Dean's Executive Leadership Series - 2009-2010

Transcript of Q & A with John Figueroa, President of U.S. Pharmaceuticals for McKesson Corporation

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Start

Dean Linda Livingstone: Well, John, thank you. It's actually a little overwhelming listening to all that you had to say and I actually e-mailed my doctor for the first time this year. We were going on a trip to Egypt and they sent us this long list of all the drugs you were supposed to take with you to go to Egypt.

John Figueroa: Yeah, we're not connected to Egypt yet.

Dean Linda Livingstone: Oh, okay <laughs>. And so, I e-mailed her and I sent her what they sent us and she replied and then she actually sent the prescriptions in and I never had to go in or anything. It was fabulous, and so I learned I need to do that more often. It'll save a lot of time in the doctor's office. So, questions? Do we have folks—yes, we'll start right here, and I think we have a microphone. Thank you.

Ken Abono: John, Ken Abono. I talked to you at the beginning. In 2000, I developed a company named doctorappointment.com and the motto was exactly this connectivity. Our business model was to contact the insurance company and ask them to increase the premium for the patient $0.09 per month per member to eliminate all these mistakes. The main concern was the security, that you cannot have everything online and it was just paranoia and I said, "You know what? I have gout and I'm willing to publish that. I don't know why there is such a concern." I wanted to know if you can put some light on that. In case McKesson is interested, I would like to talk to you about bringing that business model to you.

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John Figueroa: Well, as luck would have it, we actually have our senior vice president of that business, Brian Bertha, who is the room today because he knew I was going to talk about it and wanted to make sure I didn't screw it up, so hopefully I didn't. Your concern is still valid today and we still hear that from a number of insurance companies as we do the program. We have been running the model for a number of years—well, let me take it back. There's actually two things. The interaction between physicians is pretty prevalent today. I mean you can do that on a regular basis. The payers really don't mind because the payer isn't getting involved with the patient. The payer's getting involved with the pharmacist. So, the connectivity between the pharmacist and the payer they're fine with. There's absolutely no issue. If they had to share information directly with the patient, some of them have some issues with that. We have payers with the Medication Therapy Management Program where if you walk in and you're a diabetic and you want the pharmacist to say, "Look, you're a diabetic. Here's the regimen that you need to take and here's what you need to do over the next few months and I'll track you;" some payers still don't want the pharmacist to do that. They would rather only have the connectivity to the doctor and they're very concerned about that information sharing. Over the last three years, I would say, and Brian do this or this, and I'll pick a number, I would say we probably moved the dial from about 10 percent of the payers to maybe 60 percent, about 60 percent…

Dean Linda Livingstone: <Laughs> You're doing really good, John.

John Figueroa: ...of the payers who now allow that information, you know, to go across the entire spectrum. We believe that'll be 100 percent here quickly because not being part of this program now is a disadvantage to payers.

Dean Linda Livingstone: Yes.

Audience Member 1: I would like to see a question about the first part—health-care delivery as related to my practice and tort reform because of one the problems is, while the doctors are well covered with whatever insurance, the pharmacist is not that well covered, the practitioner/nurse. I don't think that covers. So, what happen when there is a problem there and you get sued and if you are doing something to change to do tort reform?

John Figueroa: The system what we call is adverse drug effects. So, you know, those beeping sounds that I heard all the time, nobody really knows those beeps are going off if you don't have the system. So, mistakes are happening in the hospital and we call those adverse drug effects. If you can prevent those adverse drug effects and you can show that in the hospital, what the hospital then does is they take that

