried that a few years ago and got told "no, you can't form an even smaller number of mega-payers."

But what we're seeing payers do now is merge vertically. Just this week, the CVS/Aetna merger was approved by the Department of Justice. I saw the CEO of CVS interviewed this week talking about how the whole point of this merger is to change the way healthcare is delivered. By being able to integrate not only the data, but also the decision-making that's based off that data, he believed this would create not only lots of value for the shareholders of the combined company, but also better-quality care at lower cost to the patient. So the burning platform is really the evolution of the market. And I think if you look at the cost of providing healthcare to the U.S., most reasonable people agree that something has to change. Until we change the delivery model, things are unlikely to change. So I think the logical conclusion is that the way healthcare is delivered is likely to change in the U.S. in the next few years and I think there will be a huge advantage to those who are ready for it. I mean, I think there will be a huge penalty to those who are left behind.

MW: What might that penalty look like?

JS: There's been lots of things hypothesized: Will we move to a winner-take-all market? What will biosimilars do to existing biologic brands?

Maybe the best single piece of data I can give you is from a survey we recently conducted with 67 IDNs, which is about a little more than 10% of IDNs in the U.S. Turned out in our sample that 80% of them were tracking their physicians' prescribing even in the outpatient setting and of those that did tracking, about a third actually adjusted physician compensation based on their prescribing patterns. So if we think about the ramifications of that it's easy to see why just going in there with a detail aid and talking about your clinical data and what's on your label isn't going to really be able to move the needle against a physician whose employer is adjusting their comp based on their behavior. The whole set of tools that we bring to that commercial engagement need to change.

MW: Joe, tell me more about this survey. What were some of the interesting things that came out of that survey?

JS: Turns out the way IDNs are managed, might be very familiar to all of us working in corporate America, right, and the leadership team sets the vision for the organization. In fact, they articulate this vision to their employees, so it's relatively easy to figure out what it is. The most common elements in an organization's vision tend to be made up of only a few things and there tends to be one thing that that institution is focused on.

You can divide up institutions into ones focused on financial stuff (revenue or cost) and ones focused on providing cutting-edge clinical outcomes and/or doing cutting-edge research and then finally to a third type, organizations that are focused on patient experience. It turns out the driver behind an organization's focus seems to be what that organization thinks it can change. So for organizations that are focused on financial stuff, on revenue and cost, generally they believe that the way in which they bill and provide care from a tactical perspective is going to be what determines the success or failure of that institution. Clinically-focused organizations often have kind of an academic or research focus, so that

means they often have some funding coming in from outside other than just their patient services and are looking to maintain their prestige in their role as national or regional centers of excellence across a variety of conditions. Patient care and patient satisfaction-focused organizations note that no patient is ever able to verify what quality of care they can get, right. If we go to the doctor, we get better, we don't get better. We never know if the outcome would have been different had we gone to another doctor. So a CEO of one of these organizations observed to me that when he gets a letter from a patient about what great care they got, it doesn't mean that their outcome was good, though it might have been, it means that they had a good experience as they were receiving that care. And so by focusing on that experience you can increase your standing in the community, you can get more patients in the door, therefore leading to the success of your institution.

MW: What else did you learn from the survey?

JS: Another interesting finding was about how we as pharma are engaging with these institutions. We did some work in kind of categorizing the types of pharma programs or partnerships that were currently being done. Turned out that every pharma company is doing the most of a category of engagements we call "care efficiency and optimization," which primarily focuses on things like physician and other healthcare provider education, was a bit of a disappointment then because that category is one of the ones that provider organizations found the least valuable. It doesn't surprise me, right, because if you think about physician education, it's kind of glorified detailing, you know—and we're comfortable with that, we know exactly how to do it, it's compliant, we don't have to worry about any kind of uncomfortable things or any regulatory complexities that we're not already used to dealing with—but our customers aren't finding it very valuable and in fact there are plenty of things they find more valuable that we're not doing nearly as much of.

MW: Well, what kind of things do you mean, Joe?

