John Marchica:

Welcome to Health Care Rounds. I'm your host, John Marchica, CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions. Here we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care, and attaining joy in work. Please send your questions, comments, or ideas for Health Care Rounds to podcast@darwinresearch.com. And if you like what you hear, please don't forget to rate and review us wherever you get your podcasts. Let's get started.

Kim:
Sean Brusky, Healthcare Entrepreneur, Executive Advisor, Strategist; and Former Head of Healthcare Delivery Innovation at Genentech/Roche
Sean's career has developed around a central theme: How can we innovate to help Pharma become true partners in value-based care?
Over the course of 15 years in various leadership roles with Genentech/Roche, Sean has lived experience attempting to solve the problems at the core of this challenge, directly engaging key market stakeholders from the seat of one of the world's largest integrated healthcare companies, focused on both innovative new medicines and novel diagnostics, and real-world data solutions.

Sean has built and led teams responsible for brand-focused marketing and sales, managed care marketing, channel contracting and engagement, integrated health system engagement, government & commercial payer engagement, and most recently, digital health partnerships and novel approaches to healthcare delivery. Sean spearheaded Genentech's efforts to execute value-based pricing models in collaboration with health systems and group practices. Sean has directly initiated and executed over twenty novel commercial and medical partnerships in the personalized medicine, digital health, and value-based contracting space.

This unique blend of business development, commercial, managed care, medical affairs and strategy experience has contributed to Sean's unique perspective on what is broken about the current pharmaceutical pricing, purchasing, and partnership model and how we can fix it.

John:

So, Sean ... my good friend Sean is now Sean Brusky has agreed to be on the podcast on Health Care Rounds today. And excited to get started. I thought maybe to start off Sean, why don't you tell us a little bit about your background, to orient the listeners? I say, listeners, it's funny. I've been listening to this podcast SmartLess. Have you heard of this one? It's like Will Arnett and Jason Bateman it's really funny. But they always refer to their listener, our listener instead of our listeners. So anyway.

Sean Brusky:

My mom is listening in so thank you for this opportunity.

John:

Right. So tell us a little bit about your background?

Sean Brusky:

Yeah, absolutely. Well, first of all, I'm thrilled to be here and thrilled to have an opportunity to partner with you on this, I have been a listener of the Health Care Rounds since its inception and excited to have an opportunity to engage. But John and I got to know each other for our listeners, several years back as I was leading efforts at Genentech, Roche thinking about how we might engage differently with integrated health system, with integrated delivery networks, what are the opportunities in value-based care? How should Barmah be thinking about partnership opportunities in that arena?

I've been with Genentech, Roche for 10 years prior to that, prior to us meeting various marketing and sales and men's care related roles. And I just recently made the decision to leave Genentech, Roche but, I'm excited for this next chapter, especially with all the innovation that's emerging in the digital health and value-based care arena. But in this context, John and I have been thought partners for a number of years thinking about, what is the next generation engagement model between integrated health systems and pharma?

What are some of the things getting in the way of pharma engaging as partners in value-based care? How might we effectively design account management teams, medical affairs initiatives, in a way that meets the needs of the integrated health system partners, and helps to drive innovation in this space? So, excited to speak personally based on my own experiences, that's big on behalf of my former employer, but about what I've learned over the last several years, where I see the opportunities for even deeper partnership and some of the innovations we're seeing, especially post COVID, on the horizon.

John:

Yeah so, I think it must have been 2016 I think, or 2015, when we first met and ... we call him the ... was it IPPN? We had our own acronym for health systems.

Sean Brusky:

Yeah, nothing was real until you came up with your own acronym.

John:

That's right. Honestly, Sean, I've been asking the question in a variety of forms about partnerships since maybe late 2014, early 2015. And we refer to these systems as IDNs or integrated delivery networks, it's just a fancy word for a integrated health system. And I know that there have been successful partnerships, especially in research and development, but I wanted to take a step back, and this is a two part question. What do you think that pharma means about how they define partnering in this context with the health system? And the second part of it is from the IDN's viewpoint, how do they define partnering or a partnership with pharma?

