Closer Look

MEMORANDUM

Executive Highlights

- In this interview with Medtronic Diabetes' new President Hooman Hakami and Annette Brüls (VP of the new Diabetes Services & Solutions business), we learned much more about the rationale for it's recent Diabeter acquisition, as well as further details on Medtronic Diabetes' new strategy and vision for the future.

We spoke with Medtronic Diabetes' new President Hooman Hakami and Annette Brüls (VP of the new Diabetes Services & Solutions business) following last week's acquisition of the innovative Netherlands-based type 1 diabetes clinic, Diabeter. What a set of leaders! Our conversation touched on the rationale for the acquisition, Medtronic Diabetes' new strategy, and what makes the Diabeter Model so unique.

Mr. Hakami shared a bold future vision for Medtronic Diabetes, which aims to take it far beyond pumps and sensors to a "more holistic diabetes management company." Indeed, he shared that group's ambitious goal is to serve 20 million patients with diabetes by 2020, an approximate 20-fold increase (!) from the current installed base of ~700,000 patients worldwide. To enable that step function change in care, Medtronic plans to expand much more meaningfully into type 2 diabetes and services. Its two newly created business units - alongside the traditional pump/CGM business - are making moves in that direction under Mr. Hakami's leadership. It's certainly been a series of bold moves under his less-than-one-year-old tenure as Group President and we love seeing this direction - it's clear they want to impact diabetes as a global health problem and move well beyond intensively managed patients.

The acquisition is non-traditional for Medtronic Diabetes, though it parallels what has been done in other areas of Medtronic - Cardiocom in heart failure and cath lab management in European hospitals. Management says that more integrated care approach has resulted in better outcomes and lower costs - we look forward to learning more about what learnings can be transferred - the hope is, of course, that the Diabeter can do the same in diabetes though of course diabetes is a very patient-driven therapeutic area as opposed to cardiology.

In our conversation, Mr. Hakami and Ms. Brüls expressed excitement about the potential to help scale Diabeter's highly effective, IT-enabled model of patient care throughout the Netherlands and across Europe. As we noted last week, the clinic's 36-person staff heavily leverages technology to manage over 1,500 pediatric and young adult patients with type 1 diabetes. Notably, ~85% of the center's pump/CGM users and ~50% of its MDI users have an A1c <7.5% - impressive considering the high A1cs typically seen in the young adult population. Also notable is the clinic's reimbursement model - Diabeter receives a fixed fee from insurance companies to provide care for each patient. *As a result, it's in their best interest to provide the best care at the lowest cost - and at Diabeter, that's enabled through heavy use of pumps and CGMs (over 50%), remote monitoring, data management, and personalized care.*

While this will not have a material impact on Medtronic's revenue for some time, we salute the company for thinking innovatively and trying new things. Certainly, healthcare systems and providers need help on managing people with diabetes, and we believe medical device companies like Medtronic can bring technology to help solve some of scale issues, data interpretation challenges, and slow feedback cycles that characterize diabetes.

See our full discussion below for more on the company's strategy and what makes the Diabeter mode unique.

Medtronic Diabetes' New Strategy

ADAM BROWN: Congrats on the news! Can you talk a little bit about the rationale for this acquisition? What is the vision and where do you see this going in five years?

HOOMAN HAKAMI: Let me answer on both an overall Medtronic level and a diabetes group level.

As you know, our CEO Omar Ishrak has an overall strategy for Medtronic that drives the company on three vectors: therapy innovation, globalization, and economic value. We've made some strategic investments to drive economic value for payers and providers. Cardiocom is a perfect example in heart failure patients. That aims to improve outcomes and reduce costs through an integrated care approach. We also have a hospital solutions effort, predominately in Europe, where we take over the management of cath labs. Both of these efforts have resulted in savings for providers and better outcomes. So this acquisition is part of that overall strategy to provide economic value. However, Diabeter will also help drive globalization and therapy innovation.

