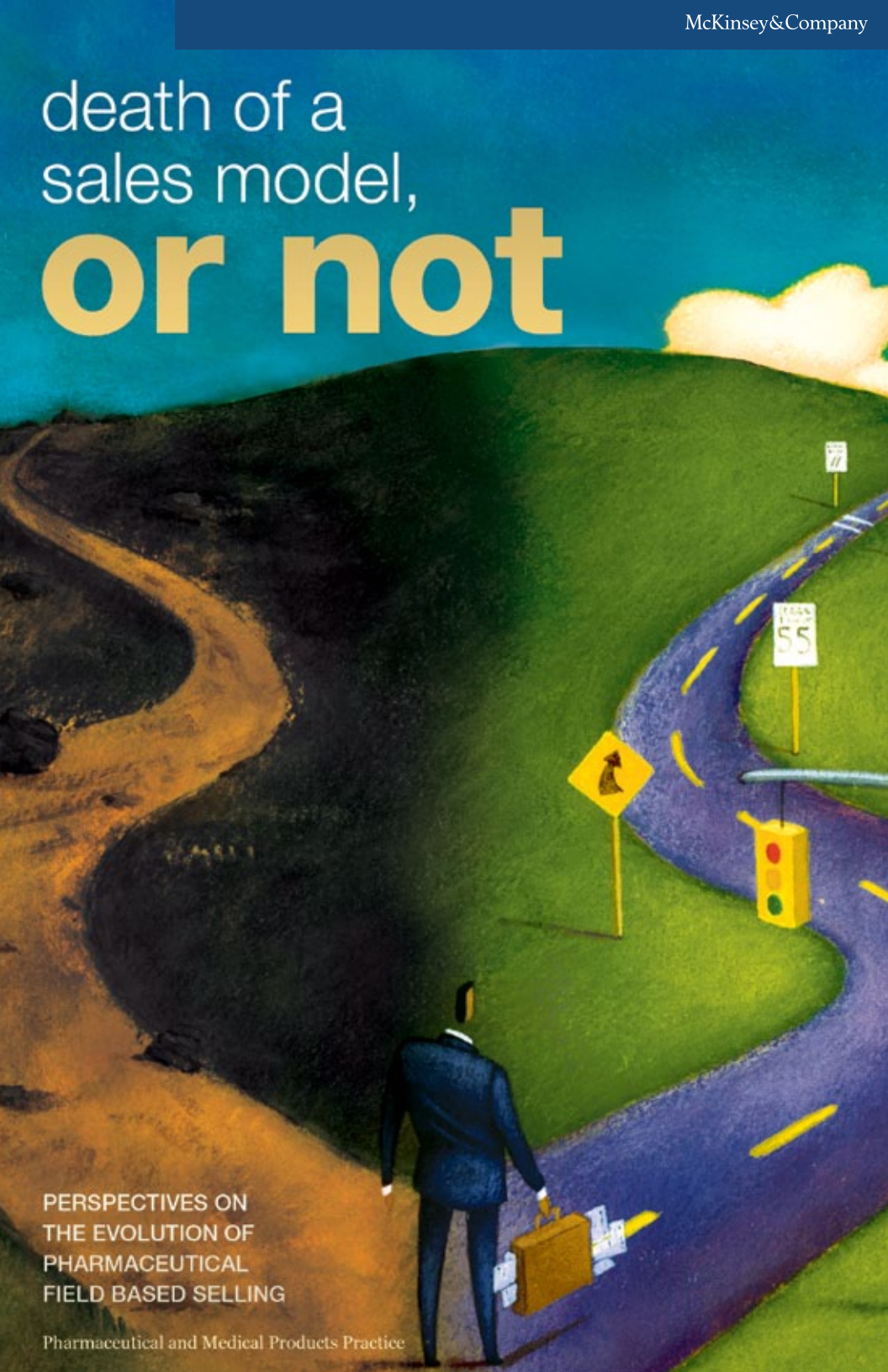


death of a sales model, **or not**



PERSPECTIVES ON
THE EVOLUTION OF
PHARMACEUTICAL
FIELD BASED SELLING

Pharmaceutical and Medical Products Practice

death of a sales model, **or not**

PERSPECTIVES ON THE EVOLUTION OF
PHARMACEUTICAL FIELD BASED SELLING

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A THANK YOU FROM LAURA MORAN AND THE SALES SERVICE LINE

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preface

AN INTRODUCTION FROM DAVID QUIGLEY

Biopharma sales reps play two critical roles: they are the leading mechanism for communicating approved label information for drugs and they are frequently the strongest link between the biopharma and provider healthcare communities. Yet, there is an ongoing debate about the effectiveness and impact of the traditional sales representative, with some arguing to discontinue the role while others sense an opportunity to improve both rep productivity and efficiency. Those who champion the role point out that using richer analytics, better leadership and aligned incentives deliver stellar results in many geographies. We have worked with a number of you on these efforts and you have seen the difference that new focus and new analytical tools bring, although clearly there is no one right way to incorporate them.

What is clear is that a new commercial model—perhaps several—are emerging to respond to the realities of today's changing healthcare landscape. The articles presented here show the transition that the current model is undergoing. McKinsey is currently investing in a multiyear research initiative designed to support companies as they experiment with a change to new sales models, structures and tools. It is obvious that this will be a challenging transition; new capabilities need to be added even as we continue to use the tried and true current model, albeit with less success. The inconvenient truth: we will have to sweat the current model and build the capabilities for the future in parallel. Those hoping for a “flip the switch” transition are likely to be disappointed.

The series of articles in this compendium, as well as future collections, conversations and conferences, reflect our industry at this unique crossroads. These articles are meant to document both pressing issues and discuss effective transition efforts to date. We hope the material here stimulates debate and we look forward to continuing our conversations with you to gain your insights and share our latest thinking on what future success might look like.



the few, the proud, the super-productive

HOW A 'SMART FIELD FORCE' CAN BETTER DRIVE SALES

LAURA MORAN
DAVID QUIGLEY

INTRODUCTION

Was 2005 really just a few years ago? It seems like a different era as far as pharma sales organizations are concerned. Squeezing costs as much as possible, U.S. pharma leaders have shed more than 20,000 field sales positions—and are looking for additional ways of getting more from their remaining field corps. European companies also have made cuts albeit at a slower rate. The twin objectives were to improve productivity and adjust to the new reality of the pharma business—which many presumed to include the death of the traditional representative detailing model. Yet, for a model that is supposed to be dead, direct marketing to prescribers remains a vital tool. When used correctly, it continues to drive sales; used without proper strategic oversight, however, it leads to costly overspending and missed sales targets. Indeed, our perspective on the past five years is that leaders that used field reductions to actually rethink the commercial model—rather than taking a “blunt instrument” approach to cuts—are reaping rewards. They’re investing in highest potential prescribers and ruthlessly scaling back interactions where

the odds are poor. These are among the key lessons learned that we describe in this bulletin.

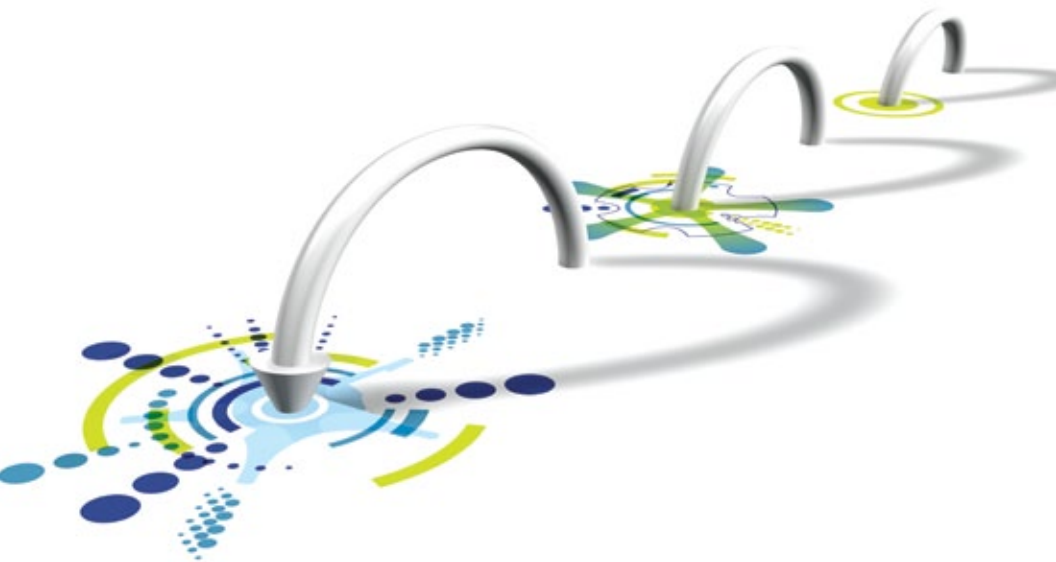
Cutting and culling

Pharma commercial leaders in the US and Europe tried several approaches to maintain customer contact as they cut field resources. For many, the first step was to address “mirrors”, i.e., multiple representatives overlapping on the same set of local customers. Some aimed to eliminate overlap by developing “micro-territories”, in which one rep became the single point of contact for all products. This sometimes resulted in large bag sizes and was most effective when incentives were structured so reps did not short-change the smallest products.

