Improving physicians’ clinical decisions, to enhance quality and contain costs

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Sources of support

• Neither I nor any faculty in DoPE accept any personal compensation from any pharmaceutical companies.
• The division’s research is funded primarily by NIH, AHRQ, and FDA.
• We receive occasional unrestricted research grants from drug companies to study specific drug safety and utilization questions.
• All of our academic detailing is done on a non-profit basis funded primarily by state and federal governments, and I receive no personal compensation for my work in this area.
Drugs & everything else

• While much of our work has involved drugs, the same issues and approaches apply to other clinical decisions, such as:
  – imaging studies (e.g., MRIs)
  – lab tests (e.g., PSAs)
  – specialty referrals
  – etc.
The problem

• Busy clinicians don’t have the time or opportunity to get current, evidence-based comparative information.
• New findings are often poorly disseminated.
• Promotional messages to doctors and patients drive prescribing toward the most costly choices
  – even when newer products are no better and/or have worse safety records.
• Many chronic illnesses are still poorly controlled
  – leading to much preventable illness.
• The U.S. spends more per capita on health care (and drugs) than any other country
  – but doesn’t achieve better health outcomes or patient satisfaction.
Information transfer

“The final translational hurdle”
Drinking from a fire hose

• To stay abreast of all important new developments, a primary care doctor would have to regularly scan dozens of journals.

• Systematic overviews cover selected fields, but...
  – are lengthy and hard to wade through
  – may not be recently updated

• Some important findings are not in journals
  – FDA alerts, ‘Dear Doctor’ letters
  – important trial data presented at clinical meetings
An informational vacuum

• In medical school
  – We do a poor job teaching students to manage risk-benefit-cost information
• The intern-resident years
  – free lunches / infomercials
• After training
  – not enough sources of non-commercial information
  – major industry role in CME / blurring of boundaries
  – no requirements for prescribing competency
• Dearth of comparative data to adequately weigh alternatives
Nature abhors a vacuum

• Industry is very effective in filling this void
• Social science research documents the persuasive effects of relationships, gifts — the symbolic power of even small presents
• Until now, little competition in this informational space
What we need to do:

Close the *gap* between the *best available science* and actual *clinical decisionmaking*, so that each choice, for every patient, is based *only* on the most *current* and *accurate evidence* about efficacy, safety, and cost-effectiveness.
One solution: academic detailing

• Medical school faculty have a solid grasp of the evidence about drug benefits and risks...
  – *but we’re often terrible communicators.*
• Drug makers are superb communicators...
  – *but do so only to increase product sales.*
• Can the *content* of the former be communicated to prescribers through a *‘delivery system’* based on the latter?
Two different worlds of communication

- **Academia:**
  - MD comes to us
  - Didactic
  - Content ornate, not clinically relevant
  - Visually boring
  - No idea of MD’s perspective
  - Evaluation: minimal
  - Goal: ????

- **Drug industry:**
  - Go to MD
  - Interactive
  - Content is simple, straightforward, relevant
  - Excellent graphics
  - MD-specific data informs discussion
  - Outcome is evaluated, and drives salary
  - Goal: behavior change
Developing an evidence-based delivery system for clinical knowledge
Assembling and interpreting the best available data

- a team of internists with expertise in evidence-based medicine reviews current clinical literature
- focus group interviews with primary care providers
  - to assess their attitudes, knowledge, practices
- recommendations are condensed into concise, actionable, user-friendly recommendations to guide optimal prescribing.
  - 50+-page review monograph
  - action-oriented key messages
  - the ‘un-advertisement’
  - laminated cards, reference tools
  - patient-oriented materials
Delivering the messages

- Educators are pharmacists, RNs, or MDs
- They are given special training in ‘social marketing.’
- They visit clinician’s office for a two-way discussion that is
  - interactive
  - engaging
  - clinically relevant
  - ...with a clear practice-change goal.
Essence of the approach

- It’s a *service* to practitioners
- Focus is the *optimal management* of a *specific clinical problem*
- *Learning about the practitioner’s perspective and needs* informs content of discussion
- Real-time alerts (*PEARLS*)
  - *Prompt Evidence Assessment and Review of the Literature*
Patient education materials