In the diabetes group specifically, we have really embarked on a new strategy. Our vision is to transform diabetes care through greater freedom and better health. It goes beyond providing just hardware - we want to be more than a pump and sensor company. So we have set up three business units: intensive insulin; non-intensive insulin; and services and solutions. The charter for Annette Brüls business unit is to get us much more broadly and meaningfully into services and solutions.

Diabeter does that in a big way. It's a step into integrated care and diabetes management. They have 1,500 patients at three sites, and a fourth is coming very quickly in Amsterdam. They have a proven model of care - it's very patient centric and IT-enabled, and we think we can add value to that. We will continue to expand this model in the Netherlands and seek to broaden it in Europe.

ADAM: What value does Medtronic hope to bring to Diabeter with this acquisition?

HOOMAN: We can help with the technology and IT side, especially if you look at the possibilities with CareLink and other technology assets we have. That will absolutely help Diabeter provide customized, real-time care management and help them scale. We also have a global footprint and relationships with ministries of health and payers. But we see this as more mutual. Because of this partnership, we can help each other. They can give us feedback in terms of things we need to be thinking about; we can help them with an integrated care approach.

KELLY: How will you measure success?

HOOMAN: This is an investment to help them scale and enhance their IT infrastructure. The question we ask is, "How do we take this proven model and take it broader?"

In terms of how we measure this, the most important number is the number of patients we serve. We want 1,500 at Diabeter to become 3,000 to become 10,000. That's the most important metric overall, which will signify we are taking the right steps to become a holistic diabetes management company.

From an overall strategic perspective, we take the patients served number very seriously. We really have a goal to serve 20 million patients by 2020. That will require us to become more meaningful in type 2 and to become bigger in services.

ADAM: At your 2014 Analyst Meeting, we estimated your worldwide installed base was as high as ~700,000 patients. So serving 20 million patients by 2020 would be a 20-fold uptick in five years?

HOOMAN: Yes, it's a step function change. And that's why we need to be meaningful in type 2, which is 90% of patients, as well as in patient and data management.

ADAM: Last month, you made an investment in Glooko, who has a similar approach to Diabeter with its Population Tracker. Can you talk about the similarities and differences?

ANNETTE BRULS: You're absolutely right. It's all about how we get clinical outcomes and cost effectiveness; how do we use new models, technology, and IT platforms to provide patients with the best care

and continued follow-up? And at the same time, how do we reduce healthcare resources? Diabeter already has this implemented through their platform - they call it "Cloud Care." Glooko's approach is similar - it's about linking patients and physicians/care teams around the same information to make the best decision possible when it comes to therapy and device optimization. So yes, they are going in the same direction. Glooko has shown some great progress in the US, and that really drives our interest.

The Diabeter Model and Patient Population

KELLY CLOSE: How much of your focus on Diabeter was driven by the reimbursement of pumps and CGM in the Netherlands?

HOOMAN: This is not driven by reimbursement rates in Netherlands. The Diabeter model intrigued us - the way they drive patient care is innovative. They get a fixed fee from insurance companies to provide care for each patient. It's in their best interest to provide the best care at the lowest cost - that was what was intriguing to us. Through near real-time, IT-enabled patient care, they engage in outreach to patients and encourage them on a regular basis to upload their data into a portal/IT system. They can triage in a much faster way, and reach out proactively to those patients that need urgent care. This isn't the model where you go see an endocrinologist every quarter or twice a year, and you're with them for ten minutes - it's real-time, personalized, triaged care. That helps avoid hospitalizations, reduce long-term complications, and helps patients with better glucose stability. All of those things are intriguing to us with respect to this particular model.

ADAM: How much is the payer/reimbursement model in the Netherlands driving what Diabeter is doing? Does that worry you as you seek to expand this model to different healthcare systems?

