A program that is gaining interest and momentum in some health care circles is so-called academic detailing. One of the most developed programs is a Pennsylvania initiative officially known as the Independent Drug Information Service (iDiS), in which trained persons meet with physicians throughout the state. The program’s goal is “to improve appropriateness of prescribing by providing unbiased, noncommercial, evidence-based, and timely information to prescribers.”

In my column this month, I along with Dr Voisine, describe the concept of academic detailing programs in the United States and Australia.

**What are the goals of academic detailing?**
The primary aim is to prevent the overuse and misuse of certain medications. This is done by educating prescribers about therapies that are clinically appropriate as well as the costs of therapeutically similar choices. It is less an issue of switching to generics than it is of step therapy or moving toward cost-effective therapeutically equivalent options.

A well-designed program should maintain prescriber autonomy and quality of care while helping manage costs of drugs to both the payer and the patient.

**How did this initiative come about?**
The Pennsylvania initiative grew out of a desire to implement sound policies for prescription drugs across all of the state’s programs. The academic detailing program iDiS replaced a point-of-sale prospective audit that rejected claims for certain drugs not on the state’s preferred list. According to iDiS, the program of prospective drug utilization did not result in any provider education and resulted in iDiS, generically called “academic detailing.”

**How does the program work?**
Academic detailing programs have a field staff that not unlike detailers for pharmaceutical manufacturers, calls on physicians who are high-volume prescribers of drugs whose costs are targeted for management under the program. The Pennsylvania program targets prescribing in appropriately half a dozen different therapeutic classes, including cyclooxygenase-2 (COX-2) inhibitors and proton pump inhibitors.

Administration of the program falls under the Pennsylvania Office of Health Care Reform. Clinical direction comes from consultants at Harvard Medical School, who have trained a team of Pennsylvania clinicians on academic detailing; the selected drug classes, including rationale for the selection; and the message for prescribers.

**Who staffs these programs?**
Academic detailers have backgrounds in nursing, pharmacy, and pharmacology. Some programs have used physicians as detailers, but this increases the costs of the program.

**How are the targeted drugs selected?**
Program leaders frequently comment that academic detailing is not about not prescribing a particular drug because of cost. Instead, they say it is about targeting certain categories of drugs that have the potential to be overused or used inappropriately and for which physicians need medical evidence regarding appropriate prescribing of these agents.

**Does this approach really work?**
Available reports suggest that academic detailing has had an impact on prescribing habits. For example, Simon and colleagues studied the prescribing patterns of antihypertensive medications for patients with newly treated hypertension who were receiving treatment at 9 clinical sites of a large HMO. The researchers randomly assigned 3 practice sites to group detailing (227 prescribers), 3 to individual detailing (235 prescribers), and 3 to usual care (319 prescribers). In the first year following academic detailing, absolute rates of use of diuretics or -blockers increased by 13.2% in the group detailing practices, 12.5% in the individual detailing practices, and 6.2% in the usual care practices (which received only a mailed practice guideline).
Regardless of the approach used, distribution of guidelines without personal contact did not appear to have any impact on prescribing.\(^5\)

**Is the effect of academic detailing sustained?**

Whether the effect of academic detailing is sustained appears to depend on the approach used to influence prescribing. In the Simon study, at 2 years after detailing, use of guideline-recommended medications over baseline was greater with individual detailing practices (14.7\%) than with group detailing practices (11.3\%), which were similar to the increase seen in the usual care practices (10.1\%).\(^2\) This may suggest a persistent effect of individual detailing but not of group detailing. However, neither type of academic detailing had a clinically meaningful effect on blood pressure control, so there was no negative impact on quality of care. It appears that to achieve a sustained impact on prescribing, the message needs to be repeated.

**Is the purpose of the program to save money?**

Saving money is not the only reason for the program. The literature on academic detailing highlights quality of care as the mission of the program. The educational focus is on appropriateness of care and, in contrast to traditional pharmaceutical industry detailing, is not targeted to marketing or sales of branded drugs.

