Has Traditional Call Planning Passed Its Prime?

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> By failing to prepare, you are preparing to fail.
>
> ***Benjamin Franklin***

1. Why Current Traditional Call Planning is No Longer Sufficient

1.1 Is Call Planning Still Important?

The short answer to this question is most definitely "yes," and probably more important now than ever before. This answer may surprise some people, especially as many have noted, that sales reps are soon to be an extinct species, given the shift to highly specialized targeted personalized medicines, and that traditional sales functions are no longer needed. In addition, the advent of digital technologies, social media, alternative promotion channels, the evolving role of medical science liaisons, the significant influence of payers in determining treatment choice and drug access, and increasing sales rep access restrictions to physicians, will make traditional sales activity either unnecessary, insignificant, and/or unable to engage healthcare professionals in a meaningful way. We argue just the opposite. Yes, the background of a sales rep will have to change given the shift to specialty medicines like those seen in oncology. Sales reps will need greater technical knowledge to disseminate scientific, medical, and clinical knowledge given the complexity of new medicines, like biologics and genomic-based therapies, and due to the lethality of the diseases treated. Further, the "selling" process has become much more complex. Today's process requires a greater focus on information delivery and coordination with multiple individuals. This focus and coordination are necessary not only in securing approval for drug treatment use in a hospital, group practice, or healthcare system but also in obtaining reimbursement by payers and access to patients. Following the patient journey through the healthcare system is necessary to achieve the predicted health and economics outcomes. This means more than ever; it is essential to have an efficient operations process to allocate the resources effectively and messaging needed to achieve strategic commercial outcomes.

The preceding backdrop means that call planning is even more essential today than ever. The question this white paper attempts to answer is thus not whether call planning is needed, but rather ***what adaptations are necessary to traditional call planning*** for this essential sales operations process to keep up with the many changes occurring in the pharma environment. Annual pharma company spending on their sales force is still among the single largest line item in the budget, and according to promotion-response and marketing-mix analyses, remains a significant driver of sales revenue and contribution. The changes in the pharma environment from a strictly volume-based to a more value-outcomes-based commercial model design (CMD), will require adaptations in call planning to this new framework. This paper will explore those adaptations companies need to make to call planning to ensure the achievement of strategic sales force objectives.

1.2 Origins of Pharmaceutical Call Planning

Before learning how pharmaceutical call planning must adapt to the future, we need to understand the origin of the current call planning process. Pharmaceutical call planning has evolved over the past for almost 70 years. The origins of

detailing and hence the need for call planning on prescribing physicians likely begins with the 1951 Food, Drug, and Cosmetics Act Amendments, or the Durham-Humphrey Amendment in short. This law required the dispensing of a drug to be supervised by a health practitioner with the prescription drug carrying the now familiar statement, "Caution: Federal law prohibits dispensing without a prescription." Meaning, physicians now had the power of prescribing. Pharmaceutical companies quickly realized the effect of this law and shifted their detailing activities to physicians as the center of their promotion. Greene (2007) provides an excellent review of the history of pharmaceutical marketing research and the prescribing physician.[1] However, sales reps needed guidance as to who to call to disseminate medical information about new drugs and influence prescribing behavior. But hard data was lacking. How did sales reps know who to call? Resourceful reps used phone books, memberships in local medical societies, and by talking to pharmacists to determine the most frequent prescribers. Lastly, Greene (2007) points out that the system of detailing was something derived in coordination between the medical profession and pharma companies. The medical profession needed an efficient process to receive information on the latest drug developments from pharma companies. Detailing provides that efficient mechanism of information dissemination. Thus, the origin for call planning is rooted as a process means to inform efficiently physicians on the latest medicines, their administration and appropriate use, and the existence of potential side effects.