HOOMAN: The reason this model exists is because of the two owners, Henk Veeze and Henk-Jan Aanstoot - they are the pioneers of this. They approached insurance companies with an alternative payment model to provide better care at a lower overall cost for the system. Payers in the US and Ministries of Health worldwide are looking for alternatives. So it's not "either/or" but "and." In some cases, some geographies have alternative methods. But we do believe this is something that will be able to scale. We have receptive parties. In healthcare systems, there is movement around the world to improve outcomes and reduce costs.

ADAM: How many patients at Diabeter are on pumps vs. MDI?

HOOMAN: When you look at Diabeter's split of patients on MDI vs. pump vs. sensor-augmented pump, it's the reverse of what you would see in almost all other parts of world - roughly one-third are on MDI, and the rest are on either a pump or sensor-augmented pump. It's an interesting approach - they recognized that in order to drive the best care and reduce overall cost to system, it was necessary to rely on technology. If you take the US as an analog, it's exactly the opposite - roughly 70% are on MDI and roughly 30% are on pumps. Their mission is to provide the best therapy available for a given patient - personalized care.

KELLY: Is everybody at Diabeter on a pump and sensor from Medtronic? What if they are not? Are you trying to drive them to Medtronic products?

HOOMAN: We are getting into this is because of the integrated approach - this takes us beyond pumps and sensors and makes us a more holistic diabetes management company. The clinical independence of this is critical - we have put in place safeguards so it's not about prescribing more Medtronic pumps. It's about better patient care and lower overall system costs. The question is how do we continue to do that in the Netherlands and across the world; how do we scale that model in a broad way?

ADAM: It seems like part of Diabeter's secret sauce is that patients are downloading their data remotely. What if patients don't do it?

ANNETTE BRULS: Diabeter has a team that is dedicated to cloud care. The team will coach patients and call them. There is continued engagement that is taking place. But in the end, very few patients really don't want to be part of this, because the value they are getting is so great.

HOOMAN: Where this gets really interesting is with the proliferation of technology to drive data to the cloud without patients having to take the extra effort to do it. We have systems in development, such as Guardian Mobile, driving to a much more cloud-based approach. That will provide rich and big data sets without any patient involvement - that's where this model can really scale. But different engagement strategies may be required.

ANNETTE: It's really about having that personalized approach for every individual. Some are on MDI, some are on pumps, and some are on sensor-augmented pumps. It's really tailor made. And in the future, the connectivity solutions will facilitate the data flowing, especially for those who are less eager to download every day.

KELLY: To what extent can real-world trials or real-world experiences be documented so that learning can be broader? Will you publish any learnings from the Diabeter model? And to what extent is this a small population where you can try different things?

HOOMAN: Papers and research will become a bigger part of the strategy as we get more experience and look to expand the footprint outside of the Netherlands and demonstrate the outcomes and costs. In terms of a living lab, I just want to go back to the clinical independence piece. This is something that the physicians in Diabeter need to drive. We're going to help them scale and improve their IT tools, but they will make the clinical decisions.

KELLY: That's encouraging to hear on the independence front, since some might wonder if Medtronic would become more directly involved in patient care. But is there an avenue for the Diabeter team to benefit from Dr. Fran Kaufman and Dr. Lee and other clinical experts at Medtronic?

HOOMAN: The organizational structure of this is that it reports into Annette's business - Services & Solutions. But there is a secondary line into Dr. Fran Kaufman; that provides us an opportunity to leverage each other from a clinical standpoint.

KELLY: Could this be a model for type 2 diabetes, especially with your new non-intensive diabetes management business unit?

HOOMAN: First things first - we want to expand this model in its existing form. Diabeter is a type 1 clinic focusing on pediatric and young adult patients. We don't want to disrupt that model. There's going to be lot of learning that will come from this. Models like this are and should be part of the solution - it has to be an integrated care approach. There will be lots of learning we can apply to what we want to do in type 2.

ADAM: Thank you so much for speaking with us! It's so valuable to hear how you're thinking about the future of the business and opportunities to help more people with diabetes.

HOOMAN and ANNETTE: Thank you!

-- by Adam Brown and Kelly Close