Sean Brusky:

It's a great question John, I'd say that definition and what is possible has been evolving with every year, and I think the current situation we're in actually, lends more urgency to, where we might go with that, and the depth to which we might be able to facilitate those types of partnerships between pharma and health systems. Honestly, I think and I learned this through some of my early engagements with different integrated delivery networks. Very early on, we were just trying to better understand how the mindset of the integrated health system, potential partners, how the executive mindset was evolving from fee for service, fill the beds, drive high quality, but volume-based care towards more value-based care delivery methods of organizing.

What does that mean in terms of how they were thinking differently about their relationship with pharma, how they'd like to see pharma show up, not only as research and development partners in

clinical trials space, but more broadly. And so through some of those early engagements, I think we learned that there was a lot of opportunity to come to the table, to bring resources to bear on population health related initiatives, quality of care related initiatives, thinking differently about real world data enabled clinical decision support and care coordination type programs, in therapeutic areas, specialty therapeutic areas that were of mutual interest, potentially, but a whole an untapped realm if you will, of areas of mutual interest.

If you're serious about improving outcomes, and doing so in a cost efficient way and lowering total cost of care to the system. And that was strategically important to the health system partner, how might we work differently together in that arena? I think a lot of what pharma has started to build over the years ... and I'll speak generally and just based on my experiences is, increased capability in health economics and outcomes research, really taking a robust and rigorous approach to assessing where a given either therapeutic intervention or clinical intervention or care delivery, transformation intervention, has impact on patient reported outcomes, has impact on quality of care, has impact on total cost of care.

Now, that's an important capability that pharma companies are starting to invest in, and rightfully so, and develop, not only to support the economic value proposition of the therapies within their portfolio, but also to think about how are these therapies being integrated in the clinical practice? And are we engaging in the right way to pull through, ensure compliance and persistence to chosen therapy to ensure that the therapies are having the intended impact that we hoped they would have, and if you do that in a robust way, a very science-driven way, and you build the economic story together around that, it makes for a really compelling win-win type of partnership opportunity.

John:

It's a great ... narrative, and an important one. I'm wondering how frequently though, the flip side that you encountered skepticism. That pharma, all you care about is selling more drugs. And why are you so interested in all of these other things? Now, I've worked with pharma long enough to know that it is beyond the pill or beyond the injection. There's a lot more of that into it. But in my interviews with CMOs, pharmacy directors, medical directors, those kinds of folks, I do encounter skepticism, so I'm wondering if that's something that you faced as well?

Sean Brusky:

Yeah, I would say absolutely. In every conversation, and rightfully so I would say because, I think there's a long history of looking at ... from the IDN perspective, looking at pharma as the vendor, the supplier, the therapeutic ... either as partnership on the R&D side and research partnerships, especially with leading academic centers, and otherwise they have a long history of collaboration there. But getting more into the care delivery space, there hasn't been the level of investment or the attention paid to partnership beyond the pharmacy relationship. And I think, as integrated health systems started to take on risk and started to think about controlling spend and cost in different areas, one of the key cost trends was the specialty drug trend.

It was the trend that the CFO and the leaders within the health system really wanted to get under control and manage it very much the ... The there was a desire as a result, to ensure that pharma engagement was funneled through the pharmacy leadership and cost was the main focus of that interaction, as opposed to letting pharma infiltrate more broadly into the clinical service lines and develop a broader set of partnership activities. And I think it speaks to one of the fundamental challenges that still exists is that, one area where we've seen positive partnership is in value-based contracting, outcomes based contracting.

There's a lot of experimentation going on in that arena. But fundamentally today, the pharma revenue model is still based on driving the demand, generating clinical data, increasing the population of eligible patients with every new clinical study, and a unit-based pricing methodology. It's a fee for service revenue model, and-

John:

Sure.

Sean Brusky:

... which for an integrated health system that is increasingly paid based on shared savings or achieving outcomes in more of a capitated way, especially those systems that own their own payer arm, that are equally as fully at risk, when it comes to the total cost of care, it's in direct conflict. I remember one of my early engagements Chief Strategy Officer at a leading health system, basically just like, I would love to partner with a leading organization like Genentech, Roche but honestly, we're on a collision course. Until we know that pharma is serious about getting on board with outcomes-based or shared savings models, and we can talk realistically about shared risk type arrangements, pharma is the specialty drug trend we're trying to manage.

And so, let's think about ways we can work together and let's build trust over time, but that's stuck with me, because I didn't think of ourselves as part of a trend that was running counter to where the broader health system community was going, but was instead of trying to look for those ways that we could bring expertise and value to the table towards our shared goal of improving outcomes and lowering costs.

John:

I want to come back to the value question in a minute, but I was just thinking of something, Sean when Roche, when J&J, when AstraZeneca, one of these larger pharma companies that has a diverse portfolio, and a lot to offer comes to the table, I can see why an inner mountain, Kaiser, Geisinger would want to have conversations with a large company with a diverse set of products. What advice would you give, because I have a sense, I don't know exactly who's listening to this podcast, but I have a sense that there are some folks from smaller companies. Also plenty of health system people that I know listen to this.

What do you say to that newer company that's got one or two cancer drugs ... let's say, they don't have anything else. They know that they've got to get on the radar. They want to form some type of alliance based on value, but they don't come with the same horsepower that the J&J does, or Genentech or ... so what advice would you give them on how to create value when they don't have as much that they can bring with maybe their one two product company?

Sean Brusky:

No, it's a great challenge. And I think, one of the constraints of operating with a single lead asset or medicine and if the financial pressures that come with that for earlier stage biotech delivering is, it is really about the initial adoption and the demand and driving in that way, I would say when approaching the integrated delivery network space, think beyond ... obviously a key stakeholders is the physician but think about how that product will be integrated into clinical practice and integrated care delivery environment, what are the other stakeholder groups within that organization that might be open to [inaudible 00:15:13].

Especially if it's something that's very transformative, you think of some of the emerging cell and gene therapies, and you think of targeted therapies that require comprehensive genomic profiling, in order to

identify the right patient, there a lot that needs to happen, and upstream of the treatment decision by the specialist or by the physician, and often I think the go-to market strategies that I've seen with earlier stage bio pharma companies, build off of the trial experience and the relationships and the academic center mindset, and don't fully take into account the broader care delivery process and the set of stakeholders that could be incredibly influential in influencing adoptions.

So everything from early ... especially if there's a diagnostic component, some of the early testing were thinking about ... population health type programs and initiatives, and a lot of these IDNs of entire centers for quality of care and in population health, and there are ... stakeholders, they weren't used to engaging with pharma. But if there were a transformative therapy coming in a given disease area that required a different approach to thinking about early detection or screening initiative, or something you might be able to partner on that would widen the funnel of eligible patients for the therapy, that's even work that potentially could be approached in collaboration pre FDA approval.

You're thinking about in a non-therapeutic specific way, how do we partner to ensure that we increase screening rates for lung cancer and specific patient populations? So that's all ... I think, an area I'd encourage earlier stage companies that don't have the benefit of the scale and the portfolio to open the necessary doors for leadership conversations to be casting a wider net when you're doing your early market research, and go-to market strategy and thinking about some of those aspects.

John:

Great. That's good advice. Last, I'm going to get in the weeds for one section then we can turn to value and IDNs. So, I don't know what maybe you think of this question but, maybe it's the people that I also know are listening to this. If you were a strategic account manager today, and you were tasked with solidifying and ultimately, a partnership with one of your customers, what would your approach be? And how would you evaluate your success?

Sean Brusky:

Well first-

John:

You're like, "John, you're giving me all these SAT questions here."

Sean Brusky:

I love it. I will say that the best and most fulfilling roles that I had earlier in my career were a strategic key account management roles, where you were empowered to represent the broader interests of your company, to engage with senior leadership to really understand what were the factors that were driving their decisions? What were their strategic priorities? What was on their roadmap for the next few years? And then try to connect the dots and introduce them to the right stakeholders within your company. It was an incredibly fulfilling role, because you could see you see how you could broker a different type of conversation partnership than historically might have existed.

In many ways you felt like an embedded member of their team of your IDN's team, really understanding what they were all about, what they were trying to do for the patients they serve within their geography, within their catchment area, and really working towards shared goals. Because ultimately, that's where the success is coming for, for patients. I'd say metrics, I put a lot of time early on as I was building teams, I focused on IDN engagement, a lot of time thinking about key measures of success, and it isn't or wasn't I actually steered away from having largely financially driven measures of success for a couple of reasons.

But more towards the types of early indicators, the types of programs and partnership activities, you're able to establish the depth and breadth of the relationships you're able to build within a given institution, the progress made on patient-specific initiatives, if you're able to have marketing programs or initiatives like collaborative activities, looking at improving screening rates in a given disease area, you're able to put some tangible metrics around those. I think, and maybe I'm jumping ahead, but I think one of the challenges that pharma has in engaging in partnership with leading integrated delivery networks, stems from the revenue model being a volume-based fee for service, drive the demand revenue model.

With that comes inherent challenges as it relates to the types of partnerships that pharma can effectively do, especially from a commercial context. Because, you don't want the perception that you're engaging and investing resources, time, energy and expertise, in order to drive demand or volume on a specific drug that starts to get into concerns about anti-kickback and other rules and regulations that still governed how pharmaceutical companies should engage. And so, you part of the answer to your question also depends on where you sit within the pharmaceutical organization and what the mission and goals of that department are.

I think a lot of the success we've had over the years, as pharma engaging has been more driven from a medical affairs standpoint, increasingly from a health economics and outcomes research standpoint, forming partnerships that are not based on volume or demand or any commercial objective, but rather are we able to answer this scientific question that'll help drive a given R&D program or inform an investment we want to make from a medical standpoint, and that really aligns I think with the way in which a lot of health systems think.

They're coming at it from a health services research, clinical service line, how do we improve quality? Lower costs? Those are things we can do together with pharma in scoping that out as a medical collaboration makes a lot of sense. And so that is one of the challenges, you can't really put an ROI from a drug demand utilization, upside around a partnership model, unless it is clearly just a marketing program seeking to drive that support where you're trying to measure the impact of that marketing investment. But, the types of partnerships that really matter to the health systems tend to take more of that broader flavor, and therefore come with inherent limitations on how you would measure the impact of this.

John:

That reminds me of ... and I think I've brought this up before on the podcast, but we had a very good customer, where we were providing our profiles that you're very familiar with, health system profiles. And a new VP came in and just basically said, I'm quoting, "I don't believe in IDNs." That was the concept. We lost that client. But it raises a larger issue, and that is, is it difficult internally to ... how do I say this? For some of the higher stakeholders in a pharma company, I'm not speaking about your former just in general, is there a tension between people who say, "Well, why are we investing in the resources to have this 35 person account team out there, when I can't see an ROI and you're not trying to drive revenue?"

You've heard this argument multiple times, unless you work for an incredibly enlightened [crosstalk 00:25:21].

Sean Brusky:

I will forever be a champion of my former employer, I think Genentech is an organization that is very people-focused, science-focused and do what's right for patients focused and was willing to make forward looking investments not knowing what the impact would be and, I had the opportunity to lead

initiatives, while with Genentech that we're about, "Okay, where is this trend of value-based care going? How might we organize differently? What is the right way to think about partnerships?" Not every organization to your point has the flexibility to take that very thoughtful approach?

Yeah, I do think it's a fundamental challenge, and many leaders within, and speaking broadly and speaking for myself, and what I've observed both across the industry, as I talk to peers and colleagues as well, the traditional way of thinking about launching a new drug is very much based on physician-driven promotion and adoption, investing in R&D, investing in the clinical, not really thinking beyond the drug to a large degree, and I think it's a missed opportunity, when engaging with an integrated care delivery entity, if you're not thinking beyond your individual therapeutic, because ultimately you're going to be relegated to the vendor supplier type of conversation.

