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Hospitals used to be much more welcoming to pharma sales reps than they are today. **Larry Dobrow** looks at how the rise of the hospitalist has changed the game plan for getting the word out about products.

It hasn't always been this way. At some point in the last decade, reps and practitioners agree, hospitals were an accommodating environment for pharma sales reps. If they weren't welcomed with open arms, then at least they were treated with the respect afforded any other person just doing his job. Don't get us wrong: it's not as if sales folk roamed free in the hospital corridors, tossing samples and promotional literature at every physician within heaving distance. But there used to be some degree of access to hospital-centric practitioners, a few appointed lulls in which reps knew they'd be able to get a human audience of some kind.

Now? Good luck finding more than a few hospitals and similar care facilities that allow reps substantial access to the doctors who toil within. This might not have been a problem 15 years ago, when the number of physicians working exclusively in the hospital setting was tiny and the rules preventing reps from engaging with them were more or less nonexistent. But it's a problem now. There are many more of these doctors and way, way, way more of those rules.

If a pharma sales rep approaches the front desk at a hospital, he will not immediately be ejected with great prejudice. He won't be dragged out by security or photographed in the event he attempts to return when shifts turn over. But neither will he find anything remotely resembling a friendly environment. Welcome to the hospitalist era, in which a rapidly growing subset of physicians are all but inaccessible to the reps charged with selling to them.

So just who are these untouchable hospitalists, these elusive figures likened by one clever industry wonk to unicorns? They're pretty much what their name implies: physicians whose primary practice venue is a hospital, medical center or large practice group with hospital affiliation. Per Society of Hospital Medicine (SHM) membership data, there are now more than 44,000 hospitalists in the US, with an average age of 37 years. "It's a new breed of professional. They're coming out of the gate eager to take on this new role," says Michael Targowski, a senior account manager at publishing giant Wiley.

Joe Schuldner, VP of integrated sales for Pharmaceutical Media Inc., which reps medical journals, puts it even more succinctly. "Hospitalists do it all. They're the glue."

According to SHM's 2014 "State of Hospital Medicine Report," unveiled in September, the profession continues to grow at a quick clip, with some estimates pinning annual growth at as much as 10%. Hospitalists are expanding their slate of professional activity (in addition to to medical and surgical co-management, they're working alongside rapid-response teams and

even doing some outpatient care) and, subsequently, their salaries are increasing (compensation for non-academic adult hospitalists rose from $233,855 in 2012 to $252,996 in 2015, a jump of 8.2%). There are even blossoming hospitalist sub-specialties: SHM reports that nocturnists, defined as hospitalists specializing in caring for patients during the night, can be found in more than 80% of adult hospital medicine groups, up from just over 50% in 2012.

They're also an increasingly influential group of practitioners. SHM estimates that 60% of hospitalists write more than 50 prescriptions per week, mostly for antihypertensive, antimicrobial/antibiotic, diabetes and pain drugs. As such, they are "the folks who triage the patient between the hospital and the real world. If you have a hospital-based product, they're using it. If you have an outpatient-based product, they're prescribing it—and if they prescribe it, the patient will stay on it," says Mike Luby, founder, president and CEO of BioPharma Alliance.

And yet hospitalists—and more specifically, attempts to convene with them—are a topic about which pharma sales reps and their bosses aren't eager to chat. For this story, *MM&M* reached out to 27 pharma companies, receiving a thanks-but-no-thanks from 12, no response from 14 and an enthusiastic "sure, let's chat!" from one exec… who canceled the interview. The lack of response could be indicative of many things, including worry that they're not doing their jobs well, or a sense that a somewhat hostile target audience is not buying what they are selling—that they haven't cracked the hospital code.

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Source: SHM 2014 "State of Hospital Medicine Report"

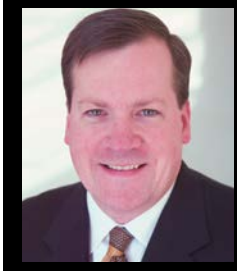
Still, at least one industry higher-up understands why pharma reps and executives would be hesitant to discuss their interactions with the hospitalist audience. "Pharma likely doesn't want to divulge their strategies of how they're accessing them… there's no upside or benefit from participating, only risk," the exec said. Luby thinks it might be more simple than that: "My sense is that an awful lot of pharma still does not prioritize the hospitalist," he shrugs.

Or maybe it's just a matter of opinion. Gareth Davies, global marketing director at Ashfield Healthcare, notes that he sees "plenty of [companies] getting this right" and that perhaps US-based reps don't realize how good they have it. "It's still really good here compared with the UK," he says. "[Hospitalist] access is relatively hard, but not as hard as it is elsewhere in the world."