Another study estimated the costs and cost savings of implementing an academic detailing program as described above.\(^3\) The costs and cost savings in the group and individual detailing arms were compared with the standard of care arm that only received guidelines by mail. Analyses took the perspective of the payer. Mean detailing time for individual sessions was 30 minutes (range, 10 to 90 minutes), including travel time to the physician’s office and time spent waiting for the meeting to begin. Group sessions lasted 60 minutes.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Total cost</th>
<th>Cost per physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline mailing</td>
<td>$1000</td>
<td>Not available</td>
</tr>
<tr>
<td>Group detailing*</td>
<td>$5500</td>
<td>$63.00</td>
</tr>
<tr>
<td>Individual detailing</td>
<td>$7200</td>
<td>$96.00</td>
</tr>
</tbody>
</table>

*Includes costs of guideline mailing.
Data from Simon SR et al. *J Clin Hypertens.* 2007.\(^5\)

The total costs of each intervention are shown in the Table. Not surprisingly, the individual intervention had the highest costs. For all patients with incident hypertension in the individual detailing arm, the annual total drug cost savings were estimated at $21,711 (95% confidence interval, –53,131 [cost savings], +$9,709 [cost increase]). The authors suggested that the results might provide guidance to health plans on the costs of academic detailing interventions to change prescribing.

**If the purpose is not to save money, what is the value of academic detailing?**

The consensus among academic detailing program managers and managed care executives is that academic detailing has value as an active method of influencing prescribing habits, rather than the passive methods of a closed/restricted formulary, preferred or tiered drug lists, rejection of claims, or prior authorization programs.

In some cases, academic detailing can be used to influence adoption of best practices. In a recent initiative in New York City,\(^2\) health educators were trained on the latest guidelines and evidence-based data for breast cancer screening to increase screening in an inner-city setting.\(^6\) After academic detailing, the results showed significant increases in physicians’ knowledge of current
guidelines for screening and increases in breast cancer screening in the target population.

**Is participation voluntary?**

Participation in these initiatives is voluntary, according to the iDiS and a Vermont program. However, this may change. For example, as large HMOs implement such programs, participating could become a requirement of re-credentialing or of health plan participation. More important, academic detailing activities have been linked to quality improvement initiatives and others have described academic detailing activities as a component of an electronic health record. In addition, because there is no commercial interest, it is possible that CME credits or Continuing Education Units could be incorporated into this type of program.

**Pharmaceutical detailers typically use incentives to gain a physician's time. Do these programs use incentives?**

“Knowledge is the main incentive,” according to the iDiS program. A program in Australia notes that physician compensation is available for participation in some of its activities but does not provide details. One program manager noted that the educators running the activity will bring sandwiches for lunch if asked to do so.

**Where are academic detailing programs in place?**

In addition to the programs in Pennsylvania and Vermont, there is also a very active program in Australia that is an initiative of the country's National Prescribing Service. Maine recently enacted legislation establishing a statewide academic detailing initiative. Programs are in place widely throughout Europe.

**How much does a program like this cost?**

There is no simple answer to that question. The cost depends on the type of program and the program’s offerings (eg, frequency of visits, individual or group detailing, staffing). The Pennsylvania program costs about $80,000 a month. Program managers note that this is not a lot of money as a component of a program that spends $3 billion a year on prescription drugs through all of its prescription benefits programs, including the state Medicaid program, the Program for All Inclusive Care for the Elderly, and the state employee retiree program.

**Are there any programs that address HIV care specifically?**

There are no HIV-specific academic detailing programs as yet. The Australian program does address HIV medicine in a variety of ways. Fact sheets for antiretroviral drugs are available and a number of program-sponsored conferences address managing HIV care.

**What is the relevance of this to HIV medicine?**

As patients with HIV/AIDS live longer, it becomes necessary to treat diseases of aging as well as the long-term effects of HIV infection and antiretroviral treatment. That includes hypertension, cardiovascular disease, and the lipid and metabolic disorders often seen in our patients. While there are essentially no generic antiretroviral drugs available for use in the United States, this may change. Significant numbers of HIV-infected persons are cared for in publicly funded programs (eg, Medicaid, the Ryan White CARE Act, and Medicare), and many states have demonstration projects under way for Medicaid Managed Care. Restricted formularies are a fact of life in managed care and publicly funded programs. The usual driver of formulary restriction is cost. A passive approach to drug utilization management is the restricted, or tiered, drug list. Prior authorization requirements are often part of this drug utilization management. An active approach, such as academic detailing, that manages costs of prescription medication programs allows the provider to retain the ability to respond to individual patient needs. In the end, it is all about maintaining the quality of care for our patients.

**References:**


Source URL: http://www.physicianspractice.com/articles/academic-detailing-questions-and-answers

Links: