



PHOTOS BY BILL BERNSTEIN

Tomorrow's rep, tomorrow's market

Pharmaceutical
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What do pharma's insiders think about the future of the industry? And what changes are in store for reps? We put together a panel of executives to find out.

It's no secret that the pharmaceutical industry has been going through big changes, with doubtless more on the horizon. Industry-wide layoffs, a looming election, and changing public perceptions are all having an impact. How will pharma companies staff their organizations? And what does this mean for the existing sales model? What kind of skills will the "new" rep need?

Pharmaceutical Representative, along with its sister publication, *Pharmaceutical Executive*, convened an executive roundtable to discuss these questions and more.

A QUESTION OF MODEL

JOANNA BREITSTEIN (executive editor, *Pharmaceutical Executive*): News of sales force downsizing has captured headlines, but how do these layoffs correlate to pharma's changing sales model?

DAVID SNOW (vice president, commercial operations, AstraZeneca): We largely make decisions on size and structure based on where we're going strategically with our portfolio. Everyone would like to be a primary care company, if the portfolio supported that. But most product portfolios are moving toward specialty. And if you have specialty products, then you probably don't need as many people in your sales force.

SANDY JENNINGS (senior vice president of selling solutions and operations, inVentic Health): Overall, we see that large and emerging pharmas are looking for a more flexible model, where they can quickly respond to FDA delays or generic hostile intrusion that is really challenging the patent expirations of some major brands. They need to create models where they can upsize and downsize without having to put out a press release to the financial community. Contract sales organizations can help them do that.

It's difficult for pharma companies as they optimize their field force structure to determine how long that optimization will

last. Ideally, you'd like to get two or three years out of the structure that you put into place.

MATTHEW HERMAN (editor-in-chief, *Pharmaceutical Representative*): Many companies are moving to the specialty model. How does the change manifest itself at the rep level?

TODD LAMBERT (national sales director, GI business unit, Shire): Big Pharma is looking at some of the ways smaller companies operate.

Specialty companies hold reps to higher standards and see that as an opportunity to create some equity for the company. That means reps will have greater access and asking power down the road, and the company can keep their name out there and continue to feed their commercial business units with more products.

RICK ROSENTHAL (associate principle, director of sales force effectiveness research, Health Strategies Group): In primary care and specialty offices, the way reps are effective ends up being very different. In a typical primary care office-based call, reps must understand what it takes to generate the intent to prescribe a drug and how to remove the roadblocks to that prescription.

An effective specialty representative encompasses all of that, but they also become

much more embedded in the delivery and the healthcare system around that condition. There's much more involvement in medical societies and patient-advocacy groups – the rep becomes a real player in how that condition is treated in their territory.

JENNINGS: Throughout the years, the rep/physician relationship – making sure that there was impact in the office – was such a key focal point. But today, doctors don't have a lot of time for small talk. They're looking for a more scientific approach and a more scientific message – and that's an important area for training. In some ways, it's almost like going back to where we started in the industry many years ago.

BREITSTEIN: All companies say reps should add value to the healthcare equation. Are these new approaches working? How can you tell?

ROSENTHAL: A relationship and ongoing conversation about the rep's products and services has to be present. With the constant realigning in the industry, it can be a challenge just to overcome that first hurdle.

Then we can see if the physician is satisfied with the relationship and values the time he or she spends with the representative. When those elements are present, at least at a basic measurable threshold level, you could say there's value.

SNOW: In the past, we were trying to coordinate 10 or 12 different selling teams in primary care. Top-tier physicians could have as many as 175 reps across the industry calling on them. That's not being customer focused, I'd say.

We started to do some research in 2004 around other options out there, and we tested several variables to understand what might work for us. However, I want to emphasize that the portfolio dictates a lot of what the structure of your sales force will be.

In January, we altered our sales force structure to drive fewer faces. But we found the real benefit is that it clears up a lot of the complexity of trying to manage across 12 different teams – that difficult dance reps do to keep out of each other's way on a four- or six-week cycle.



That's made the reps feel more accountable, because they have ownership over their practices in key physician relationships. And it helps us to be much more flexible in driving changes, and understanding what's going on, at the physician level. It's really been a good change for us – and other larger companies' experience has been consistent with that. Lilly and Merck have also been down that path.

COUNT ON ME

HERMAN: Accountability is not a new concept in pharma sales. But we're hearing more about it. Are companies using accountability in a new way?

RICK KEEFER (chief operating officer, Publicis Selling Solutions Group): Accountability is what has generally appealed to high-performing reps in the specialty market. It's what attracts the high-performing rep to say, "Let me show you what I can do."

Now, in the large primary care sales forces, pharma companies are trying to assign product accountability and responsibility to one rep, rather than a pod or a multitude of reps. It's changing the model. We're now seeing a different profile of rep that companies are beginning to hire because some reps don't like that accountability. It's hard to hide.