For those attempting to get a better handle on hospitalists and what makes them tick, it's worth taking a look back at their quick rise within the medical profession. The notion of a hospitalist, in fact, only dates back to the early aughts. Back then, pharma reps with responsibility for the hospital environment were deemed to be specialists. Their job was to call on the traditional cast of characters—fellows, attendings, residents, med students, nurses, administrators and hospital pharmacists—and chat them up about new products.

Kristin Scott, now the SHM's director of business development, was one of those reps. She remembers her days calling on hospital accounts with some small degree of nostalgia. "I'd go to journal clubs, I'd do grand rounds, maybe I'd do some inservices for my customers. It was very, very different from how it is now," she says.

The iPad's path from being a game changer to Just Another Device



Mike Luby

Return with us, if you will, to the halcyon days of January 2010. A little ditty called "Hey, Soul Sister" set the nation's toes a-tapping. Peyton Manning's Indianapolis Colts acquired an aura of semi-sorta-inevitability as they powered through the first two rounds of the AFC playoffs. And on the 27th day of that fateful month, an obscure American technology concern announced an addition to its product portfolio, a tablet-shaped tchotchke it chose to dub the iPad.

And just like that, the rules of the game completely changed—for content-starved commuters and at-wits-end parents, sure, but especially for sales reps who were used to toting around their laptops and piles of paper. With its fluid graphics and futuristic finger-swipe-y control, the iPad promised to wow sales prospects into a state of submission. In pharma, salespeople would have a whole new set of presentation tools at their disposal, ones which would hopefully help counteract their narrowing windows of physician access.

Flash forward to November 2014. While you'd be hard-pressed to find a pharma rep who will discuss their disappointment on the record, the iPad and the digital sales aids that it enables haven't proven to be the panacea that they were made out to be. Once iPads achieved ubiquity somewhere towards the middle of 2011, they officially became Just Another Device.

"What we saw was an example of the novelty effect," says Mike Luby, founder, president and CEO of BioPharma Alliance. "If you were the first person using [the iPad], it was a really cool toy and you were the cool person who had it. But when every rep had one, it stopped being a big deal." Adds Jennings principal Dan Dunlop, "It became just another gimmick to get [reps] in the door."

Looking back, healthcare vets suggest that the industry indulged in a bit of wishful thinking, that it focused on the coolness factor of the iPad to the detriment of the product-specific content that the device was intended to showcase. Too, contrary to pharma industry hopes, iPad presentations didn't really help those wielding them achieve a significantly greater level of customer intimacy.

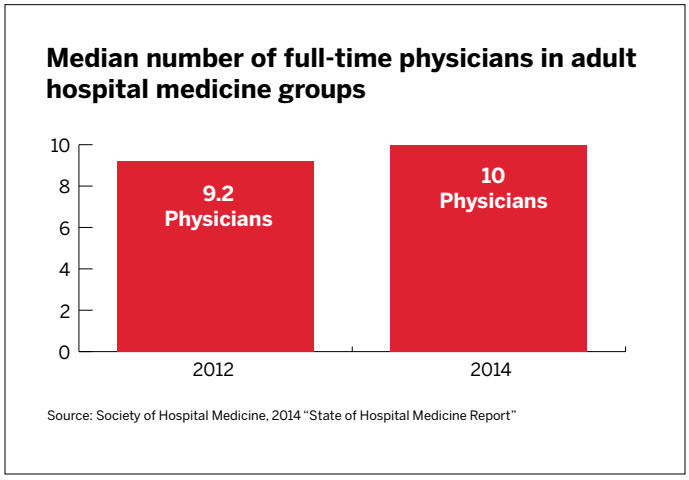
"The salesperson's skill has always been navigating the hospitalist through the information," notes Gareth Davies, global marketing director at Ashfield Healthcare. "It always comes back to improving the patient experience."

It didn't help that by the time most reps were iPad-enabled, rules had been put into place limiting their physical access to the doctors who would, at least in theory, be surprised and delighted by the content featured on the new device. "When you start putting together your digital sales aids, you assume that the rep is going to be in front of the doctor. But if the rep can't get an audience, it doesn't matter what's in there," says Society of Hospital Medicine director of business development Kristin Scott.

So while reps will continue to make the iPad their content-showcase device of choice, it's likely they'll begin to acknowledge its limitations as a panacea—that is, if they haven't already. "Maybe an iPad or another digital thing can help extend a discussion," Luby says. "But in the end, the magic is much more in the message than in the medium. That's where the focus should always be."

