How Medical Device Companies Should Think About Patient Engagement

Engaging with patients in a genuine and transparent way is tough. Really tough. It's challenging for all healthcare stakeholders - payers, providers, and industry.

From a medtech perspective, we often times get stuck in a certain mindset when trying to engage with patients. Whether it's a continuous glucose monitor for diabetic patients or a new hip implant for orthopedic patients, we gravitate towards communicating the features and benefits of our particular product. For example, this may sound familiar - "Joe Patient, you should consider our knee implant because it has a greater arc than Competitor X."

But is this really the right approach? If our end-goal is for a patient to take action, is this the best way to engage with them? To answer this question, I invited Neal Sofian to the program. He's currently the VP of Engagement & Innovation at Vivacity, a subsidiary of Premera Blue Cross. Neal is recognized internationally for his work in population health management and behavioral change. Here are some of the topics we cover:

- What does patient personalization really mean? And why messaging around life and context is so important.
- Why do so many life science companies fail to effectively personalize their messages to patients?
- What technologies can actually support effective patient engagement?
- Examples of companies that have been successful at patient personalization.
- How to overcome some of the legal challenges associated with patient engagement.
- The top 2 things that medtech or biotech companies should do right now to improve their patient engagement initiatives.

SCOTT: We're going to be talking about things related to patient engagement, especially as it relates to how medical device companies, pharmaceutical companies, biotech companies, etc., should engage with patients in a meaningful and a more transparent way.
Having said that, let's start with personalization. What does personalization to the patient really mean, Neal?

NEAL: It means a couple of things. One is we are actually people, we're not patients. I think too much of what's happened in healthcare in general is when we've looked at people, we've tended to look at their risk, their disease, their condition, their current costs or circumstances

and we forget that for the most part, we spend most Itof our lives not being patients, but being people, and that we're motivated by all sorts of things. Health, other than when you don't have your health, is not particularly motivational.

Most people don't get up in the morning and say, "What can I do to be healthy today?" People make decisions and strive to achieve goals around what they can do to make their life better, how they can do better at work, what they can do for their family, getting together with friends, etc. Those sort of things. We have a scale of preference, but health is rarely at the top of that list.

I would say talking about health risks is better than a stick in the eye, but it's not exactly what I would consider personal, because it's really just conditional, as in focused on the condition.

SCOTT: I like your comparison of better than a stick in the eye. That's pretty funny. It's a pretty low bar to set, for sure.

NEAL: It's a really low bar. But then again, in our field, our bar is extremely low, and that's sad. We do not use technologies that almost every other industry uses to personalize, and in some cases we use none. As fragile and important as our services are in the healthcare industry, we are still making use of archaic technologies in a modern world.

SCOTT: I couldn't agree with you more on that comment. I still find it amazing how the technology we use in healthcare would be considered almost obsolete in any other vertical.

You made a comment about personalization with respect to patients – how we need to put ourselves in the shoes of the average patient and treat them as a person vs. a patient. On that note, why do you think most companies fail to do that?

NEAL: I think there's a paradigm problem. A laziness problem. And a legal problem. We are more focused on trying to change people's behavior by simply telling them what they should do, with the presumption that if we provide them with enough information, they'll do the right thing. But it doesn't work that way. Information can be an important motivator. It can be an important precursor to behavior change. But information is not sufficient.

And yet, if you think about it from our world with legal issues, with HIPAA issues, with things like this on our mind, we are more focused on doing the right thing. We tell ourselves, "Let's just make sure whatever we tell you is accurate. And if it's accurate, you can't sue me. And if

you can't sue me, then at least I've checked off that box." My goals in these cases are organizational or institutional goals. They're really not about changing people's lives.

Furthermore, they're not focused on my views from a public health perspective. The goal from this perspective is not to simply change lives; the goal is to curb the prevalence. So if I have a population of a million people who have diabetes, it's not enough that I helped one person. I need to ask myself, "How do I positively affect the entire subset of patients with this disease?" Now, the paradox of that is, of course, I have to do it one person at a time, which means I need to understand them. So I need the public health prevalence view, and then a highly personal and tactical strategy to make it happen.

SCOTT: That's somewhat easy to grasp, I think, from an intellectual standpoint. But it's difficult to execute on both - that macro strategy, or population health mindset, in conjunction with the tactical approach to each individual.

Let's discuss that a bit. From an industry perspective, we shouldn't be communicating XYZ health problem, or to use your example, the problem of Type II or Type I diabetes. We really need to be talking about context and the life of that particular patient. Correct?

NEAL: Absolutely. I'll give you an example. It's not about a disease, it's about weight. Amazingly, a lot of people lose weight in the New Year. Another is when people prepare for their weddings. These are very specific times.

