

Academic Detailing: What's in a Name?

Changing prescribing patterns in a systematic manner can be accomplished in many different ways. Here are some of the approaches—and definitions of the often-confusing and overlapping terms for academic detailing.

Academic detailing, educational detailing, and counterdetailing are tools being used by managed care organizations to influence physician prescribing practices. On the surface, counterdetailing seems a rather direct process, albeit with local variations and styles. However, these terms represent widely different approaches to contacting and convincing prescribers of new ways of thinking about pharmacotherapy.

In this article, I will analyze the definition problem, discuss what each approach involves, and present expectations and potential outcomes.

TWO SCHOOLS OF THOUGHT —

Experts in this field and researchers on methods' effectiveness cite a variety of options for operationalizing detailing and use different terms to identify the nature of their programs. Pharmacists involved in these programs tend to fall into essentially three schools of thought. The major differences seem to

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be focused on how the various practitioners view their roles.

One school identifies counterdetailing, academic detailing, or educational detailing as equivalent terms representing programs for approaching physicians about their prescribing behaviors. This school tends to be represented by pharmacy managers of provider groups, pharmacy benefit management companies (PBMs), and health plans. The major focus is to use clinically trained pharmacists to offer information to targeted prescribers with the goal of achieving well defined outcomes (e.g., formulary compliance, contract compliance, appropriate drug use, appropriate dosages). When face-to-face encounters occur, the pharmacists provide mini tutorials on drug categories that are directed more to the promotion of formulary guidelines rather than the promotion of specific products. In health plans and managed care organizations, customers can measure specific cost savings or behavioral changes. For PBMs—where formulary or contract compliance may be the goals—purchasers can identify the effectiveness of their benefit designs.

The second school, largely represented by university and staff model practitioners, consider academic detailing to be a more pure program of prescriber education that carries an aura of higher credibility, because it does not focus on commercial objectives. They point to the work of Jerry Avorn, M.D., of Harvard University, who in the 1980s demonstrated that one-on-one visits with physicians offering objective and scientifically supported drug information could change prescribing behaviors. Additionally, Avorn was promoting better geriatric care rather than focusing on costs. These practitioners cite that counterdetailing seems to be the term applied for counter-marketing programs, which are directed to contradict the information and impressions left by sales/professional representatives from drug manufacturers. Detailing by Pharm.D.s and Ph.D.s working for drug manufacturers focuses on product, while the goal of counterdetailers is to

educate the physician in the proper treatment of disease. This process is based on the development of long-term relationships with prescribers, rather than achieving short-term financial goals.

The third school, largely represented by drug manufacturers, holds that detailing is a product-focused activity. They contend that limitations on access to physicians—closed formularies, prior authorizations, and stepped-care approaches to therapy—essentially are counterdetailing methods since they prevent conveyance of information about a specific product, company, or representative. Detailing by professionals with outstanding credentials (e.g., Pharm.D., Ph.D.) allows application of a wealth of drug and disease information for educating prescribers about the most effective use of the company's agents and other collateral disease information necessary to manage patients properly.

All three schools consider the term detailing to be offensive and offer alternative terms to represent their intentions to physicians and other prescribers—terms such as physician visits, clinical interventions, and pharmacy interventions. Pharmacy practitioners differentiate among efforts that are based on the three motivations for the intervention:

- ▲ Education
- ▲ Behavioral modification
- ▲ Commercial or financial sales of a product

Prescribers and other managed care players continue to be unaware and uninformed about the distinctions between these terms and the need to label the various points of view. By extension, detailing is totally transparent to the payer/purchaser. As a result, the value of these activities is based on their contribution to the goals of the pharmacy practitioners rather than an intrinsic value or return on efforts/investment in the marketplace.

DEFINING DETAILING

While detailing in its various manifestations is commonly used by PBMs, health plans, and provider group pharmacists, the process is in transition and

new approaches will become more effective. Current approaches include face-to-face interviews with prescribers, e-mail, faxes, report cards, and letters. Most industry experts believe that these programs are effective in the aggregate. However, not all situations require the same methods of communication. Each situation, whether staff, group, network, IPA, or other requires a different approach. Several authorities indicate that prescribers value detailing done by professionals who have experience in direct patient contact. Thus, provider group pharmacists and health plan pharmacists may be seen as the most credible, while PBM pharmacists and pharmaceutical company representatives may be viewed as the least credible. Health plan pharmacists, especially in staff-model settings, undoubtedly are able to stress their common care for the patient.