Unlike many other reps from that era, however, Scott had a passing encounter with the physician genus we now identify as a hospitalist. Here's how she recalled the experience in a piece she originally wrote for the SHM web site: "I remember the day when I heard about a doctor that only worked on the floors and only treated inpatients—he was called a hospitalist and I eagerly spread the word to my manager and my teammates about this new concept (likely from a pay phone!). I left information in his staff mailbox several times, but never heard from him. I spent three years in that job and never once met him or any others like him."

If you contrast Scott's experience with that of the modern-day pharma rep charged with detailing hospitalists, the only thing that hasn't changed is the lack of direct and immediate access. But 15 years after Scott and her peers gazed upon the hospitalist as they might an unclassified species of human life, hospitalists are too great in number to ignore, especially if you're a company in the pain-management space or one with products that treat stubborn



infections. Reaching them, then, requires reps to cast aside dated assumptions—and, perhaps, embrace a new attitude.

"For pharma reps, the model has historically been based around interruption. They go in and interrupt physicians' lives," says Dan Dunlop, principal at healthcare marketing agency Jennings. "In this day and age, getting in somebody's way isn't the best thing to build your business model on… These physicians in particular didn't go into medicine to deal with all the side stuff. They want to care for patients."

Keeping that in mind, here are five tips offered by experts to reps hoping to crack the Hospitalist code.

Perfect the total office/hospital call: Hospital rules about rep access are designed to shield physicians; they generally don't say a whole lot about all the people in the physician's immediate work orbit: nurses, managers and the like. Luby wonders why reps who complain about access to hospitalists don't instead focus their attention on these other audiences. "Lots of reps just aren't wired to recognize the importance of the office or hospital staff," he shrugs. "It's a bit of an old-school mentality: 'I go in and detail a doctor. That's how I've always done it.'"

Luby points to an observational study of in-office rep visits his organization conducted as extremely telling. "Less than 50% of what we see are total office calls. Our observers report back that a lot of the time reps are just standing there with a nurse or someone else with whom they can have a business conversation—and instead of having that conversation, they just make small talk," he says. "Take the nurses—they're explaining to patients how co-pay cards work and they're talking about side effects, and they're frustrated they don't know more. Some of them will accept samples. Why wouldn't a rep take the time and talk with them?"

"It was very, very different then from how it is now "

— Kristin Scott, SHM

Bend the rules: Nobody is saying that bad guys finish first or that potentially antagonizing an individual you want to charm is a risk worth taking. That said, experts believe reps should keep an eager eye open for selective enforcement of the rules governing hospitalist access, or opportunities that might reside in some kind of grey area. For instance, the organizational mother ship might ban all interactions, but its satellite locations might be far more forgiving.

"Practices and hospitals are closing the doors and restricting access—this is happening," Luby says. "The opportunity is that in many of them there's inconsistent compliance. I don't want to make it sound like there are doctors who are going rogue, but we know of places that are officially closed to reps where they'll still accept co-pay cards or samples or literature for the doctors."

Don't whine about it: Few sales-connected execs dispute the challenges of marketing to the hospitalist profession. At the same time, it's not like salespeople in other walks of professional life have it easy, especially in these buttoned-up economic times. "It doesn't do [reps] any good to complain. Innovation is hard. People don't like to try new things," says Dunlop. "This should go without saying, but we're all spread so thin. It's no different in the hospital setting," Pharmaceutical Media's Schuldner adds.

To this end, reps have to be ready to unleash their spiel on a moment's notice. "If you get an audience, don't complain that you only have a few minutes. Have your elevator pitch cued up and ready to go," Schuldner continues. Targowski agrees, emphasizing the necessity of seizing on rhetorical work-arounds: "Not every 'no'

"Access is relatively hard, but not as hard as elsewhere in the world"

— Gareth Davies, Ashfield Healthcare

is a complete 'no.' It might be 'no' to samples or to doctor detailing. Sometimes the 'no' you hear is only a portion of what you can do, not all of what you can do."

Ask the questions: Indeed, Pratap Khedkar, managing principal for pharmaceuticals and biotech at consultancy ZS Associates, says if that there's a mistake that reps make most often in their dealings in and around the hospital environment, it's that they give up far too easily. "Once a door is closed, you can only do so much. But we're dealing with a new breed of physician, who likes to get information from multiple channels and in different ways."

Luby agrees, pointing again to observations conducted by his

firm. "Reps go in and the first thing they hear is 'we don't allow X, Y and Z.' Too many of them say, 'Okay, have a nice day' and go outside and put the doctor or hospital on the do-not-call list." Instead of accepting the initial response as infinite in its finality, those reps would be better served by extending the conversation young-child-style: that is, by continuing to ask question after question, in the hope that one will reveal an opening, however slight. "Do you accept co-pay cards?" and "Would it be possible to speak with someone in nursing services?" are, to hear Luby tell it, among the first questions that should follow an initial rejection. "There are all sorts of levers you can pull."