However, the development of an efficient call planning process ran into an immediate obstacle. Physician-level data did not yet exist. So, sales reps needed to generate data on their own and compiled from a variety of sources. This was crude and unscientific. Another issue was the need for a modeling methodology to optimize sale force effort to physicians. Forward a few decades, Lodish (1975) is credited with creating the scientific analysis of sales territory alignment to maximize profits and the related problem of specific call frequency determinations.[2] However, data limitations on physician-level prescribing information still existed. That problem was eventually resolved by the creation of physician-level prescriber data in October 1993 by IMS. This data allowed for greater granularity of segmentation, sales rep targeting, and physician-level sales response modeling. This data led to an explosion of improvements in the optimization of sales force investment, territory alignment designs, physician-targeting, call planning, objective setting and incentive compensation design, sales reporting, and sales management. These improvements have refined over the past 25 years.

1.3 Current State of Call Planning

Since the creation of physician-level prescriber data, pharma companies have taken different approaches to the scientific analysis and execution of call planning as envisioned by Lodish. Current call planning is a sales operations process that traditionally comes after territory alignment. The traditional purpose of call planning is to guide the sales reps within each territory on the amount of effort each product the business wants direct towards the physicians to achieve company and brand-level revenue and contribution objectives as well as other commercial stragegic goals. Call plans typically should guide a well-incentivized, well-coached, and well-informed sales rep perform as per expected goals. We know sales reps are not robots. Sales reps will deviate from the call plan, even under the best of sales force operations processes for a variety of reasons. Thus explains the crucial role of a first-line sales manager (FLSM), whose function, among others, is to minimize this deviation through effective coaching, mentoring, and reviewing activity metrics to ensure that the sales reps follow the call plan. A well-constructed call plan accounts for typical 'deviations' that may occur in the field. Sales reps collaborate and provide inputs for these deviations. Thus, the call plan system builds in some "slack." So, when headquarters calculates the call plan adherence rate per sales rep (the total number of calls made toward plan targets / the total number of calls according to the plan), a compliance rate achievement of something less than 100%, say 90%, is still sufficient to deliver on sales force strategy goals. Therefore, current traditional call plans focus on the *allocation* of sales force *effort* delivered to predetermined physician targets as dictated by the brand-level segmentation.

Sales rep activity is then linked up to effort-driven and segment-level sales-response models to project how each brand will perform to ensure all sales force strategy outcomes are on target. This process establishes itself on the principle of the "reach-frequency" model where the higher frequency of calls on physicians that matter (according to the segmentation analysis) are given precedence over physician reach to achieve higher sales, as per the 80-20 rule (or, most of the brand prescriptions are concentrated amongst a small set of physicians). The focus here is on delivering and measuring "transactional" sales rep activity based on a "persuasive" selling model on physicians. Pharmaceutical empirical studies have shown that despite the resistance by some companies to have specific and directed call plans, sales achievement is greater with such a process in place, than without. The next section will explore whether the current practices of call planning need adjustments, a complete overhaul, or a repurposing given changes in the pharma environment.

1.4 Is Current Call Planning Becoming Obsolete?

Is the call planning process as currently executed becoming obsolete? Is new thinking required, especially given the industry's shift to specialty personalized medicines targeted to smaller and often orphan drug-like patient populations? We believe the answer to both questions is an emphatic "yes." This does NOT mean we believe call planning should stop, but rather, rethinking and repurposing (or adaptation) is required given significant trend changes occurring in the pharma environment.

Industry practitioners realize the growing obsolescence of the primary detail equivalent (PDE)-driven transactional sales model which is the objective metric behind call planning execution.[3] A sample of pharma practitioners on both the client and consultant side responded to a Spring 2015 survey conducted by researchers with the assistance of the Pharmaceutical Management Science Association (PMSA) to determine the focus of future emerging sales force issues.[4] The survey focused on 5 sales force (SF) management areas: strategy, operations, analytics, big data, and environmental changes.[4] Survey respondents were asked to provide their top 2 leading items of focus for current and emerging (beyond 2 years from 2015) sales force challenges in each of the 5 areas.[4] The report highlighted results of the top two leading issues from all respondents. The following 2 issues were listed as the emerging challenges in SF strategy: a) institutional sales forces, especially for integrated delivery networks (IDNs) and accountable care organizations (ACOs), and b) outcomes and value-based messaging.[4] Furthermore, under sales force analytics, health outcome / cost-effectiveness analysis was the leading emerging issue identified among industry practitioners.[4] These survey results correspond to changes in the US pharma industry, rapidly focusing its attention on specialty-based medicine portfolios that are now approaching 50% of total medicine spending.[5] Speciality therapies and orphan drugs for rare diseases will drive future spending growth and medicine use, but overall net spending (inclusive of all discounts and rebates) will temper pricing pressures in the system and possible policy changes.[6]

