EXECUTIVE BRIEFING

THE VOICE OF THE ORGANIZED CUSTOMER

Pharma’s Opportunity to Meet the Needs of Health Systems in a Shifting Healthcare Landscape

AUTHORS
John Strapp, Jr. | Leonard Fromer, MD | John Walker, MD

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Acknowledgements

Authors

John Strapp, Jr.
Co-Founder, Chairman and CEO
The Kinetix Group

Leonard Fromer, MD
Former Chairman, AAFP Commission on Health Care Service
Assistant Clinical Professor, Department of Family Medicine, UCLA
Medical Director, Group Practice Forum
Senior Strategic Advisor, The Kinetix Group

John Walker, MD
Former Chief Medical Officer, Cornerstone Healthcare
Former Chief Health Enablement Officer, Cornerstone Health
Enablement Strategic Solutions (CHESS)
Senior Strategic Advisor, The Kinetix Group

Special Thanks to

Gordon Moore, MD
Senior Medical Director, 3M Health Information Systems, Inc.
Faculty Member, Institute for Healthcare Improvement

Editor

Ulrich Neumann, MSc MA
US Managing Director, eyeforpharma
Fellow at the Royal Society of Arts, Manufactures and Commerce

The Kinetix Group (TKG) combines unique healthcare delivery expertise with a skilled managed market agency staff to develop Business to Business (B2B) programs that establish market leadership for TKG clients among their health system stakeholder customers. The innovative B2B programs include all the elements necessary to ensure commercial success including discovery, design, implementation and key account manager training. The Kinetix Group has two business operations:

• IMP Consulting: A healthcare delivery innovation and consulting firm, offering health systems, provider groups and payers customized blueprints and tools to build and sustain a new way of thinking. Our solutions help delivery organizations assess, develop, re-design and measure models for addressing the key Triple Aim objectives: improved clinical outcomes, significant cost savings, and increased patient engagement.

• TKG Agency Services: TKG is a full service managed market agency. The TKG relationships with health systems, the foundational healthcare landscape knowledge and the granular understanding of health system needs have generated new life science health system AOR contracts.

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It's our mission to make pharma more open and valued. Join us as we're creating a movement for industry leaders who prioritize value for patients and HCPs.
Landscape Overview

The most prominent narrative in the US healthcare landscape continues to be the industry-wide effort to control national health spending. Healthcare costs absorb a significant proportion of government and household budgets, with national healthcare spending expected to surpass $3.2 trillion in 2015.\textsuperscript{1,2} Rising costs can be attributed to several factors:

- Prevalence of chronic diseases
- Improved life expectancy of the US population, including those with chronic diseases such as diabetes and obesity\textsuperscript{3}
- Increased Medicare enrollment by 30% in the next ten years, and by 80% by 2039\textsuperscript{4}
- Rising expenditures in prescription drug spending which is projected to have grown 12.6% in 2014 and will continue to grow 6.3% per year over the next 19 years.\textsuperscript{5}

As such, stakeholders have accelerated their efforts to achieve the Triple Aim – improve patient outcomes, enhance the patient experience, and reduce per capita costs. Renewed emphasis on value-based care delivery is a key driver in shifting the focus and has helped to redefine relationships among all stakeholders. The movement towards alternative payment models, in particular Accountable Care Organizations (ACOs), highlights the institutional support of value-based care delivery. By the end of 2016, the Department of Health and Human Services hopes to tie 30% of Medicare payments to alternative payment models and increase that to 50% by the end of 2019. ACOs are now in all 50 states and 90% of all Hospital Referral Regions.\textsuperscript{13} Healthcare executives estimate that 30-70% of their payments from commercial payers will include value-based mechanisms within the next three years, with Medicare-related savings of up to $417 million.\textsuperscript{9,5}

\textbf{FIGURE 1: Number of People Age 65 or Older, by Age Group}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{people_age_65_or_older.png}
\caption{Number of People Age 65 or Older, by Age Group}
\end{figure}

\textit{Source: Congressional Budget Office}\textsuperscript{4}
The Voice of the Organized Customer
Pharma's Opportunity to Meet the Needs of Health Systems in a Shifting Healthcare Landscape

Landscape Overview

FIGURE 2: Embracing the Primary Care Model

As illustrated in Figure 2, the increase in performance-based payment and shared risk models impact stakeholders across the continuum: physicians, payers, and pharmaceutical companies. This has resulted in three prominent driving forces:

- Rapid Consolidation
- Greater Leverage of Data Analytics and EMR Systems
- The Increasing Role of the Consumer

Rapid Consolidation

As a result of new payment and delivery models, providers – both physicians and health systems – are beginning to consolidate. The difficulties of navigating these new payment and risk models have led to a visible shift of physicians from small group practices towards large, professionally managed healthcare systems. A survey of over 600 physicians nationwide reported 72% of physicians switching their place of employment in the past five years and moving to larger healthcare organizations with increased professional management – reflecting the change in interests and perceptions amongst physicians. As recently as 2005, more than two-thirds of medical practices were physician-owned. Within three years, that share dropped to below 50% as more than half of the practicing US physicians are now employed by hospitals or integrated delivery systems. This trend is only expected to accelerate as private practices will struggle to remain profitable within the new landscape.