"A [rep] who doesn't offer the doctor value hurts everyone's case"

— Addie Blackburn, Sudler New York

Provide value: This likely holds for sales and marketing to physicians in general, but it can't be emphasized enough in the hospitalist context. Sales reps must provide something more interesting than a shiny piece of paper adorned with words, either relevant data or product information not easily conveyed outside a person-to-person setting. "Salespeople are used to these [interactions] being a branding exercise and keeping colors and logos in front of [the doctor]. They have to be a resource now. They have to use data to position a product properly in the mind of the physician," Schuldner says.

Addie Blackburn, a senior media planner at Sudler New York who works with infections specialist Cubist Pharmaceuticals, similarly emphasizes that reps need to make themselves useful. "Kantar Media is showing that only 15% of physicians in the hospital setting see reps on a regular basis," she notes. "If somebody comes in with no information of value, that person is hurting everybody else's case."

Focus on the state of the patient: Not everything can be blamed on regulations keeping sales reps well outside the hospitalist loop. One might argue, in fact, that the campaigns aimed at this audience deserve at least some of the blame for the animus hospitalists are said to feel towards sellers and marketers.

Those campaigns largely ignore the types of patients who are most commonly treated in the hospital environment: the ones who arrive at the hospital with a complicated condition and the ones needing attentive care, like, right now. Rather than hammer hospitalists with the same brand message that has been broadcast to other physicians, pharma companies would be advised to pay more than passing attention to the types of patients hospitalists see—to acknowledge, for instance, that they're likely making the acquaintance of a patient with a heart condition under drastically different conditions than those of the friendly neighborhood cardiologist.

The reps who forge mutually beneficial relationships with hospitalists will likely employ several if not all of these tactics. Too, it's not as if reps are being thrust into the hospital environment with just their wits and maybe some bottled water to sustain them. "I'd be very surprised if pharma companies are sending people in there without some basic training about how to have a useful conversation," Ashfield's Davies says.

That's likely true, which doesn't mean that companies have prepared their reps for every contingency—like, say, when a pharma company/hospitalist relationship spirals into the realm of ugliness. The still-fomenting feud between Genentech and Ascension Health, which operates more than 1,900 hospitals and clinics in the US, serves as a prime example.

In early October, Genentech changed its distribution scheme for three of its top-selling cancer drugs—Avastin, Herceptin and Rituxan—which collectively generated more than $7 billion in sales in 2013. On the surface, the move sounded innocuous enough: Instead of using the existing wholesalers that had been distributing the three products, Genentech would shift to specialty distributors that are, in essence, divisions of those wholesalers. The company cited distribution efficiencies as the primary motivation for the move: Only five distribution centers now handle the products in the US, as opposed to the previous 80.

To say this move didn't go over well with Ascension and other large hospital groups would be something of an understatement. Claiming that the move would spike their drug costs by tens of millions of dollars every year—and possibly impact patient care as a result—Ascension banned Genentech sales reps from its facilities. In an email sent to its employees, Ascension accused Genentech of making it more difficult to provide healthcare.

Other organizations quickly weighed in on Genentech's decision. During a media conference call, Novation CEO Jody Hatcher, whose group purchasing company represents hospitals, estimated that the switch would cost its 2,000 or so customers around $50 million per year. In a letter attributed to its board of directors, the Hematology/Oncology Pharmacy Association wrote to Genentech that, "Your decision will have a direct and negative impact on our cancer center operations and have adverse effects on patient care… This decision creates an unnecessary burden on everyone in the healthcare system except for Genentech and the selected distributors."

Other hospital groups are said to be considering similar bans of Genentech reps. An exec for one of them, the University of Wisconsin Hospital and Clinics, told the *Wall Street Journal*, "We would restrict [Genentech's] access to our providers, so it would be harder for them to promote their products… Any way that we can move [Genentech] market share without compromising patient care, we will do so."

"These physicians didn't go into medicine to deal with all the side stuff"

— Dan Dunlop, Jennings

Neither Ascension nor Genentech returned requests for comment, but the very public dust-up reveals just one of the many tensions burbling beneath the surface of the pharma rep/hospital relationship. There are rules and restrictions galore. There are new nonpersonal channels galore. There's a target audience that may have little desire to deal with non-patient-related aspects of the job. Really: What's a hard-working pharma sales rep to do?

"It's tougher sledding, for sure," Luby says. But just look at how [hospitalists] have evolved. Reps have to do the same thing. It can't just be walking in, asking for the doctor and then sitting around until he sees you. These are different times with different challenges." ■