

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**

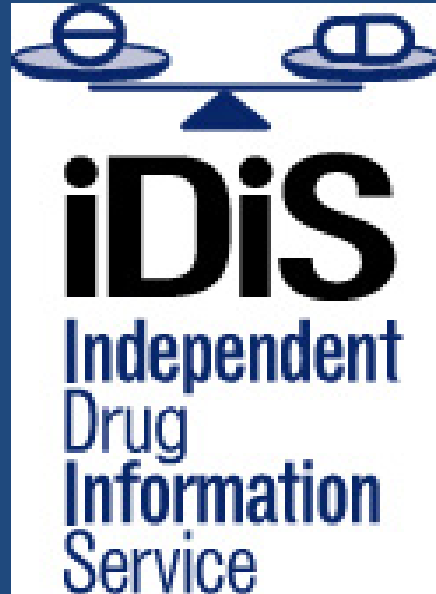
- memos or brochures (“the truth”) sent through the mail
- lectures delivered in the doctor’s office
- about formulary compliance
- about cost reduction primarily
- merely an attempt to un-do pharma marketing
 - that’s why it’s *not* ‘counter-detailing’!

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 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](http://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

Survey item [5 = strongly agree; 1 = strongly disagree] *Mean ± SD*

1. The program provides me with useful information about commonly used medications. 4.6_±.5

2. The content represents unbiased and balanced information about drugs. 4.6_±.6

3. The program provides a perspective on prescribing that is different from what I get from other sources. 4.4_±.7

4. I find the patient materials useful in my practice. 4.3_±.8

5. It makes sense for the Commonwealth of Pennsylvania to devote resources to this activity. 4.4_±.7

6. My Drug Information Consultant is a well-informed source of evidence-based information about drugs I prescribe. 4.6_±.6

7. Being able to get Continuing Medical Education credits from Harvard is a valuable component of the program. 4.1_±1.2

8. I would like to see this program continue. 4.6_±.6

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](http://www.RxFacts.org)

[www. NaRCAD.org](http://www.NaRCAD.org)

[www. DrugEpi.org](http://www.DrugEpi.org)

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

www.PowerfulMedicines.org