PAUL STICKLER (senior director of sales, Ovation): I've seen that holding reps more accountable for their activity drives superior performance, and that performance is going to drive more value. It's a simple thing that really can make a big difference.

BREITSTEIN: How do you make reps accountable?

LAMBERT: Well, sales, right? Ultimately, sales is about driving prescriptions – it's the metric that analyzes your impact and ability to influence prescribing behavior.

SNOW: I'd be careful about suggesting that it's only about the prescription. We care a lot about the quality of the call, and we recognize that it's a bigger world out there than just this rep/physician relationship and just driving a message and driving an Rx.

NEW MODEL, NEW SKILLS NEEDED

HERMAN: Are companies redefining the profile for representatives? What are the skills reps must possess to be successful in the new sales model?

SCOTT HULL (manager of field sales technology, Abbott): We need to make reps smarter and better able to handle multiple products across disease states. But they need to have more than just product and disease knowledge. It's about knowing the payer mixes and the lifecycle of the product, which has relevance to how reps promote and bring value into doctors' offices. That takes a much higher level of business acumen on the part of the rep.

ROSENTHAL: Based on a study on business acumen among sales reps and regional and district managers, I can tell you that pharma companies generally think of business acumen

as a collection of facts reps can recite and knowledge they appear to have.

But what differentiates them from their peers is not what they know, it's what they do with what they know. I would encourage each company to think more about getting people to translate knowledge in their head into the actions they can take.

HERMAN: How?

SNOW: The field sales force has to be more focused on solutions and on patient outcomes. That means that, from a brand standpoint, reps have to be able to convey solutions for the practice and for the patient long term.

JENNINGS: Before we can prepare our reps, we have to define what the profile of that rep should be and the actual role they're playing in the practice. I see a lot of pharma companies using the tiered approach by having a sales representative, a customer-service rep, a medical-science liaison, a clinical-nurse educator, on-call nurses, and others approach the practice. And as we start to look at doctors' offices more around therapeutic area, we can plug and play those different roles so we can offer the doctor a full understanding of the disease state, therapeutic class and the offerings to treat their patient population.

TRAINING DAY(S)

BREITSTEIN: Do pharma companies have the necessary training systems in place to ensure that reps have the skills they need?

LAMBERT: From a pure training perspective, Big Pharma does a pretty darn good job of investing in their people. Having been in specialty, I've looked at hiring Big Pharma people simply because of the rigor and discipline that they've had in their training.

ROSENTHAL: But training is a temporary state of affairs. District managers are only with an individual rep one out of 40 or 50 days – if they're lucky.

JENNINGS: It's important to understand how these managers are going to coach the reps. We have a population of first-line managers that don't have the experience around the scientific approach. Even when it comes to business acumen, depending on the pharmaceutical company you've worked for, you might have been exposed to only a very narrow scope of what a district manager might do. We need to make sure the district managers know how to be successful, because they are the number one reason reps leave the job.

SNOW: You also have to consider that the variability of reps across the United States can be quite large. Distance-learning platforms can help the industry in diagnosing individual rep needs, which is different than

a one-size-fits-all three-day event.

KEEFER: We're also seeing the benefit of new gaming technology that puts very high science into a training format that reps can identify with. That's really starting to mushroom

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in terms of interest in the industry.

GO-GO-GADGET REPS

HERMAN: Within the sales organization, where are companies finding the most success with new technology?

STICKLER: We have only 51 representatives across the country, divided into two different sales forces and two different therapeutic areas. We've made a decision to go with the tablet PCs and electronic promotional material.

One of the quick learnings is that sit-down meetings are by far the most attractive venue to use tablet PCs and promotional material. There's a lot of intrigue by the healthcare professionals, and they're giving us a lot more time. In other situations, that

doesn't work as well – like when reps have hallway conversations and other quick, impromptu meetings.

SNOW: We've broadly deployed tablets in specialty and in primary care and have been working with the technology for over a year.

Traditionally, sales reps used printed promotional material about 25 to 30% of the time. With interactive technology, that can be substantially higher. But what we've seen is about garbage in/garbage out – if the interactive materials are good, then you can have impressive results.

BREITSTEIN: Has anybody had a different experience with tablet PCs?

ROSENTHAL: There's been a lot of hype around tablet PCs and how they are going to transform the sales force. But we've been trying to measure exactly what it is that they do – what do they transform? Most physicians have participated in a detail that included a tablet PC. And we know with the exception of oncology, most specialists don't prefer it. In fact, they much prefer to view patient assessment and education materials, or clinical reprints, or a visual aids, in a call.

In just trying to dig into this a little more, we

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think that that's because a tablet PC doesn't make a rep any more effective anymore than a telephone makes you a better communicator. It's still only a tool.

STICKLER: Tablet PCs look like they can have other benefits though. In particular, we think it can really have an impact in terms of dollars and cents as we look into the future and the concept of rapid delivery of new promotional materials. For instance, think about product launches. The sales force can simply download the materials, which can shave off a number of days between the customary paper launch and electronic launch.

