Models for Establishing Academic Detailing Programs to Increase Evidence-Based Prescribing

The Pennsylvania PACE Program and the Academic Detailing Experience

THE NATIONAL COMPARATIVE EFFECTIVENESS SUMMIT

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Pharmaceutical Assistance Contract for the Elderly
The PACE Program

- Began in July 1984 to provide Pennsylvania seniors with comprehensive Rx coverage
- Persons served, FY 2010/11 – 343,400
- Funded by Pennsylvania lottery and tobacco settlement

The PACE Program in CY 2010

- Total pharmacy benefit $733.7 M
- Cardholder share $92.5 M; 12.6%
- State share $297.3 M; 40.6%
- Third party coverage $343.5 M; 46.8%

  (Medicare Part D, employer and union sponsored coverage)
- 81% of enrollees have Medicare Part D

Eligibility

PACE and PACENET

- 65 years of age or older
- Resident of PA for at least 90 days
- No asset test

2011 PACE Income Limits

PACE

- Single applicant $14,500
- Married couple $17,700

PACENET

- Single applicant $14,500 - $23,500
- Married couple $17,700 - $31,500

Benefits for Cardholders *Enrolled* and *Not Enrolled* in Medicare Part D PACE Partner Plans, 2011

Comprehensive Rx coverage:

- First $ coverage
- Open formulary
- Open pharmacy network
- Low copays
- Program pays Part D premiums if enrolled in Part D

Premiums and Copays for Cardholders *Enrolled* in Medicare Part D PACE Partner Plans, 2011

PACE*Plus*	PACENET*Plus*
▪ PACE pays Part D premium	PACENET pays Part D premium and collects premium at pharmacy
▪ $6 Copay, Generic Rx	$8 Copay, Generic Rx
▪ $9 Copay, Brand Rx	$15 Copay, Brand Rx

Premiums and Copays for Cardholders *Not Enrolled* in Medicare Part D PACE Partner Plans, 2011

PACE	PACENET
No program premium	$34.07 monthly, cumulative premium
$6 Copay, Generic Rx	$8 Copay, Generic Rx
$9 Copay, Brand Rx	$15 Copay, Brand Rx

July 2011 Persons Served

- **PACE** 120,100
- **PACENET** 184,100
- **Total** 304,200

Typical Enrollee

	PACE	PACENET
Average age	79 yrs.	78 yrs.
% female	81%	67%
Married	9.4%	38.9%
Average income	$11,800	$21,400
Own home	54.5%	69.7%
Rx per enrollee	37.8	34.9
Therapeutic classes	5.6	5.4

- Nearly 40% of survey respondents indicated they did not complete high school.

Enrollment Assistance

- Local pharmacies
- Legislative district offices
- Senior centers
- PA Department of Aging website
  - PACEcares.magellanhealth.com
  - aging.state.pa.us
- PACE call center 1-800-225-7223
- Outreach by Benefits Data Trust 1-866-712-2060
- Residency, age and income documents not required

Ensuring Safe and Effective Rx Utilization

- Program history of comprehensive and aggressive drug utilization review with prescription payment stopped at pharmacy counter
- Developed by physicians and pharmacists
- Tailored for older patients
- Focused on safety and effectiveness (dose, duration, concurrent usage)

Ensuring Safe and Effective Rx Utilization

- Physician focused medical exception process
- A-rated generic substitution
- Step therapy for selected therapeutic classes Examples: sulfonylurea, insulin or metformin before pioglitazone (Actos); calcium acetate (PhosLo) before sevelamer (Renagel); culture and sensitivity test results to choose antibiotic prior to linezolid (Zyvox)
- Drug utilization coordinated with Part D drug plans

The Pennsylvania Academic Detailing Program, 2005 - Present

The Independent Drug Information Service

iDiS

Goals

- To provide physicians with current, evidence-based, non-commercial drug information

- To facilitate physician use of the information to make the best prescription choices (efficacy, safety, and cost) for patients

Goals

- 3rd goal added in 2008

To provide physicians with information for the prevention of hospitalization and institutionalization due to cognitive impairment and associated behavioral problems, falls and mobility problems and incontinence

Program Design

- An innovative program that provides clinicians with the latest findings about the drugs they prescribe
- For primary care offices
- Delivered face-to-face in the primary care office setting by drug educators

Strengths
Service, Credibility, and Integrity

SERVICE

- Providing useful, practice-relevant information...
- in a very time-efficient way...
- that would be difficult to assemble oneself...
- delivered in a professional, supportive manner.

