NPA Avoiding Conflict-of-Interest in Medicine
Leadership Development Call Series Archive

Rx Information: Non-Biased and Evidenced-based or Industry Influenced?
June 26, 2013

CALL NOTES

9 pm - Welcome and Introductions: Rachel DeGolia, Call Facilitator
Welcome to this bi-monthly Conflict-free Leadership call hosted by the National Physicians Alliance as part of its Unbranded Doctor project which takes place under the Partnership to Advance Conflict-free Medical Education, PACME, grant. I am Rachel DeGolia, facilitator for this call and a board member of the National Physicians Alliance. In my day job, I direct the Universal Health Care Action Network.

According to our pre-registrations as of yesterday, we have a good mix of physicians, faculty and students from across the country on this call including the following states: AZ, CA, IL, MA MI, NJ, NY, OH, OR, PA, VA, WA

The PACME grant is the result of a state Attorney General settlement regarding the inappropriate marketing of the drug Neurontin. Partners for the grant include the National Physicians Alliance, American Medical Student Association, Community Catalyst and the Pew Charitable Trust. The goal of the project is to reduce conflicts of interest created by the pharmaceutical industry in the medical profession and medical research. The partners on this grant promote a number approaches to raise awareness of the issue and to build leadership in the medical profession to eventually eliminate some conflicts.

For more information about the National Physicians Alliance and PACME, please visit the NPA Unbranded Doctor Website at: **npalliance.org/conflict-free**

The topic for tonight's call is "**Rx Information: Non-Biased and Evidenced-based or Industry Influenced?.**" We have two terrific speakers with us tonight. They are:

- **Michael Fischer, MD, MS**, Director of *the National Resource Center for Academic Detailing (NARCAD).* Dr. Fischer is a general internist, pharmaceoepidemiologist, and health services researcher. He is an Associate Professor of Medicine at Harvard and a clinically active primary care physician and educator at Brigham and Women's Hospital. He has extensive experience designing and evaluating interventions to improve medication use. Dr. Fischer will describe NARCAD, how it came to be and how it can help programs develop academic detailing

- **Noah Nesin, MD** is a family physician and Chief Quality Officer at Penobscot Community Health Care in Bangor, which is the largest FQHC in Maine. Previously Dr. Nesin served as Medical Director for the Health Access Network in Lincoln, Maine and in private practice for over 20 years in the region

served by Health Access. He continued a medical practice begun by his father 50 years ago. Dr. Nesin is a fellow of the American Academy of Family Practice and also chairs Maine's Academic Detailing Advisory Committee. He is going to describe for us the Maine's unique Independent Clinical Information Service as well as programs provided physicians and patients by the Alosa Foundation regarding evidence-based medication.

Becky Martin, NPA Project Director
Becky: As part of the PACME project, the National Physicians Alliance provides educational opportunities and outreach to our members across the country, as well as medical students and other physicians and interested parties. These bimonthly leadership calls and our National Grand Rounds series cover topics related to conflict of interests and opportunities for reducing such conflicts. We have sponsored 7 calls over the last year and a half, recordings area available on our website along with our archived National Grand Rounds webcast series at www.npalliance.org/conflict-free

I also want to bring your attention to our national conference which will take place on Oct. 19-20th in Washington DC and will feature workshops and networking with NPA members and leadership. Please visit our website at www.npalliance.org for more information.

Michael Fischer, MD, MS, Director of *the National Resource Center for Academic Detailing (NARCAD)*
Dr Fischer: I will given an overview of academic detailing recognizing that many of you have some familiarity with it. Then I'll talk about what the National Resource Center for Academic Detailing does. It came about as a result of problems about how clinicians learn about new drugs. In our pre-clinical training we learned little about how to evaluate the literature to understand which medication would be the best choice in a given circumstance. Once we are out of training and into clinical practice there really is no ongoing mechanism to help us keep up on the ongoing literature and what is most clinically important. The original insight in the later 70's was that there was education out there that was effective that pharmaceutical detailers were providing coming into doctors' offices to provide one-on-one with clinicians. This allowed them to identify what clinicians were interested in and how to give them information that would change their behavior. CME is usually dry and boring and really doesn't change clinical practice, so it does not compare favorably with the visually attractive materials and approach by the pharmaceutical detailers. We needed to deliver good, academically valid content and present it in a way that was more effective.