Oncology is the therapy area of greatest focus for development and new drug launches, for a variety of reasons, and now seen as the primary driver of future sales among a growing list of companies.[7] The oncology therapy area epitomizes the changes in the pharma environment and requires a different "selling" approach as opposed to primary care therapies (or to primary care physicians (PCPs)). This different selling approach raises questions on the value of traditional call planning currently being followed by many companies. Oncology drugs provide insights into the changes needed in the development and execution of call planning for the future. The selling of such drugs requires a more in-depth scientific/medical/clinical discussion than PCP-driven medicines. Sales and marketing must gear for "informative" as opposed to "persuasive" promotion, the latter being the basis of current traditional call plans.[8]

Further, the success of a drug requires various touchpoints between industry representatives and the healthcare system, and during the patient journey than a simple metric captured by a PDE of calls between a sales rep and physician. Also, oncology medicines are far more expensive, and health plans, PBMs, patients, and healthcare providers need to see the value for adoption and continued adherence as compared to traditional primary care drugs. Therefore, overcoming the challenges of drug access and affordability are critical to drug success, and they require value-based messaging and dissemination of evidence of improvements in health and economic outcomes. The difficulty is empirically demonstrating that disseminating scientific evidence on drugs leads to higher sales, though developments in the marketing science literature have provided some guidance.[9-11] Nevertheless, call plans must adapt to a changing pharma environment and move beyond providing sales reps with transactional persuasive effort guidance to more of a value-based approach. The next section explores different changes to current traditional call planning.

2. Going Beyond Traditional Call Planning in a Changing Pharma Environment

This section will provide further avenues that sales operations teams can take to adjust to current call planning methods and utilize analytics of data from call execution in response to a changing pharma environment (deviations from current practice).

2.1 Simple Additions to the Call Plan (adding raw data and results from simple calculations)

a. *Differential Messaging by Physician Segment (periodically updated)*

Currently, call plans are effort-based which they have been traditionally. However, the more significant effect of calls, especially to specialists, is not on the number of calls made, but on the quality (or the degree of customer engagement) as measured by message delivery, delivery effectiveness, and sales rep-physician relationship. So, call plans can include the physician segment designation (by letter or numeric) next to each physician name, which would signify the nature of the content, specific to that segment, that will resonate with the target specialist physician, based on the segmentation analysis. Content can be delivered via a tablet, which not only provides visual slides but also and more importantly, allows for the viewing experience (and the length of content exposure) to be digitized into a physician database for analysis at a later stage. This adaptation has implications on sales rep hiring and training. For example, let's say a sales rep carries 4 products in their bag, and each product has 4-5 physician message segments. Meaning sales reps must learn 16-20 differential messages and know how to seamlessly navigate each message across multiple drugs they may detail during the call. The technology can help in linking each physician segment with the preferred message for the segment. So for this adaptation to work well, the call planning process would require a good physician segmentation analysis, an excellent sales training group, experienced FLSMs to coach the sales reps and contemporary technology to adapt each message into iPad/Android content. It would also mean hiring sales reps who have the necessary skill set to deliver on this adaptation.

b. *Identify the Extent of Sales Rep Access Restriction by Physician (periodically updated)*