In Texas, the merger of Baylor Health Care System and Scott & White Healthcare further illustrates the growing national model in which large health systems are merging to gain leverage when negotiating with payers. Health systems are also recruiting doctors away from private practices and small health systems in an effort to increase their capacity for internal referrals.

Private insurers are similarly beginning to consolidate as evidenced by Aetna’s recent acquisition of Humana and Anthem’s merger with Cigna. Small insurers have struggled with the high regulatory burden imposed by the Affordable Care Act. As such, the average number of insurance companies across the nation available to an individual consumer has decreased from 36 in 2012 to 3 in 2014, although the number varies by geography.
Landscape Overview

FIGURE 3: US Physicians Continue to Leave Independent Practice

Greater Leverage of Data Analytics and EMR Systems

According to a survey of healthcare executives by the Healthcare Financial Management Association, the most important capability for health systems in the new era of value-based care is the interoperability of data systems. The ability to exchange and use data effectively will have a significant impact on a health system’s clinical performance, as well as its financial performance. Despite the noted importance of data analytics and interoperability, only 16% of executives believed their organizations were “highly capable” of interoperability.11

Meaningful Use incentives have accelerated the adoption of Electronic Medical Records (EMR) and led to unprecedented data collection on patients and their health systems, care interventions received, and health outcomes. Recently, several health systems have consolidated utilization of EMR systems to share patient-specific data. Mayo Clinic, Geisinger, Kaiser Permanente, Intermountain Healthcare, and Group Health formed the “Care Connectivity Consortium” to share patient information in a secure Health Information Exchange (HIE). With the intent to further align with outcome-based care, patient data can be utilized for population health based analysis, clinical treatment, patient adherence, performance evaluation, and predictive models.

The Increasing Role of the Consumer

Consumers are now being brought to the forefront of the conversation. Health insurance exchanges have increased overall transparency while rising healthcare expenses (e.g., out-of-pocket costs and premium contributions) have heightened overall consumer awareness. Moreover, consumers are taking greater responsibility for their own care and self-management. The emergence of personal medical technology has only served to further promote individual accountability. Americans are using mobile devices, applications, and other internet-based tools to manage and track their own health, communicate with providers and peers, and ultimately make informed decisions about their care plans. Increased access to information and the enhanced ability to communicate directly with providers has increased the overall transparency of the healthcare industry.

Source: National Family Planning & Reproductive Health Association | Manatt, Phelps & Phillips, LLP
The Voice of the Organized Customer

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The Voice of the Customer

As outlined in the first section, the healthcare landscape is changing rapidly as we shift from volume to value. And with it, the Organized Customer (e.g., health systems, integrated delivery networks) must adapt to a new value-based delivery of care. TKG conducted deep dive interviews with C-suite executives and physicians to better understand the perspective of the Organized Customer within the rapidly changing healthcare landscape. The results identified were organized into four areas of intervention:

1. Team-based Care Coordination
2. Transitions of Care
3. Patient Engagement
4. The Use of Data and Health Information Technology (HIT)

“Our potential to succeed in this environment is predicated on our ability to deliver systematized care of the lowest cost and highest quality.”

Chief Medical Officer at an East Coast Health System

“We are trying to navigate to become a value based system while still keeping our doors open.”

Practice Administrator at a Midwest Health System

“We’ve decided to embrace population health. We are trying to figure out what that means, how we do that, and what the implications are.”

Specialist at an East Coast Medical Group

Team-Based Care Coordination

Delivery of healthcare in the United States is often fragmented. An analysis of 1.79 million Medicare cases from 2000 to 2002 revealed that the typical Medicare patient sees two primary care physicians and five specialists, with these providers working across four different practice settings. Approximately one in three Medicare patients changes physicians from year to year due to poor care coordination and fragmentation. As a result, patients, families, and caregivers are left to navigate the system across different care settings without assistance.

Poor communication between providers can lead to errors, waste, and duplication of services. Continued evolution of the healthcare system will require greater accountability and care coordination between providers and sites of care.

The aging US population and rising prevalence of chronic disease also requires that providers move away from simply the delivery of acute and episodic care. However, healthcare systems lack an adequate communication infrastructure to meet the needs of patients with chronic disease. Providers and organizations act independently and remain disconnected from one another. Lack of coordination between providers and sites of care often results in poor provider access to patient information, medical histories, and treatment plans.