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data and they go back to the insurance company and say, "My premium of a gazillion dollars need to be gazillion dollars minus 20 percent because we are a safe hospital that is tracking everything that's happening." So, you can change your premiums by utilizing this type of technology, number one. Number two, the tort reform question that you have and the concern that you have that everybody in the health-care system is going to have the ability to do something, they're doing that already. What this does is, it tracks everything that was done and in fact, nurses initially say, "I don't want to do that because I don't want my name or my bar code to be responsible for something that's happening." They quickly change because it tracks everything that they're doing and if they're doing something wrong, it beeps and tells them not to do it. So, the efficiency rate of what they're doing and the quality of what they're doing goes up tremendously. That doesn't solve for the tort reform issue, but when they're being sued, they have tons of data to back up whatever happened with that patient. The doctors also have the ability to get real-time information for whatever disease state that they're seeing. So today, a doctor walks in and you walk in a specific disease state, the doc says, "Oh, I saw this about eight years ago and I remember this is what I did and this is what I prescribed and I remember reading an article on it the other day" and so it's all done by memory. Today, they can see that disease state. They can actually push it out or get it through the information on their system. They can tell you the protocol for that disease state and recommend solutions for that doctor as they're with that patient. So if a mistake is made, they can actually go back to the system that was published for that specific disease state and it helps from a tort reform perspective. It's a problem and I'm not trying to say this solves the tort reform problem. I think that's the one thing our government missed or one of others, but that is certainly the one thing that they missed in this debate.

Dean Linda Livingstone: But this kind of system, you should have fewer malpractice cases.

John Figueroa: Absolutely.

Dean Linda Livingstone: That would in effect help that issue independent of tort reform because you're going to have fewer mistakes.

John Figueroa: Well, and it's subjective today—"The doctor said I needed to do this and it was the wrong decision." Well, the doctor is asked that question now. He's got sheets of information that says, "This is why we prescribe this therapy."

Dean Linda Livingstone: The hospital in Ohio that is doing this, that's kind of the pilot, I don't know if you would have this data, but what have they shown in terms of the reduction in, you know, accidental deaths

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or reduction in mistakes, and that may be confidential data, but what are they seeing just in general in regard to that as they've implemented this system?

John Figueroa: Yeah, I think they've only been in operation for a little over a year now.

Dean Linda Livingstone: It's still early.

John Figueroa: They're compiling the data. What they have said, and said publicly, is they certainly are reducing a ton of costs and the quality of care is certainly in the area that they projected it to be in the business case, but they haven't given any specifics yet.

Dean Linda Livingstone: Yes.

Audience Member 2: John, your company is $90 billion. They're still with much larger players. The government and some players are not very efficient. Is there any interest to buy hospitals or HMOs so you can expedite the process to implement new technology because those are the bottlenecks?

John Figueroa: Yeah, that's a great question and I think we are constantly looking—I actually brought my merger and acquisition guy here today too. So, you can give me the sign.

Dean Linda Livingstone: We should have had a panel discussion at the end of this, shouldn't we?

John Figueroa: Exactly. You know, always be prepared. You know, we are constantly looking at mergers and acquisitions and looking at the different parts of the supply chain. I mean, I think we have always been a company that is grounded on the principle that we don't compete with our customers and I don't think there's a desire for us to go downstream and actually get into the practice of health care. I mean I think we want to provide systems, automation, expertise, all of the things that we can do to make the health-care professional who's actually in front of the patient a heck of a lot better, but there's no desire in our company to actually be that healthcare provider. But, we are constantly looking at all kinds of different opportunities to enhance our business relationship within health care, but I don't think that's one that's on our radar screen.

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Dean Linda Livingstone: Mike.

Mike: Thank you, John. None of us are very excited about the idea of the government running health care in the country. It always boggles my mind when I talk to my friends. Just, with the executives in your industry, across all segments in your industry, it's almost like, why are they letting this happen? Why can't we lock 100 of you guys up in a room and not let you out until you fix this problem instead of letting the government do what they're doing? Is it because it's so diverse that there's no communication between hospitals and doctors and suppliers? Is it just too big to fix?

John Figueroa: It is a massive bureaucracy. There are a lot of disparate areas within the healthcare system that don't talk to each other and quite frankly, there are a lot of different venues for success. A manufacturer's success is a lot different than a hospital's success. I think they look at the industry differently. We like to say at McKesson from a public policy perspective that you better be at the table or you're going to be on the menu, and that's how we kind of handle public policy. And in order to be at the table, you have to come in with solutions and a number of our groups in health care will walk in with their individual mandate—"This is what I need, this is what I want and this is how it impacts the health care." When you have 10 different sides to an argument and you're a politician in Washington, you very quickly cut off all 10. What we are trying to do as an organization, and I think McKesson is trying to lead the way in herding the cats, to come up with a solution set that represents the industry, that walks in and says, "Here is the best solution that we all can agree on." The good news is we can do some of those things on certain issues; the bad news is it's very difficult to get everybody to agree on the same principle and that's why the government has really taken it upon themselves to make some of those decisions. I don't think the industry is going to like the outcome. Look, there are certainly some good things about getting more people into the health-care system. For me personally, it's going to be more people taking pharmaceuticals. So, I'm going to move more through my channel. It's a good thing. The bad thing is they're looking are reimbursement throughout the entire channel and they're decreasing those reimbursement points. So, the margin impact across the segment is going to hurt. So, everybody walks into Washington and says, "Look at my little segment. You can't touch mine. Touch everybody else's," and it creates issues. I wish we were better than we are.