CREDIBILITY

- Evidence-based materials, developed by experts
- Non-commercial viewpoint

INTEGRITY

- Only goal is to improve prescribing and patient care
- No pharmaceutical company funding
- Salary is not based on sales performance

Goal 1: To provide physicians with current, evidence-based, non-commercial drug information

HOW?

- Offer a flexible schedule for visits
- Respond to questions knowledgeably, honestly, and with the weight of the evidence
- Offer free CME credits to add value to the interaction (1,799 issued)
- Present easy to use materials in a pleasant demeanor as professional training
- Build long term relationship with the office

Goal 2: To facilitate physician use of information to make the best Rx choices (efficacy, safety, and cost) for patients

HOW?

- Identify the physician's needs, priorities, and concerns
- Offer tools and resources to facilitate better choices (data summaries, patient education materials, prescribing tools)
- Refrain from excessive bashing of drug manufacturers
- Provide CME website access

Program Structure

- Each clinical topic becomes an educational module that includes key components
- Staff have no affiliations with a pharmaceutical company, paid or unpaid
  - No Consulting
  - No Employment
  - No Manufacturer Speakers Bureau, Seminars, or Conferences

Module Components

- **The Un-Ad**
  a short, glossy overview of the data
- **The Evidence Document**
  the meaty material with supporting data and references
- **Laminated Prescriber Reference Card**
- **Age Appropriate Patient Education Materials**

The Un-Ad, pages 1 and 2

Life after Vioxx...

The unexpected withdrawal of Vioxx in September 2004, followed by Bextra in April 2005, has led many physicians to reassess the place of selective cox-2 inhibitors in pain management. These concerns were heightened last spring when the FDA applied the same "black box warning" to all NSAIDs as well, cautioning that they each can increase the risk of cardiovascular events. What is really known about the comparative efficacy and safety of these drugs?

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Independent Drug Information Service
Balanced data about medications

Clearing the air about efficacy.

The overwhelming evidence from clinical trials shows that selective cox-2 inhibitors do **not** have any stronger analgesic efficacy than conventional NSAIDs such as naproxen (e.g., Aleve) or ibuprofen (e.g., Motrin).[1] Different patients may respond differently to different analgesics, but there's virtually no evidence that the cox-2 drugs relieve pain any better than their older counterparts. Elaborate media campaigns directed at patients created an aura of superiority that was not backed up by clinical trial data.

A word on gastroprotection.

The main advantage of drugs like Vioxx (rofecoxib) or Celebrex (celecoxib) was the expectation that they would lower the risk of gastrointestinal bleeding compared to older NSAIDs. **However...**

- this protection was relative, not absolute;[2,3]
- concurrent use of low-dose aspirin for cardioprotection can sharply reduce the g.i. protection offered by these drugs;[2]
- only a small proportion of patients who will need chronic analgesics are at high risk of NSAID-induced g.i. bleeding in the first place;[4] [see box]
- there are other effective ways of protecting patients from analgesic-induced g.i. side effects, such as adding a proton-pump inhibitor to a conventional NSAID.[5]

Which patients are at most risk for g.i. side effects?

• older age	• history of peptic ulcer disease	• using oral steroids	• taking warfarin (Coumadin) or another anticoagulant

The tipping point for cardiovascular risk.

There has long been concern about whether selectively inhibiting the cox-2 enzyme might increase the risk of cardiovascular events through a variety of thrombogenic effects as well as other mechanisms. A key randomized trial of rofecoxib (Vioxx) published in 2000 unexpectedly demonstrated a 5-fold increase in the rate of myocardial infarction in patients randomized to that drug.[3] Several large observational studies since then have also found higher rates of MI in patients taking Vioxx.[6,7] In September 2004, a Merck-sponsored randomized clinical trial found that patients given Vioxx had twice the number of MIs or strokes that controls did.[8] The company withdrew the drug from the market. Bextra (valdecoxib) was withdrawn seven months later.

What about the benefits and risks of the drugs that remain?