Patient-centered medical homes (PCMH) and ACOs have emerged in an effort to promote a patient-centric, team-based collaborative approach to care. The importance of a high functioning, well-integrated Care Team to meet the clinical and non-clinical needs of the patient cannot be overemphasized. Leaders in the practice should structure the team, define roles and responsibilities, encourage team collaboration, and provide feedback in order to ensure efficient teamwork. In addition to the physician and the practice staff, the patient is similarly an integral member of the team and must be engaged in shared-decision making.

The foundation for patient-centered team-based care is a defined set of roles and responsibilities for each member of the team coordinating transitions across providers and sites of care, establishing systematic care processes, and improving clinical efficiency and productivity.

The team-based model is essential in the treatment plan development for Medicare patients with multiple chronic diseases, which represent the highest risk and corresponding cost. A coordinated multidisciplinary approach is required to effectively develop and manage the complex treatment plans.

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The Voice of the Customer

Figure 4 illustrates what a virtual high risk patient management team can look like. This model can be applied to any healthcare delivery setting and provides physicians the specialty expertise necessary to manage the clinical challenges represented by the high-risk patient populations.

FIGURE 4: Team-Based Care Coordination

Transitions of Care

Transitions of care focus primarily on collaboration in the community with assets, people, and resources to help actively manage the transition of patients across various settings such as primary care offices, specialty care practices, pharmacies, and the patient’s home. Well-managed transitions of care are the predictors of patient trust and patient adherence. As such, it is becoming an increasingly relevant area of implementation; a proactive, rather than reactive, approach can make all the difference.

“Care needs to be coordinated between the right providers of the right levels to make sure that patients get the most effective care at the right cost.”

CMO at a West Coast Large Integrated Health System

Primary care providers have historically referred patients to specialists over the phone and subsequently discontinue care until the patient sees the recommended specialist. Research indicates that this mode of care delivery compromises both efficiency and quality of care. Alternatively, “parallel care” should be provided: after the patient is referred to a specialist for consultation, the primary care provider continues engaging with the patient while working directly with the specialist to promote a seamless handoff between providers.

“I would prefer that they (the patient) have a PCP. However, much of the responsibility falls on the practicing specialist.”

Director of a Midwest Hospital-Based Academic Center
The Voice of the Customer

The heart of transitions of care evolves from the concept of the “medical neighborhood” of a patient-centered medical home (PCMH). This multidisciplinary approach to care supports the idea that the members of the Care Team need to be expanded beyond the four walls of a physician’s office to include specialty providers and ancillary services. A successful transitions of care framework is thus built on the active coordination and bi-directional flow of information, timely communication, and data between providers and care settings. Simply speaking, a transitions model such as that outlined in Figure 5 can be applicable to any specialty therapeutic area for the effective delivery of care.

![FIGURE 5: Transitions Model to Care Delivery](image)

*Source: The Kinetix Group*

Patient Engagement

Activating patients in their own self-management has a tremendous positive impact on overall health outcomes, leading to greater safety and efficacy in healthcare delivery. And while patient engagement can overcome non-clinical barriers to maximize health outcomes and integrate patient values into the care plan, many providers struggle to appropriately implement and execute strategies to enhance shared-decision making. Physicians are often rooted in the status quo of physician-directed decision-making and are hesitant to move towards shared decision-making models.

Lack of patient education poses a major challenge to treatment adherence because of knowledge gaps in health literacy. Although there are multiple barriers to patient engagement – including time constraints, poor training of providers, lack of incentives, and information system shortcomings – medical practices face a pressing need to address inadequate patient education.

Patients face significant barriers to becoming fully engaged including health literacy, social and cultural differences, and cognitive issues. In order to promote patient responsibility in healthcare management, pharma should help providers tailor all education to the varying literacy levels of their patients. Providers must be trained to recognize and understand socioeconomic differences in their patients – and, in parallel, learn different approaches to multicultural patient engagement. Providers should also consider leveraging Motivational Interviewing techniques to foster patient-centered relationships and facilitate health behavior change. In addition to tailoring language in educational tools, providers should also consider leveraging multiple platforms – e.g., print-outs created by care givers that are also available through the patient portal – to bolster patient education and responsibility.

As patients become more educated about their disease and treatment options, they can become more engaged in their own self-management. The use of technology has only further empowered patients. Digital services such as online pay and appointment scheduling have facilitated patient access to care. By the end of 2019, 66% of US health systems will offer digital self-scheduling and 64% of patients will book appointments digitally, delivering $3.2 billion in value and a competitive boost for health systems.

“Patients have poor insight into their disease process. They need an understanding of their disease state, therapies needed for treatment.”

