Educational outreach ("academic detailing") to improve the quality and affordability of prescribing

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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.

The problem

- Busy clinicians don't have the time or opportunity to get current, evidence-based comparative information on the benefits, risks, and cost-effectiveness of drugs.
- New findings on therapeutics are often poorly disseminated.
- Promotional messages to doctors and patients drive prescribing toward the most costly choices
  - even when newer drugs 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 medications 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 drug 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 Rx 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.

Big change is in the air

Not because we've gotten smarter, but because we're heading off a cliff

- and health care is poised to take the entire economy with it.

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
  - in our programs, most are experienced clinicians on Harvard Medical School faculty
- ***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

- Outreach educators are pharmacists, nurses, or MDs
- They are given special training in ‘social marketing’ to enable them to deliver information…
  - in the prescriber’s own office
  - in a two-way discussion that is
    - *interactive*
    - *engaging*
    - *clinically relevant*.

Essence of the approach

- It's a ***service*** to practitioners
- Starting point is guiding ***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*
- Can also be used for clinical decisions other than drugs
  - imaging studies, lab tests, referrals

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 what might be the first "direct-to-consumer un-advertisements"
  - e.g., "Common Sense About The Common Cold"

What academic detailing **is not**

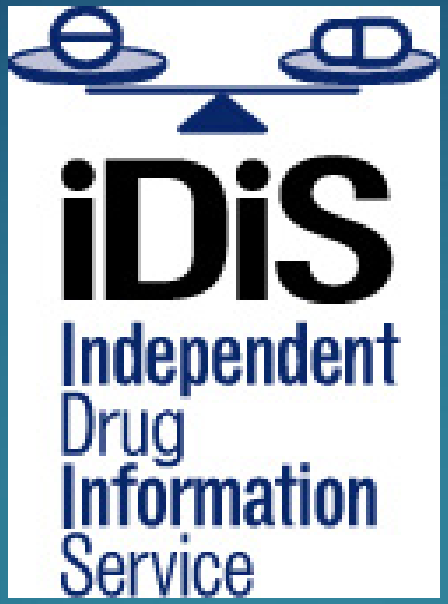
- memos or brochures (“the truth”) sent through the mail
- lectures delivered in the doctor’s office
- about formulary compliance
- about cost reduction primarily
- merely an attempt to un-do pharma marketing
  - that’s why it’s ***not*** ‘counter-detailing’!

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** – "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)*

iDiS Independent Drug Information Service

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:

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

www.**PowerfulMedicines.org**

www.**RxFacts.org**

www.**NaRCAD.org**

www.**DrugEpi.org**