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## Ep.2: From Software CEO to Healthcare Software CEO with Richard Resnick

**Rusty Ray (00:05):**

Hi, I'm Rusty Ray with Alantra. I head up the US Healthcare Investment Banking team here in New York. You are listening to Crossroads, our podcast focused on interesting technologies and services in the healthcare space with an eye towards M&A. We have here today with us Richard Resnick. We worked with him on one of his first exits. He was the former CEO of a business called GQ Life Sciences. GQ was a healthcare IT company that allowed pharma to search gene sequences to enable faster, better, cheaper drug discovery. He's since moved on to his next adventure.

**(00:40):**

He is now CEO of a business called Cureatr, another healthcare IT company that's a pioneer in the value-based care universe as it relates to pharmacy and medication management. We wanted to get his perspective on medication management, or mismanagement, as one of the key drivers of re-admissions into hospitals, what Cureatr are doing to solve that and, more generally, what it's like going from a traditional software CEO to a healthcare software CEO, and how very different it is selling into one of the more complex environments and highly regulated environments imaginable, as well as get his perspective on some of the things we could be doing different as healthcare providers in order to provide better outcomes.

**(01:24):**

To start, Richard, tell us a little bit about yourself and what you're doing now at Cureatr and what the company's all about.

**Richard Resnick (01:31):**

I'd love to, thank you for having me. Cureatr is a national medication management clinic. The problem statement is simply, there's somebody out there that's taking medications that are being prescribed by multiple doctors. The age old thing that happens in healthcare, we don't have enough interoperability between data and every doctor. The bulk of healthcare, as everybody knows, is not what happens in the doctor's office or in the hospital but what we do when we're not in those places. There's very few areas in medicine where you get to survey all of the different things that are happening. You end up being really expert at a very narrow thing and having to do it frequently, too frequently for your comfort. It's tough.

**(02:24):**

Let's say I have this acute event. While I am in the hospital, all those medications that I'm normally taking to just keep me well, I'm not being given those pills. They're in my medicine cabinet, they're waiting for me at home, but I'm being cared for in this other way. There's these intravenous bags that are flowing things through my veins and I'm not really sure what they are. I'm confused. When I go home, this lovely discharge team comes at me and they give me all these instructions and I'm doing my best to follow them. All of those medications in that medicine cabinet are waiting for me and that discharge summary, if it's really well done, is going to tell me exactly how to integrate those medications with the new things that I've been told to pick up.

**(03:09):**

But often it's just not the case because we don't always listen on a critical admission to a hospital about all the things that patients are taking at home. And so, there's a really dangerous moment here, Rusty, where patients end up going back to the hospital because of medication confusion or medication errors. In fact, in the world of healthcare one of the primary metrics for good hospital care is how many patients that you've discharged come back within 30 days. That's sort of seen as a failure, and a whole third of those, 33% of all of those 30 day returns, 30 day readmissions we call them, are because of medication errors that could easily be addressed.

**(03:56):**

What Cureatr does as a technology company, and by technology we say technology and lots of data, is we provide telephonic clinical care to help people at that moment as they're being discharged, in those first 24, 48, 72 hours, to understand what they're supposed to be doing and often to help them to reconcile the things that they should actually be stopping. Or, if we see that they've been asked to do something at the hospital, let's say their primary care, their cardiologist or their oncologist wouldn't agree with, we're going to call those prescribers and have conversations with them. Our job is to make sure that patients take medications safely. We can know things about our patients the moment that they're discharged and everything that happened in the hospital without them telling us. We can do this very effectively in just a few days where it really counts to do it.

**Rusty Ray (04:57):**

You make it sound simple. What you're doing is infinitely complex because you're dealing with hospital systems, you're dealing with different care providers, you're dealing with patients that are not always easy to deal with. My parents, for example, never follow doctor's orders, and family members who may be challenging or not fully engaged. As an owner operator of this business, how is tech in this milieu just so much different than how we think of tech in other sectors, business services, industrials or tech for tech's sake? It seems so much more challenging.