*Medical Director at a Southeast Academic Medical Center*

“Patient engagement is the key to successful disease management. The secret sauce is having tools and resources available that provide personalization at the individual patient level to help providers and patients achieve their disease management goals.”

*Medical Director at an East Coast Academic Medical Center*
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The Voice of the Customer

In addition to appointment scheduling and bill paying, patients have indicated interest in having online access to their test results.

The Use of Data and HIT

Critical to the movement towards value-based care is the ability to gather and analyze a wide range of data to gain a deeper understanding of how to deliver high-value care. The utilization of Health Information Technology (HIT) is an essential component of population health management programs and can be utilized to address care gaps. The utilization of HIT leads to information-powered clinical decision-making via the usage of robust patient data sets to support proactive comprehensive care. A few applications include the ability to provide real-time quality feedback to providers, feed personalized insights to doctors, and uncover patterns that can improve care delivery.

“Understanding the importance of technology means understanding that there will always be a growing, ageing population and a shortage of primary care physicians, and that many of these mechanisms and deliveries have to be delivered from a technology solution.”

Chief Clinical Officer at an East Coast Integrated Health System

“Once a patient is motivated and engaged, it’s important to know how to leverage technology to track and follow the patient’s status over time including remote visits, interventions, etc.”

Patient Navigator at a Southeast Health System

HIT applications play a large role in the process of care coordination: various providers within the care continuum can exchange patient information through HIT to provide the best possible clinical decision support to patients, as well as to increase patient satisfaction through activating patients in managing their own care. EMRs manage patient data and protocols critical for care delivery and can promote communication between providers and patients. The key component for successful use of these EMRs is the system’s interoperability i.e., the ability to transmit patient data between providers.

Although the EMR adoption rate is high, frustration with the use of HIT is widespread. EMR problems are regarded as one of the main pressures affecting practices; provider comments range from “decreased productivity because of the EMR” to the “excessive burdens of meaningful use.” Because hospitals and health systems often utilize different EMR systems, it is virtually impossible for them to interact and successfully coordinate care.
The Voice of the Customer

HEALTH SYSTEM BEST PRACTICE CASE STUDIES

HEALTHCARE PARTNERS:
Comprehensive Interactive Voice Response (IVR) Telemedicine System

HealthCare Partners Medical Group is a Southern California-based IDN featuring more than 600 primary care and specialty physicians across over 65 medical offices. The medical group provides services to fee-for-service patients as well as PPO and HMO enrollees.

In 2011, HealthCare Partners piloted a comprehensive Interactive Voice Response (IVR) telemedicine system to support COPD patient management post-hospital discharge. The IVR system was designed to capture consistent patient information on COPD patients, anticipate their respective needs, and effectively reduce hospital readmissions. The IVR system was patient-friendly, ensuring that patients were effectively conducting self-assessments and monitoring their symptoms. Moreover, the system provided real-time updates to the Care Team as patient conditions evolved. The expanded Care Team included integration of a telehealth care coordinator, high-risk nurse, and two project management directors of Disease Management.

Healthcare Partners saw significant improvement in readmissions rates and a reduction in overall healthcare expenditures as a result of the IVR program. Additional savings are expected in the fifth year of the program as the health system pilot expands to additional disease states (e.g., oncology).

FIGURE 6: HealthCare Partners IVR System – Program Outcomes

**OBJECTIVE:** Reduce readmissions and costs associated with COPD patients

**ACTIONS**

- Patient-friendly Care Interventions
- 9-question survey administered on phone keypad at same time every Monday
- Survey did not replace in-person time between the patient and their nurse care manager; instead made patients more comfortable with outreaching to their care manager
- Automated Risk Stratification and Care Team Notification
- Survey results correspond to a specific action plan for the Care Team
- Scores indicating patient facing exacerbation of their COPD symptoms prompted immediate notification to nurse to contact patients as a first priority
- Total survey score changed by two or more points between consecutive surveys prompted nurse follow-up.
- All survey results emailed to the Care Team

**OUTCOMES**

- Reduced COPD-based hospitalizations by 50% for patients
- Reduced re-admission rates for COPD patients to 4.97% compared to 14%
- Saved $1.30 for every dollar invested in the IVR system; ratio of savings per dollar invested is projected to increase to $18 for every dollar in the fifth year of the program
HEALTH SYSTEM BEST PRACTICE CASE STUDIES

CORNERSTONE HEALTH CARE:
Patient Care Advocate Program

Founded in 1995, Cornerstone Health Care is an integrated multi-specialty group with more than 375 physicians and mid-level health professionals across 90 locations in the US. At the forefront of innovation, Cornerstone redesigned their Care Team model with a Patient Care Advocate Program. More specifically, the program focused on using population health data and clinical analytic tools to identify and monitor high risk diabetes patients. Cornerstone also trained ancillary staff (Medical Assistants) as Patient Care Advocates to proactively schedule primary care appointments, improve care coordination, identify simple interventions, and assist patients in their own self-management.

