Imagine that your P&T committee wants to find the latest information on drug-prescribing activity in the community. Imagine that the committee also wants to create individual physician profiles of hospital-based practitioners and to learn how their outpatient prescribing habits might compare with those of other practitioners. Would such a database be valuable to P&T committees around the country?

I believe the answer to my rhetorical question is a resounding yes! Fortunately, there is a place one can turn to. For more than 40 years, IMS Health, headquartered in suburban Philadelphia, has sponsored the National Drug and Therapeutic Index (NDTI). For the last nine years, I have had the privilege of serving as the chairman of the advisory board for the NDTI.

Today, nearly 3,000 physicians across dozens of specialties submit quarterly reports to IMS Health headquarters about their individual prescribing behaviors. Without identifying individual patients, these scores of physicians, with a compliance rate exceeding 90%, dutifully submit this information on a disease-specific basis. Although I know that some readers might be incredulous, I have carefully reviewed these reporting tools myself. Patient-related variables that are reported in the NDTI include age, race, sex, method of payment, referral, blood pressure, and interval since the last visit. Pharmaceutical product-related variables include dosage, therapy status, desired action, strength, and diagnosis. By multiplying these patient-related and product-related variables with 3,000 prescribing physicians in hundreds of geographic locations throughout the nation, the NDTI creates a unique snapshot of current outpatient physician-prescribing behaviors.

Currently, the NDTI is principally a pharmaceutical company marketing and strategic planning tool. It provides product acquisition and market analyses, line-extension opportunities, and a glimpse of the competitive landscape. Even so, I see the NDTI through a somewhat different lens.

Ad-hoc studies and other syndicated reports available under the NDTI umbrella might give P&T committee members crucial benchmarking information that is simply unavailable elsewhere. This would give hospital medical directors and managed care leaders an opportunity to sit down at a negotiating table, without the political rhetoric, armed with detailed current practice information. The value of academic detailing could be greatly improved if clinical leaders brought NDTI data to physicians and enabled them to see how they relate to their local peers, in a nonpunitive fashion. Instead of thinking about some national practice guideline from an organization thousands of miles away, the NDTI could give virtually every community-hospital-based P&T committee an opportunity to focus directly on local practice with local implications.

The NDTI is linked with other commercial tools from IMS Health, including “Writxte Decision,” which offers in-depth insight into the market for promotional planning and targeting applications. It takes the NDTI database and links it to the American Medical Association’s Annual Physician Survey and U.S. census data. IMS Health describes it as a physician focus group on your personal computer. I would think of it as an opportunity for P&T committee members to regularly reassess formulary design and construction based on reliable current and local prescribing behavior.

Recently, the NDTI has become more Web-savvy. With readily available software, P&T leaders can create patient-specific and disease-specific graphs showing, for example, how patient visits for esophagitis have increased dramatically over the last six years and the types of products that have been prescribed for this malady. Because years’ worth of data are available from a longitudinal perspective, P&T leaders can judge the impact of drug utilization evaluation (DUE) programs and the like via NDTI tracking tools. Educational programs launched in 2001 can be reevaluated in 2003, lending credence to the measurement of educational outcomes.

Surely, I am biased because of my personal involvement over a long period of time with the NDTI and with my IMS Health colleagues. However, I have reviewed the NDTI specialty profiles for pediatrics, general surgery, neurology, and the like. I’ve learned a lot about ambulatory practice and the challenges inherent in good pharmacological care. I’d like to see this information move beyond its historical marketing prowess to a new plateau, one characterized by a robust outcomes research agenda and by documented improvements in physician-prescribing behavior. Doctors ought to have access to this kind of information on a regular basis; this step would enable them to close the feedback loop, to limit variation, and to improve patient outcomes. The NDTI of the future might be just what the doctor ordered.

You can learn more about IMS and the NDTI at www.imshealth.com or by calling 1-800-523-5333. As usual, I am very interested in your views. You can reach me at my email address: david.nash@mail.tju.edu.

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