Other companies organized around customer types. Multiple field members represented the same products in a geography, but with different roles. For example, some reps specialized in high-value customers. (We'll discuss field roles in greater detail in an upcoming bulletin). Other companies sought to merge the best of mirrored and single-accountability models, by varying the level of mirroring depending upon local conditions. This required more sophisticated support operations and increased both reporting and managerial complexity. Still, these approaches were all mere step changes over traditional nationwide mirrors.

However, much more fundamental change went a step further. Downsizing could also be seen as an opportunity to question reliance on a fundamental input for field force allocation—past prescribing behavior. This, in turn led to a more comprehensive and sophisticated view of the physician—a “factored” measure of volume that takes into account additional considerations, including a physician's managed care environment, attitudinal segmentation (e.g., “early adopter”, “generics general”), office access, and more. The new model matched field resource levels to this factored value, and as a result, maintained or grew volume, even with reduced headcount. Calculating a “factored”

Calculating a **“factored” value** for
physicians is **more accurately** predictive
of **prescribing potential**



value for physicians is more accurately predictive of prescribing potential. By contrast, companies that cut evenly across the board, or allocated resources solely on historic prescribing volume, saw measurable declines in sales and profit.

Old and new ways of getting more from less

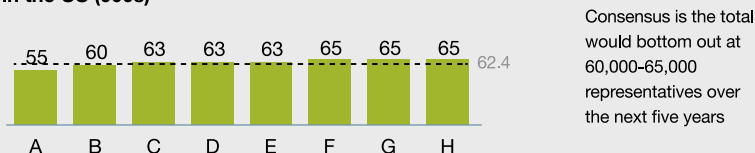
Pavlov was right—humans learn to respond to incentives. To that end, we believe that personal promotion will remain a powerful tool for revenue and profit maximization, and downsizings will reach a natural floor as best practices spread. Specifically, we have learned that traditional representatives who were assigned a tightly focused list of highest-potential physicians generated better growth than reps who were geographically deployed across the whole territory. At the same time, there is still room for adaptability—companies that significantly reduced field strength in highly payer-controlled markets, or de-emphasized highly-controlled physicians, did not lose share.

We also see that content is crucial to successful deployment: Companies must craft their message to resonate with the specific type of prescriber. For example, showing a group of P4P (pay for performance) doctors how particular products can help meet their performance goals can yield better results in TRx volume than more generic, traditional

Exhibit

Total industry sales representatives are expected to continue declining slowly, settling around 60,000-65,000 by 2014

Industry perspective on future number of total sales reps in the US (000s)



SOURCE: McKinsey sales executive interviews

messaging. Using this approach, teams that specialized in large group practices (a customer channel we'll return to later in this compendium) gained share where the traditional field had stagnated.

How to work harder and smarter

How to make sure these lessons are put in practice with field reps who are already juggling constantly evolving customers? Executing against a short list of mindset and tactical changes has been helpful for leading companies.

1. **First, retire the idea of using a single field deployment model for the whole country and for every type of customer.** Companies need a set of sales approaches that are tailored to the target environment. Also, use several measures in addition to volume to gauge physician value. Successful companies have factored in the region's standing on a payer influence index, for example, in order to better customize field sizing, footprint and field roles in a geography.
2. **Second, get comfortable making decisions in uncertainty.** As the industry updates the commercial model, innovators will need to size the field based upon the (uncertain) potential of new approaches. Typical industry sizing and deployment analysis is built on backward looking, nationwide physician data, which measures responsiveness to traditional reps. Continued reliance on this analysis would be misplaced for determining the value of deploying a different type of field resource to a subset of physicians. Innovators must experiment, learn and rapidly adapt.

3. **Third, stop investing in losing propositions.** Deploying incremental representative resources until the point of zero marginal returns rarely makes economic sense because below a certain level of return, an in-person representative is unlikely to be your best investment to drive the next NRx with a given physician. In such a case, you must have another type of outreach handy.
4. **Accordingly, companies will need to develop a full toolkit of personal and non-personal interactions from which to choose.** Build an arsenal of personal promotional levers including field-based promotional medical, sample droppers, patient educators, etc. In addition, consider ramping up non-personal promotions: outbound tele-details, emails, and even “snail-mail.” Pharma companies will need to experiment with deploying a mix of resources—even on the same physician—to get optimal sales results at the acceptable return on investment.

CONCLUSION

In summary, our perspective is that there will remain a role for the sales rep, but maximizing rep productivity requires more insight, more flexibility and more variety in roles. The future will look far different from the sales rep armies of the past descending on offices.



organization men

UNDERSTANDING THE CHALLENGES AND SERVING THE NEEDS OF CORPORATIZED HEALTHCARE PROVIDERS

BHAWANA MALHOTRA

NICK MILLS

LAURA MORAN

DAVID QUIGLEY



INTRODUCTION

Should you be afraid of the corporatization of healthcare? Not necessarily. The shift from physician owner-managed practices toward centralized large institutions or affiliations of smaller ones has been a long time coming and is gaining momentum. In this article and the companion article focused on group practices, we highlight some of the innovations that pharma commercial organizations are using to meet the challenges presented by the consolidation of healthcare providers.

The penetration of corporatized healthcare is high and growing. In 2010, some 40-50% of large medical groups (more than five physicians) were corporate-owned, and more than 25% of large medical groups were affiliated with integrated health systems. Depending on how well the accountable care organization (ACO) works (ACOs link reimbursement to quality of care and reduced total cost of care) and when the cloud of uncertainty over healthcare reform clears (whether the law sticks and how it is implemented), groups of risk-bearing integrated providers will become increasingly common or even the norm. The number of practices that are affiliated with integrated health systems is expected to continue to grow. This trend is most pronounced in primary care, but can also be seen in single specialty and multi-specialty practices.

Some commercial leaders see corporatized healthcare as an ominous shift, imposing “care by protocol” which impinges on physician discretion, sets arbitrary utilization targets, and carries restrictive representative office access policies. All these are possible, and may create hurdles to using the standard pharmaceutical commercial business model. In truth, these changes have significantly impacted some or all pharma brands, with many brands underperforming in corporate groups in the retail setting, and some therapeutic classes may even be blocked in select in-patient settings. However, companies can mitigate these challenges using strategies grounded in high quality granular information, and commercial approaches that are carefully targeted towards the needs of these large, sophisticated customers and the various stakeholders within them.

New corporate structures require new approaches

The industry has responded to consolidation in several ways such as aligning “key account managers” to major customers, better coordinating institutional and retail field members, and developing “tools” to serve these entities.