Confusion increased when FDA warned in April 2005 that *all* NSAIDs and the remaining selective cox-2 inhibitor, Celebrex (celecoxib), would be required to carry the same black-box warning that they can increase the risk of cardiovascular events.[9] This created concerns for physicians and patients over the whole class of agents, but provided little guidance on what to do or whether the risk is the same for all of these drugs. The evidence suggests that it is not.[10] We have reviewed the data from all available randomized controlled trials (RCTs) and epidemiological (epi) studies and summarize it here:

The Un-Ad, pages 3 and 4

Vioxx (rofecoxib)	Considerable evidence of increased risk of MI, stroke, and other cardiovascular complications seen in RCTs and epi studies, especially at higher doses. [withdrawn from market]
Bextra (valdecoxib)	Doubling or tripling of cardiovascular events compared to placebo in two RCTs of patients undergoing cardiac surgery. Also causes potentially fatal dermatologic side effect of Stevens-Johnson syndrome. [withdrawn from market]
Celebrex (celecoxib)	At high doses (200-400 mg b.i.d.), dose-related doubling or tripling of myocardial infarction in one RCT compared to placebo, but no increase in risk found in another RCT with a single daily dose of 400 mg/d. Several epi studies have found no elevated risk compared to Vioxx or other NSAIDs.
Motrin, etc. (ibuprofen)	Conflicting evidence of risk, much less clear than with previous three drugs. However, little information is available on cardiac risk from randomized placebo-controlled trials
naproxen:	Evidence of slightly *reduced* risk of MI in many but not all RCT and epi studies.
aspirin:	Clear evidence of reduction in risk of MI based on large RCTs in men; less evidence of benefit in women.

References are provided in the evidence document accompanying this material.

Back to basics.

One good outcome of the current resurgence of interest in the risks and benefits of the coxibs and NSAIDs is that many prescribers have begun to re-think their management of acute and chronic pain.[11] Pain specialists and rheumatologists recommend this approach:[12]

1. **Start with acetaminophen (Tylenol, etc.).** Because it is sold over-the-counter and has been available for decades, many clinicians underestimate the utility of this drug. Unless a patient has contraindications such as liver disease, alcoholism, or poorly controlled hypertension, consider 1 g t.i.d.-q.i.d. as an initial pain medication. This may well be adequate for a significant number of patients and can form the foundation of further treatment for others.
2. **Naproxen is probably the safest NSAID in terms of cardiac risk.** If a non-aspirin NSAID is needed, the bulk of evidence indicates that naproxen carries the lowest cardiac risk, and may even be cardioprotective to a small degree. (But it should *not* be used to replace low-dose aspirin for this purpose.) Naproxen is also available at low cost from multiple generic manufacturers [see cost comparison chart]. It should be taken with meals or milk. If g.i. symptoms develop, or a patient is at high g.i. risk [see box], consider adding an H2-blocker or a proton pump inhibitor. There is evidence that taking omeprazole along with a conventional NSAID can provide gastroprotection comparable to that provided by Celebrex.[5]
3. **All patients who require cardioprotective use of low-dose aspirin should receive it regardless of their NSAID regimen.** Unfortunately, the available evidence suggests that (a) low-dose aspirin reduces the modest gastroprotective benefit of the cox-2 inhibitors, and (b) this does not seem to protect against the elevated risk of MI caused by the coxibs.
4. **Whatever regimen is chosen,** prescribe the **lowest dose** that will control pain, and the **shortest duration** of therapy. **Monitor patients** for side effects including fluid retention, hypertension, reduction in renal function, and evidence of gastrointestinal toxicity (abdominal pain, black stools, fecal occult blood, anemia).

Who really needs a cox-2 inhibitor? The recommended approach will work best for most patients. The available data indicate that the one cox-2 inhibitor remaining on the market, Celebrex, appears to pose less cardiac risk than did Vioxx and Bextra, and little is known about its safety compared to older non-selective NSAIDs. However, the greater rate of cardiac events seen at high doses in placebo-controlled trials is worrisome. Taken together, the data suggest that Celebrex be reserved for patients who require an NSAID, are at increased risk of the gastrointestinal complications from which it provides modest protection, and cannot tolerate the suggested regimens.

Source: www.drugstore.com

For patients with chronic arthritis pain, rheumatologists advocate several additional strategies to avoid having to commit a patient to years of high-dose NSAID therapy:[12]

1. **Protect the affected joints** with a cane, brace, weight loss, and lower extremity exercise programs.
2. **Evaluate the need for controlled opioid analgesics.** For carefully selected patients, measured use of codeine, tramadol, or oxycodone may be a safe and appropriate choice.
3. **Don't wait too long before surgery.** For some patients with severe osteoarthritis, the most effective treatment is joint replacement, which will usually improve function and will lessen the need for pain medication in many cases.