The original studies of academic detailing were done by the Chief of the Division where I did my research and were published in the early 80s. They worked with 4 Medicaid programs in diverse states, used the Medicaid file to identify doctors who saw a lot of Medicaid patients and randomized them to send them mailed brochures about how to prescribe better or to receive academic detailing by clinical pharmacists trained in social marketing (this is the technique the pharmaceuticals were using) and had learned how to engage people and be persuasive. They did a series of educational interventions around avoiding the overuse of antibiotics for respiratory infections, reducing the use of cerebral dilators for dementia, and getting people to avoid using Darvon for pain (not removed from the market for another 30 years). The analysis of the data showed a 14% reduction in prescribing of the overused drugs who got the detailing intervention and a very positive response from them. A follow-up cost effectiveness analysis showed it save $2 in drug costs for every $1 spent on the intervention. A second study a few years later focused on nursing homes trying to reduce the use of some sedating drugs and showed a similar impact.

In terms of the evidence base for academic detailing, there have been subsequent studies with out patients and in-patients which showed that it is an effective intervention although it really makes a difference how well it is implemented. It has to be done with high quality to be effective.

What happened in the US is that after the initial studies not much happened. In the 80's Kaiser Permanente had one large program that is still going on today. Kaiser has a distinctive structure with everything under one roof, so the patients they see are also covered by them and the concepts underlying evidence-based prescribing make more sense. In the rest of the US, the fragmentation of the health care system has made it much more difficult for academic detailing to get traction. Under Medicaid, for example, any given doctor is only likely to see a minority of patients, so a program would have to pay quite a lot to train a given doctor and only see the benefit from 5 or 7 or 10 patients that clinician sees. That collective action problem is a major limitation.

Over the last decade, that has begun to change. In some areas where Medicaid programs have a high density, for example, academic detailing is being used not only for drugs but also for other public health programs. In Connecticut, for example, a child health program has provided education for pediatric office clinicians on development screening, as well as programs sponsored by the CDC in a variety of states to try to improve cancer screening rates especially for colon cancer.

In 2009-10, HRQ put out a new portfolio of new grant programs utilizing comparative effective research. They wanted to create a resource center to support academic detailing – it's been proven it works – the purpose was to help programs interested in using it to get programs started. It was challenging to get the approach implemented.

For three years now, NARCAD is helping get programs started and to assist programs already under way to improve and evaluate their impact. Go to www.narcad.org for more information. One of our core activities is to train people on how to be an academic detailer – we've had them every 6 months, 5 so far, and trained about 100 people from 12 or more programs to date. These are intensive 2-day trainings in Boston which involve a series of exercises that teach you how to do social marketing. How do you establish a relationship, give them information that will allow them to improve their practice, and make sure that when you talk about a change and they agree with you that they will actually make that change. The next one is Sept. 16-17 in Boston. We are trying to get funding from HRQ to extend a few more years.

We also work with programs on needs assessment to look at their data and identify the problem areas they might want to address. We help programs craft and develop their messages – it really is an art so it effectively communicates in a one-on-one encounter. We help organizations manage programs they have in the field and assess if they are succeeding.

<u>Questions for Dr. Fischer:</u>

Q: What is AHRQ?

A: The Agency for Healthcare Research and Quality which is not a division of NIH, but it funds a good deal of health services and comparative effectiveness research.

Q: Do other countries utilize academic detailing as a mechanism for reaching out to prescribers and if so, does NARCAD interact with other programs nationally.

A: Yes. Other places internationally employ academic detailing very effectively where the environments are move favorable for this. About half all the doctors in Australia, for example, see academic detailers which is possible given their national health care system – it makes it easy to invest in this. Several Canadian provinces do as well, some regions of the UK. We at NARCAD communicate with these programs.

Q: What is your email if someone wanted to contact you directly?
A: People can reach me at <mfischer@partners.org> or through NARCAD.