• In focus groups, many physicians said they’d be more willing to change their prescribing if they had an easier way of explaining to the patients why the change was necessary.
• So we created the first “direct-to-consumer un-advertisements.”
What academic detailing is not

• memos or brochures ("the truth") sent through the mail
• lectures delivered in the doctor’s office
• about formulary compliance
• about cost reduction primarily
• merely an attempt to un-do pharma marketing
  — that’s why it’s not ‘counter-detailing’!
Where the field is now

• Academic detailing programs operating in Canada, Europe, Australia, developing world
  – public payment for drugs = a spur to public action
  – programs funded by government, but controlled by profession

• HMO uptake in U.S.
  – rising drug costs drive payors to action

• Government-funded programs in PA (flagship program), NY, SC, DC, New England, Veterans Admin.

• 2010: AHRQ funds an $11 million contract for nationwide academic detailing program
Status of the evidence

- A cottage industry of literature studying academic detailing has developed in the last 25 years.
- Cochrane Collaborative exhaustive review, 2007
  - 69 randomized trials
  - Confirmed efficacy
- High physician acceptance
- Evidence for cost-effectiveness
- Effectiveness varies with quality of execution
  - Like brain surgery; it’s not a pill
- www.TheDailyShow.com – “Dr. Spin”
Balanced data about medications

A non-profit organization supported by governmental grants and contracts, with no ties to industry.
Existing iDiS modules

- G.I. acid symptoms
- anti-platelet drugs
- hypertension
- cholesterol
- diabetes
- depression
- osteoporosis
- COPD
- Alzheimer’s disease
- incontinence
- gait impairment, falls in the elderly
- sleep meds
- atrial fibrillation
- chronic pain
- *client-specific specialty topics (e.g., HIV)*
Physician reaction
<table>
<thead>
<tr>
<th>Survey item [5 = strongly agree; 1 = strongly disagree]</th>
<th>Mean ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program provides me with useful information about commonly used medications.</td>
<td>4.6 ± .5</td>
</tr>
<tr>
<td>2. The content represents unbiased and balanced information about drugs.</td>
<td>4.6 ± .6</td>
</tr>
<tr>
<td>3. The program provides a perspective on prescribing that is different from what I get from other sources.</td>
<td>4.4 ± .7</td>
</tr>
<tr>
<td>4. I find the patient materials useful in my practice.</td>
<td>4.3 ± .8</td>
</tr>
<tr>
<td>5. It makes sense for the Commonwealth of Pennsylvania to devote resources to this activity.</td>
<td>4.4 ± .7</td>
</tr>
<tr>
<td>6. My Drug Information Consultant is a well-informed source of evidence-based information about drugs I prescribe.</td>
<td>4.6 ± .6</td>
</tr>
<tr>
<td>7. Being able to get Continuing Medical Education credits from Harvard is a valuable component of the program.</td>
<td>4.1 ± 1.2</td>
</tr>
<tr>
<td>8. I would like to see this program continue.</td>
<td>4.6 ± .6</td>
</tr>
</tbody>
</table>
Summary of savings from PPI module in PA

- $286,000 less PPI use in PACE by intervention physicians vs. comparable MDs in 6 months following 1st visit
- $572,000 if changes persisted for a year
- Considers only savings to PACE program
  – does not include savings to Medicaid, state employees, other insurers
“How can we possibly afford this?!”

• The U.S. already spends more per capita on drugs than any other nation.
  – Much of that is wasted.
• Government (federal, state, VA) is footing a big part of the bill.
  – e.g., Medicaid spent $1 billion a year on Vioxx
  – similar argument for Avandia, Zyprexa, etc.
• ACOs, medical homes natural settings for this.
• Providing evidence-based drug information will save more than it costs, and improve quality.
One part of the solution

• Academic detailing can’t fix the widget-oriented mis-financing of the U.S. health care system
  
  “It’s hard to get a man to understand something when his salary depends on his not understanding it.”
  
-- Upton Sinclair

• It is one tool among many we need to re-engineer and optimize health care delivery.
For more information:

www. RxFacts.org
www. NaRCAD.org
www. DrugEpi.org

J. Avorn, “Powerful Medicines: the Benefits, Risks, and Costs of Prescription Drugs” (Knopf)

www.PowerfulMedicines.org