PBM pharmacists are at a disadvantage because they lack clinical contact and must establish some clinical credibility. PBMs simplify their approach by stressing client representation. They can then stress clinical problems identified through drug-use review and statistical analysis of client-specific data. As a result, prescribers, uninitiated to the differences between pharmacists and practice settings, are presented with information from credible sources (i.e., PBM or health plan pharmacists) representing health plans with which they are contracted.

PBM, health plan, and provider pharmacists indicate that the reality of cost constraints requires that they use face-to-face encounters sparingly and in a very directed manner. Face-to-face encounters are not individually cost-effective in this case, so they must be used in a very focused manner to target specific physicians and specific prescribing behaviors. Several authorities indicate that the face-to-face encounter should be used only for initial contacts to establish relationships and to initiate large behavioral changes. On the other hand, some staff model pharmacy programs make extensive use of physician-pharmacist visits and indicate that this helps them to build long-term relationships that lead to better clinical decisions.

These authorities indicate that IPA or network models may require other methods to achieve the same outcome.

An interesting sidelight to discussions with industry experts is the important role of pharmacists in the detailing process. Introducing clinically trained pharmacists to prescribers brings a level of credibility and professionalism to the process. All experts stress the use of pharmacists, and none mention the use of pharmacist extenders, technicians, or other noncredentialed personnel in these programs. Presumably, this approach effectively counters pharmaceutical manufacturers' nonpharmacist representatives, but it may not be as effective in countering those manufacturers represented by pharmacists, Pharm.D.s, or Ph.D.s. Many physicians value the message brought by pharmacists equally regardless of professional credentials, although some specialty physicians do notice the credentials of the messenger.

MOTIVATING THE PRESCRIBER –

Is a detailing program effective in its own right, or does it merely augment risk-sharing capitation or other incentive-based initiatives for the prescriber? Authorities agree that detailing programs must be part of a program that includes some incentive for physicians. Several experts believe that at least half of the benefit of these programs is a result of built-in physician incentives.

Proponents of academic detailing (as described in the second school of thought) believe that these programs must include an understanding of "what's in it for me" for the prescriber. In their caretaker role, prescribers must

have a view of their total obligations on the clinical and financial fronts. Prescribers must be at risk not just for pharmacy dollars, but for all their decisions affecting use of resources. Carve-out programs, such as pharmacy, do not mitigate the prescribers' responsibility to be educated about the overall effects of their decisions. As a result, one of the long-term goals of academic detailing is to educate the prescriber about risk.

PBM and provider group pharmacy experts indicate that detailing programs are most effective when there is a well-defined prescriber risk. Without some element of risk, the outcomes and benefits of detailing programs are less demonstrable. Since most of these programs are directed toward cost containment, cost drives many detailing interventions. Therefore, prescribers must be at risk for pharmacy benefits for these programs to be effective, and for the PBM and provider group pharmacists to detect prescribing pattern changes based on interventions.

FINDING DEMONSTRABLE RESULTS

The educational benefit of academic detailing is an optimal prescribing decision. Direct education may be of benefit, and long-term relationships are crucial to the development of consistent and persistent patterns of care. However, the measurement of effectiveness in the long- or short-term must be accomplished in some manner, and behavior modification allows a measurement against a frame of reference based on current prescribing practices. Academic detailing programs should have measurable outcome objectives, but the rela-

tively short duration of these programs or the nature of the industry may prohibit the widespread dissemination of these results.

PBM and provider group pharmacists would seem the most data-rich with regard to prescribing practices, and their effectiveness is measured by costs contained or by specific clinical parameters modified. While industry experts indicate that their detailing programs have proven effective, few have published any long-term data on the sustainability of their recommendations in the face of market pressures. Do physicians continue to follow clinical recommendations after multiple encounters with PBM/provider group/health plan pharmacists versus pharmaceutical manufacturer representative visits? One provider group pharmacy expert indicated that they use follow-up tools to evaluate the effectiveness of their interventions, and that the results of these measurements are overwhelmingly positive. Yet, long-term benefits for purposes other than formula compliance seem to be poorly documented at the present time.

While the outcome of detailing programs in actual costs contained is a well-kept secret, one source indicates that a minimum of \$5 of total health care costs are saved for every \$1 spent on pharmacy-detailing programs. As in all businesses, the return on investment is a fundamental indicator of financial performance, and detailing programs will be held to both financial and clinical scrutiny. The use of detailing to achieve financial and clinical goals seems to be one of those tools that will be refined over time to achieve acceptable outcomes in both spheres. ■