The program successfully improved the quality of care delivered and reduced healthcare expenditures for the patient population, and was a key component to facilitate Cornerstone’s transformation to a fee-for-value healthcare delivery model. The number of high-risk patients decreased by 32% and Cornerstone earned an additional $245 of revenue per patient appointment. The Patient Care Advocate program also played an important role in getting Cornerstone’s primary care practices to be recognized as Patient-Centered Medical Homes. Future opportunities are currently focused on expanding the program to other high risk, chronic conditions including heart failure, oncology care, COPD, and poly-chronic conditions.23,24

FIGURE 7: Cornerstone’s Patient Care Program – Outcomes25

**OBJECTIVE:** Improve outcomes and reduce costs associated with high risk diabetes patients

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>BY THE NUMBERS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standardize care protocols</td>
<td>Outreach Phone Calls 5,528</td>
</tr>
<tr>
<td>• Implement analytic tools to identify/monitor high risk diabetes patients</td>
<td>Scheduled Appointments 1,816</td>
</tr>
<tr>
<td>• Redesign the Care Team</td>
<td>Scheduled Appointments within the 6 month window 1,128</td>
</tr>
<tr>
<td>• Train Medical Assistants as Patient Care Advocates</td>
<td>Appointments Attended 999</td>
</tr>
<tr>
<td>• Patient Care Advocates proactively reach out to schedule appointments for high risk diabetes patients; manage/coordinate care; identify interventions; assist in patient self-management</td>
<td>Referrals to Specialists 115</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOMES</th>
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</thead>
<tbody>
<tr>
<td>• Standardized care and high risk patient identification</td>
</tr>
<tr>
<td>• Decreased the number of high-risk diabetes patients by 32%</td>
</tr>
<tr>
<td>• Increased practice revenue by $245 per appointment</td>
</tr>
<tr>
<td>• Helped in the designation of all primary care practices as PCMHs</td>
</tr>
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HEALTH SYSTEM BEST PRACTICE CASE STUDIES

QUALITY BLUE PRIMARY CARE: Primary Care Re-Design Program

The Quality Blue Primary Care (QBPC) program has evolved from the foundation of successful Blue Cross care coordination and quality improvement programs. With an evolving population health management initiative, the QBPC program focuses on multiple cardio-metabolic conditions via effective risk management. The program’s pilot, called ATGOAL, was a joint collaborative effort among Blue Cross, Consortium of Southeast Hypertension Control (COHSEC) and 10 primary care practices to decrease the risk of cardio-metabolic conditions among patients and improve care coordination. QBPC in its first year has been embraced by more than 440 participating primary care physicians and more than 141,000 attributed patients.25

Patients with the diagnoses of diabetes, hyperlipidemia, or hypertension were considered to establish a baseline performance for the participating practices in the pilot. Based on the practice’s baseline, each provider received a customized Continuing Medical Education (CME) module and received data reports each quarter, along with comparisons to other practices.25 The enrolled practices’ performance were evaluated after a 24 month period and showed an overall positive trend of improvement in risk factor control rates.

The QBPC program successfully engaged and educated primary care providers, improved quality outcomes, enhanced care coordination, and decreased healthcare expenses. After the success of the pilot, the QBPC program was implemented state-wide in Louisiana.25

FIGURE 8: QBPC Program – Outcomes27

OBJECTIVE: Reduce healthcare costs and improve chronic disease management via effective risk management

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>BY THE NUMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Performance dashboard reports shared with practices:</td>
<td>10% or greater improvement in baseline measurements for patients with:</td>
</tr>
<tr>
<td>• At the baseline, and 6 month and 12 month marks</td>
<td>• Systolic hypertension 52%</td>
</tr>
<tr>
<td>• Compared the practice’s performance against aggregate QBPC and regional peer groups</td>
<td>• High LDL cholesterol 48%</td>
</tr>
<tr>
<td>• Benchmark the practice against state and national standards26</td>
<td>• Elevated HgbA1c 37%</td>
</tr>
<tr>
<td>• Quality Navigators work directly with the staff of the practices to identify care gaps, improve workflows and processes, identify patients with chronic conditions, and improve the experience of patients</td>
<td>Improvement on quality measures:</td>
</tr>
<tr>
<td>• Providers were incentivized by a payment tier system that rewards providers who are delivering high-quality care, leading to improved health outcomes which translates into overall lower healthcare claims costs26</td>
<td>• Diabetes 12%</td>
</tr>
<tr>
<td></td>
<td>• Hypertension 28%</td>
</tr>
<tr>
<td></td>
<td>• Vascular disease 32%</td>
</tr>
<tr>
<td></td>
<td>• Chronic kidney disease 69%</td>
</tr>
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OUTCOMES

• Improved risk factor management for primary care physicians engaged in a performance improvement initiative
• Increased primary care physician appointments by approximately 30%
HEALTH SYSTEM BEST PRACTICE CASE STUDIES  Continued...