Noah Nesin, MD is a family physician and Chief Quality Officer at Penobscot Community Health Care
Dr. Nesin: I was in private practice for 20 years and in the 90's I stopped accepting samples, which was standard practice till then, something I had never been comfortable with anyway. By 2000 I stopped accepting literature or anything from pharmaceutical representatives. Instead, I started listening to primary care medical abstracts which is a great resource for exactly what Michael talked about. Most of us in primary care do not have the expertise to critically review the literature and this does it for you. I was fascinated by a report on the Pennsylvania academic detailing program on one of those EDs and it energized me behind the idea that we needed to separate ourselves from the pharmaceutical industry in our prescribing choices. Maine is a small state and health providers here were aware of my interest. In 2008, the Maine Legislature passed a bill to start an academic detailing program with funding from an assessment on the pharmaceutical companies doing business here. It wasn't much money, Maine is very rural with 1.3 million people and providers spread out over a large area with some concentration in cities. The program was housed in the Maine Department of Human Services and administered by the Maine Medical Association. It's been a good partnership but with some challenges. The mission of MMA to advocate for the interests of physicians does not always fit perfectly with the goals of an academic detailing program. When the program started, I was asked to chair the advisory committee since it was launched in 2009 and includes pharmacists, advocates, and others with expertise in this area. We have two part-time staff as academic detailers for the entire state. They do an excellent job, have been trained through Michael's program, but that makes it a challenge to reach as many providers in the state as we'd like. We have not been able to reproduce the evidence for the effectiveness of academic detailing in Maine because of our limited resources. Jerry Ahorn had an op/ed in the NYT a few weeks ago about the challenges.

Our model involves a traditional detailing visit as well as speaking to professional association groups and speaking to groups of physicians at practices. That allows us to reach more people with limited resources. While we don't have robust evidence of the effectiveness regarding how it affects prescribing practices, but responses have been very positive and the majority who have experienced one of these trainings do invite us back to address other areas of interest. We think it is having an important effect.

Our modules so far include hypertension and chronic pain – Maine is one of the worst areas in the country for misuse of opioids, and obesity is our next module. These are important topics in primary care.

A challenge for us is that some providers, write in their evaluation that the presentation is good, visually pleasing, and the materials we leave with them are helpful – a pocket card and more details, but occasionally they say they wish the presenter was an expert. When they get a detailer from the

pharmaceutical company that person is not an expert, but they don't realize that. We are presenting well-distilled best evidence so hopefully it doesn't require an expert.

We have run into our own problems with conflict-of-interest around antipsychotics, for example. We discovered that one of the people on the panel that advise the Maine Medicaid program on these drugs for children had a very significant relationship with a pharmaceutical company producing these drugs. We discovered this from ProPublica which posts payments that doctors receive from pharmaceutical companies around the country; you can look people up by name. It was uncomfortable to address this conflict-of-interest because the MMA, to which this person belongs, administers the panel.

Our program is not as robust as Pennsylvania's but we think will mature into something even more effective and that more and more providers around the state see as more and more valuable. There is gradual realization of the role the industry plays and the problems this has caused in our state.

A few resources that are important for providers:
AHRQ <www.ahrq.gov> has links to their evidence-based resources which are very clinically appropriate and useful. Also, the Primary Care Clinical Abstracts are easy to listen to, very entertaining, and give you a general feel for how to evaluate studies as well as provide information on the specific topics they cover. Physicians for Responsible Opioid Prescribing <www.supportprop.org> is a good resource. Michigan State puts out a very useful newsletter, *Evidence-based Medicine*.

Q: What is your email address?
A: nnesin@pchc.com

Q: How does Maine determine what therapeutic classes of drugs to provide information on? How does it decide what modules to offer?
A: Primarily we see what's available and current from the Alosa Foundation since they are really on top of what people are most interested in most of the time, such as their anti-psychotic module and their module on obesity. We make sure they've been updated recently enough, then get trained in presenting them and then launch them. The decisions are made by the Advisory Committee I chair but with deference from the detailers who hear directly from the providers about topics they'd like to hear about.

