



How do you measure **PATIENT PROGRAMS?**

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Industry experts discuss definitions of success in patient education—and ways to measure its value. **James Chase** takes the chair

James Chase (MM&M): What does patient education mean to each of you?

Deborah Dick-Rath (FactorTG): I spent eight years as the head of global advertising at Novartis, and had the opportunity to develop and launch lots of campaigns across a lot of categories, across a lot of media. I always think of patient education as the cross-hairs between PR and physician education. Today, with all of the amazing, new local apps and all kinds of applications that we have in the digital world, we have a broader channel selection than we used to. To me, it's about educating a patient about the potential disease that they have. A big part is also caregiver education.

Mary Petrowski (Hologic): I think of patient education as a process. I think that first, you have to figure out what your goals are: I see it as taking a patient from awareness of a condition, to really understanding the condition, to a pathway of how to approach treatment, like, "What are the treatment options? How do I get there? What do I ask the doctor? What kinds of conversations do I have?" Then, hopefully, your procedure or your pill will be the right thing for them.

Craig Lipset (Pfizer): My perspective here from the clinical research side is how do we raise awareness, educate patients, empower them around clinical trials, improve their engagement, get them involved and

familiar that there are clinical trials going on — but take advantage of the ePatient, Health 2.0 and the empowered patient, and really look at how that patient is more than just a subject in a study, but a real partner and participant? And how can we raise their level of engagement by taking advantage of these new technologies and trends, and get some momentum?

Monique Levy (Manhattan Research): It comes down to when in the patient journey you deliver that information. Also, are you just delivering the information, or are you trying to change behavior? And who is delivering the education? Is it the pharmacist, is it the payer, is it physician, is it the caregiver? And how much should we expect a consumer or patient to take care of themselves?

Jill Balderson (HealthEd): We look at patient education very broadly, and that it should be held accountable, not necessarily to deliver a specific ROI, but to be effective, it needs to be measured against what those objectives are, those educational goals. If you count that in your sites as a target, and measure against those, then the brand will benefit, versus having the brand goals in the sites and then hoping that along the way the patient will benefit by doing that value-add.

Jack Barrette (WEGO Health): It's empowering patients to become more like their physicians, to act more like peers with their medical professionals and become part of that treatment team, whether it's adherence, whether it's initial diagnosis. Whether it's helping other folks—it's that this is really the fundamental shift that we're seeing among the folks in social media. It comes down to sometimes, "You should fire your doctor if he doesn't understand this." That feels, to me, like a good outcome of patient education, that I feel strong enough and equipped with good information to actually have a one-on-one with my health professional.

Meryl Weinreb (ex-AstraZeneca): It's not necessarily about the brand at all—it's really about the user, it's about the patient. I think that's very frequently lost sight of in the world of pharma, because it usually starts with the brand, instead of with the patient. It's a fabulous opportunity to engage the customer—and that's another thing that pharma doesn't do a very good job of, and then laments the fact that everybody hates pharma and thinks we're evil. It's a process where you can engage and start a dialogue, and that is the essence of brand building—that's real marketing, and it's not done as often as it should be. And, we should all care about outcomes. I mean, the payer cares about outcomes; the physician cares about outcomes; certainly, the patient is not taking this drug without an expectation of an outcome. Education is the basis to assure that the best outcome can be reached, because if the

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doctor doesn't get the desired outcome, he's going to switch brands. If the payer doesn't see the drug working for patients, you're going to lose formulary positioning. So, all of those things are ultimately going to affect ROI.

Craig: There are a lot of different stakeholders in the process, but there is only one stakeholder who is going to put that pill in their mouth, put that needle in their arm, and everyone else is a stakeholder to that.

Meryl: It's OK to have multiple customers, but, unfortunately, the patient is usually the one who is neglected, or, it's just assumed that the doctor will tell them what to do.

Jack: I think good patient education empowers everyone to say, "Hey, I know you [the doctor] don't have time to deal with this, but I have the wherewithal to bring it to you, because I really think you should."

Monique: On that point, on our physician surveys, about 41% of physicians say it is a positive thing when patients bring information; very few, about 10%, say that it's negative. On the whole, there's this idea that patient empowerment is slowing down physicians, but there are more indicators that it's actually helping them.