FIGURE 9: QBPC Implementation Model

Symphony Performance
Health/MDI

PATIENT REGISTRY
✓ Patient visits
✓ Population mgmt
risk assessment

SUPPORT SERVICE
✓ Clinical integration tools
✓ Patient education
✓ Provider

Practice Site
Practice Site
Practice Site
Practice Site
Practice Site

Practice Coordinator
Practice Coordinator
Practice Coordinator
Practice Coordinator
Practice Coordinator

Practice Daily Briefings
BCBSLA Quality Navigator
High Risk Patient Management

Nutritionist
Specialist Referral
Pharmacy Counsel
CDE
Home Care
RN Educator

Continuous Quality Improvement CME
• Baseline • 3 months • 6 months • 12 months

Source: QBPC Implementation Model
The Voice of the Organized Customer  
Pharma’s Opportunity to Meet the Needs of Health Systems in a Shifting Healthcare Landscape

The Pharma Opportunity

There is significant opportunity for pharma to partner with health systems in an effort to improve care delivery and patient outcomes. Under new value-based models, health systems have expressed interest in pharma-sponsored unbranded programs that focus on population health management, patient engagement and education, the patient journey, and provider education. Thus, pharma will need to pay greater attention to health systems as the drug utilization landscape changes in tandem with overall healthcare delivery. The number of patients receiving care from health systems is higher than ever before. Pharma needs to adapt and contribute to protocol development, formulary decision-making, and population health management.

By surveying integrated delivery networks diverse in size and geography, TKG conducted research to better understand the working relationship between health systems and pharma, as well as to assess potential opportunities for collaboration.

The survey began by evaluating the health system leaders’ current level of trust with the pharma/life sciences industry on a 10 point scale, with 10 indicating “Extremely Positive” and 1 indicating “Extremely Negative.” 75% of all respondents rated their level of trust between 5 and 7, indicating that the information and services provided by the industry help in improving patient care. Conversely, those respondents that indicated lower levels of trust highlighted the profit motive, product promotion, and an overall lack of prioritization on population health as primary concerns. A leader of a prominent health system commented that “[pharma] is still primarily driven as typical for-profit organizations whose primary focus is to drive shareholder value, which is not always in alignment with the goals of many not-for-profit healthcare organizations.”

The remainder of the survey assessed current use of resources provided by the pharma/life sciences industry, as well as opportunities for future collaboration. While 60% of those who were surveyed indicated that they did not currently use pharma/life sciences industry resources, 93% of health system leaders indicated that they would collaborate with pharma in the future. Moreover, 96% stated that they would consider utilizing unbranded resources in an area of need, notably patient education, disease management, patient experience, Care Team implementation, and market insights.


FIGURE 10: Health Systems Use of Pharma Resources
Q2  Do you currently use any Pharma/Life Sciences industry resources?

FIGURE 11: Key Areas of Collaboration
Q4  What areas of your interests and needs should the Pharma/Life Sciences industry explore that you would support/participate in?

FIGURE 12: Openness to Leveraging Non-branded Programs
Q5  If a Pharma/Life Sciences company had a completely non-branded program in an area of need, would you consider utilizing their resources?

FIGURE 13: Thirst for Pharma-Stakeholder Collaboration
Q3  Would you collaborate with the Pharma/Life Sciences industry in the future?
The Voice of the Organized Customer
Pharma’s Opportunity to Meet the Needs of Health Systems in a Shifting Healthcare Landscape

The Pharma Opportunity

Commercial Effectiveness Methodology for Health System Partnerships

As the survey results reveal, most health systems are willing to collaborate with the industry to address care gaps and improve the process of care delivery. There have been multiple instances of health system-pharma alignment based on standardized care and protocol adherence, multi-disciplinary care coordination, improved HIT utilization, data capturing and sharing, individualized patient engagement and adherence, and staff education and support which have led to improved quality outcomes and decreased costs.

In order to collaborate with a health system, pharma needs to establish the appropriate framework and go to market model. The traditional pharma product training model must be discarded and replaced with a B2B solutions model, requiring both, a different skill set, as well as new customer engagement strategies. To assist in the development of a successful B2B program, we suggest a defined methodology that includes elements of discovery, design, implementation, and Key Account Manager (KAM) training. Of critical importance across all phases of development is the necessity of a cross-functional team that includes sales, managed markets, health system marketing, brands, and customers.