Mike: The Alosa Foundation is a nonprofit based in Boston and I am a clinical consultant to them. It's dedicated to spreading evidence-based practice. By the way, Alosa is the genus of fish that swim against the current such as salmon. Their website is www.alosafoundation.org and the materials that Noah mentioned are available from rxfacts.org which are from the last three years. Feel free to contact me if you have questions about working with them.

Q for either Dr Fischer or Dr. Nesin:
Does the industry every weigh in on your programs... do they or are you aware of any back lash from the industry regarding the services you provide?

Noah: In Maine there has not been tremendous backlash directly from the industry although they resent the assessment that funds the program. We have had individual providers with strong

relationships with the industry vocally criticize us as being biased against the pharmaceutical industry, or trying to drive them out of business, or who feel personally judged by what we do.

Mike: One criticism that comes up of academic detailing is that it's just about cutting costs, just say no to the drug. It's important to not let a program get pigeon-holed as counter-detailing andr eally to go where the research takes you. When there's a break-thru therapy that's proven to help patients and be effective, than academic detailers should be in there telling physicians about it and encouraging them to prescribe it. If it's the same message as the pharmaceutical industry's, then so be it.

Noah: That's right. We ran into that with the diabetes module that favored the use of older drugs and we said that and that undermined exactly that argument.
Mike: If you are looking to start a program it is key to be very clear about that with the sponsor of the program. If the evidence says there is a more expensive test or treatment we will get out there and say that's what the evidence says. If the sponsor is looking purely for cost containment, this can be a source of conflict.

Back to the question of backlash from the industry … there has been a large effort on two tracks. One is to assert that academic detailers should be restricted in the way that pharmaceutical detailers are and not be unable to talk about anything that is not a labeled indication of the medication. That doesn't make sense because detailers often talk about a range of drugs, and they address diabetes not a specifc drug, for example. They try to put this in the context of a First Amendment issue and given the affinity for corporate free speech as a policy issue may turn out politically to be a winning strategy. There is a bill in Oregon that would have made academic detailing virtually impossible. The pushback is there.

Q: Do you see social media being used for academic detailing?
Noah: Not in Maine, but I will bring it up at our next meeting – excellent suggestion.
Mike: I have not seen programs using social media. Generally it's an area that people are trying to get a handle on it and are discussing it.

Q; Is there a cost to the participants in the trainings to become an academic detailer you described and are you full up for the September session?
Mike: The charge is $800. AHRQ covers 80% of the charge. There are still openings in September.

Noah: ProPublica.com now has published providers' prescribing profiles from 2010 and in Maine we need to move forward with more targeted detailing to target providers who are outliers in prescribing based on the evidence. I wonder if anyone is using their data to do targeted detailing.
Mike: No one yet because it's new and provocative, but very interesting question. A big part of academic detailing is building a reporte with the person you are educating. If you come to someone for the first time they want to know why you are there and are suspicious. If you say it's because of their profile that may be the end of the discussion. That's a challenge. The Pennsylvania program targets based on the type of patients they see. Another approach is if you are educating on a wide variety of topics some people who are problematical in one area may not be another and you may be able to correct their misconception that is leading to the problem without threatening them. In places like Kaiser where there is a culture that leads people to expect they will get data as to how they are doing this is not a problem.

Rachel: Our next Conflict-Free call will be in approximately two months – watch your email for the date and information. Recordings and notes of past calls are archived online at http://npalliance.org/conflict-free/

Again, for more information about NPA and this project, visit the NPA Unbranded Doctor website at: npalliance.org/conflict-free . For more information on the AMSA PharmFree Scorecard, visit http://www.amsascorecard.org/

Thank you to our speakers and to all the participants!

NPA is a proud partner in the Partnership to Advance Conflict-free Medical Education (PACME). This partnership and related materials were made possible by a grant from the state Attorney General Consumer and Prescriber Education Grant Program which is funded by the multi-state settlement of consumer fraud claims regarding the marketing of the prescription drug Neurontin.

For additional information please contact Becky Martin, NPA Project Manager, at becky.martin@npalliance.net