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— Meryl Weinreb**

very ingrained habits—not flossing, not eating cereal for breakfast every day—that’s very hard. But if you really refine the educational objectives from a patient’s perspective or an HCP’s perspective at each different point in a journey—“So, what is it, as a patient that I need right now to do what I need to do?”—then craft an educational program or intervention or something that is just doing that, and measure whether you were able to achieve that or not for a significant portion of your population... That, to me, is looking at a focused way of keeping your educational programs accountable.

Craig: It sounds like the goal of the education process is to get me to a place of being empowered and aware to make that decision. And the decision may be, “I’m informed, and I’m still not going to take that medicine today,” and therefore, your metric of number of scripts fulfilled isn’t really the right metric to look at, because you’ve succeeded in informing me, but I’ve made my decision and I just don’t agree with you.

James: Is it possible to deliver quality patient education and maximize brands at the same time? Are they counter-intuitive objectives?

Meryl: I think people who are prescribed a medication will very often go to a branded website to learn about the medication. And I always think it’s helpful, if I can’t find that information there, to give me a link—a resource, to a patient advocacy group, a third party, a non-branded site—where those sorts of things can be discussed. And I think the brand benefits, because the brand has engaged with the customer, and they’ve recognized who you are, and if they can’t deliver it, they can at least send you in the right direction. I think that’s an obligation that the brand has. But the brand can’t do everything, just because of the regulatory.

Jack: I think there’s been a certain shame in being branded that consumers don’t agree with. Again, we keep asking folks what are supposedly the super-objective leaders in social media, what education do you want? They complain that pharma companies try to tell them about their damn drug path, with these long lists—the lifestyle, the diet, nutrition, and all the things that surround it—and they’re like, “I want to know about the medication.”

Meryl: We did a lot of research on that—doctors could care less about MOA, but patients really care a lot about how a product works, and you would think it would be the other way around.

Monique: We asked consumers, “What do you want on an unbranded site?” and the top response was, “Information on a prescription.”

Meryl: Sure—how they take it, what to expect—

Meryl: But, frequently, patient education is a form of lecture, and, unfortunately, that’s not well-received.

Jack: We ask a lot of questions of our social media influencers, who think they know everything about the disease: “What would cause you to buy this?” It used to be, and this was two years ago, a KOL physician has to lead it at some clinic, like the Mayo, and that’s radically changed to saying, “It has to be someone who has absolutely proved to me that they know my feelings—it can’t be just a neurologist—but I also need a patient that I want to have a conversation with.”

Deborah: I always find that patient stories are the most motivating and the most engaging, if you’re looking for information.

Meryl: One of the things we learned about breast cancer is that yes, you talk to your physicians first, but the second person you talk to is someone who has been diagnosed, because there’s this sisterhood. It goes back to understanding who your customer is, and where they are on that journey, because information has to be relevant. People’s need for education will change as they progress on that journey.

Monique: You have so many variables influencing health actions. It’s so complicated. You would see your patients week in and week out and have a 45-minute discussion, and that even isn’t enough to change behavior. I mean, people have been trying to make people floss their teeth for 50 years, and they’re still not doing it. It’s very, very difficult to change behavior.

Jill: I think it goes back to what are you trying to change in the first place. If you’re trying to change specific health behaviors, that’s really hard. Especially

those are usually the very top of my questions, and it's surprising, sometimes, how difficult it is to get the answers.

Mary: One thing, as brand marketers, we can do, is to tie our programs together. So, you don't just have the physician side going off and doing the physician thing, and over here, we have the patient people, and they're doing their thing. I think to tie in, even if it's the imagery, or the themes, to inter-connect them so you're kind of telling the whole story, versus having the brand physician, versus maybe an unbranded for the patients.

Jill: I think it requires a very nuanced understanding of what the patient, or the caregiver, or the HCP, is going to experience at each moment in time. For example, you take an oral oncology therapy that might lead to a rash that the patient might need to be able to recognize and manage proactively. And if that specific issue is what's causing a significant portion of their patients to drop off their therapy sooner than they might have otherwise been able to, because they didn't either recognize or know how to manage that graph, then that's a really clear-cut case. So, then, let's focus a lot of our efforts

on making sure that we help every stakeholder understand what to expect—not to put acne medication on it, because that's going to make it worse—as clear, and as focused as possible. Then, measure whether you've been able to do that or not.