Dean Linda Livingstone: Chip.

John Figueroa: Didn't you just graduate? You just can't get enough of this stuff.

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Chip: So, yeah, always lots of questions all the time. So, one of the interesting experiences we had as recent graduates, we were able to visit Bangkok General in Thailand and the level of IT integration in those hospitals, obviously because it's much more of a green field situation and a host of other factors, it was off the charts. I've never seen anything like that. You mentioned that, you know, McKesson's developing kind of this core competency particularly as it relates to the pharma side in, you know, integrating information to drive cost out of the system. Do you see opportunities for McKesson to kind of expand your footprint beyond pharmaceutical delivery and application as a growth area?

John Figueroa: Yep, great question. I talked a lot about the distribution piece and especially the position that we have in North America. That's what I live and breathe every single day. That's what I do. Another part of our business is our technology business and the technology business is actually a global business. We run all of the health-care systems for Great Britain. I believe we also do it in France and Australia, New Zealand, and a number of countries in the world where we have exported our information technology and is being utilized on a regular basis. Yes.

Audience Member 3: Thank you. I actually have two questions and I have the mic. I have a feeling John's going to ask you, Brian, to answer the second question, but anyway, in my past, John, I've worked with Grady Memorial in Atlanta, the largest health system in the south, Rapid City Hospital system, you know, really big and one of the most frustrating things with these organizations was change—trying to get them to do things differently tomorrow from what they did yesterday. As you bring in new technology or any new system for that matter, the resistance among the employees within that enterprise, whether it's a hospital or a payer or whatever, is tremendous. How do you deal with engaging those employees within the client company to embrace the new technology, a new way, the key learnings and all of that? Because that seems to me to be a huge obstacle. And then the second question, I guess I'll just ask you straight, Brian, is just from a consumer standpoint in terms of the drug delivery. For example, I had a personal experience—my daughter went to the dermatologist and he prescribed Solodyn, which is an antibiotic. I guess you guys have a relationship with the manufacturer and there's a card where the first prescription is free, the second one is $10 and the third one is $10, but the fourth one is $1,400 and the insurance company won't pay for it. So in terms of keeping people going, I mean how do you deal with some of these intractable issues and the huge high costs? I'm not saying you get people hooked for the first 90 days because there will be a different kind of drug delivery system.

John Figueroa: It's actually a great question, and a great question and two very large concerns as we innovate and try to change how things are done. The first one, you know, when we walk into hospitals, when we walk into pharmacies, and we talk about implementing technology, there is a change management concept to that and like any, you know, good change within a corporation, you have to kind

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of take it from beginning to end on how you change behavior. What we call it is workflow. What we do is we study how a pharmacist actually does his daily business, how a nurse actually does her daily business, and if you can bring technology into their workflow, you're going to be extremely successful. This is how you do it and this technology keeps you doing it the same way you're doing it. You can do that overnight. That's wonderful. If you have to modify a workflow in any way then you have to bring in change management, you know, expertise to get these folks, you know, moving in the right direction. We also do it by department. Normally, you pick the departments who are ready to do it, who have the most pain, and that usually goes through the hospital a lot quicker once it's done in one spot and it's successful in one spot, but it is change management, it is workflow management, and we have to deal with that on a regular basis and it is not easy, not at all. The second piece is in fact Brian's business and it is our adherence business that I was talking about to keep you on your medication. So of course, that is certainly a phone call that we receive—"Hey, I'm on the medication. This is wonderful. Fourteen hundred dollars— are you kidding me? You know, I'm done. You know, I got three scripts, but I'm not going to get four." Manufacturers also understand that. So, manufacturers and payers all know that you get to a point where, you know, you have to finish the regimen and we have programs that basically say if you are using our adherence program, you're using our cards that we specifically make and work with the manufacturer, we will give that to you. So when you walk in, we know your fourth prescription is going to be $1,400. We know that. So, we say, "Look, if you sign up for this adherence program, either the manufacturer or the payer or somebody has agreed to reduce the amount of that pay on the fourth if you stay on your regimen, or if you do what you're supposed to do." If you come in here every 30 days, answer these questions, make sure that your blood pressure is right, do the things that you're supposed to then the system will give you a discount on that fourth prescription because we want you to stay on the fourth prescription, and those programs vary by manufacturer. I'm not telling you that happens every single time, but most of these manufacturers understand the value of a cash-paying customer to reduce those fees.