**Richard Resnick (05:36):**

There's this funny meme that I saw once that shows the typical software-as-a-service tech CEO, which is something that I used to be, coming in and looking at healthcare and being like, "God, that's such a big part of our economy and they're just still faxing things and all they need is me. I'll figure this out, this is just technology." That's the first step, and then you come in and you build some incredible thing and then you realize that was really dumb because if you're going to try and sell to a hospital you're selling it against an EMR. The idea behind them is like, "Hey, let's digitize what we do in hospitals so we're not using paper and faxes and all that stuff." There was this rule called meaningful use. Suddenly, they were out there and then the government required that they do this.

**(06:30):**

Like all government programs, intentions are pure, implementations are horrible, and incentives are never well thought through. Folks were forced to use EMRs because of government regulations, and those EMRs, they're sort of a duopoly, really, that's been created because of the government requirement that we use them. EMRs, instead of being a really cool system that could have enabled providers to just deliver better care and share data better, essentially have become systems for billing, for billing things; super, super siloed.

**(07:16):**

There's some perverse incentives in here. First of all, EMRs are very expensive. A large health system is going to spend a billion dollars on one of these things over a bunch of years, and when you're the CIO and you just argue to spend that kind of money and then a little tech company says, "Look, I've got this thing and it's going to help this thing happen way better and your cardiologists love it," they say things like this. "Our doctors don't like two screen solutions, can it fit into the EMR?" Then you spend a year saying, "Yes it can because they've got these app stores and you can get into these app stores, make it an app on the EMR." The EMR company actually owns all of your intellectual property and you've got to share a significant ... It's just really tough to build businesses that way.

**(08:04):**

If you say, "No. This is going to be a two screen solution. There's the EMR here and there's this thing over there," then the CIO says, "Hey, I just checked and our doctors do love your solution but I checked and our EMR company has exactly your solution on its roadmap and it's committing to deliver them in the year 2319 and I cannot allow us to buy anything that's on our EMR roadmap." It is so hard to sell software and technology here. Then you say, "Well, maybe data because, God, data's so bad. Everybody's got these silos and if only we connect this and this and this."

**(08:46):**

They start going around like, "Hey, hospital A, if you shared with us your information about when your patients are coming and going and we were really benevolent and we promised contractually we would only share this with other hospitals and only if they shared their data back with you, then we'd have this community of sharing and we could manage the population of patients that we share better." They're like, "I'm not going to give .... Because we want all of their patients."

**(09:15):**

Culturally, medicine is a place where the educated, ultra-educated doctors and their staff are slow to trust and often led by administrators who are culturally trying to be in line with their staff. Then there's one other big feature of healthcare which makes it my favorite place to try and sell software and data, and that's regulation. In the world of healthcare, regulations change every year, incentives change every year, and some of these regulations are really, really valuable, far reaching. For instance, have you heard of HIPAA? It's an important law because the worst thing that we could imagine happening is to have our personal health information escape.

**(10:13):**

There's really bad things that can happen if health information gets out in a big way. Everybody is so nervous about that, rightfully, that we cause patients harm so regulations constantly change. And Rusty, I'll finish this thought with regulations around how we're paid are the most complex.

**Rusty Ray (10:35):**

What you've outlined is insurmountable, right? You've got siloed doctors, you've got siloed hospital administrators reluctant to change. You've got embedded tech that is not cooperating with newer, lighter, faster solutions. Then you're surrounded by an extremely difficult regulatory environment, both from a provision of care as well as reimbursement.

**Richard Resnick (11:05):**

The way that we've paid for healthcare has basically been if you're a doctor, you get paid when you see a patient. And so, if you see a patient for an annual physical, hopefully it's because they need an annual physical. If you want to just have them come into the office for an office visit before you decide to refill that prescription and there's no real reason to do it except that it will make you an extra couple hundred bucks, we call all of that kind of payment model in healthcare fee for service. I give you a clinical service, you pay me a fee. That's the way healthcare has largely been. The incentive of the doctor typically, even though there's a lot of reason why what they're asking you to do is good for you, their incentive is to see you more, to treat you more because that's how the money gets made.