If that is the laser focus that you have when working in this space. I believe in IDNs, I believe in the value of integrated care, and I've witnessed firsthand the benefits of organizing care in that way, there are good reasons why there's a lot of inefficiency as well baked into the integrated health system model and why you see large payer PBM organizations attempting to get deeper into care delivery and have their own narrow networks, why you've seen physician driven groups come together to build scale to compete effectively, as well. There are a lot of dynamic aspects of ... especially here in the US, this play out where I don't think the IDN approach alone is necessarily the only answer.

John:

Sure.

Sean Brusky:

But it is one, you have to understand that the mindset of that type of organization as you seek to develop a new one go-to market strategy for any drug, but yeah, I will say, go back to 20 ... as we were first meeting, and I was diving into this space, I held educational sessions on the triple aim, and just using the language of health systems, how do we start speaking in a way that's going to resonate, and educating our marketers, who are very much driven by the clinical data and advertising and promotion. And how you think about go-to market strategies, it just requires a different muscle you have to build and flex.

John:

Yeah, I remember coming in to lead one of those sessions. I think it was on ACOs. And [inaudible 00:29:32] like, "What's an ACO? What's value-based care?" Yeah, and at that time it was like an ACO is a unicorn. What does that even mean and why should I even care about it? So Sean, I wanted to get back to that collision, that Chief Strategy Officer and get to the notion of value, like if we're in this fee for service model, and we're in this volume-based model of selling drugs, how do you get to value or value-based arrangements? And what are some of the things classic things that you've seen that get in the way of executing an agreement that's based in more in value or outcomes?

Sean Brusky:

Yeah, no, it's good ... and through lived experience here and trying to get creative with how we might approach that differently, there are some systemic and real barriers that pharma companies are grappling with. Like I said, the rules and regulations that exist today, are designed around the fee for service, volume-based, unit based model, including things like best price regulations that limit how a pharma company can think creatively about outcomes or shared savings type contracts without it affecting how a given drug is reimbursed across Medicaid or how it impacts ASP dynamics.

I think that is one area that, I think together with leading health systems, innovative pharma companies could approach CMS or the Center for Medicare and Medicaid Innovation, seek waivers to try to pursue some novel arrangements in a way that would really start to get closer to the vision. Ultimately, I think what would enable a different type of partnership, is facilitating a financial relationship, where the incentives of the pharma company are aligned with the financial incentives of the health system, that we're not working at cross purposes, that if patients do better, we're able to measure and track and demonstrate that outcomes have improved.

And when total cost of care in a given area is maintained or goes down, that there is a shared savings and outcomes based method of payment that is established. And there's been a lot of experimentation in that area, some which groups have published on, my close friend and colleague [Mark Watrous 00:32:35] published a paper in Health Affairs, thinking about duration of therapy-based contracting, outcomes-based contracting and oncology and some of the limitations around that based on experiments that he led that we lead ... together.

But a lot of those experiments have been that, they've been ways to learn, they've been ways to understand the data requirements, the data limitations, if you really want to peg payment to outcomes, is there a way to do that based on pharmacy purchasing data alone, or claims data? Or do you need to dig into the electronic health record and all the constraints that come along with that, to get at the measurable outcome measure you're trying to peg a negotiated price to? So I think the data limitations have been a serious area of consideration. Yeah, I mentioned the government price reporting, limitations.

And I would say just the willingness to truly engage in an at risk shared savings type arrangement in a given therapy area, when as the pharma company, if you're thinking about total cost of care, you're only a fractional component of that spend. And there's so much else that goes into that from ED visits to hospitalizations, to coordinated care. And so how do you think about sharing the savings in an appropriate way in a given therapeutic area? Those are all challenges, but I'm convinced that we're moving in that direction or the industry needs to move in that direction and develop scalable, measurable approaches to aligning financial incentives.

And once you align financial incentives, if the drug company is making money based on outcomes and shared savings, if for example you were to establish a subscription-based all you can eat buffet type access to a given therapy in a given class, or a portfolio of therapies in lung cancer for example, and then measure the impact of ensuring that every appropriate patient had access to those therapies, what is the impact on outcomes? What's the impact on total cost of care, if you were to structure the finances around that, and the drug company is making money based on outcomes and shared savings in a way that's incentives are aligned.