JS: One of them is offering innovative contracts. More and more provider organizations are taking value-based payments, which means that what they get paid is a function of the outcomes they can offer. They would like to also pay their expenses in a similar way, right. Turns out provider organizations for the most part are very open to contracts that share risk so that if they get a good outcome they'll pay a high price and they'll also get good reimbursement on their value-based payment schemes. Whereas if they don't get a good outcome they would like to see less of a price because they'll also down the line likely see less reimbursement as a result of that.

MW: So I think that's a nice summary of the problem, Joe. I guess what I'm more interested in now is what are some of the things that can be done?

JS: I think the number one thing that we need to do is understand these organizations better. An organization like I described with professional management that may or may not have a background in patient care, may or may not be clinicians by training, they're going to have different needs. They're going to have different interests than the primarily physician audience that we in pharma have promoted to over much of our recent history. Now once we gain that understanding, I think there's two tangible things that need to be done:

One is tailor our messaging so that the things that we talk about when we're explaining the value of our products resonate with what these new types of customers care about.

The second is I think we need to develop and promulgate programs, partnerships, value-added services, whatever you want to call them, things that help our customers as pharma, so help these provider organizations realize the full value of our medicines to deliver the best patient care possible.

If you think about the business plan of many of these providers that are continually emerging, it usually has something to do with gaining scale in a particular geographic area. You know, I want to control a meaningfully large part of the Bay Area healthcare market or the Atlanta healthcare market. I want to control that and make sure I can capture enough of patients' full spectrum of care from primary to acute to post-acute that I can meaningfully move the needle on the cost, and thus make taking value-based payments make sense, else it's probably best to stay in the fee-for-service world. Providers can achieve that, but if you think about it they'll never have scale in a therapy area. We as pharma have exactly the opposite kind of scale. We don't really have scale in any geography, right? Our patients are spread out across the U.S. in a way that basically mirrors the U.S. population. However, if you think about the therapy areas we work in, generally there's only a couple of brands playing in even the most crowded therapy area and, as a pharma company, there's only a few therapy areas all but the very largest pharma companies play in. So we have a lot of scale in that therapy area that lets us make a different kind of investment than a provider organization can make—and we're only really going to improve healthcare in this country, from both a cost and an outcomes perspective, when both groups are investing in a way that's most appropriate for them and hopefully driving us forth.

MW: So Joe what are the implications of this local focus. How does that translate into different motivations that provider organizations might have?

JS: That's a very interesting question. I think a lot of the things we talk about today with value-added services, value-added programs, we first talked about a few years ago in the context of payers. But if you talk to people that work at payers versus people that work at healthcare providers, IDN, it becomes obvious very quickly that you're talking to two very different types of people. Payers are fundamentally a financial service. Basically, what a health insurer does, the essence of their business, isn't that different from a car insurance company or a life insurance company or the people that insure my house. Now, a healthcare provider is very, very different. They're interested in operations, OK. They see the patient on a day-to-day basis and so there's all kinds of things that they can do differently, they can control in how that patient has their care delivered that is reasonably, totally outside the control of a payer who's just seeing the claim and paying it or not paying it. This opens us opportunities for doing things that actually change how transition of care between, you know, acute and post-acute happens, how patients are educated about their condition, how they're followed up after medicine is given, how evidence is collected in the real world so we can understand the behavior outside of a control-trial population. It opens up opportunities for contracting in new ways that we tried with payers but they kind of weren't all that interested in but that providers are now showing more interest in. The fact that you're dealing with someone whose goal is operations, is actually providing care to that patient, creates so many more opportunities than when you're dealing with a person who's just paying a claim and is just fundamentally a financial service.

MW: And I guess they have a longer term focus because people don't move as often as they change plans, right?

JS: That's true. The average payer thinks they'll be with a patient for two or three years max because that's when people are going to change jobs and get a new plan. Now provider organizations, if, as I

mentioned before, you've achieved meaningful scale in a geography, you can expect to have that patient in many cases through their entire life and certainly over a much longer period than two or three years.