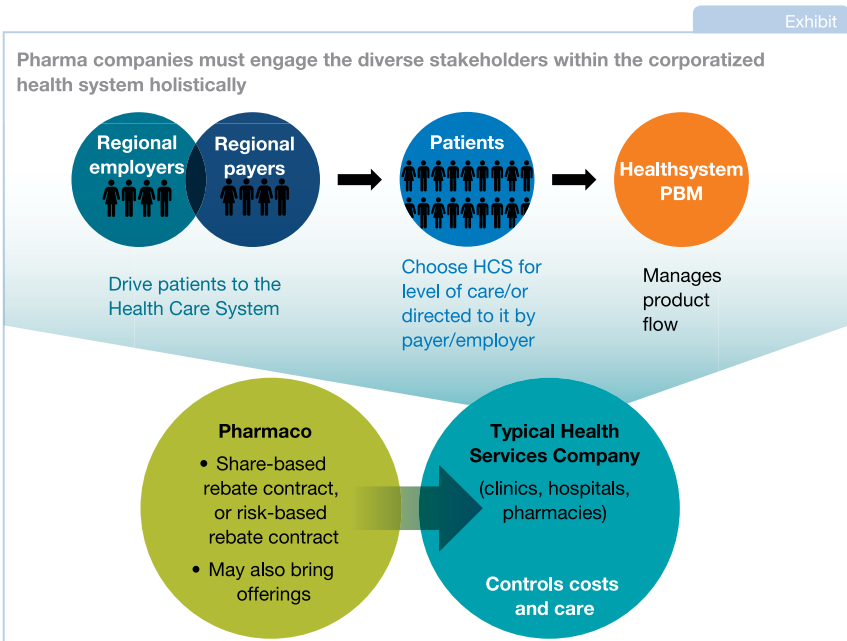
These efforts are steps in the right direction, yet the response remains fragmented, supported by one-off or incomplete data, and not entirely coordinated. With some customers, this hit-or-miss response has sown confusion or frustration. But with many, these changes barely register as they only scratch the surface in addressing the new business model. Additionally, companies typically lack rigorous best practice information sharing to accelerate performance with corporatized customers.

Overall, companies recognize that highly controlling and highly consolidated corporatized healthcare groups are different from even large physician practices. The often high degree of centralized control of decision-making in corporatized groups, combined with internal strategic priorities within the group, and the relationships between diverse stakeholders (e.g. VP of Quality, Chief Medical Officer), renders the pharma commercial model even less effective. To better address these customers, a successful pharmaceutical company must demonstrate deep capability in several areas. These include:

- **Information excellence:** Companies need to generate credible, actionable insights about integrated entities such as physician affiliations, risk level, behaviors, and needs. This capability also encompasses having the necessary back-end analytical support to operationalize and institutionalize the approach and measure the impact of specific components.
- **Integrated, cross-functional account teams:** Teams capable of serving B2B2P (business to business to physician) with a collaborative, cross-functional approach in the field (including Commercial and Medical, and extending to the full range of relevant products

to that customer). These teams should develop and adhere to a strategic account planning process that drives activities across several field-based functions.

- **Relevant value propositions targeted to each customer:** Equipping the field with a menu of appropriate value propositions that are directly relevant and meaningful to different types of corporatized groups and to stakeholders within the group.



Embracing the inevitable, quickly and holistically, pays off

How to put these three capabilities into practice with corporatized healthcare providers? Key success factors include the following:

- **Act now to enhance access and influence.** The industry is experimenting and learning as it tries to optimize its approach to these corporatized customers. But increasing the pace and focus may secure a company favorable/exclusive positions with integrated players, could influence group standards as they are being set, and will give the company an information advantage over companies that have not made significant moves. Leaders are already investing, innovating and changing their market approach in significant ways.

- **Take cross-business unit and cross-functional action to deliver maximum value to customers.** By definition, many of these “corporatized” customers are multi-specialty and multi-functional in nature. An integrated “one company” approach across the entire organization would allow for a more holistic value proposition/potential partnership model for these customers. Potential next steps in building this integrated approach would be: creating a single data set (insights, segmentation, etc. for each group), formalizing B2B2P account teams across organizations with a single quarterback, and creating value propositions for each brand that serve as standalone communications but are also able to mix with different brands across the combined portfolio.
- **Build non-deployment levers such as underlying skills and tools to increase likelihood of success of new deployment strategies.** It is essential to continue developing “softer” elements such as collaborative, team-based selling model centered around accounts; efficient field-based account planning and profiling (integrated with HQ-based analytics and segmentation), and brand and “DA”-based value propositions able to deliver on customer needs across the full spectrum of the B2B2P sell.

CONCLUSION

The corporatization of healthcare is here to stay, demanding new skills and approaches from pharma companies. Focused investment to understand, reach and serve these entities effectively will separate winners from losers as both healthcare reform and the needs of corporate physician groups become clear.



the more the merrier?

‘ACCOUNT OWNERSHIP’ AND OTHER ENGAGEMENT
TACTICS FOR LARGE PHYSICIAN GROUP PRACTICES

MIKE LEVY
NICK MILLS
LAURA MORAN

A decorative image at the bottom of the page featuring several colorful balls (green, yellow, blue, and white) of different sizes, some of which are partially cut or broken, creating a sense of movement and depth. The balls are arranged in a cluster on the left side, with others scattered towards the right.

INTRODUCTION

As anyone who has had to wait in line at the post office knows, bureaucracies—faceless or not—are hard to relate to. And the large medical groups that are forming in US and Europe pose a particular challenge for the pharmaceutical industry. Pharma companies estimate that more than one in five of the highest prescribing physicians in the US belong to large groups. With 20% of the highest prescribing physicians affiliating with

large groups, pharma companies need to refine their deployment models to maintain connection with and engage group decision-makers. Furthermore, this number will likely increase as physicians choose to affiliate with large groups, in response to factors ranging from soaring malpractice and administrative costs to the need to be part of patient referral networks. This phenomenon is growing in European markets as well (witness the polysystems in the UK, MVZs in Germany, FTOs in the Netherlands and Quality Circles in Switzerland). As a consequence, more of pharma's most important physicians/customers will be placed in an environment where standard detailing and field deployment practices may be increasingly ineffective because physician prescribing behavior is influenced more by the group and prescribing data may be incomplete or unavailable. Unless companies find ways to market and sell effectively in these group environments, the prognosis is poor: market shares are often 20% lower among doctors in large group practices than in the broader physician population.

Relationship status: more complicated

Unfortunately, there is no all-purpose remedy because, just like institutions such as hospitals, group practices come in many flavors in the US and Europe. They vary both in size (from small German MVZs of typically less than seven physicians to very large regional healthcare networks in the US with hundreds of doctors) and composition (from just primary care, to also including many specialties or even a single specialty). They also vary in approach and governance. Some are loose-knit Independent Physician Associations (IPAs) whose members typically maintain significant autonomy, while others are tightly controlled integrated health systems in which a central board enforces a standard formulary. In addition, practice-management capabilities vary—some simply provide shared back-office functions, while others have invested in complex EMRs and other technology to track and measure outcomes and provide physicians with recommended treatment algorithms.

With 20% of the highest prescribing physicians affiliating with

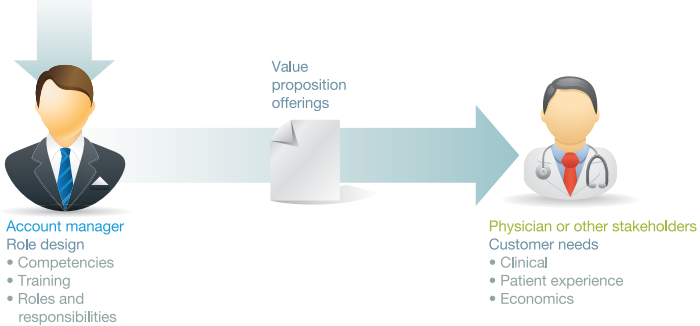
large groups, pharma companies need to **refine their**

deployment models to **maintain connection**

and **engage group decision-makers.**

Enabled by tools, processes and offerings, account management is key to creating a customer-centric approach

Enabling tools/processes and incentives and compensation (IC)



Complicating matters further is the opacity of the large group market. Even the best third-party industry data sources are only about 50-70% accurate. They can omit large and influential groups or fail to clarify the relationship between different groups under the same umbrella, making it difficult to get a complete picture of group affiliation, probable influence paths, and individual prescribing metrics.