There are two critical success factors that must be incorporated in all development phases to achieve a successful commercial effectiveness strategy:

- **Build the platform in collaboration with key stakeholders.** Privileged insight must be gained from both customers and non-customers. A thorough market assessment is crucial to identify areas for improvement and to tailor resource development and customer messaging accordingly. This should be a phased peer-to-peer interview process with stakeholders across the continuum (e.g., healthcare professionals, C-suite executive, clinical coordinators, practice administrators). Pharma must expand expert input on the program concept and design to include insights from their clients. The C-suite must first and foremost be made aware of the clinical and economic implications of uncoordinated, disease-specific teams and the impact to the system, and then be provided with scalable and adaptable solutions that support adoption of value-based, disease-state specific care.

- **Include field participation at each phase of the commercial effectiveness strategy.** Real world experience should balance the decisions at each commercial effectiveness phase. KAMs must be trained beyond just the program solutions and resources; they must be able to appropriately discuss the landscape dynamics and have the skill set to manage B2B selling.

**FIGURE 14: B2B Solutions Model for Health System Collaboration**

- **Discovery**
  - Defining the opportunity
  - Customer deep dives
  - Stakeholder assessment

- **Design**
  - Build the platform
  - Validate
  - Platform development

- **Implementation**
  - Activate the customer
  - Training and implementation Excellence – Key Account Manager

- **Analyze the Impact**
  - Measurement
  - Tracking
  - Feedback

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PHARMA-HEALTH SYSTEM BEST PRACTICE CASE STUDIES

Below are three exclusive best practice case studies that illustrate points of KAM deployment in four areas of customer interventions.

Enhancing Field Team Credibility through a Turn-Key Population Health Management Program

A large biopharma company enhanced the field team credibility by providing a validated, turn-key, population health management customer program for IDNs. Following an in-depth landscape assessment of best practices and comprehensive market research, the population health management program, including a standardized, patient identification, and referral protocol for IDNs, was developed. Key program elements include:

- C-suite data analytical tools identifying steps to mine EMRs and claims data for patient population
- PCP-facing population screener to identify at-risk patients for quick specialist referrals
- Specialists care coordination and a practice redesign program.

FIGURE 15: Team-Based Care Coordination, Transitions of Care & Data/HIT

<table>
<thead>
<tr>
<th>CUSTOMER TYPE</th>
<th>SYSTEM RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large non-university based academic medical center, founded on providing the best patient care, research and education</td>
<td>Redesigned medical center clinical workflow</td>
</tr>
<tr>
<td></td>
<td>Streamlined 17 specialty-specific order sets to 1</td>
</tr>
<tr>
<td></td>
<td>Conducted primary care education system-wide for the order set usage</td>
</tr>
<tr>
<td></td>
<td>Added therapeutic-specific diagnostic sheets to the patient portal</td>
</tr>
<tr>
<td></td>
<td>Engaged with the biopharmaceutical company’s Health Economics and Outcomes Research team to develop a specialty care area registry</td>
</tr>
<tr>
<td></td>
<td>Implemented a care coordination team with embedded primary care physician teams, specialty teams, and case managers</td>
</tr>
<tr>
<td></td>
<td>Decreased referral appointment wait time from primary care to a specialist from 90 days to 2 days</td>
</tr>
</tbody>
</table>

OVERALL PROGRAM RESULTS

- Program has expanded to 7 therapeutic areas, 147 customer engagements
- Led the biopharma company to win a marketing excellence award and obtain a HIRC ranking of #1 for quality programs
Promoting Patient Engagement through a Series of Customizable Solutions

A global diagnostics company strategically promoted patient engagement through a series of customizable solutions in order to foster a team-based approach to diabetes management, establish account managers as key members of the patient’s Care Team, and encourage patients to become more engaged and activated in their diabetes care. The company engaged customers with four unique offerings, each designed with resources that promote patient engagement and team-based care, including:

- An evidence-based approach to lower A1c levels
- A cloud-based mobile diabetes management system
- Personalized coaching for patient activation
- Care Team resources to support a team-based approach to diabetes management.