MW: So Joe, what are some of the key questions and challenges you're facing as you start to address provider organizations?

JS: I think one of the big challenges as we talk about how pharma should engage with provider organizations is dealing with the scale. If every pharma brand does something, it's going to be a logistical nightmare for anyone to actually engage with all of them, right? The last thing our customers want is lots of complexity in having to engage with all kinds of pharma companies on all kinds of different programs that cost them time and resources. I think solving the logistical challenges behind scaling these types of programs, I think that's a huge challenge. There are regulatory challenges that need to change things like safe harbor to ensure that these types of programs, when they benefit the provider and the patient, are accepted by regulatory bodies. In fact, just a few weeks ago, we saw a lawsuit by the California Commissioner of Insurance against Abbvie for some of the programs they're running around Humira, and it's not clear to me where the objection was. Of course, the lawsuit claimed a lot of egregious stuff, but many of the other things that were mentioned, such as Abbvie's nurse program to help Humira patients take their injections, it didn't seem to me [sic] why that was something that caused the California Insurance Commissioner or others damage. So I think there's a clear need for clarity on what is acceptable and not acceptable from a regulatory point of view.

And maybe the last thing that we need to figure out is the question of how we engage with providers in a more trusting way. There is a reasonable percentage of physicians and other healthcare staff that are very mistrustful of pharma. They see us as just wanting to push pills, as not really understanding or caring about the way their organizations work, the way that they're trying to care for their patients, and this is a shame, right? It's not only a missed opportunity from a customer engagement standpoint, it goes against the attitude of the vast majority of people working at pharma companies that I've ever met who, for the most part, are in it because they want to develop innovative medicines that improve patient care. I think we need to figure out what we've done wrong that has caused the trust gap to appear and rectify it as an industry moving forward.

MW: What are some of the things that companies have tried to do already with provider organizations?

JS: I think we have a lot of great descriptions of programs that people have tried. I think we're seeing a lot more attention around real-world evidence generation that I think will be very powerful as more of it gets created. I think there's a lot of overlaps with the digital health space. The idea that if you have scale in a therapy area, one of the things that you can invest in is development of something like an app that you pair with maybe a service that helps follow up on the patient in some conditions that can provide better monitoring and quicker responses when there's an incident than some of our more traditional healthcare delivery channels. I think there's lots of technological ways that can be used to improve this system and I think there have been some really interesting examples of that so far—Takeda's Project Sonar, Johnson & Johnson's Care4Today are two of the more better-known attempts, but there has been quite a number of other ones out there as well.

MW: So Joe, anyone out there who's thinking about focusing on provider organizations, what would you say to them?

JS: The number one thing I would like to see our industry do more broadly is acknowledge that the delivery of healthcare in the United States is changing. If we as pharma don't change our commercial model, don't change the way that we engage with customers, we shouldn't reasonably expect it to work, right? We have something that worked well in the model that existed in the past, but if the world—if the ecosystem changes, then we need to change as well. I don't think anyone has a silver bullet yet, but if someone waits around until that silver bullet exists, then I think they'll find that the industry has passed them by. I hope that our clients broadly will look at this change as an opportunity and hopefully create some real value for patients in the process.

MW: I'd like to wrap up just by asking if you have one cool thing that you think people might be interested in.

JS: I was doing a project some months ago. We were categorizing ICD-10 codes. Do you realize there's an ICD-10 code for people getting sucked into a jet engine? And in fact, there's separate codes for the initial time you get sucked into a jet engine and getting sucked into a jet engine in a subsequent encounter. Do we really need that level of detail? I'm just saying, do we really need to differentiate the first time you got sucked into the jet engine from the next time? How many times has that code been used in the history of healthcare?

MW: Joe, that was great. Thank you very much.

JS: My pleasure.

MW: So there you have it. A view on provider organizations from ZS Principal Joe Stevens. If you have any questions or comments about this week's episode, or any suggestions for future episodes, get in touch with us: podcast@zs.com.

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MW: Until next time, bye-bye.