How easily companies can meet these challenges posed also depends upon internal factors. These include the structure, management and capabilities of each company's field organization. The nature of existing relationships with the group, as well as the group's structure and geographic spread will also factor heavily in performance improvement initiatives. In many cases, companies will need to build capabilities in the field so reps have the knowledge and tools to serve physicians in large groups better—and so that they can gather the intelligence the company needs to understand group behavior. In some cases (i.e., where central control is strongest) companies may decide to reduce detailing of individual physicians in groups to redeploy resources more productively and, in parallel, engage group management through B2B relationships.

Bend account teams to the shape of group practices

Despite the challenges, many pharma companies have launched efforts to adapt to the group phenomenon. Some are building new sets of capabilities and knowledge for large groups: databases, insights, analytics, segmentations, etc. Most, however, are taking a “learn on the ground” approach. They are piloting variations in roles, rep targeting, messaging and other field activities with a few group practices, evaluating results, and adapting what they learn for wider roll-out.

One trend we see consistently is companies adopting more disciplined processes related to account management. Specifically, we see four primary “account ownership” models emerging that target C-suite/centralized decision makers in group practices:

1. **Group Practice Account Manager/Team Leader:** District Managers double up as group practice account managers within their geographies.
2. **Payer Account Manager:** A field managed markets manager, who also doubles as a group practice account manager, deals directly with the payers (captive or third-party) that influence large group formularies.
3. **Key Account Manager:** A full-time manager targets select group practices, alone or with a dedicated district manager plus team of representatives.
4. **Account Quarterback:** No new field role is created, but field leaders or reps are designated “account owners” and spearhead account-level strategies

Each of these models has had some success, particularly in the US where there is significantly more experimentation by pharma. The common lesson from implementation is that improvement depends upon understanding the unique needs and characteristics of the group and its physicians at a granular level. The main challenge that pharma companies face is developing this customer insight capability and then designing approaches that incorporate and respond to the insights generated. Companies that have established effective new B2B interactions with large groups have first developed insights into the group’s priorities, influencers, and decision dynamics. For example, pharma can collaborate with groups at the C level to mine EMR data and identify specific opportunities for improved patient care with the company’s products.

Sustaining engagement

The ability to successfully engage physician groups will become increasingly important for pharma companies. Given this growing need and what we know from existing approaches, companies will have to make a greater and more comprehensive commitment to large group practices. This will involve everything from building new sets of data/insights (to make up for what is not available in the market), to revising traditional segmentation approaches, to changing the deployment model (and related rep metrics/compensation) that reflect new interaction roles and programs. The sequence of these initiatives will vary, depending upon a company’s overall priorities and appetite for change, but successfully addressing the physician group phenomenon will be important for all leading pharmaceutical companies.

CONCLUSION

Physicians throughout the US and Europe have responded to healthcare reform and changing patient needs by banding together in large group practices. Serving these organizations (and their physicians) effectively will require companies to test and refine new sales approaches and business intelligence skills so that field teams can accurately assess, engage, and maintain connection with decision-makers in these groups.



it's a multi, multi-channel world

TAKING THE ANXIETY OUT OF TRYING NEW CHANNELS

USMAN RABBANI
RENA ROSENBERG

INTRODUCTION

With apologies to Linus and all other youngsters, pharmaceutical companies cling to the traditional face-to-face selling model like a giant security blanket—and for good reason. Even though it's tremendously costly and, in some circumstances, has marginal and declining effectiveness, it's familiar. And it works. This is why efforts to employ new channels have been relatively modest in pharma—even as frustration with the direct channel builds, the security blanket is clearly fraying, and the need for new approaches becomes more urgent.

While we would never advocate giving up direct selling entirely, we are convinced that alternative channels are increasingly important to the new commercial model—and some have the potential to become the preferred method for reaching certain customer segments. We also believe that the only way leading companies will overcome their reluctance to commit to new channels is to get a taste of the benefits first. This is precisely what we are beginning to see.

Companies use alternative channels (such as inside sales, virtual real-time dialogue, etc.) to achieve near-term tactical goals, such as reducing marketing costs for an established drug to free up resources for growing brands. These are real, institutionalized processes and programs that allow a company to test and learn—not doomed-to-fail pilots that senior leaders are not invested in. A few such programs proved that companies can actually rely on fewer field resources and still sustain performance—because the alternative channels chosen are perfectly matched to the circumstances, i.e., the right, customers are selected, on specific occasions, for particular product types. These successes are helping pharma companies get more comfortable with the idea that they don't have to put a highly-trained, highly-paid rep in front of all physicians—at least not as frequently as they do today.

Getting real: assessing channels' efficiency and effectiveness

What pharma leaders are beginning to understand—and other industries such as financial services are instructive analogues—is that focusing on the incremental efficiency opportunity that multichannel offers actually underestimates the value of the

Focusing primarily on the incremental

efficiency opportunity underestimates the

value of the increased **effectiveness** in terms

of higher quality interactions and greater reach.

change in sales model because it can increase effectiveness as well. Specifically, it can allow pharma companies to:

- **Extend** their reach to “under-served” or hard-to-see customers
- **Produce** higher quality interactions by serving customers in ways they prefer—including different models and potentially less interaction than today; and
- **Help create** a “stereo surround sound” effect to boost “new news”.

For example, entire segments of physicians no longer respond to any type of product push. By simply identifying who these customers are, pharma companies can improve quality while generating significant near-term savings by changing the forms of interaction. This would dramatically decrease rep time spent trying to detail them.

Another segment that alternate channels can address is the “long tail” of physicians who operate beyond the reach of the traditional commercial model. Even the largest pharma field forces touch perhaps a third of all potential prescribers. Alternate channels make it possible to turn the “unreachable” two-thirds into new sources of growth by creating new touch points and ways for companies to interact with those customers.

Finally, in specialty disease areas like oncology where products may have multiple indications, extending existing relationships beyond the rep’s call could be a useful way to amplify your messages without increasing the time demands on your customers.

Given the brief record so far in pharma’s use of alternative channels, it is useful to look for insights from other industries as well. For example, vendors of commercial technology (e.g., computers, data communications, and software used by business and government) have rebuilt their sales models to incorporate less costly channels, such as inside sales, along with traditional field sales. As a result, some have enjoyed up to nine-fold increases in profit, through lower costs and better performance.

Tech is a particularly instructive example because the essential marketing challenge is similar though the product differs: Both industries must convince expert customers to select their products based upon complex technical criteria—which is why both pharma and tech built massive and costly field forces in the first place. The difference is that high-tech companies developed additional, lower cost ways to connect with, inform and support customers throughout the sales process. They not only reduced costs by opening new channels, they also increased share by tapping hard-to-serve segments (i.e., small and medium-size enterprises) and increased the quality of their customer



experience by tailoring interactions based in part on what customers wanted—including different and in some cases, fewer—interactions.

The final lesson is that multi-channel models need not diminish the role of sales reps. Rather, they concentrate these expensive resources on activities that add the most value such as acquisition of high-potential physicians who respond to rep interaction. The corollary: reps devote less time to repeat customers and inherently low prescribers.

Putting the customer at the center

Adding new channels alone may help increase value capture in the near-term, but based upon our experience the real impact will come from fundamentally changing the model from largely brand-oriented to being predominantly customer-oriented.

We see four critical steps to achieving best results from multi-channel efforts:

1. **Differentiate approach by customer segment.** Don't assume a "build it and they shall come" attitude with the new model. Companies must be able to tailor the types and amount of resources they invest to customer needs and preferences—in addition to their financial value to the business. This is the foundation of evolving to a multichannel model. Effective differentiation requires understanding the "decision journey" that the members of important segments travel before prescribing and determining the role that each channel plays in that journey. Like everybody else, physicians (and their office staff) have become online information consumers. Some are mere dabblers while others are digital media junkies, using Web sites, iPhone apps and Webinars. Pharma companies need to know how their specific customers use online information. We know that most, if not all, doctors now seek information online before choosing a prescription drug. Pharma companies need to know what sort of information is important to such physicians throughout the various stages of prescribing and particularly the circumstances that would trigger a change in behavior and what a doctor is viewing at that very moment.

With that information in hand, companies can engage with these doctors more appropriately at different points during the decision journeys. Incorporating a click-to-chat option on mobile apps can give doctors with questions on drug interactions or new label data a convenient channel to reach out, for example, which could lead to serious consideration of a product or conversion. The ability to pursue differentiated, focused strategies for individual segments that reflect customer preferences and needs (such as those of the uber-tech-enabled) ultimately increases the effectiveness of individual interactions which is a large part of the value of a multi-channel model.

2. **Create "hooks" to migrate customers to new channels.** Convincing physicians to move away from the tried-and-true sales approach requires understanding the "pain points" of the current model. For instance, a doctor may be seeking information on a drug, but find it inconvenient to interrupt her work day to get it from a rep. The company can relieve that pain by providing such doctors with self-service or interactive channels that they can use when it is most convenient for them, such as call centers staffed by experts.

Similarly, companies continue to wage detailing campaigns with a subset of high volume physicians in large group practices, when the chief pharmacist or CFO is the relevant target for gaining access to formularies or protocols. These decision makers should likely continue to get the person-to-person approach on key occasions like

formulary adoption—potentially with tailored resources that include both economic and clinical content. Individual doctors in the group can subsequently be briefed online or given “on demand” access to the company’s medical experts for their questions. This two pronged approach saves money for the company, focuses on the right target, and makes the doctor’s life easier, too.

3. **Build in performance metrics from the start.** Companies need to examine each customer segment to design the right channel mix and to determine the right combination of high- and low-touch treatment. This requires a “common currency” that measures impact across traditional and non-traditional channels, and with the proliferation of channels it’s important to accurately and consistently gauge the performance of each to determine comparative effectiveness. Today, most companies only have data based upon the primary detail equivalent (PDE) yardstick, which falls short if certain customers are likelier to tune in and are significantly more engaged with a different, more tailored approach. To normalize results across channels, we employ a proprietary tool that measures three factors for all channels: fully-loaded cost, percent of targeted customers reached, and quality of engagement with those customers. With this data in hand, marketers can create efficient, targeted campaigns that capitalize on the full range of channels. Some customer needs—like requests for samples—may be dealt with via lower-touch channels, while higher-skill resources should be deployed when and where they are most likely to produce quantifiable gains.
4. **Integrate all channels and customer interactions.** Multi-segment marketing is complex. Companies must avoid bombarding customers with mixed messages and must clarify who at the company is ultimately responsible for each customer account. Part of the solution is to invest in IT resources, such as CRM systems, which track all customer profiles and interactions. The other part is developing clear governance and ownership over each customer account. Together these tools will allow companies to implement a coordinated approach. For example, if a physician calls an information hotline and the rep who answers learns of a reimbursement concern that may trigger a switch to a competitor product, the rep should have the account

With the **proliferation**
of channels it's important
 to **accurately and**
consistently gauge
the performance
of each to determine
comparative
effectiveness

information needed to quickly notify a specialist who can reach out and appropriately address that concern.

Developing these capabilities and data sources will allow pharma companies to reach each customer segment with the tailored messages and via the most appropriate vehicles during each point in the decision-making journey—and convert them more quickly.

CONCLUSION

Given the search for a new commercial model, there is no question that pharmaceutical companies must find more effective and relevant ways to reach and influence customers, including ways that have the potential to selectively reduce costs. At the same time, companies are understandably reluctant to do anything that might limit the success of the current model. We believe a solid business case and clear processes exist for expanding channels that can both deliver immediate tangible impact and set companies on a path to long-term performance improvement.



win the formulary, then **seal the deal** with **pull-through**

USING THE SALES FORCE TO TAKE FULL
ADVANTAGE OF FORMULARY GAINS

ANNA DRAGANOVA
RAJIT MALHOTRA

INTRODUCTION

Mary Kay—and her pink-Cadillac driving, lipstick-and-lotion-selling legion—knew a thing or two about sealing the deal. And her insight is timely for U.S. pharmaceutical commercial leaders who are focusing more and more energy and resources on payers. And against long odds, they secure advantaged positions in formularies and grow sales in the face of increasing restrictions aimed at discouraging branded prescriptions. But then, with victory within their grasp, many companies have neglected the final critical step: matching the skill and precision that go into formulary negotiations at headquarters with targeted pull-through efforts in the field.

Some companies that recognized pull-through as one of the last untapped opportunities to reach more patients and drive sales secured the benefits by launching supporting field

efforts. They have invested in the analytics, management systems and tools to put reps in front of the physicians who are in the best position to choose their products—and tell a compelling story about their brands. The results are impressive: Our experience across a wide range of brands is that sophisticated pull-through efforts can single-handedly increase sales by 15% in select territories, and by 1-5% overall.

Segment, target, approach. Repeat as necessary.

Generating strong pull-through gains begins with an exhaustive breakdown of payer segments that can reveal the optimum pull-through target list for every rep. A strong approach starts by understanding the strategic importance of each type of managed care plan. Companies can select among Medicare, Commercial, Medicaid and Managed Medicaid “High-priority plans” based upon key factors such as: 1) formulary advantage vs. key competitors; 2) the level of payer control; and 3) favorable patient mix. With this analysis in hand, companies can supply the rep with 25-50 high potential targets (less can be more in this case) – the physicians who represent the best opportunities for pull-through.

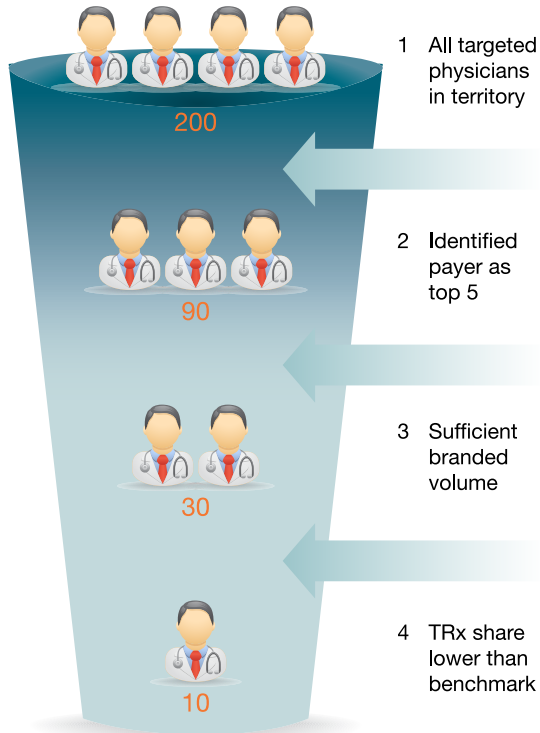
Going even farther, when there is significant opportunity, we recommend modifying the field deployments to shift headcount to geographies with more open access, or increasing physician detail frequency based upon pull-through potential. It also helps to remove organizational barriers between health systems account managers and regional sales leaders—bringing Managed Markets and Marketing into the effort. Dedicated “pull-through” managers who support the process in the field are another valid option especially for products that compete in highly complex payer environments.

Finally, we believe you will achieve the best results when incentives are clearly aligned with pull-through impact and the tools and messages used in the field are not too complicated. Execution has to be easy.

Sophisticated pull-through efforts can **single-**
handedly increase sales by 15% in
select territories, and by **1-5% overall.**

Bottom-up physician-based diagnostic tool can be used to help reps focus on largest pull-through opportunities

Territory-level physician-based funnel
Number of targeted physicians



Quick and easy carry the day with doctors—and reps

No need for the blizzard of reports and collateral—it's not only expensive, it's counterproductive for most pull-through efforts. On the road to establishing best practices for pull-through in managed environments, it is possible to make some wrong turns. Here are some ways to avoid those traps. Make your field efforts:

1. **Short and focused:** Avoid overloading reps with several long lists of pull-through opportunities, each with highly tailored messages. This can result in reps becoming confused and overwhelmed and causing them to step back from the opportunity completely.
2. **Easy to use:** Another misstep is sacrificing ease of use for analytical rigor. Most reps do not want to analyze lengthy, complex plan-level spreadsheets to generate their own best pull-through prospects. The most effective field tools hide the fancy analytics and simply show the top opportunity physicians by territory, and perhaps even giving the field discretion to add or drop a few.
3. **Physician-friendly:** Finally, instead of overcomplicating the physician messaging by attempting to generate custom content for each physician, create simple prescriber-facing brochures with head-to-head comparisons among competitive brands on formularies of top payers.

