

Content from HealthLeaders-InterStudy's
New England Health Plan Analysis, Spring 2010, Vol. 9 No. 2:

April 23, 2010

Academic Detailing Spreads As Maine, Mass. Join Vermont

The national trend to give providers impartial information about prescription drugs has roots in New England and is gaining adherents. “Academic detailing” aims to provide physicians with a more complete, and presumably unbiased, education about what specific drugs will do, using pharmacists to offer current evidence-based information to doctors.

Vermont led the way in New England, putting its academic detailing program in place in 1999. Maine came online in 2009, as did Massachusetts. Now academic detailing is springing up across the country, with at least 10 programs active.

Table 1-1: New England Academic Detailing At A Glance

State	Structure	Topics
Maine	Mandated by legislature; operated under auspices of medical association	Type 2 diabetes, anti-platelet therapy
Vermont	Department of Health directs program In collaboration with Univ. of Vermont	Insomnia, depression, hypertension, cholesterol, heartburn
Massachusetts	Collaboration w/Commonwealth Medicine	Type 2 diabetes

Source: Prescription Policy Choices

“We don’t want to be the substitute for the pharma companies if that is where a doctor decides to get information, but what we’d like to have is equal access so we can provide evidence-based information, and I think for the vast majority of doctors and prescribers, that is what they want,” said Noah Nesin, M.D., chair of Maine’s academic detailing advisory committee.

While Vermont’s program has been around longer, the Pennsylvania initiative is the most expansive, due to its \$1 million a year budget (financed through state lottery funds). Pennsylvania’s program, PACE (Pharmaceutical Assistance Contract for the Elderly), is the brainchild of Jerry Avorn, M.D., a professor of medicine at Harvard University. He conducted research showing that for every dollar spent on academic detailing, overall healthcare spending goes down by two dollars.

“The real concern about healthcare, as well as healthcare reform in general, is that while there has been some tweaking in terms of cost control, there has been no real momentum in terms of controlling costs,” said Ann

Woloson, executive director of Prescription Policy Choices, a Maine-based nonprofit providing research and information on prescription drug policy.

“What we hope academic detailing achieves is that patients and prescribers will have access to non-biased information that shows what really works best, what is the most effective and the safest. Many times new drugs are heavily marketed, and there is nothing wrong with that,” said Woloson. “If we can improve the quality of care by promoting more effective and safe medicine, then savings will come.”

Recent studies show physicians support the need for impartial information on drugs. The March 2010 *Journal of the American Medical Association*, reported that only about a third of 328 recent studies published in six top medical journals offered comparative effectiveness data. Two-thirds of the studies compared a drug to either an unavailable drug or a placebo—information not helpful to physicians faced with a choice.

An academic detailer’s job is to give unbiased, complete information to enable physicians to make the best decisions for their patients. “The idea is not just to put people on cheaper drugs, but not on ones that are overly expensive if the evidence is not there,” said Marcia Hams, director of prescription access and quality for Community Catalyst, a Boston-based healthcare advocacy group. “Pharma may argue they are doing education and this is not necessary. But it is clear from the incentive structure set up, they are there to promote their product.”

Vermont Program Has Roots Back To Late ‘90s

Vermont’s program is run through the University of Vermont (UV) College of Medicine, with support from Blue Cross Blue Shield of Vermont, the Fletcher Allen Community Health Foundation, the Vermont Department of Health and the University of Vermont. The program is funded by a 2007 fee on Medicaid prescriptions. The fee is 0.5 percent of the previous calendar year’s prescription drug spending by the office, with around \$200,000 of the collected fees directed toward the academic detailing program. Vermont’s team consists of three clinical pharmacists and three physicians.

“Our goal is to help prescribers make decisions in alignment with what the medical evidence says. We don’t go in to try and counter the drug companies’ message, and sometimes the latest drug to market is the best choice,” said Amanda Kennedy, PharmD, director of the Vermont academic detailing program. “We look at efficacy, safety and cost, and it is important to balance all three. With all the literature coming out, there is really no way primary-care providers can keep up with all of it.”

Table 1-2: Top 5 Pharma Companies In Vermont Based On Marketing Expenditures

Ranking	FY 07	FY 08	FY 09
1	Eli Lilly	Eli Lilly	Eli Lilly
2	Pfizer	Pfizer	Prizer
3	UCB	Novartis	Forest Laboratories
4	Novartis	Merck	Merck & Co., and Merck/ Schering-Plough
5	Merck	Forest Laboratories	GlaxoSmithKline
Top 5 avg. expenditure	\$351,230	\$303,949	\$246,108

Source: Office of the Attorney General

Vermont’s team does more than 100 sessions a year and has presented information on management of migraines, depression and insomnia, among others. The team doesn’t target prescribers but goes where it’s invited, and chooses topics in answer to expressed needs.