In summary…

The renewed concern about the safety and efficacy of old and new NSAIDs can provide a fresh opportunity to reassess the approach to pain management. In many instances, such reassessment will enable patients to experience better analgesic results with lower risk of cardiovascular as well as gastrointestinal side effects.

References: 1. Helfand M, Peterson K, Carson SM, Drug class review on NSAIDs. Final Report. http://www.ohsu.edu/drugeffectiveness/reports/documents/NSAIDs_Final_Report_u2.pdf. **2. Silverstein FE,** Faich G, Goldstein JL, et al. Gastrointestinal toxicity with celecoxib vs nonsteroidal anti-inflammatory drugs for osteoarthritis and rheumatoid arthritis: the CLASS study: A randomized controlled trial. *Journal of the American Medical Association*. 2000;284(10):1247-1255. **3. Bombardier C,** Laine L, Reicin A, et al. VIGOR Study Group. Comparison of upper gastrointestinal toxicity of rofecoxib and naproxen in patients with rheumatoid arthritis. VIGOR Study Group. *New England Journal of Medicine*. 2000;343(21):1520-1528. **4. Gabriel SE,** Jaakkimainen L, Bombardier C. Risk for serious gastrointestinal complications related to use of nonsteroidal anti-inflammatory drugs. A meta-analysis. *Annals of Internal Medicine*. 1991;115(10):787-796. **5. Chan FK,** Hung LC, Suen BY, et al. Celecoxib versus diclofenac and omeprazole in reducing the risk of recurrent ulcer bleeding in patients with arthritis. *New England Journal of Medicine*. 2002;347(26):2104-2110. **6. Solomon DH,** Schneeweiss S, Glynn RJ, et al. Relationship between selective COX-2 inhibitors and acute myocardial infarction in older adults. Circulation. 2004;109(17):2068-2073. **7. Solomon DH.** Selective Cyclooxygenase 2 Inhibitors and Cardiovascular Events. Arthritis and Rheumatism. 2005;52(7):1968-78. **8. Bresalier RS,** Sandler RS, Quan H, et al. Cardiovascular events associated with rofecoxib in a colorectal adenoma chemoprevention trial. *New England Journal of Medicine*. 2005;352(11):1092-102. **9. Food and Drug Administration,** April 7, 2005. Accessed at: http://www.fda.gov/cder/drug/advisory/COX2.htm. **10. Antman EM,** DeMets D, Loscalzo J. Cyclooxygenase inhibition and cardiovascular risk. Circulation. 2005;112(5):759-770. **11. Bennett JS,** Daugherty A, Herrington D, et al. The use of nonsteroidal anti-inflammatory drugs (NSAIDs): a science advisory from the American Heart Association. Circulation. 2005;111(13):1713-1716. **12. American College of Rheumatology Subcommittee on Osteoarthritis Guidelines.** Recommendations for the medical management of osteoarthritis of the hip and knee. Arthritis and Rheumatism. 2000;43(9):1905-1915.

Additional references documenting these recommendations are provided in the evidence document accompanying this material.

This material was produced for the Independent Drug Information Service (iDIS) by Dan Solomon, M.D., M.P.H., Assistant Professor of Medicine at Harvard Medical School, and Jerry Avorn, M.D., Professor of Medicine at Harvard Medical School. iDIS is supported by the PACE Program of the Department of Aging of the Commonwealth of Pennsylvania. This program is not affiliated in any way with any pharmaceutical company. These are general recommendations only; specific clinical decisions should be made by the treating physician based on an individual patient's clinical condition.

iDIS Independent Drug Information Service

Balanced data about medications

September 2005

Laminated Prescriber Reference Card, front and back

LDL goals and levels to initiate therapy, by risk category

Risk category	LDL level at which to initiate therapeutic lifestyle changes (TLC)	LDL level at which to consider drug therapy	LDL goal
Low risk: 0-1 risk factors	≥160 mg/dL	≥190 mg/dL (optional for 160-189 mg/dL)	<160 mg/dL
Moderate risk: 2+ risk factors with 10 year risk < 10%	≥130 mg/dL	≥160 mg/dL	<130 mg/dL
Moderately high risk: 2+ risk factors with 10-year risk 10-20%	≥130 mg/dL	≥130 mg/dL (optional for 100-129 mg/dL)	<130 mg/dL (consider <100 mg/dL)
High risk: CAD or CAD-risk equivalents, or 2+ risk factors with 10-year risk >20%	≥100 mg/dL	≥100 mg/dL (optional for selected patients 70-99 mg/dL)	<100 mg/dL (consider <70 mg/dL)