All together now: make higher pull-through a group goal

Leaders of successful pull-through efforts do a few things very well. Specifically they know to:

1. **Make it an integrated effort.** Driving the pull-through effort requires integration among Managed Markets, brand teams and the field force. Close ties to Managed Markets, for example, enable the field to adjust quickly to changes in formularies. “Giving our key account managers real ownership of district pull-through meetings was a breakthrough” says one sales leader. To support pull-through, companies in therapeutic areas facing coverage restrictions (i.e., prior authorization, step edits) should be adding or upgrading managed care field leadership capabilities on the front line. This can be done through up-skilling and training existing district managers or by adding additional managed-care specialists. By forging close ties to marketing, field teams involved in the pull-through effort can provide physician feedback on promotional tools and messages to drive continuous improvement.
2. **Keep the analytics rigorous but the communication simple.** Simplicity is key for both physicians and reps. Simple messages overcome physician frustration and confusion generated by multiple payer communications as well as the imbalance between cost/coverage data and clinical data. Reps are energized if they understand the rationale and know when to apply which message.
3. **Invest in field buy-in.** Contests and awards are great, but turning DMs into pull-through champions is a must-have. DMs should be closely involved in designing the pull-through effort and should lead the communication to the sales representatives.

As one sales VP says, “If my DMs are talking up targeted pull-through during rides, the reps know they’ve got to do it.” Weekly tracking tools (and weekly reviews of the results) help ensure progress toward capturing the pull-through opportunity.

CONCLUSION

Companies have done a tremendous job of working with payers to expand listings on formularies and drive sales. Yet, to reap the most from payer approvals companies need to support them with field pull-through activities that are focused, simple and made a priority by managers.



overlooking the obvious

EXTRACTING MAXIMUM VALUE FROM COMMERCIAL SUPPORT SERVICES

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INTRODUCTION

Many companies treat commercial support services (CSS) as the corporate equivalent of the IRS—necessary, perhaps even helpful, but they would rather not think too much about it. Not surprisingly, instead of systematically examining how to leverage CSS functions such as commercial analytics and market research, as well as sales and marketing operations and training groups which together typically account for their largest non-sales headcounts, most pharmacos have simply treated CSS as unavoidable overhead to be minimized. The results are predictable: every year, companies chip away at CSS budgets, outsourcing or offshoring to save costs, but never finding ways to generate greater value from CSS investments.

There is a better way—and it leads to far better results. Companies can re-imagine CSS as a corporate thought partner and, consequently, a driver of performance. In this model, CSS leads the commercial organization to new opportunities, rather than simply following orders and filling requests for analysis and data. And, with a clear vision of how CSS delivers topline growth, it is possible to attack CSS costs more strategically—outsourcing or even eliminating low-value activities and investing in value-creating ones. Companies that take a more strategic approach to leveraging Commercial Support

Services are rewarded with greater revenue, reduced costs and improved CSS capacity, and can generate \$50-100 million in incremental revenue for single brands, reduce costs by 15-30% and improve capacity by 15-20%.

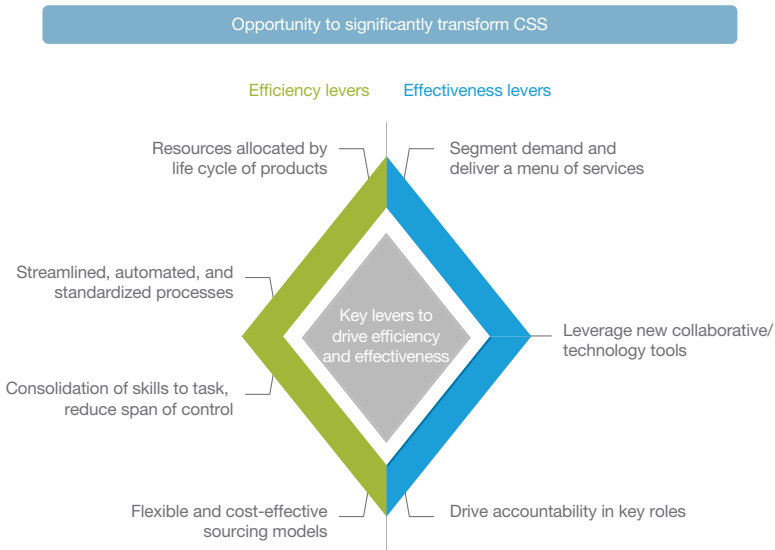
Stop selling CSS short. Most people try to live up—or down—to expectations once they are made clear. CSS teams are no different. Managing for value-creation in CSS is possible, and requires initiatives on two fronts:

- 1) Creating an **efficient delivery model** that prioritizes value-creating activities, reduces costs and frees up capacity, and
- 2) **Empowering the CSS** organization.

Creating an efficient delivery model

Companies that derive value from CSS will have a very clear set of priorities that guide both investment and efficiency efforts. Priorities are set by first classifying CSS services into three main types—revenue enhancing, transaction-oriented, and customer facing. Candidates for investment, cost reduction/offshoring and elimination are then identified.

Exhibit



As a result of such screening, it is possible to free up as much as 50% of headcount by eliminating lower-value reports and increasing use of automation and outsourcing/offshoring to complete many standardized, repeatable reports.

The highest priority candidates for investment are typically revenue-enhancing services, usually sales force incentive compensation, commercial, managed care and sales analytics. After selecting specific services for investment, management then makes sure they are closely aligned with the business and have access to the right mix of internal and external resources and talent.

A second tier of services—highly repeatable execution-oriented services—don't create top-line value and are reviewed for their impact on cost/compliance. Some may be retained in-house because they are critical to compliance (e.g., promotions management). Others are outsourced and/or offshored where possible to create more flexibility. These typically include marketing promotion approvals, speaker/event management and business planning.

The third set of services creates value but don't require a heavy in-house commitment, and are also examined for possible savings.

For example, with only a thin layer of internal expertise to supervise third-party vendors, companies can offload a range of services for smaller products/tail brands—such as online KOL mapping, sentiment analysis, 24X7 information access and physician information support. Similarly, pharma companies can leverage innovative vendors to provide stable, yet cutting-edge solutions in social media and other forms of promotion.

In addition to prioritizing the three types of CSS services, it is possible to free capacity in their delivery model by eliminating redundancies across global, regional or local organizations. By mapping activities, creating service catalogs, defining service levels and determining resourcing by service and by country, companies can further optimize capacity.

Empowering CSS

For CSS to deliver all the value it can, it must have visibility within the company and the same quality leadership as other units within the commercial organization. For example, the leader of CSS should be a VP or above and should have broad experience in other

Companies that take a more strategic approach to leveraging Commercial Support Services are rewarded with **greater revenue, reduced costs and improved CSS capacity.**



commercial functions (e.g., sales and marketing). He or she must be a trusted partner to the business and involved in major decisions for the commercial organization. He or she must have a clear vision of the CSS mission and be capable of shifting mindsets from an order-taker mentality to a more customer-focused approach, where initiative is rewarded.

The CSS organization, itself—people and processes—must also be refocused on value creation. To this end, leading companies have created analytics centers of excellence (CoEs) that focus on delivering revenue enhancing services. The analytics CoEs calculate profitability by customer (i.e., physician or group) to show where the business should

focus to drive growth, rather than simply tracking performance by brand, territory, etc. Typically, when companies see the results, they shift resources—from devoting 80% of FTE capacity to historical analyses, to applying 60-80% of analytics manpower to work that drives revenue and predictive insights. The emerging model of the analytics CoE is essentially a mini-consulting unit that is engaged by the business leaders and leverages other shared capabilities (e.g. reporting, customer insights) as needed.