Now, some of the considerations around kick back and otherwise are not relevant, you're driving towards a shared goal. But you're driving towards a shared financial set, and you're able to invest differentially and together in care coordination, in optimal screening and diagnosis, in the types of initiatives that will help patients do better at a lower cost. Whereas today, it's difficult for a pharma company to invest in those types of things outside of the context of a clinical trial or a medical affairs type evidence generation initiative.

John:

Right. I agree with you, I think it's going to need to go in that direction. I think there are those ... maybe a little bit more cynical that say, is it really worth all the effort, the time and effort to put into something like that? To which I would reply, "Yeah, I think it is worth the effort, certainly to be able to execute on some of these pilots." So, last question I had is, I need to preface this by as you're aware, we launched

an IDN engagement tracking study back in May, to just see what was going on with COVID, how they were engaging with patients, how they were ... what kind of changes in care delivery, site of care, things like that.

And I'm just wondering from your perspective, and thinking about these IDN relationships, what's happened over the last year? What's happened in terms of pharma engagement, in terms of the ability to even execute some of these ideas around value-based arrangements? What have you seen? And how does that bode for the future I guess as we're at least starting in theory to get out of this nightmare, with people getting vaccinated?

Sean Brusky:

Yeah, no, it's great. I think the last year for all of us personally and professionally has ... brought dramatic change. I'd say specifically as it relates to the types of conversations that are happening between pharma and integrated health systems, I think I've seen a dramatic shift towards how might we work together, especially in areas that weren't ... strategic areas of focus prior to COVID. But, virtual at home care delivery models, digital health, remote patient monitoring, virtual clinical trials, novel approaches to using real world data to ... democratize access to clinical research in a bigger way?

Those areas were always of interest but within pockets, within integrated delivery networks, I think the top three strategic priorities of health system executives over the last year, get through COVID, survive the financial implications of COVID, and then think about how is this going to change how we need to operate, moving forward? And pharma needs to be thinking about those topics in a much bigger way. If it's going to take advantage of this opportunity, where there are positive tailwinds and perceptions among the public about pharma given the COVID vaccinations and the innovation that we're seeing, how do we take advantage of some of that tailwind, to partner in a different way and to think about how to pursue clinical trials differently?

How to ensure high quality care in a lower cost of care setting? These trends are here to stay. I think the budget impacts of COVID alone are going to necessitate integrated health systems and payers driving towards that, telemedicine, remote patient monitoring progress made in the last year is here to stay. So how is that going to change the way in which we think about how our therapies are being used in clinical practice? And how we even pursue clinical trials in a novel way. I think the other thing that became ... and a huge priority is thinking differently about ... diversity and inclusion in clinical trials and thinking differently about clinical trial networks, and how to ensure that the data being generated, represents the entire patient population in the real world patient population.

How do we democratize access to clinical research through partnerships in a different way? And some of the emerging virtual and at home tools, how do we apply those in a very regulated clinical trial setting to open up new sites of care to enable access to patients who otherwise wouldn't be able to go into a leading academic center to get eligible for a clinical trial? How do we open up that so that it's not just 4% of US adults who are going on to a clinical study, but more and more patients have access to cutting edge treatment through clinical research, leveraging some of these new tools.

So I think the forward thinking companies, including my former employer are investing heavily and thinking about this area as critical, not only to how to be a better partner to the health system coming out of COVID, but how to really drive the science in a robust way moving forward. So, that's an area I think is, it would be a shame if this were a missed opportunity and we're not having those types of discussions about what was broken about the previous engagement model, and how do we need to re envision that moving forward? The other thing I'll say is I think the COVID has rightfully so limited direct in-person engagement and traditional pharma rep to doctor type model.

I don't see that moving forward in the same way post COVID. So I think building teams that are engaging around, what are the key needs of the health systems and the provider or partners in a given geography, really organizing around that, and deploying the brilliant people we have out there in the field, and empowering them to show up as partners in this new environment is going to be critical, because the traditional promotional model is no longer relevant in my mind post COVID.