The other thing is in the hospital selling environment: It's not uncommon for providers to ask reps off-label questions. The standard approach would be for the rep to give the doctor a business reply card, and the physician would sign it and fax it in. With tablet technology, we can capture a signature, confirm that the physician is, in fact, asking an off-label question, and then send them an answer to that question right then and there. It's a nice value-add.

SNOW: One thing to watch for here is FDA's capacity to review these materials. It is a real challenge, and we certainly hope FDA can move forward on the digital materials, because that's a real area of opportunity for the industry at large.

BREITSTEIN: How do companies view electronic detailing efforts as compared with the more traditional approach to sales?

LAMBERT: One-to-one is still going to give you the greatest impact and the highest return.

ROSENTHAL: The number of rep-guided e-details has been consistent over the last couple of years. But we are picking up a trend toward increased acceptance by physicians for self-directed e-details. The accept-

ance rate by physicians is marginally higher than it is for dinner programs the reps invite them to.

If that trend continues, companies will see that channel as worthy of investment. The effectiveness of them, I can't speak to yet.

JENNINGS: It's given small pharma companies – those that simply can't afford to put



representatives in practices – a chance to act big. They are building platforms where doctors can have an e-detail with a rep, and then go online and order samples, or sign up for a net conference.

HULL: I'm somewhat of a cynic until I see it. We can't get too far ahead of ourselves. After all, the organization first has to have the internal fortitude to have the systems in place that can use this information for the benefit of sales and marketing. If you don't have those underlying operating systems that support all of the new information, what's the point?

BREITSTEIN: Many Big Pharma companies are working under corporate integrity agreements. Is there a natural intersection where technology can monitor compliance?

JENNINGS: We have to find ways to prove that we are providing a scientific or a clinical message to doctors that will benefit their

patient population and increase the wellness of our communities. As the technology changes, we're going to have sources, like with tablet PCs, to prove that we are doing that, even down to the page or the chart being presented in the doctor's office.

At some point, there will be some tie-in – even from an incentive standpoint – to make sure that reps drive the right message and we have proof sources to demonstrate that they are compliant and selling on label.

MANAGED CARE IMPACT

HERMAN: How will the industry modify its sales approach to handle the increasing impact of managed markets?

HULL: We've seen huge growth at Abbott in the managed care system that supports our customer units. And throughout the rest of the industry, I see more of an account-based sales force as well.

JENNINGS: Some of our larger clients are beginning to understand where the access is and explore the regionalized approach – again. They're experimenting and trying to maximize their dollars within each geographic area.

HULL: The situation is driven by physicians, who are now employees. My wife is an internist. She's told what to prescribe by people who sign her check. That's why we've all seen a decline in our sales rep responsiveness with our customers. It changes the dynamic and the rep/physician relationship.

STICKLER: One area that has not been affected as much by managed care has been in the hospital. And that's been a very nice place to operate as a company because all of our products are covered under a DRG (diagnosis-related group).

SNOW: For those of us who have been in the industry a while, to hear that the hospital market is so attractive just gives you an idea of what we're facing today.

We're working hard to maximize access, but by no means have we got that whipped. It's a challenging environment and changing every day. Medicare Part D had a lot to do with the change.

BREITSTEIN: With this year's election, what will – and won't – change for reps?

SNOW: The US government is the largest customer – and that's not going to change. I think we all take pause when we think about what could potentially happen down the road.

ROSENTHAL: The increasing importance of government as a payer for the pharmaceutical industry has larger strategic implications outside of sales forces for how companies price and market its products. But if the effect of government's involvement is to fund a benefit through plans, then the job of the representative isn't going to dramatically change. Maybe the rules of the game will shift, but I don't expect there

to be a dramatic impact.

HERMAN: Looking to the future, the challenges seem to grow even greater. What is the prognosis for reps? Can they still succeed?

STICKLER: Restricted access to physicians is going to continue to be a real challenge for the industry. In an issue of *Newsweek*, there was an article called "Thanks, but No Thanks." It described a number of medical schools, hospitals and doctors offices across the country that have basically signed up to say, "We're not going to accept any representatives' visits at all."

KEEFER: It's true – as physicians become less of a decision maker about what to prescribe, their need to see reps is sometimes perceived to be less. A lot of offices have shut out reps due to state, clinic and hospital regulations.

At the same time, clinics in the retail drug stores are rapidly ramping up, staffed by

nurse practitioners or physician assistants. That's new to the industry, and we now have to be able to put that into the mix.

ROSENTHAL: Reps who face the same managed care hurdles still demonstrate a wide variety of performance results at the end. So even though managed care can set up roadblocks that make it more difficult, you still find reps, regardless of the environment they're in, that outperform people with the same market dynamics.

SNOW: Obviously with single-payer systems in Europe, you still see lots of personal selling. We can take some satisfaction in recognizing that in markets where the margins are lower and the challenges higher, personal selling and conveying information is still an important part of the industry and is seen as valuable by the physicians in those markets.

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