Interestingly, another fascinating time people lose weight is in preparation for their 10th and 20th high school reunions. Why? Let me assure you, it's got nothing to do with health. This is a group of people that you haven't seen in 10 or 20 years in some cases, so you want the people you haven't seen in a long time to admire you, you want to show them what they've missed, you want to show them how much you've changed. Or maybe there's somebody you are looking forward to see, and you are hoping they're available. In other words, this is all about relationships and sex. It's got nothing to do with health. And yet it's a huge motivator to get people to take action.

So that's an example of context, where a factor that seems totally unrelated can be of huge influence on getting people to do something. Because you're keying into an aspect of their lives that is meaningful to them at that point in time.

SCOTT: That makes a ton of sense. Do you have one that's a bit more specific to how an organization could do better in terms of communicating this to the end patient?

NEAL: Sure. Let's start by asking what information do we need to make this happen? I'll start at the base, the foundation. The first thing I need to know is how to contact you. I can't communicate to you if I don't know where to find you. So that's first.

Second, we need to start thinking about a different kind of data. Right now, the data we tend to collect on people is related to claims. We might have biometrics; we might have risk data if it's an employer population. We collect cost data, we'll collect claims data, we will collect risk data, because we can risk-rate you based on your pharmacy utilization, your diagnostic codes, and your costs. But I'd like to propose that a patient is more valuable than the cost and the diagnoses. As a patient, you have a purpose, you have other important things going on in your life. For example, are you a caregiver? How are your relationships? How are your finances? Those sorts of things. But this means that I need to have a tool to help me collect the right data.

I can do that in two ways. First, a lot of the data is purchasable. You want to buy a psycho-demographic profile on a population of people? You can do it. There are a handful of companies in the marketplace that will sell the data of hundreds of millions of people for pennies per person.

So I can actually find demographic profiles on people. I can find purchasing profiles on people. Do these people buy sporting goods, do they have pets, are they value shoppers at the grocery store, or do they tend to be shopping high-end? And based on all that, I can either use that to assume a psycho-demographic profile, or I might even be able to predict what their hobbies are and what motivates them.

And then lastly, I can go the old-fashioned route. Assuming I can connect with people, I can ask them what they care about. Surprisingly, we don't do that. We might ask them about their health behaviors in a health assessment – do you smoke, do you drink, do you wear a seatbelt, did your mother have breast cancer, things like that.

But we don't ask them things like, how do you sleep, how's your energy level today, how do you feel about what you ate, did you move, what's your stress level today. And then accompany that with some simpler questions like, what do you value in life, is your career more important than relationships or family or health or finances. Let's get that information about you as the person, and then find out how you're spending your time in relation to that. Let's ask more of those simple questions.

If I put that together, if I combine the data with the context of information I gather from third parties, as well as the questions I ask, I can build a composite profile on a person that's surprisingly robust and meaningful. Based on that, I can make some assumptions of who you are, so that when I begin to reach out and build content for you, I can build it based on who I think you are, and tailor the content precisely. And I don't mean like you'll get the diabetes brochure versus the asthma brochure, but I mean tailored down to words within sentences that speak to your values, to your circumstances, and to the sort of things that you might want to do.

And if I do that, through high personalization of the words, the images, etc., I can significantly influence the level of behavior changes down to the individual person.

SCOTT: To summarize, presuming I've got a valuable solution that I want to promote to a particular set of patients, first and foremost I've got to figure out how to best communicate to them. What is the best channel to communicate our message to this particular subset or cohort of patients?

The second item is in regards to creating a persona about the individual patient, a patient avatar so to speak. What you're saying, Neal, if I understand you correctly, is that patient avatar needs to be more robust than claims data and risk matrix data. It's got to involve a lot more than just health issues. You're talking about involving psycho-demographic analysis and utilizing other data sets to build out a really robust patient profile that's not just about health.

NEAL: Yeah, absolutely. Let's consider another example. So you need a knee replacement or a hip replacement, but I also realize that you're caring for both children and you have an elderly parent staying in your home, and your finances are strapped. That changes the conversation about what you think you can afford or not afford to do in terms of a surgical procedure. And it's not the money, necessarily, because you may have insurance. But you've also got a 92-year-old mother upstairs in your house, and if I don't help you manage her, you're not going to do that surgery, however much pain you're in, because you can't afford the time to rehab yourself.

So I need to understand the context of your life if I expect you to have that procedure done. I have to understand your whole life circumstance. Obviously, you're letting a parent live with you. That's an incredibly important thing. The message should be focused on how you can take care of your mom after your surgery and how we're going to help you get through the transition.

That becomes a very different conversation than saying, “Clinically, your hip joint has had it and you’re going to need a hip replacement.”