Finally, to ensure alignment on what constitutes CSS value creation and capture lessons learned, leading companies have established cross-functional leadership taskforces. These groups track how investment and efficiency initiatives are delivering, usually with a “dashboard” that captures value created for CSS “clients” by using new key performance indicators. These taskforces have helped identify value-creating tools that can be adopted across brands and customers (e.g., marketing, sales and managed markets).

Reinforcing CSS’s higher calling. We have found that the keys to realizing gains from CSS are:

1. **Building** alignment around the value proposition for transforming CSS with senior leaders from Commercial, Finance and IT
2. **Selecting** a CSS leader who has the capability to lead this transformation, and
3. **Setting** explicit expectations on what the transformation will deliver and by when.

CONCLUSION

In summary, we believe CSS is an area that can drive top- and bottom-line impact at a time when companies need both. Market-leading companies will not overlook this opportunity, which has been hiding in plain sight.



going the distance

LEVERAGING THE SALES FORCE TO
ENSURE PATIENT SERVICES PAY OFF

RAJIT MAHOLTRA
BRENDAN MANQUIN

INTRODUCTION

Few things are more frustrating than seeing good treatment programs—a solid diagnosis, treated with the right meds, prescribed by a dedicated doctor—go awry. Pharmaceutical companies and their reps frequently can help keep programs on course, and many companies are expanding engagement with patients to optimize outcomes seeing it as a natural extension of core product sales. These efforts are frequently in the form of wrap-around services that go beyond the pure delivery of a product or therapy, particularly for patients whose treatment involves expensive specialty drugs. Patient services fulfill diverse functions; including helping patients and physicians navigate the reimbursement and distribution process, empowering patients to self-administer and better manage complex treatments, and helping patients (or caretakers) manage symptoms, therapy side effects and connect with others for support. Although the impact of these services can be significant, they are not cheap or easy to deploy. We have found that they need to be tightly integrated with the sales force in order to reap maximum benefit from the investment in their development.

Totally worth the effort

We believe that the use of patient services will continue to grow, driven by patients' growing role in treatment decisions, and the industry's increased focus on the high-cost, complex diseases where these types of services have the highest impact. For biologics,

the need to differentiate against coming biosimilar competitors will further reinforce the importance of effective patient services.

Companies leading the way in
deploying patient services
 typically see a **total revenue**
gain between 5-10% as a
 result of these programs

Patient services can be a powerful tool in both growing and retaining sales. We estimate that companies leading the way in deploying patient services typically see a total revenue gain between 5-10% as a result of these programs, and this is before considering the more diffuse reputational benefits that may accrue.

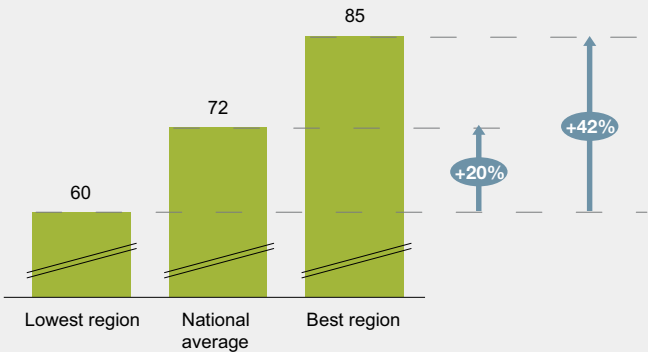
Triangulate for maximum impact

Many companies are experimenting with patient services—trying to find the right mix of services, point of offer/intervention, and appropriate implementation team. Our observations show that in successful programs:

- **The sales force plays a critical role in maximizing uptake:** Patients typically receive information on services from their physician, usually at the time of the first script. The sales force plays a crucial role in ensuring that physicians are convinced of the value of the services so they recommend them to patients. The importance of a proactive sales force is reflected in significant variations in the proportion of patients who sign up for patient services between geographic areas (even between areas with similar socio-demographics and regulatory environments).
- **The entire office must be engaged:** Although the initial recommendation usually comes from the physician, office staff play the main role in helping patients sign up for services. The best results are achieved when patients are signed up before ever leaving the physician's office, so it is critical that companies develop and execute a plan to help office staff understand the sign-up procedures and the value of the services to the patient.
- **Ongoing coordination between sales and patient services is crucial:** The patient services personnel will usually be interacting directly with the office staff, e.g., to verify insurance status, or signal a concern with the patient's adherence to treatment. While not all information can be shared with the reps (to preserve patient

Significant variation of uptake between sales regions

Percent of patients signing up for ongoing support



SOURCE: Blinded data, McKinsey analysis

confidentiality) it is important to ensure ongoing coordination between the sales force and patient services in managing physician accounts.

Educate, coordinate, reward

Not exactly the classical virtues, to be sure, but we found these to more accurately describe what it takes to deliver value-adding patient services. Fortunately, many of the processes used by companies in product education, and the skills already possessed by sales reps and account managers, can also be deployed to optimize patient services.

1. **Ensure the sales force understands the value of the services.** In order to convince an (often initially skeptical) physician that they should refer their patients to a manufacturer's services, reps must first fully understand how the programs can help patients. Concrete examples and testimonials go a long way in educating reps and convincing doctors as well. Some manufacturers actually force all their reps to rotate through their patient services organization, so they can observe them first hand.

Of equal importance is that the reps understand the impact that services can have on sales – and their own long-term success. Identifying and celebrating reps who have done well because of their efforts promoting patient services is crucial.

2. **Provide reps with the data and tools they need to market the services.** Appropriate training of the sales force is also critical, as promoting services may be a significant departure from the classic product-focused detail for many reps. The service offerings should also feature prominently in the detail aid. One rule of thumb, if programs are not robust enough—in scope or impact—to warrant space in marketing collateral, then it is worth considering whether money should be spent on them in the first place.

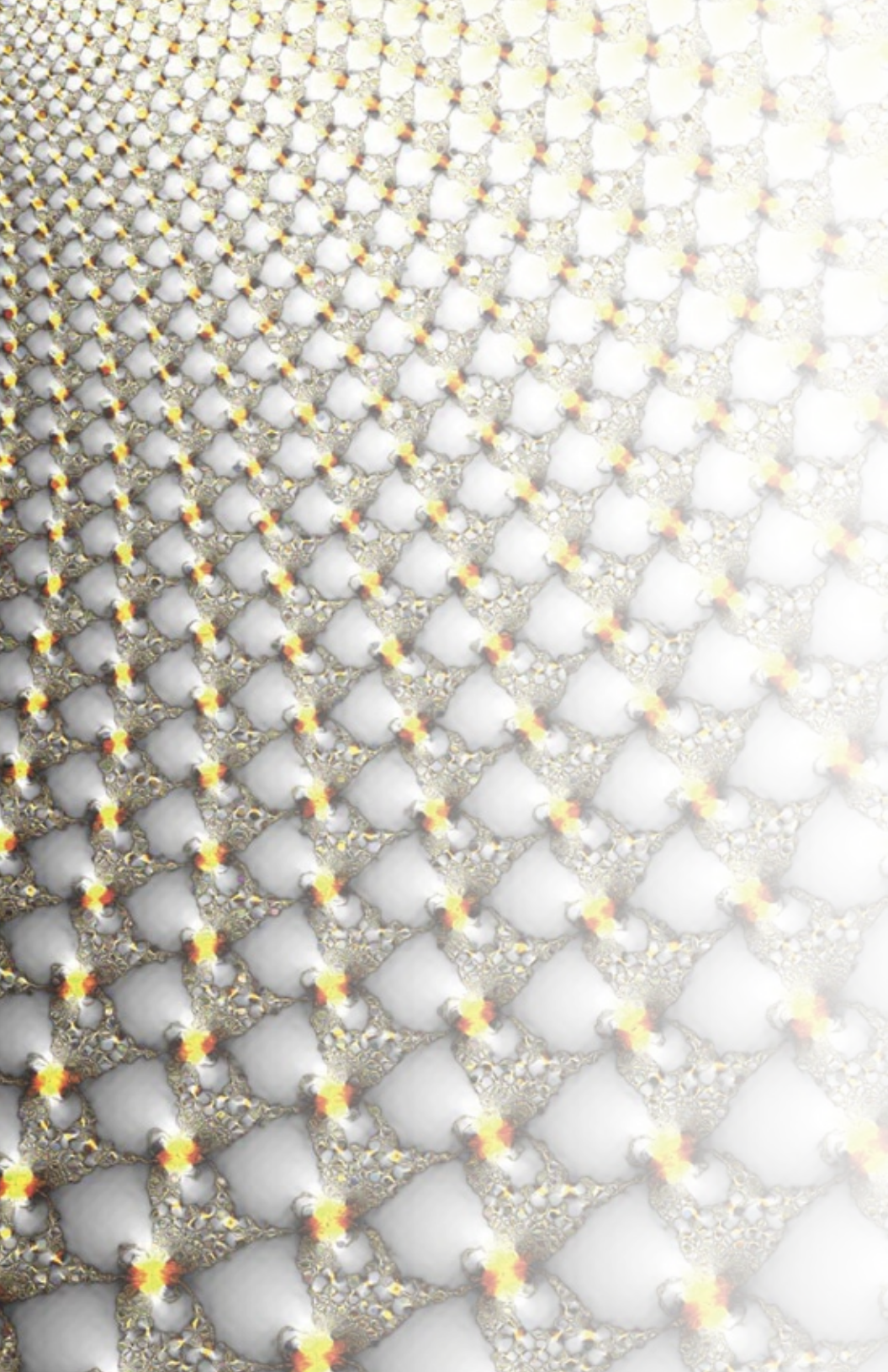
Data mining can identify which physicians or offices are not steering patients towards the offerings. This information should be included in rep and DM dashboards to help focus their effort.