“If Medicaid is saying they see a lot of agents being used to stop migraines that are expensive, and if providers are saying they are seeing a lot of patients with migraines, then it may seem like a good topic to select,” Kennedy said. “We have a good relationship with BC/BS, and we can ask them for de-identified data that can help us [when developing modules]. We don’t want to know names, but we can ask how many scripts are coming in for the targeted medicines we are interested in, like for antipsychotics. It would be helpful for us to know if the scripts are being written by psychiatrists or primary-care providers, for instance. We want to know where the scripts are getting started. We are just trying to understand the patterns in the state, so we can understand where we need to focus our scientific review of the data.”

With a limited budget, the state has not yet developed a specific protocol to see if prescribing patterns are changing. Providers fill out a follow-up survey that asks how likely the providers are—based on the evidence presented—to change prescribing patterns after a detailing presentation.

Vermont officials have taken steps to curb pharma marketing practices. The state attorney general’s office tracks pharma spending, and found that in the 12 months ending July 1, 2009, 85 pharmaceutical manufacturers paid \$2.6 million to Vermont doctors, hospitals, universities and others to market their drugs, down from nearly \$3 million the previous year. In 2009, the Vermont legislature banned most gifts to healthcare providers by manufacturers of prescribed products. The legislature also eliminated the “trade secrets” protection, so that starting next year, the public will be able to look up the name of a doctor or a drug or device and find out how much manufacturers spent on each. The gift ban does not apply to speaking fees; expenditures for research projects, clinical trials, or specialized training for medical devices; donations of medical device demonstration units and other educational materials; and free samples of medical devices. Top drug marketers in the state are Eli Lilly, Pfizer, Forest Laboratories, Merck and GlaxoSmithKline.

Maine Program Under Auspices Of State Medical Society

Maine’s program is partially funded by a fee on pharma companies doing business in the state. The team consists of two detailers, both physician assistants, and is run under the auspices of the Maine Medical Association. It has been active since September 2009.

“The Maine Medical Association brings a lot of credibility when you are trying to get into physician practices and remove some of the barriers you may face otherwise in getting a visit,” said Noah Nesin, M.D., chair of the Maine academic detailing advisory committee. “There can be a knee-jerk reaction and physicians can say ‘this is just Medicaid sending people out to try and cut costs.’ The first clinical module we did on diabetes, the evidence does point to the least expensive drugs, but for anti-platelet therapy, the best evidence supports use of more expensive drugs. That refutes the idea it is all about cost savings. But on the other hand, the appropriate use of expensive drugs, like anti-platelet drugs, for appropriate periods of time will result in some cost savings.”

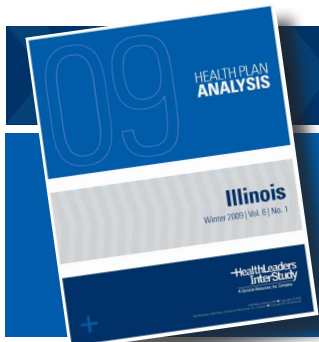
As with Vermont, Maine’s program does not target prescribers based on any discernable trends. “Maine is a data-rich state, with tremendous access to data, especially through Medicaid,” said Gordon Smith, executive vice president, Maine Medical Association. “I’m sure there is a temptation on the part of the state to say let’s get the biggest bang for our buck and call the top 10 prescribers of the most expensive drugs and say let’s target those prescribers. We will not do that. We are interested in helping prescribers have independent clinical information prepared by experts so they can better manage patients. If it is a more expensive drug, so be it, and if it is less expensive, that is wonderful.

“We are not critical of the industry at all,” Smith said. “And we know there are still close relationships out there between some prescribers and the industry. In any week, we may have two presentations in the state on one module, where there could be 100 or more visits by pharma marketing and sales people. And we have a good relationship with the pharma industry. We asked if we could present one of our modules to them—we wanted the industry to know what we were doing and wanted their feedback. We presented and had a nice exchange, with everyone from Pfizer to AstraZeneca. I felt it was positively received.”

Presentations are for diabetes and anti-platelet therapy, with data on when clopidogrel is better than aspirin, for instance, as well as the role of prasugrel. “We are not just going in and saying this med is cheaper so use this,” said Noel Genova, one of Maine’s detailers. “I worked in [primary care] in England for a year, and the pressure was pretty stiff to use the least expensive medication if it had proven to be just as good. We don’t go in with a hard sell to look at the cost. We look at the comparative information and clinical data as well.”

Outlook

Without supplanting the role of the pharma representative, academic detailing provides another voice to help physicians use medications more effectively. As prescribing becomes more complicated and expensive, counter detailing will grow more prominent, especially among payors that demand comparative effectiveness among prescribers data. ■



Get To Know Us Better

HealthLeaders
InterStudy
A Decision Resources, Inc. Company

This article is just one example of the comprehensive managed care and healthcare market intelligence HealthLeaders-InterStudy delivers. To learn more about how our national and market-specific data and analysis products can meet your business needs, visit www.HL-ISY.com.

To purchase our Health Plan Data & Analysis reports, contact **Randy Hagopian** at **781.296.2694**.