Unfortunately, the physician specialties targeted by pharma companies are the most sales-rep access-restricted according to data provided by 3rd party groups that monitor this trend.[12] For example, oncologists are the most access-restricted according to a 2016 report, with 55% reported as access restricted and 27% severely access restricted, both being the highest percentages across all specialties covered.[12] The call plan can provide the sales rep with the physician-level access restriction numerical designation provided by AccessMonitor™ such as 8-10 accessible, 4-7 access restricted, and 1-3 severely access restricted.[12] This way, the sales rep can assess which physicians may require alternative means for access to disseminate necessary and useful information. Sales rep contacts on physicians greater than the average industry metric should involve sharing those methods used to generate that access with other reps facing similar restrictions. Sales reps with access less than the industry average should involve the FLSM to investigate and coach the sales rep to improve access. The plan should factor in the number of calls achievable as per sales rep access restrictions. Previous industry studies show a significant cost to pharma companies as a result of building in an unachievable level of calls into the plan. Another cost to be considered is lower sales rep morale as a result of unattainable call plans resulting in lower sales, thus leading to a lower incentive compensation reward. Therefore, it is imperative to build sales rep access restrictions into the sales force strategy analysis and operations processes.

c. *Payer Plan Distribution of Rxs Paid (weekly updated)*

Data readily exists at the physician-level to know what percentage of patient Rxs are paid via 3rd party commercial (and by top plans), Medicare Part D, and Medicaid. "Payer service reps" engage office personnel on the payer distribution of patients seen by physician. This information is important for sales reps to know, especially if one the key messages to deliver concern access and affordability by patients, and to coordinate effectively with "payer service reps."

d. *Patient Adherence Rate by Product (monthly updated)*

Anonymized Patient Level Data (APLD) now allows companies to calculate the patient adherence rate for a physician by each product. Knowing the trend of this rate is essential if a pharma company wishes to enter into a payer performance contract based on the achievement of health and economic outcomes. Target health and economic outcomes are more likely to be achieved as the patient adherence rate increases, meaning patients receiving the indicated benefits of the drug according to the FDA-approved label supported by the clinical data analysis. If the adherence rate is trending as falling, this tells the sales rep to engage the physician to determine reasons for the occurrence and take corrective measures to address it.

e. *Physician Group Practice and/or Institutional Affiliation*

Following the patient journey through the healthcare system is critical to ensure that they are receiving the maximum benefit from their drug utilization. Patients taking specialty medicines for diseases that often require institutional visits would mean tracking them between office-based and institutionally-based physicians. This would also mean coordinating activities with sales reps who have strictly institutional responsibilities.

2.2 Complex Additions to the Call Plan (applications of "Triggers", AI/ML and NBA analysis)

The most promising areas of adaptions to call planning come from the applications of "Triggers," Artificial Intelligence (AI) / Machine Learning (ML), and Next-Best-Action (NBA) solutions. The movement to specialty medicines, many times involving small physician segments and patient populations, means there needs to be speed in identifying threats and opportunities, and in formulating a response to guide new and next sales rep actions. The combined use of all the previously mentioned applications in the white paper, can more efficiently alert sales reps and recommend new actions, all done in real-time. Such applications require expertise in the areas mentioned above, analyzing and deriving insights through various modeling techniques of both unstructured and structured data, and translating insights into new actions. This section provides a non-exhaustive list of examples.

a. *Using "Trigger" Analysis to Identify Threats and Opportunities*

   Sales reps need to be alerted to reduce the risk when a physician may be considering turning to another drug, or to increase the opportunity to acquire potentially a new target). This means having a strong analytics team that can use predictive modeling to identify a threat or opportunity at the physician level and then alert the sales rep of this insight, along with a prioritization scheme to allow the rep to decide who to go after and when to go after that target. Threats can include moves by physicians to other branded competitors or considering switching to a generic or biosimilar drug, and opportunities would consist of switches occurring in the opposite direction.

