The Little Engine that Could: A 20-year Perspective from the Vermont Academic Detailing Program

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I have no conflicts of interest to disclose
Plan for Today

- **Context**: Provide an overview of the Vermont Academic Detailing Program

- **Current State**: Evaluate the current strengths and challenges of academic detailing through the perspective of the Vermont Academic Detailing Program

- **Future State**: Expand our vision of academic detailing to enhance patient care (i.e. think about the conference theme!)
Vermont

623,657 people
US Census, 2017

Produce ~50% of the maple syrup made in the USA. USDA, 2018

Better than USA average:
• Life expectancy and general health
• Smoking
• Pneumococcal vaccinations
• Childhood vaccinations
• Obesity, Physical Activity, Diabetes
• Insurance coverage
Kaiser Family Foundation, kff.org

Worse than USA average:
• Adults reporting mental illness
• Suicide
• Opioid overdose deaths, age-adjusted per 100,000 (18.4 vs. 13.3)
Kaiser Family Foundation, kff.org
Vermont Primary Care

185 Primary Care Practices
- 43% private, 36% hospital-owned, 18% FQHC, 3% concierge
- 825 total clinicians across Family Medicine, Internal Medicine, OB/GYN, Pediatrics

578 Family Medicine and Internal Medicine providers
  349 physicians
  229 nurse practitioners and physician assistants

https://www.med.uvm.edu/ahec/workforereresearchdevelopment/reports
“Vermont demonstrates that academic detailing can do a lot with a little.”

A TEMPLATE FOR ESTABLISHING AND ADMINISTERING PRESCRIBER SUPPORT AND EDUCATION PROGRAMS: A COLLABORATIVE, SERVICE-BASED APPROACH FOR ACHIEVING MAXIMUM IMPACT. A REPORT BY PRESCRIPTION POLICY CHOICE’S ACADEMIC DETAILING PLANNING INITIATIVE, JULY 2008. REPORT PREPARED BY JENNIFER RECK, MA
Vermont Academic Detailing Program (VTAD)
Vermont Academic Detailing Program (VTAD)

Affordable Meds Program
Team-based Academic Detailing (2005, 2006)
Vermont Academic Detailing Program (VTAD)
Sustainable Funding: 33 V.S.A. § 2004

(a) Annually, each pharmaceutical manufacturer or labeler of prescription drugs that are paid for by the Department of Vermont Health Access for individuals participating in Medicaid, Dr. Dynasaur, or VPharm shall pay a fee to the Agency of Human Services. The fee shall be 1.5 percent of the previous calendar year’s prescription drug spending by the Department and shall be assessed based on manufacturer labeler codes as used in the Medicaid rebate program.

(b) Fees collected under this section shall fund collection and analysis of information on pharmaceutical marketing activities under 18 V.S.A. §§ 4632 and 4633; analysis of prescription drug data needed by the Office of the Attorney General for enforcement activities; the Vermont Prescription Monitoring System established in 18 V.S.A. chapter 84A; the evidence-based education program established in 18 V.S.A. chapter 91, subchapter 2; statewide unused prescription drug disposal initiatives; prevention of prescription drug misuse, abuse, and diversion; treatment of substance use disorder; exploration of nonpharmacological approaches to pain management; a hospital antimicrobial program for the purpose of reducing hospital-acquired infections; the purchase and distribution of naloxone to emergency medical services personnel; and any opioid-antagonist education, training, and distribution program operated by the Department of Health or its agents. The fees shall be collected in the Evidence-Based Education and Advertising Fund established in section 2004a of this title.

https://legislature.vermont.gov/statutes/section/33/019/02004
Continuous Quality Improvement

Past
- Team-based AD
- Food and financial incentives

Present
- Improved statewide focus
- Small group visits with 1 detailer
- CME
**Same approach to content with an improved look**

### 2003

**PPI Tapers**
- Rebound hypersecretion can occur in the weeks following PPI discontinuation. Since the duration of action of PPIs is so long that it may take several weeks to present.
- No evidence that the increased acid secretion is of clinical importance.
- Some literature suggests a 2-6 month taper, however data are lacking.

**VA study**
- 71 patients who were “PPI dependent”
  - 42% could not be taken off PPI
  - 42% could be managed with H3RAs or combo
  - 15% could be taken off of medication

**Summary Points**
- 80% of patients will refill prescriptions for H2RAs/PPIs without a clinical re-evaluation of need!!
- If you prescribe empiric therapy, reevaluate the patient in 4-8 weeks - Don’t give a prescription with 11 refills!
- Evaluate PPI doses - Most patients do not require BID dosing
- Discontinue any medications (including PPIs) not deemed necessary - Simplify the medication plan any time it is possible
- Evaluate all medications after hospital discharge for assessment of need

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### 2017

**Managing Opioids Safely and within Vermont Rules**

#### Summary for Primary Care Providers

**Recommend Non-Opioid and Non-Pharmacological Treatment**
- Nonsteroidal anti-inflammatory drugs (NSAIDs) and/or acetaminophen
- Acupuncture
- Chiropractic
- Physical therapy
- Yoga

Only prescribe opioids if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, combine with non-opioid alternatives.