Dean Linda Livingstone: One more question here and then I'm going to conclude with a question. We'll wrap up our evening.

Audience Member 4: Yes, John, thank you for taking my question. I'll just give you two examples. The 98,000 death is too high. I had a personal experience with online and offline and I'll tell you my mom's physician does it on paper. He spends about 15 to 30 minutes, and he does a very good job. Now, he recommended a surgeon. My mom went for both knee replacements. The surgeon is a pioneer in the Bay Area. We made the appointment online. He sent a CV and I filled out the paperwork, took my mom into his office, 55 minutes with the x-rays, we were done. However, when surgery happened, she ended up having four more times and then I had to stay all the time to make sure nothing goes wrong. So, my thing is the last numbers that I read were 37,000 deaths and 98,000—if I had not been at the hospital, she might have died. So, what can we do to minimize those numbers?

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John Figueroa: Well, I mean, I think that was kind of my hope in today's conversation. I mean I think as individual consumers, whatever hospital that you are going to utilize, I think you need to do some research on how much they have done from a technology perspective. If they haven't done anything, then I think you can call your insurance company and go to the other hospital that's in the next town perhaps that is utilizing the technology. So, I mean I think there has to be a demand from a consumer's perspective. I think there is certainly a mandate from the government's perspective that they're going to have to evolve to the point where they will have technology tracking patients, but it's going to take some time. I mean we're doing it on a regular basis every single day, trying to get folks to convert and utilize the technology to save lives. I think the good news about, you know, the government's decision is they understand that there's a tremendous amount of savings with technology and they're paying for it. So, you know, the health systems need to take advantage of that, need to get on the schedule to move towards that. That's really all we can do, I mean, I think as individual consumers—know the system that you're using, and they'll be more than happy to tell you what they're using or if they're not. Well, they won't be happy to tell you that they're not, but they'll be happy to tell you exactly what they're doing in their hospital to prevent errors, and you can see it. You can walk in and you can see the technology. If anybody's holding a clipboard— problem.

Dean Linda Livingstone: So, the last question I wanted to ask you actually builds on that and it was how do we as individual consumers or within the companies that we're in or influence for some of our business owners in the room, how do we sort of prepare for these changes that are coming down with the new health-care bill? I mean are there some concrete things we can be doing to ensure that we're prepared and we're doing the most we can do ensure quality healthcare for our companies or for our families?

John Figueroa: Yeah, I would say that if your HR department or benefits department is not researching what this is going to mean from a tax perspective, what this is going to mean from a cost perspective to initiate the coverage that we're supposed to be covering or paying for, you need to get on it pretty quickly. I would also advocate that as business owners or business executives that you are utilizing programs that give your employees the information to track their own health care and that means, you know, the consumer-driven health-care plans, which are tough. I mean it's tough to say, "Hey, 100 percent of the time we take care of you forever" to "Here's the amount of money we normally spend on you. It's $8,000 a year or whatever it may be. We're going to give you an account for $8,000 and you have to apply it to the things that you want to apply it to." It's a difficult transition.

Dean Linda Livingstone: It would take a lot of education I expect of the employees.

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John Figueroa: It takes a lot of education. And you know what, we're seeing some early evidence that it does change behavior and if it can make them healthier and reduce costs I think it's a good thing.

Dean Linda Livingstone: Wonderful. Well, thank you, John, so much for being here.

John Figueroa: You're welcome.

Dean Linda Livingstone: We really appreciate your time.

John Figueroa: My pleasure.

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