Percentage LDL lowering required to achieve target LDL levels

		Baseline LDL (mg/dL)				
		100	130	160	190	220
Target LDL (mg/dL)	70	30%	46%	56%	63%	68%
	100	-	23%	38%	47%	55%
	130	-	-	19%	32%	41%
	160	-	-	-	16%	27%

Use atorvastatin 80 mg/day or rosuvastatin 40 mg/day
Use any statin that lowers LDL by 40-50%
Use any statin that lowers LDL by < 40%
- Already at goal

These are general recommendations only; specific clinical decisions should be made by the treating physician based on an individual patient's clinical condition.

Additional information on coronary artery disease (CAD) risk factors, CAD risk equivalents, and calculation of 10-year CAD risk is available in the accompanying evidence document, and on the Independent Drug Information Service website at www.RxFacts.org.

Expected percentage LDL lowering for different statins

Drug	Daily dose of statin (mg) 5	10	20	40	60	80
rosuvastatin (Crestor)	38%	43%	48%	53%	-	-
atorvastatin (Lipitor)	-	37%	43%	49%	-	55%
lovastatin (Mevacor, generics)	-	21%	29%	37%	-	-
lovastatin (Altoprev)	-	21%	29%	-	42%	-
simvastatin (Zocor, generics)	23%	27%	32%	37%	-	42%
pravastatin (Pravachol, generics)	-	20%	24%	29%	-	33%
fluvastatin (Lescol)	-	-	21%	27%	-	33%

Expected to lower LDL by ≥ 50%
Expected to lower LDL by 40-50%
Expected to lower LDL by < 40%
- Not available at this dose

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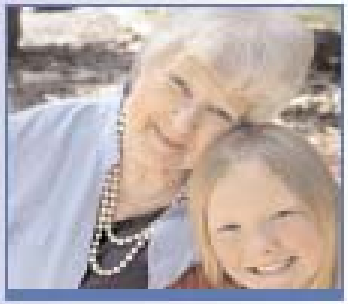
alosa
The Alosa Foundation

Age Appropriate Patient Education Material, cover and back



What is depression?

Feeling sad once in a while is different from having depression. People who are seriously depressed feel little joy in life or from things they used to enjoy, and this unhappy mood is present nearly every day and lasts for two weeks or more. Depression may cause additional symptoms such as:

- Lack of interest in social activities
- Feeling tired or unmotivated
- Sleeping too much or too little
- Changes in appetite or body weight
- Feeling worthless, empty, or hopeless
- Thoughts of death or suicide
- Feeling guilty or a burden
- Unexplained aches or pains
- Reduction in sex drive
- Feeling restless, nervous, or irritable
- Trouble concentrating, remembering, or making decisions

If you think you might be depressed, talk to your doctor

Like other health conditions, depression can cause physical and emotional symptoms. When you are older, depression may last longer, make other health conditions worse, and even lead to premature death. Occasional thoughts of death are normal, but a person who is depressed may think about death often and may be at risk for suicide.

Talk to your doctor if you answer "yes" to either of these two questions:

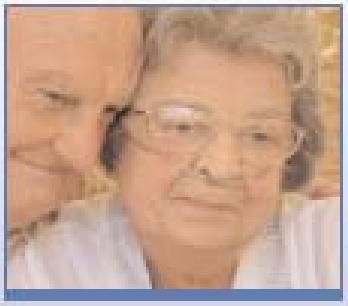
- During the past month, have I been bothered by feeling down, depressed or hopeless?
- During the past month, have I been bothered by little interest or pleasure in doing things?

Many people do not talk to their doctors or loved ones about depression, or may not realize they are suffering from a treatable condition. As a result, they do not get help. But treatment is available and it often works.

How will my doctor help?

Depression is not a natural part of getting older, and your doctor can help you feel better. Your doctor may ask about how you feel, do a physical exam, and review the medicines and over-the-counter products you are taking. Your doctor will also check to see if the way you feel is being caused by a separate medical problem.