3. **Create processes for coordinating between sales and patient services.** Our analysis has shown that the best performing reps usually work hand-in-hand with their patient services colleagues to discuss approaches for specific accounts. To the extent possible, try to align the geographic responsibilities of specific patient services agents with those of reps. This alignment increases transparency and builds a sense of teamwork and joint ownership. Scheduling regular check-ins between reps and agents (e.g. weekly) helps, much as one would do for multiple reps calling on the same account.
4. **Align incentives.** Many of the benefits from patient services take a certain amount of time to materialize, especially those focused on increased compliance and persistence. This can lead to a lack of focus from reps worried about fulfilling shorter-term quotas. Including patient services uptake in management by objectives (MBOs), or designing sales contests around patient participation/uptake metrics, can help alleviate this issue.

CONCLUSION

When correctly deployed, patient services can substantially enhance the patient experience and outcome, greatly help physicians and improve product sales. The sales force plays a crucial role in ensuring that physicians and their staff (and through them, patients) understand and take advantage of these services. A few simple steps can help set up the sales force for success.





cell2cell approach

HOW A VIRAL FRONTLINE TRANSFORMATION
MAINTAINS MOMENTUM

JONATHAN DOOGAN
IOANA PARSONS

INTRODUCTION

Start nattering on about “transformation” and most employees’ eyes glaze over—some may look around for the nearest door. And no wonder—most transformations fail, or have roots about 2cm deep. Yet, faced with multiple pressures—increased regulation, reduced physician access, deeper resistance to traditional sales methods—pharma companies are rethinking how to interact with physicians. Many companies are genuinely committed to transforming their frontline operations, yet typical efforts are too narrow. Most focus on capacity reallocation and productivity targets, some add new digital or remote channels, while others launch new technical tools and training for reps. Unfortunately, few manage to fundamentally change the customer value and experience. Why? Because these programs fail to create an integrated way of interacting differently with physicians. Indeed, one Country Manager admitted, “We just cannot get all the building blocks of the (transformed) model to work together as designed.”

Start with a ruthless focus on improving the customer value and experience

No two transformation efforts are alike; underneath similar goals lie an array of different contexts and motivations. What is common, however, is the imperative to look at all roles and touch points that affect the customer experience. Only after clearly defining

the hoped-for experience from the customer's point of view can a company identify the behaviors and tools that the frontline (reps, their managers, KAMs, medical staff, marketers, etc.) need to deliver that experience. Then the major battle can begin, as the most difficult challenge in any transformation is the one waged between the ears of every frontline and back-office staffer— that is, changing their mindsets.

Our research shows that only 3 in 10 transformations succeed, and pharma is no exception. Besides cost and speed considerations, the need to “get it right” the first time is compounded by the danger that a failed effort will reinforce people's natural skepticism and resistance to change. The risk of derailing is real, and we need to accept that some of the frontline will never adapt to working in the new world. An unprecedented level of attention is required at the frontline to allow for experimentation and to shift the mindsets and behaviors required for success.

Enlist an army of change agents for cellular conversion

We have tested a Cell2Cell approach in multiple client situations (situations where there were no upfront sales force layoffs). While transformations take a variety of shapes and span months to years, adhering to a handful of principles in designing and delivering the Cell2Cell approach dramatically increases the effort's chance of success:

- **An individual performance cell should be at the core of the transformation.** The cell should be the smallest self-contained customer-facing performance unit of the organization, e.g., a sales district or a small country marketing team. For example, in a transformation where the sales team is the “spider in the web”, one “cell” could include around 10-15 sales reps, their district manager, a KAM, a medical liaison and some allocation of marketing, customer operations, HR, and IT support.
- **Each cell goes through the transformation rapidly**, in a compressed period of time (e.g., three months), during which multiple change interventions are deployed, such as: intensive field-and-forum capability building, team coaching, viral communication, role-modeling from leadership and peers, and new incentives. It is a pressure cooker approach geared to achieving “one mini-transformation at a time”. The transformation then proceeds in waves of cells, each wave learning from the ones before. The overall pace of transformation is dictated by the need for each cell to have a deep experience of transformation—so it takes time—12-24 months, depending on the organization's size and capacity to support learning.
- **In each cell one pivotal person** usually plays a multi-channel integrator role, ensuring reps and other frontline roles are adopting the new channels to interface with their customers. Integrators will need to be respected change leaders who

Starting with a few cells to test and refine the model, the transformation reaches massive scale in several waves

Phase 1

From a few...



Phase 2

...to many...



Phase 3

...to all



actively model the new behaviors and mindsets towards customers, and support and challenge the frontline to follow suit.

- **Each cell should seed the next wave/train future trainers.** The cells function as transformation units as well as learning environments. To support successive waves the initial cells should include “extra” frontline employees from other districts and even countries who are then responsible for leading and supporting transformation initiatives within their own performance cells.
- **Transformation is also required outside the cell.** All the support and other functions need to align behind the transformed cells, so cells are not doing changed work in an unchanged environment. The back office support functions are critical to ensure success at the customer interface as there are more “customer-touching” roles than just the front line (e.g., receptionist, finance). These roles may not be part of the cell itself, but are important enablers. In parallel to the cell-to-cell rollout, a system-wide transformation effort will be needed.

Making resistance futile and transformation endure

To maintain transformation momentum, leaders should:

1. **Describe in crystal clear terms the desired future model:** make sure the whole organization understands and is aligned around the changes in the customer and frontline experience, together with the expected impact these changes should have on business, customer, and frontline performance metrics. “A day in the life of” customers and of reps and “From-to” scenarios are tools commonly used to achieve this.
2. **Put in place “hard” and “soft” support for behavioral change** to drive integrated changes in the operating model; overinvest in the “soft” elements that kick-start shifts in mindset and behavioral change. Operating model enablers could include new solutions for healthcare professionals or technology tools for reps, while mindset enablers could include capability building, reflection, role modeling, or incentives.
3. **Think “one mini-transformation at a time”:** articulate, pilot and scale-up a comprehensive program of change initiatives that ties the new model and the new behaviors together into a series of mini-transformations, one in each cell. The first wave includes only a couple of cells that also refine the tools provided and start building a network of champions to facilitate the second wave of 10 to 30 cells. Following waves can include 50-100 cells, but in every single one of them the initiatives should be rolled out simultaneously to create the pressure cooker effect.



CONCLUSION

There are of course other ways to drive massive change at the frontline. However, the Cell2Cell approach has demonstrated its impact time and time again. Its effect is unparalleled in organizations where the company culture is more empowering and less command and control, and when its context allows for sustainable rather than urgent action.

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