b. *Applying AI / ML*

   The use of AI / ML represents platforms that drive new insights for sales rep to consider new actions. If robust predictive/simulation models can be derived, with little human intervention, then sales reps can be given more time to prevent an adverse action or move quicker on an opportunity, meaning a higher chance for success. Critically important is that AI / ML be used to analyze both unstructured and structured data. Unstructured data could be reports filed by service reps coming to the office and by fellow team sales reps that provide indications as to future physician behaviors and decisions. Both physician and patient-level structured data also use such applications. Trend analysis of physician-level Rx data can give indications of switching and adoption behaviors. A similar analysis of patient-level APLD can be used to predict the likelihood of patients using a drug under the supervision of a physician to achieve target health and economic outcomes needed to support payer performance-based contracts. Sales reps can provide insights to their target physicians regarding the performance of patients under their supervision. Medical science liaisons (MSLs) can be

brought in to give a more clinical/medical explanation, and possible steps physicians can consider to improve patient outcomes. These innovations allow for both more effective sales achievement and improvement in patient outcomes. The latter type of analysis requires a bringing together of real-world evidence (RWE) and health economics and outcomes research (HEOR) into commercial operations.

c. *Applying NBA Analysis*

The primary objective of any NBA solution is to guide sales reps to opportunities in more real-time. Much of the data that is needed to build an NBA engine exists within the pharmaceutical company. However, sales reps are not trained to analyze large volumes of data and take the right action. The NBA solution analyzes large volumes of data from multiple sources in more real-time and recommends the best action a rep can choose to engage with his/her targets. The action can either be to deliver the right message or to use a particular tactic (such as email or virtual detail) to engage with their targets. Any successful implementation of an NBA solution requires sales reps to buy-in to the solution. They need to believe that using the NBA solution can help them engage with their core targets in a more meaningful manner, which in turn, can lead to more desirable outcomes.

d. *Using Forecasting and Prediction Analyses*

A critical problem in the current call planning process is the existence of data lags that form the basis of any solution. Many times, the data is already 4-6 months old by the time the sales rep sees the call plan for execution. This means the sales reps is working to achieve objectives with old data that may not represent current market dynamics. How can this problem be rectified? One way is to use forecasting and prediction analyses to project data elements used in the sales force optimization analysis that would be subject to potential change and determine whether such changes require alterations in the territory alignment and subsequent call planning processes. A pre-determined decision-criteria could be established to say that changes beyond a specific percentage limit (e.g., 2-3%), would warrant adjustments. While this would begin to address the data lag problem, it would come at the expense of generating other potential issues, such as introducing forecasting and prediction risk and error. Nevertheless, the question of data lags is real and significant, and undermine the faith and confidence of sales reps in the call planning process. Whether the solutions are what we have suggested using forecasting and/or prediction analyses, or something else, the answer to this question lies with the use of technology and analytics.

2.3 Adding Visualizations to Call Planning for the Sales Rep

Headquarters must also provide sales reps with easy-to-read call plan visualizations on their progress in delivering on all key performance indicators (KPIs) from activities to outcomes. Each KPI should have its own gauge with an arrow pointing to their current progress, using different colors to note current achievement expressed as a percent of goal (e.g., "red" for high risk of failing, "yellow" for moderate to low risk of failing, "green" for being on goal, and "blue" for being significantly above goal). These visualizations should be updated real-time or weekly so sales reps can accurately assess their progress and make course corrections. In addition, a verbal summary can be produced to the sales rep to indicate relative areas of weakness and strength, and what suggested actions can be taken to address outcomes less than the target.

3. Conclusion

Call planning is an essential process to guide sales rep activities to ensure the achievement of sales force strategic outcomes. This white paper strongly suggests that changes in the pharma environment warrant a rethinking, adjustment, and an adaptation of the current process given the evolution of the external environment facing companies. This paper explores simple and more complex additions and solutions to a myriad of issues facing future changes to call planning. A central theme in all of the proposed solutions is the use of data-driven analytics and technology to improve call planning in an ever-changing pharma environment. We strongly suggest that pharma companies consider analytical experimentation and beta-testing of new approaches on small case studies to determine operational viability before rolling out any final solution on the scale necessary for successful national implementation. The success of such an experimentation approach requires choosing a strategic partner with a strong combination of expertise in advanced analytics, fluency in data management and governance principles, ability to create easy-to-use technology-driven platforms, and experience with commercial strategy and operations.

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