An Assessment of a Randomized, Academic Detailing Intervention in North/West Vancouver
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BACKGROUND
Academic detailing (educational outreach)

• academic detailing (AD), is an educational technique where a health professional visits physicians in their offices to discuss therapeutic issues in an effort promote evidence-based practices

• Avorn & Soumerai in the U.S. were the first to demonstrate prospectively, in a randomized trial, changes in prescribing from their AD intervention. May et al. in Australia in a prospective (non-randomized) trial, were able to decrease admissions for GI bleeds from their NSAID AD intervention.

• there are currently no Canadian, prospective, randomized studies published primarily to quantify the effects of academic detailing on prescribing or patient outcomes

BC Community Drug Utilization Program (BC CDUP)

• BC CDUP (www.cdup.org) was the first AD program in Canada, and is situated in North/West Vancouver. It services general practitioners (GPs) associated with Lions Gate Hospital (a 231 acute care bed facility). AD visits are based on an in-house newsletter, “the review.”

Systolic heart failure

• Systolic heart failure (HF) is a common serious illness with many proven therapies to reduce morbidity and mortality. Despite this, management of HF is suboptimal.

METHODS

• primary endpoint: to assess the impact of AD on prescribing, by GPs, for HF

• secondary endpoint: to assess the impact of AD on hospitalization and death of HF patients

METHODS (cont’d)
Identification of GPs

• GPs were randomized to one of two group (Figure 1): the HF group received a newsletter and AD visit on HF the internal control group received a newsletter and AD visit on another topic

• GPs in the same office and call group were randomized together

• randomized GPs data were included if they participated in an AD visit

• another group was created from GPs associated with hospitals in Richmond, Burnaby, Surrey and other non-randomized GPs from North/West Vancouver. This was the external control group and as per their usual practice, did not participate in AD visits.

Matching physicians

• AD visit dates in the HF group and internal control group occurred at unequal intervals because AD visits were based on mutual availability of the physician and academic detailer. Thus, in order to define time periods for impact analysis, each GP in the internal control group was retrospectively matched in sequence to a GP in the HF group.

• for each matched pair, this resulted in the start date being the date of the HF visit in the HF group, and the stop date being the date of the HF visit in the matched internal control group (this was available because after 6 months, the GP groups were crossed over)

• GPs in the non-randomized external control group were also randomly matched retrospectively to a GP in the HF group who participated in an AD visit

Identification of HF patients

• patients belonging to study physicians were labelled with HF if they met the following criteria:

• at least two BC MSP services coded with ICD9 428.X on two distinct service dates after 31Mar1992

• one hospital admission after 31Mar1992 with ICD9 425.X or I50.X

Majority source of care (MSOC) patients

• since HF patients could belong to ≥1 practitioner group, only MSOC patients (defined as those who received more than 50% of their BC MSP paid medical services from a single GP) were included

• only MSOC patients with ≥1 visit to a physician in their MSOC group in the baseline period (Period 1) were included

METHODS (cont’d)
Statistics

• changes in prescribing and changes in patient outcomes were assessed by comparing the change in # of patients after the AD visit (Period 2) to the baseline period (Period 1) between the HF group and each of the two control groups. (During Period 2, the two control groups each act as control groups for the HF group.)

• adjusted relative risk was adjusted for MSOC patient days of follow up

RESULTS

• the baseline demographics for GPs and patients are described in Table 1

• the prescribing changes and patient outcomes are described in Table 2

DISCUSSION & CONCLUSION

• to our knowledge, we are the first in Canada to develop and evaluate a randomized design to quantify the impact of academic detailing using provincial administrative databases

• there was a borderline significant change in starting a new prescription of HF medications (beta blockers (bisoprolol, carvedilol, metoprolol), amlodipine) in the HF group compared to the external control group, but not to the internal control group

• no significant changes in admission to hospital or mortality for HF were observed

• more studies with larger numbers are needed to fully quantify the effects of AD on prescribing and patient outcomes