James: How do you set out and measure the success of those objectives? What does success look like?

Mary: There are different ways; one of them is surveys. So, people who would come to the website and sign up for a brochure, or your network—ask them what was the outcome, what happened? I know in pharma, it's more script-level data, which we don't have in medical device. You can look at revenues: you launched a campaign—what was the delta on the revenue before launching that campaign? What were you expecting to make in revenue? Another way to measure it, more recently, is conversations. Looking at the listing platforms and saying, "OK, we've launched this initiative: Did we see conversations in the social media space increase greatly, or not?"

Jill: What was the tone and quality of the conversation, and that kind of thing?



"I think there's a certain shame in being branded that consumers don't agree with"

— Jack Barrette

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Meryl: I think, ultimately, it’s around asking the user, because with script data, there are too many other factors that could be affecting that. But it’s very difficult sometimes to take any specific program, put it in isolation, put a microscope over it, and somehow measure how many of those 100 scripts were caused by that one, versus this one. But, to your point of surveying, it’s asking the patient whether or not they got what they wanted. And there’s lots of different ways of asking that question. I know in the past we’ve used: “How likely would you be to recommend this product to somebody else? How likely would you be to tell someone that just got diagnosed to go to this site?” It’s those kind of questions—“Did you find this of value, and would you be willing to recommend it to somebody else?”—I think is a very strong measure that you’re having an effect.

Mary: Exactly. And then: “Did they have the procedure, or have the medication, and then who did they tell? How did they find out about it? Was it from a website, friends, the doctor, a combination of all those things?” So, there’s quite a lot you can accomplish with surveys.

Jill: I think if you tailor it back to what you are trying to accomplish, that would dictate how you measure it. So, in the device category, if you have a device where a patient has to do something, you can give them instructions, for example, or a video, or something like that, and find out, “Can they do it or not? Did it work? Are they able to do it?” People forget that you can even measure those things, and it’s shocking when you do measure it, how well or not a lot of the instructions work.

James: So, what do you do with this information once you’ve got the qualitative data, and spotted the trends, and changes in behavior, and things that work and things that don’t?

Meryl: You have to continually fine-tune your programs. I think that is something people forget; it’s very often you create it, you put it out there, and it collects dust—done. I think one should continually be fine-tuning. Patients change, patients’ level of information of a disease is going to change over time, so I think it’s never done.

Mary: Well, I think that’s because things change, too. New and better drugs and devices come out, and things become obsolete.

Meryl: I think it has been a problem in pharma that we don’t look to the long term. Brands have a pretty big, fat expiration date on their forehead. I’ve worked on brands that are forever. Hamburger Helper is going to be around for another 50 years, and it’s important, if I’m the brand manager of Hamburger Helper, that I

know that, and that I’m not doing anything that could in any way jeopardize my brand. We don’t have that luxury in pharma.

Jill: The learning you can develop, if you pay attention to whether your initiatives are working or not, you can then leverage when you come out with new products, particularly if you’re focusing on the same categories.

Monique: I’m wondering how many of these good companies are more tolerant of their customer doing business ideas as opposed to everything having to have an ROI, which you mentioned earlier?

Mary: Well, I think, sometimes, physician programs are a given. People know they have to educate the physicians, so there’s no ROI that I’ve seen on that,



in my experience. But, on the patient side, it becomes critical to figure out what the ROI is going to be.

Jill: We have found success in going in an awful lot higher within the pharma company to have discussions about the role and the dynamics of the patient, really. In not only their product, but in their franchise. And, to start demonstrating a lot of regular, quick wins to be able to move needles, small needles. You have to find some enlightened and powerful people to believe that this is important and that’s what’s been driving our business.

Meryl: I also think that the advent of e-prescribing, as that begins to pick up, that we will be able to track better, because right now, we kind of lose track. We see a script has been written, but you don’t really know what happens—did that script get filled, how long did it sit on the kitchen table once it got filled, did it get refilled? ■