The Independent Drug Information Service (IDIS) is supported by the R&D Program of the Department of Aging of the Commonwealth of Pennsylvania.



When you're feeling down...

You can get help and feel better. Many people feel sad, worried, or lonely at some time in their lives. This can happen after difficult life events, such as the loss of loved ones, an illness or injury, or unhappy situations or relationships. But when sad feelings occur nearly every day, are severe, and last for two weeks or more, it may help to discuss it with your doctor.

Age Appropriate Patient Education Material, inside

How is depression treated?

The most common treatments include counseling, also called talk therapy or psychotherapy, and antidepressant medications.

Counseling

Counseling helps people understand their feelings, deal with troubling relationships or problems, and make healthy choices. Counseling works as well as medications for some people, especially those with mild depression, and is generally a good option.

It can also be used along with antidepressant medication. Spending time with friends, family, and support networks can also help relieve symptoms of depression.

Antidepressant medications

Many antidepressant medications are available. When used as directed, most commonly used medications are similarly effective. Antidepressants start to work in 4–6 weeks, so it is important to follow your doctor's instructions and take your medicine as directed, even if you do not feel better right away. Medications work differently in older people, so your doctor may start with a low dose and adjust the type or dose over time.

Some common antidepressants are:

Drug class	Examples
Selective serotonin reuptake inhibitors (SSRIs)	citalopram* (Celexa) sertraline* (Zoloft) paroxetine* (Paxil) escitalopram (Lexapro) fluoxetine* (Prozac)
Serotonin-norepinephrine reuptake inhibitors (SNRIs)	venlafaxine* (Effexor) duloxetine (Cymbalta)
Dopamine-norepinephrine reuptake inhibitors	bupropion* (Wellbutrin)
Noradrenergic and specific serotonergic antidepressants	mirtazapine* (Remeron)
Tricyclic antidepressants (TCAs)	amitriptyline* (Elavil) imipramine* (Tofranil) nortriptyline* (Pamelor) desipramine* (Norpramin)

*Available as generic

Side effects are common and are different for different medications. Common side effects with SSRIs include upset stomach, restlessness, trouble sleeping, headache, and sexual dysfunction. Other drugs will have different side effects. Many side effects become less severe or go away with continued use. Some people find that starting on these drugs initially makes them feel worse, and may even cause them to think about hurting themselves. This may be a medication side effect. Call your doctor immediately to talk about these feelings or any other side effects you may be having.

It is important to continue taking your medicine after you start feeling better, usually for at least 6 months. Stopping your medicine too quickly can make you feel sick and cause dizziness, upset stomach, fatigue, aches, chills, anxiety, and irritability. Your doctor will work with you to decide which medicine is best for you, how long to take it, and how and when to stop taking it.

What can you do?

You can do many things to help yourself feel better.

- Make time to relax.
- Identify problems and work on fixing them.
- Think positively.
- Be physically active, 30-60 minutes per day, most days of the week.
- Spend time outdoors.
- Get involved with groups or volunteer work.
- Spend time with friends, family, and people who can support you.

Remember, depression is not a normal part of getting older, and treatment is available. Treatment takes time, so be patient. Follow your doctor's instructions, stay committed to your goals, and talk about how you feel.

If you need help

Many resources are available for you. Call or go online for more information.

American Geriatrics Society
www.healthinaging.org
1-800-563-4916

Geriatric Mental Health Foundation
www.treatmenthelps.org
1-877-654-7850

National Institute of Mental Health
www.nimh.nih.gov
1-800-421-4211

National Mental Health Association
www.nmha.org
1-800-969-NMHA (1-800-969-6642)

If you are in crisis and need help right away, call this 24-hour help line:

National Suicide Prevention Lifeline
1-800-273-TALK (1-800-273-8255)

Educational Modules

- Nonsteroidal anti-inflammatory drugs (2005)
- Acid suppressing therapy (2006, 2011)
- Antiplatelet therapy (2006, 2009)
- Cholesterol-lowering drugs (2006, 2009)
- Antihypertensive therapy (2007, 2010)
- Type 2 diabetes treatment (2007, 2009, 2010)

COMPLETE SET OF EDUCATION MATERIALS FOUND AT RXFACTS.ORG

Educational Modules

- Depression management in the elderly (2008)
- COPD (2009)
- Osteoporosis (2010)
- Insomnia (2010)
- Atrial fibrillation (2011)
- Chronic pain management (2011)

COMPLETE SET OF EDUCATION MATERIALS FOUND AT RXFACTS.ORG

Long Term Living Educational Modules

Preventing the need for hospitalizations and institutionalizations

- Falls and mobility management (2009)
- Cognitive impairment and associated behavioral problems (2009)
- Incontinence (2010)

COMPLETE SET OF EDUCATION MATERIALS FOUND AT RXFACTS.ORG

What Makes a Medication Educator Unique?