FIGURE 16: Team-Based Care Coordination, Patient Activation

<table>
<thead>
<tr>
<th>CUSTOMER TYPE</th>
<th>SYSTEM RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large integrated health system in</td>
<td>• Facilitated diabetes management on a personal and population level through in-</td>
</tr>
<tr>
<td>the Mid-Atlantic</td>
<td>clinic and remote monitoring of patient blood glucose levels</td>
</tr>
<tr>
<td></td>
<td>• Provided timely access to glycemic information for patients, caregivers, and</td>
</tr>
<tr>
<td></td>
<td>other Care Team members</td>
</tr>
<tr>
<td></td>
<td>• Management system included algorithms that flag patients displaying at-risk</td>
</tr>
<tr>
<td></td>
<td>glucose trends and sorted patients by various glycemic categories allowing for</td>
</tr>
<tr>
<td></td>
<td>timely and appropriate interventions</td>
</tr>
<tr>
<td></td>
<td>• Streamlined workflow to help maximize consultations with patients and</td>
</tr>
<tr>
<td></td>
<td>substantially improve patient engagement</td>
</tr>
<tr>
<td></td>
<td>• Utilization of platform resources to create a meaningful dialogue between</td>
</tr>
<tr>
<td></td>
<td>patients and their Care Team members</td>
</tr>
<tr>
<td></td>
<td>• Enabled the system to track metrics and analyze success factors</td>
</tr>
</tbody>
</table>

OVERALL PROGRAM RESULTS

- Demonstrated the value of account managers in the patient’s Care Team thus increasing field team access and enhancing pharma-customer relationships
- Company is now seen as a trusted partner in patient engagement and population health management strategies
- Leveraged metrics to enable appropriate pharma interventions and potential for increased ROI
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Engaging Customers Utilizing the Patient Journey

A leading pharma company implemented a patient-centric, team-based care program to enhance strategic dialogue with customers within therapeutic areas. It highlighted simple strategies to improve health system performance on key quality metrics, specifically:

- Practice resources (e.g., roles and responsibilities task grid and patient journey) to coordinate Care Team members
- Patient education resources to improve health literacy and promote medication adherence and patient self-management.

“It is an excellent program going down the path of integrated care. It was very timely and well put together – we have had so many opportunities based on this program.”

Chief Medical Officer at a Large Health System

FIGURE 17: Team-based Care Coordination, Patient Engagement

<table>
<thead>
<tr>
<th>CUSTOMER TYPE</th>
<th>SYSTEM RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not-for-profit health system</td>
<td>• Coordinated Care Team activities to ensure appropriate deployment of personnel</td>
</tr>
<tr>
<td></td>
<td>• Standardized discharge protocol</td>
</tr>
<tr>
<td></td>
<td>• Conducted provider education around patient engagement</td>
</tr>
<tr>
<td></td>
<td>• Improved patient self-management and medication adherence</td>
</tr>
</tbody>
</table>

OVERALL PROGRAM RESULTS

- Implementation in 29 accounts with a reach of over 400 healthcare professionals and over 10 million patients
- Additional corporate partnerships
- Enhanced customer relationships
Outlook

As we have argued in this briefing, the pharmaceutical industry should embrace the opportunity to partner with health systems to navigate the rapidly changing healthcare landscape. Most health system leaders are opening their doors to collaborate, refuting the perception that health systems do not utilize any pharma resources. As the survey results in this briefing reveal, health systems have noted the importance of leveraging pharma’s unbranded programs to improve outcomes, while preferring to avoid any promotional program models. Given this preference, the unbranded platform represents one of several avenues pharma could pursue to achieve a successful B2B partnership with health systems. As systems are moving towards value-based models, pharma can also play a role by assisting them with team-based care coordination, transitions of care, patient engagement, and health information technology application.

“The disconnect between strategy and sales is costly, dangerous and pervasive... relatively few strategies – some studies indicate less than 10% – carry through to successful execution and, on average, companies deliver only 50-60% of the financial performance that their strategies and sales force forecasts promise.”

Frank Cespedes, Senior Lecturer at Harvard Business School

TKG market research indicates that there has been some improvement in B2B program design and execution; however, the majority of pharma’s current go to market strategies do not achieve the expected results. It is pivotal to develop and execute B2B programs based on a validated commercial effectiveness model that meets customer needs.

“I wish that pharma would stop bringing me tactics and bring me solutions.”

Chief Medical Officer at an East Coast Large Medical Group

“The best tools we use from pharma are unbranded, short and simple pieces.”

Chief Medical Officer of National US Payer

“If pharma approached our team, in terms of how do we improve outcomes and save money as a partner, they would find very open access.”

Practitioner at a Midwest Medical Group

The traditional pharma “go to market” model is frequently based on a series of independent, internal initiatives with limited coordination. For example, healthcare landscape analytics are executive level consulting projects, burden of illness data analytics are HEOR projects, marketing platform development models are agency projects, and key account training is a project led by a separate internal department. This fragmented structure can isolate best practices and critical intellectual property learned from each initiative, negatively impacting the commercial effectiveness strategy.

It's time for a change.
References


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References


24 Personal Interview of John Walker, MD. Conducted August 4, 2015.


27 Data was based on QBPC clinics that had been in the program at least 3 months as of October 2014 and were active throughout 2014.