John:

Yeah, I was just thinking about that. What kind of implications does this have? We were talking about account management or strategic account management, but what kind of implications does COVID have or what has it shown us, about the traditional detail rep, call on doc relationship? I would imagine, at least from the conversations that I've had, those of all shut down, and very, very recently, only some of that activity, where certain reps are allowed in hospitals. But I'm thinking, is the traditional detail rep doctor relation, is that model gone for good?

Sean Brusky:

I think it's changed dramatically. There will always be a role for education, there's huge disparities of information gaps regionally, geographically, but especially when it comes to integrated delivery networks and health systems, I don't see us returning to a model where, 100 different reps from any one large company can engage effectively with an integrated health system, you really need to be aligning around how those partners are organized and aligning around how we work together towards a shared goal and that is a strategic key account management function that's a way of organizing, that my former employer and others have embraced now moving forward as the way to really show up as partners in improving outcomes and lowering costs.

Is to organize around our customers and geographically in a more robust way than maybe we had previously where it was more about a single therapeutic area, single rep with a product or a group of products. But more in the B2 partners in healthcare delivery, is the way to engage moving forward. It's easier I'd say for some larger companies with huge portfolios to think about doing that than it is necessarily with a smaller company, but I'd say, smaller companies should be thinking about their role as a rep or a strategic account manager, more along the lines as a strategic account manager, and how do you think not only about your position stakeholders, but the broader set of stakeholders that are going to impact uptake, adoption and ultimately, better patient benefit from the product you're representing?

John:

Right. Couldn't agree more? Well listen, Sean, I appreciate you spending this much time, we went a little bit over. But that's fine. Hopefully, and we'll give it a year, I'd love to have you back and see where life has taken you, and what your next endeavor is going to be, with no doubt, it's going to be exciting I just know it.

Sean Brusky:

Well, it's an exciting time to be in this space. I'm currently working with several early stage companies that are doing innovative things and genomics and digital health and value-based care, transformation, there are new therapeutic modalities emerging, which have the potential to truly change the paradigm for patients in different disease areas. It's an exciting time, there's a ton of capital flowing to healthcare right now. And rightfully so, we have this unique window in time to reimagine what the future could look like. And hopefully we find a way to do that together, across stakeholders, across pharma, across health systems, across digital and tech, to really advance care for patients.

And really drive down total cost of care in a meaningful way.

John:

Well, and I know this maybe this doesn't sound as exciting to you, but it's an exciting time to be in doing the kind of research that we do. Especially since the beginning of the ACA, right? There's been constant change, people trying to understand how healthcare is paid for, why we pay for it the way that we do, policy, all the different things that we touch on. I love what I do. It's exciting to me.

Sean Brusky:

[crosstalk 00:48:12] amazing work John, I will ... I-

John:

Thank you.

Sean Brusky:

[crosstalk 00:48:16] for all of our listeners. I looked long and hard in various leadership roles for a reliable, trusted source of information on how we should be thinking about the integrated delivery network, integrated health system space, and no one even came close to the level of insight and expertise you were able to bring to the table there John, and continue to do in your portfolio of research assets and tools, continues to grow and expand and I value our thought partnership as, wherever I find myself next, you'll be one of my first calls.

John:

Absolutely. Well thank you for the plug. And for the compliment, I appreciate it. I don't get them very often. It's one of the hazards of small business. It's like you don't get a lot of attaboys. But, I've got a great team. And we've worked really hard to get to where we are today. So thank you. Of course we'll stay in touch, keep me apprised of your next exciting venture. And like I said, let's regroup on air in about a year.

Sean Brusky:

Sounds good John, thank you for the opportunity to share some thoughts and ... kudos to everyone out there working in this space. It's important work.

John:

Yeah. So thanks again.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Health Care Rounds is produced and engineered by me, Kim Asciutto. Theme music by John Marchica. Darwin Research Group provides advanced market intelligence and in-depth customer insights to healthcare executives. Our strategic focus is on healthcare delivery systems and the global shift toward value-based care. Find us at darwinresearch.com. See you next round!