**(12:05):**

And so, in that world, you want for people to come to your hospital, even if they're sick. But you might prefer to get the orthopedic knee replacement to come to your hospital more frequently than the heart attack patient because the knee patient, they just have a bigger profit margin. They're going to pay more, you get them out, they're healthy, and you keep more of the profit. The heart patient, you're definitely going to get them or their insurance company to pay but you might not make any money on it. That's bad for people, that's not good healthcare. That's the old way of doing it. My favorite thing about healthcare is that there's all this innovation and a new way of doing things called value-based care. The whole world of value-based care is where we should have always been.

**(12:58):**

Doctors who get paid the same amount for an office visit, for instance, regardless of what happens to that patient thereafter, they're going to maximize office visits regardless of what happens to that patient after. So value-based care, in our context, is about owning some responsibility for a patient's outcomes after they've been hospitalized. What we do is we make a bet. It turns out a lot, more than half of these patients, have medication errors in their instructions so what we do at Cureatr is we take a risk with the plan.

**(13:32):**

We provide value to the patient and the plan by saying, "Let us intervene as your members are being discharged from hospital stays for whatever reason and we're going to talk to them. We're just clinical pharmacists with a bunch of data and a great big heart so we're going to talk to them. Remember, we are a software and data company at the core. We're going to have a compassionate conversation with you about that. Just for that one conversation, if we need to, we're going to call your prescribers, ask them to make changes on your behalf." Providers make those changes and the bet we make to the health plan is that we're going to reduce the percent of people that end up back in the hospital within 30 days, let's say.

**Rusty Ray (14:14):**

In practice, when patients are discharged and you're talking to them, providing them instruction about their post-discharge care as it relates to their pharma package, do most of the patients that you interact with feel they benefit from your counsel? Is it some? How many times are you avoiding incident? Is it the majority of the time?

**Richard Resnick (14:41):**

There's lots of risks when you participate in healthcare. Not all of them are around medication but medication is the primary intervention that we offer patients. I think 70 something percent of all healthcare encounters involve a change in medication. For 100 patients that are discharged in a typical Medicare population, which is a generally healthy population but over 65ish, about half of them will really

engage with us. I think the way to think about how we move the needle is that kind of a population, about 12, 13, 14% of them are going to be readmitted within 30 days after the discharge and, if we're doing our job well, we can take that 12, 13, 14% and drop it down to eight or 9%, which is an enormous amount.

**Rusty Ray (15:33):**

Very interesting. I'm sure lots of families looking back probably could have used a service like yours. From personal experience, we've had family members come out of the hospital confused about what they are taking, medications change, it doesn't react well, and as a result it leaves a loved one feeling worse off or feeling like they didn't get the attention that they deserved in the hospital. Maybe the physician is doing the best job they can but the reality is the perception by the patient is that they're a terrible physician, they didn't listen to me, they gave me the wrong medicine – that is the conclusion that I hear quite often.

**Richard Resnick (16:11):**

There's a huge reward when you've got a clinic that you're enabling and there's all these patient stories that happen every single day. It's like fuel for your team and you become absorbed by that energy of helping people that is so right next to you. Thank you so much for the time. It's been great, Rusty.

**Rusty Ray (16:29):**

Thanks, Richard. It's been great talking with you and great seeing you again. To our audience, I hope it was a helpful perspective from a serial entrepreneur in the software space, specifically healthcare software. It's really interesting to see how much human error there can be within the healthcare system and how new kinds of software can help eliminate that and how they can create new incentives for payers and providers. In our practice as investment bankers, we often wrestle with challenges in explaining the value proposition of a business and, for example, just how hard it can be to sell a piece of software into a healthcare or hospital system.

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It's really a very different sales process than any other industry and this is especially challenging when you're introducing a company to an investor or buyer that may not have as much experience in healthcare reimbursement and how payers and providers are incentivized. It all ultimately comes down to the right positioning that you take in the marketing materials and the education that you're providing to the buyers in your conversations. It's a thoughtful process but one we enjoy. If you want to learn more about how we navigate these kinds of problems for our founders and owners, please reach out to the Alantra team to chat.