**Query the Vermont Prescription Monitoring System (VPMS)**

**Nine-time Prescriptions:**
- Prior to writing a first opioid prescription for greater than 10 pills (e.g., oxycodone, tramadol)
- Prior to writing a first prescription for a benzodiazepine, buprenorphine, or methadone
- Prior to starting a patient on a chronic opioid (>15 days) for non-palliative therapy

**Re-evaluation:** At least annually or at least twice annually for long-term prescribing.
- Centers for Disease Control (CDC) recommendation: every prescription, or at least every 90 days

**Replacement:** Prior to writing a replacement (e.g., lost, stolen) of any scheduled or non-controlled substance

**Provide Patient Education and Obtain Informed Consent**
- Discussion of risks, including side effects, risks of dependence, and overdose, alternative treatments, appropriate storage and safe disposal
- Provide patient with the Vermont Department of Health (VDH) Patient Education handout
- Obtain signed informed consent, even for acute prescriptions
- VDH education resources:
  - [www.healthvermont.gov/alcohol-drugs/professionals/resources/patients-and-providers](http://www.healthvermont.gov/alcohol-drugs/professionals/resources/patients-and-providers)
  - CDC education resources:
    - [www.cdc.gov/drugoverdose](http://www.cdc.gov/drugoverdose)
    - CDC: Establish realistic treatment goals for pain and function and establish patient and clinician responsibilities for managing therapy, including when to discontinue therapy

**Prescribe Nasal Ritalinone when Indicated**
- High Dose 90s
- Lower Dose 30s

**Concomitant Benzodiazepine Patients:** Patients prescribed both an opioid and a benzodiazepine
- CDC recommends avoiding co-prescribing of opioids and benzodiazepines
- CDC History of abuse, history of substance use disorder, 50+ MME per day prescriptions
## PPI Tapers

- Rebound hypersecretion can occur in the weeks following PPI discontinuation. Since the duration of action of PPIs is so long that it may take several weeks to present.
- No evidence that the increased acid secretion is of clinical importance.
- Some literature suggests a 1-6 month taper, however data are lacking.
  
  [Ref text](https://www.ncbi.nlm.nih.gov/pubmed/10725335)

**VA study**

- 71 patients who were “PPI dependent”
- 42% could not be taken off PPI
- 42% could be managed with H2RAs or combo
- 15% could be taken off of medication

**Summary Points**

- 80% of patients will refill prescriptions for H2RA/PPIs without a clinical re-evaluation of need!!
- If you prescribe empiric therapy, reevaluate the patient in 4-8 weeks - Don’t give a prescription with 11 refills!
- Evaluate PPI doses - Most patients do not require BID dosing
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### Managing Opioids Safely and within Vermont Rules

**SUMMARY FOR PRIMARY CARE PROVIDERS**

- **Recommend Non-Opioid and Non-Pharmacological Treatment**
  - Nonsteroidal anti-inflammatory drugs (NSAIDs) and/or acetaminophen
  - Acupuncture
  - Chiropractic
  - Physical therapy
  - Yoga

- Only prescribe opioids if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
  - If opioids are used, combine with non-opioid alternatives.

**Query the Vermont Prescription Monitoring System (VPMS)**

- Nine-time prescriptions:
  - Prior to writing a first opioid prescription for greater than 10 pills (e.g., opioids, tramadol)
  - Prior to writing a first prescription for a benzodiazepine, buprenorphine, or methadone
  - Prior to starting a patient on a chronic opioid >90 days for non-palliative therapy

- Re-evaluation:
  - At least annually (or at least twice annually if opioid-naïve)
  - Centers for Disease Control (CDC) recommendation: every prescription, or at least every 90 days

**Replacement:**

- Prior to writing a replacement (e.g., lost, stolen) of any scheduled H-IV controlled substance

**Provide Patient Education and Obtain Informed Consent**

- Discuss the risks, including side effects, risks of dependence and overdose, alternative treatments, appropriate tapering and safe storage and disposal

- Provide patient with the Vermont Department of Health (VDH) Patient Education handout

- Obtain signed informed consent, even for acute prescriptions

**VDH education resources**

- [www.healthvermont.gov/alcohol-drugs/professionals/](https://www.healthvermont.gov/alcohol-drugs/professionals/)

- CDC education resources: [www.cdc.gov/drugoverdose](https://www.cdc.gov/drugoverdose)

- CDC: Establish realistic treatment goals for pain and function and establish patient and clinician responsibilities for managing therapy, including when to discontinue therapy