SCOTT: I think that example that you just shared is really easy for everyone to understand. With regards to your point, the most important issue in that person’s life is going to be taking care of their 92-year-old mother or father. For all they know, their hip hurts or their knee hurts, and their doctor, their friends and family have said that it probably needs to be replaced. But that person’s thinking is: “How is this even going to be possible to have my knee replaced or my hip replaced and then still take care of my mother or father?”

From the standpoint of a device company, if you’re an orthopedic company, and that persona makes up a significant percentage of the patients that you’d want to contact, you should incorporate content that aligns with that particular scenario a little bit better.

NEAL: Yes, and you might even rethink your product, whether that’s at the device level or the care level. For example, if you’re thinking of a bundled care product, maybe that comes with three forms of additional help. Your reaction might be, “I don’t need help for me; I need help because I’m a caregiver, and I need to get three days or a week’s worth of support for a parent.” Maybe that gets bundled into the product.

I realize that this is a bit off the reservation from how we think about these things today, but that’s just an out-of-the-box example that might really make a difference. Our considerations around care go beyond the care itself. It’s the swirl of life that’s going on around us. Don’t just support me with the device, but support me with multiple choices on how I can manage the device and the incident so I can manage my life better.

SCOTT: Are there technologies that you use to help collect demographic data to help with some of this stuff?

NEAL: Sure. In terms of building out the questions, that’s actually something we’re doing at Premera.

But there are folks doing similar things. There’s a company called JOOL. It’s kind of an outgrowth from the University of Michigan that’s looking at how we can gather data around life, purpose, etc.

There’s a company called Tuzag, that’s looking at building out tailoring capabilities. They take all that data and then create highly tailored messages, offers, and images to people on the fly.

They're even getting down to how they can they push tailored video, so that on the fly, you can compile different little snippets of video together into a complete video that is specific to a particular person. This could be very interesting. If we know five or six key items about you, wouldn't it be great if you could get a 3-minute video that was totally customized to your needs and your circumstances that would specifically address your issues? It might even speak in a style and language pertinent to your circumstance.

And then I think companies like Eliza, a company in Boston, that is looking at the kind of research it takes to look at those underlying issues around the enablers and inhibitors of health. Things like caregiving and relationships. depression and finances that do and don't drive health. They've built assessments that can help with that sort of thing.

So there's a lot going on in the space, but for the most part, they're pretty new companies. It's a major paradigm shift, moving away from thinking medically and thinking more life-oriented and finding the what's and the why's in people's lives.

SCOTT: In your experience, Neal, are there any use-cases that you can share that would give us a better idea for who's doing this right? Or maybe on the flipside, if it's easier, examples of who is doing this wrong?

NEAL: I think almost everybody is doing it wrong, so that's a long list. I was once taught that when treasury agents are taught how to tell what is counterfeit money from forgeries, they don't spend their time looking at forgeries. Mostly what they do is look at the real money. What they try and do is become really, really familiar with what real money should look like. And if you really know what true north looks like, it's easy to tell when it's not.

I like that notion of focusing on where we want to go because we have tons of examples of what's wrong. The whole industry has just been lackadaisical about this.

If you look at an example outside the industry, a pretty good vendor for this is called Amazon. They have an amazing ability to personalize. And they don't even tailor down to the word level, but they certainly tailor at the offer level in terms of offering you highly relevant choices.

I think that the work that we're doing with an assessment called Track is an example of how we can use certain data to push messages to patients that can be then tied to whatever their need is. Or it could become a dashboard of information that a care coordinator could use.

Like I mentioned, I think Jool is doing some very interesting things in this space. I've seen companies like Jiff and Welltalk trying to do this sort of work. So I think there are now beginning to be examples of the things we're discussin. I wouldn't say any of it is totally mainstream yet, but I think it's going to be adopted quicker than we might think.

SCOTT: I think a lot of people will appreciate your example of Amazon. But allow me to play devil's advocate. From an industry perspective, most organizations feel like they have a target on their back from a legal standpoint. They're going to say, "Neal, some of these things that you're mentioning are going to be too hard to overcome from a legal standpoint." How do you answer that point?

NEAL: Actually, I think we believe it's a legal issue more than it actually is. Do we have to be careful? Sure. Do we need people's permission as we start getting more personal with them? Absolutely. But people will provide permission if you offer them value. I think privacy is a huge issue, but we've made it more insurmountable than it needs to be. People don't tend to get as distressed by their privacy being invaded if they think they're getting something of value in return.

Now, some people clearly don't want this kind of process, and we have to absolutely respect that. At the same time, if we were more valuable to people, they wouldn't view us as a nuisance. And the more valuable we become, the more trusted we become. The more trusted we become, the more value they're going to be willing to let us share with them, and the more personal they'll let us become with them.

It doesn't happen all at once, but I think it's just us starting, inch by inch, to do some of these things. So you have to be careful with how personal you get, and the rate at which you do it, but I think it's going to be surprising. People are just hungry for something that's meaningful to them as opposed to the common approach of industry just sending them stuff that meets the industry's goals, but doesn't meet the needs of the patient.

SCOTT: Would you agree that the fear of legal ramifications is sometimes just a cop-out?

NEAL: I think the legal folks are very vigilant, and their job is to reduce risk, and that's highly appropriate. But at the same time, I think it's our job, if we want to change behavior, to push back and say, look, we absolutely have to stay on the right side of anything that's legal. But how close can we come to being in tune with all the right safeguards, and at the same time, don't presume that because we haven't done it before, we can't do it now.

The critical issue is being transparent and to always ask permission. If you get the right permissions from people, you can do a lot, and you're more likely to get the right permissions from people if you offer things of value. We've assumed that people don't give us permission and they just don't like us or trust us, but that's probably because we haven't been offering anything that's worth their while. So we just have to get better. Once you have people's permission, you can do a lot.

SCOTT: Your comment reminds me of Seth Godin's book, *Permission Marketing*, which he published close to 10 years ago. But the principle still very much applies.

NEAL: Absolutely.

SCOTT: Before we get to the last three rapid fire questions, to sum up this conversation, let's pretend that I'm leading an organization at a medical device company or a biotech company, what two to three things that I should begin to act on now with respect to messaging to patients in a more meaningful way?

NEAL: Number one is that you should remember that people treat health as a means to an end. Think about the "what" and the "why", but in the context of someone's life. If you don't understand the "why" behind the issue or the procedure and why that's meaningful to that person and how it will help their life, you're not going to be effective.

Number two, you need to look for the required technologies that can help you build those capabilities. In the past, we've assumed that they're not there, but in fact they are.

SCOTT: Thanks again for wrapping that up, Neal. I appreciate it. Let's get to the last three rapid fire questions. They're rapid fire questions but they don't necessarily have to be rapid fire answers.

First question, what's your favorite non-fiction business book?

NEAL: It's an old book. It's from the '80s. It's a book called *Intrapreneuring* by Gifford Pinchot. It talks about how you make change happen, how you propagate innovation within large corporations. I know we're in a big world of tech startups, and everybody wants to be the next Facebook or Google or something, but once you're in those kind of organizations, how can you facilitate change being made? How can you create the skunkworks that create real changes? How can you facilitate speed within the bowels of the beast?

I'd really recommend that book. It's fun.

SCOTT: Second question, is there a business leader that you're following right now, or maybe one that you find inspiring?

NEAL: Well, there's two. One is Dave Lawrence, who was the CEO of Kaiser. I got to know Dave and I found that he was a model of servant leadership. When he walked into a room, everybody was delighted to see him. He had a clear vision and yet a huge, warm personality. So he's one of the guys I've always emulated.

The other is a guy you've never heard of. His name is Richard Catlett. Almost 40 years ago, he was the director of a street drug crisis center in central Missouri. We handled some very strange people in the mid-'70s, people who had been released from mental institutions, drug abuse issues, all sorts of things. Street people. He was the president of the board of directors.

Rich Catlett was a Quaker and a conscientious objector during the Second World War, which was a very rare thing. And then he ended up owning a health food store after he got through the war.

Everything he did was principle-based. He had clear principles, and yet at the same time he was an amazingly flexible guy. He would try and say, "How can I be effective, how can I help manage circumstances and stay within the guardrails of my principles, and yet be absolutely flexible and warm in the process of meeting these principles?"

For example, he refused to give money to any government that supported war, which of course included the United States, and he ended up in jail. They were going to put a lien on his health food store, so he just gave it away. They put him in prison, so he started organizing people in prison, so they got him out of prison as quickly as possible. All the prison guards just loved this guy.

He demonstrated decades of tenacity tied to principle and humanism. So I think those kind of things formed my opinions about leadership.

SCOTT: Okay, for the last question, when thinking about your career in healthcare, what's the one piece of advice that you'd tell your 30-year-old self if we had the option to rewind the clock?

NEAL: Keep a sense of humor. Keep a sense of vision. As I've looked back over all the years, there's just a couple of major themes that I have found in my work, and I would tell myself that's the thing to do. Find something you care about a great deal in terms of a vision – and in my case, it's always been around personalization to drive population change.

Also, a sense of humor helps a lot, because it helps to drive the tenacity to keep doing this. Because some of the things I've started, I found out took years and decades before they come into fruition. That's where the humor helps get you through. That's what provides the tenacity. So I'd say a little humor plus a lot of vision will equal tenacity, or the resilience, because you understand why you're doing it. There's meaning for you in it. That helps you through it.

SCOTT: Neal, thanks so much for doing this interview.