**Prescribe Nasal Naloxone when Indicated**

- High-Dose 90s – Morphine Milligram Equivalent (MME) per day
- Concurrent benzodiazepine patients prescribed both an opioid and a benzodiazepine
  - CDC recommends avoiding co-prescribing of opioids and benzodiazepines
- CDC: History of overdose, history of substance use disorder, 50+ MME per day prescriptions

2003

- [Ref text](https://www.ncbi.nlm.nih.gov/pubmed/13121001)

2017
# Evaluation

## Survey Responses of Prescribers who Attended an AD Session in FY18

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Range</th>
<th>N*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program met stated objectives</td>
<td>4.8</td>
<td>3-5</td>
<td>646</td>
</tr>
<tr>
<td>2. Program provided unbiased, evidence-based content, where available</td>
<td>4.9</td>
<td>3-5</td>
<td>649</td>
</tr>
<tr>
<td>3. Program topic was appropriate for your needs</td>
<td>4.8</td>
<td>1-5</td>
<td>648</td>
</tr>
<tr>
<td>4. Program had practical clinical value</td>
<td>4.8</td>
<td>1-5</td>
<td>649</td>
</tr>
<tr>
<td>5. Program speakers were prepared</td>
<td>4.9</td>
<td>2-5</td>
<td>649</td>
</tr>
<tr>
<td>6. Program format was appropriate</td>
<td>4.8</td>
<td>2-5</td>
<td>648</td>
</tr>
<tr>
<td>7. Overall impression of the program was favorable</td>
<td>4.8</td>
<td>3-5</td>
<td>648</td>
</tr>
<tr>
<td>8. Time for discussion was appropriate</td>
<td>4.7</td>
<td>2-5</td>
<td>645</td>
</tr>
</tbody>
</table>

Scores ranged from: 1= Strongly Disagree to 5= Strongly Agree
*The N refers to the number of surveys where that specific question was answered.
### Evaluation

<table>
<thead>
<tr>
<th>Survey Responses of Prescriber Participants in FY18</th>
<th>Yes</th>
<th>Percent</th>
<th>N*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel the information presented will impact your prescribing?</td>
<td>563</td>
<td>92.1</td>
<td>611</td>
</tr>
<tr>
<td>Do you feel the information presented will impact your practice/patient care?</td>
<td>581</td>
<td>94.2</td>
<td>617</td>
</tr>
<tr>
<td>Would you be willing to attend a similar session in the future?</td>
<td>631</td>
<td>99.2</td>
<td>636</td>
</tr>
<tr>
<td>Was this program free of commercial bias?</td>
<td>594</td>
<td>99.8</td>
<td>595</td>
</tr>
</tbody>
</table>

*The N refers to the number of surveys where that specific question was answered.
Evaluation

Great, interactive presentation

This was really helpful! Appreciated the discussion based approach.

Awesome! Keep coming!

Handout very helpful

We have a strong sense of community at the sites that we go to, and having us as academic detailers becoming part of that community is what makes us successful.

This was my first time, really enjoyed it and very accessible way to get CME
Challenges of Real-World AD

MOST visits go smoothly, but unexpected things do happen.

.Raise your hand if any of these scenarios have happened to you:

- Arrive to a practice to discover a sign on the front door that reads, “On Vacation”
- “Oh, she’s off today. Did she have a meeting scheduled with you?”
- “Do you mind if our nurses join?”
- “I invited all of the providers. Is that a problem?”
- “I’m glad your program is recommending that book for patients. I have ADHD too and have found that book very helpful.”
Challenges of Academic Detailing

Name one challenge you faced with academic detailing and describe how you or your program overcome that challenge?

• Turn to a partner
• 1 minute!
Challenges of Academic Detailing

Solutions are often context-dependent!
Strengths of Academic Detailing
Reflections from *my* years of detailing

- AD is longstanding interprofessional education
- The underlying effectiveness of AD is not solely connected to any one topic
- The basis of AD is a human connection, even when using data
- AD should be evidence-based, but never afraid to tackle areas where the evidence is weak
- There is value to both one-to-one and small group AD
- AD must continue to be a service. This means a willingness to be flexible, drive far, etc.
- There are still unsolved challenges to address: How to best share content and collaborate across programs; scope of evaluation.
Expanding our vision and enhancing care

*How will we use academic detailing for enhancing patient care in 10 years?*
- What will we be doing differently from today?
- Turn to a partner
- This is just for fun – don’t worry about budgets, feasibility, etc.
- 1 minute!
Available Topics

• Management of Fibromyalgia
• Management of Opioids in Primary Care
• Advanced Management of Opioids
• Stroke Prevention in Atrial Fibrillation
• Management of Type 2 Diabetes

*In development: Cannabinoids!*
Thank you!

Thanks to the Vermont Team:
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• Gary Starecheski, RPh
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• VTAD Program Advisors

www.vtad.org