DRUG REP

- Serves: drug company
- Product: drug
- Goal: maximize use of a particular drug for profit$

MEDICATION EDUCATOR

- Serves: doctor
- Product: facts about drug
- Goal: share knowledge with prescriber that will result in optimized prescription choices

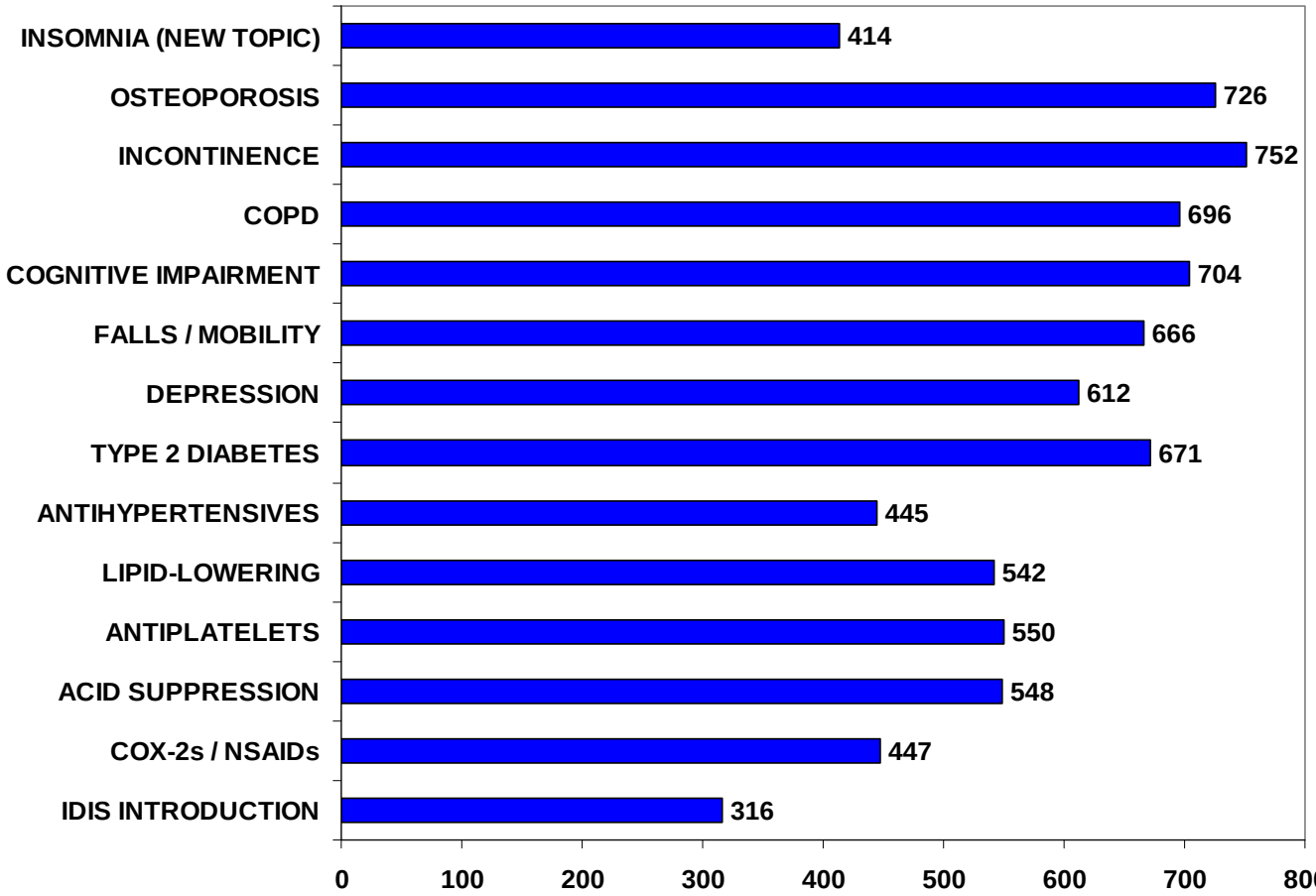
Medication Educators

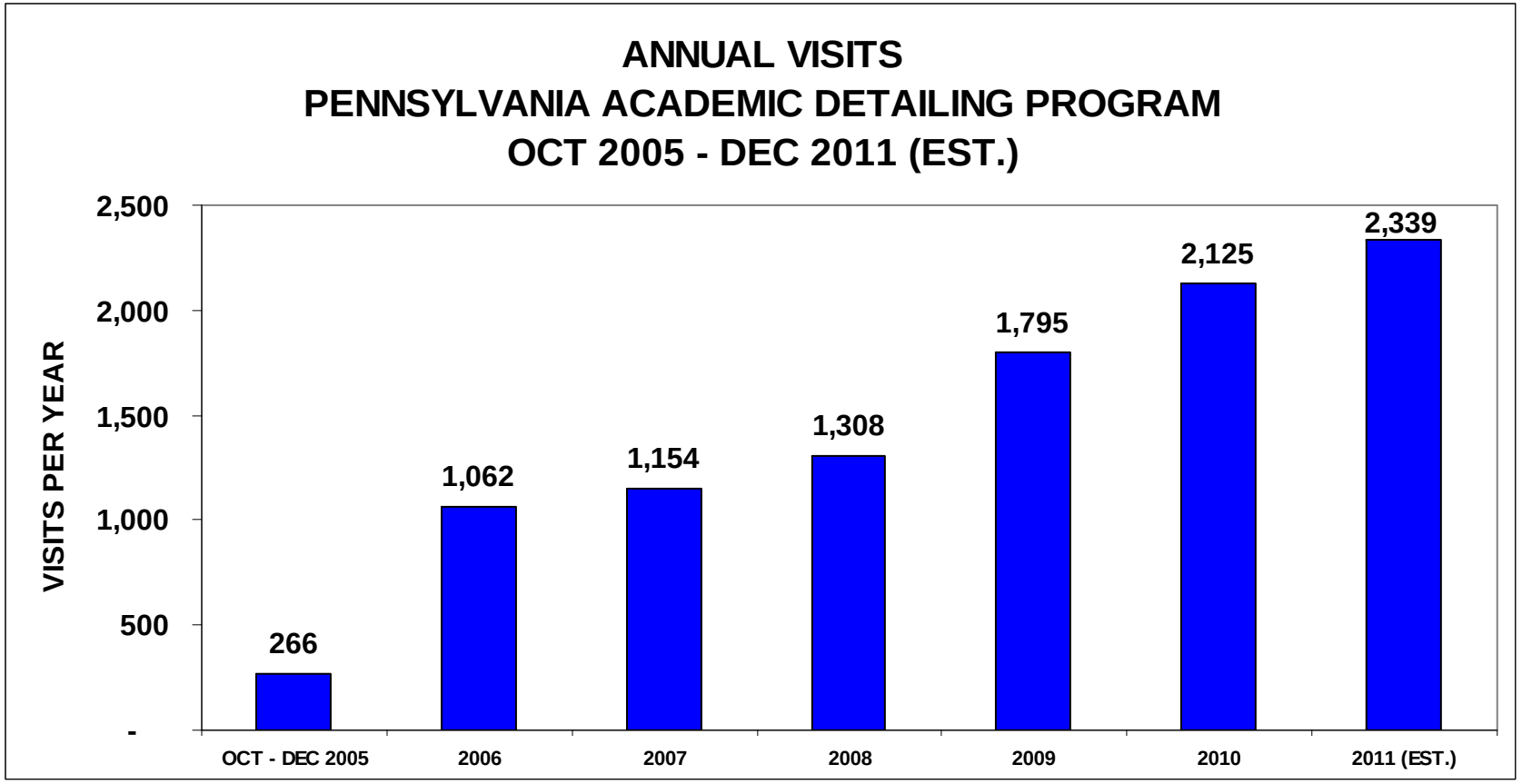
- Clinical background - nurses, pharmacists, allied health; 11 individuals, 10 FTE total
- Located in areas with highest density of PACE enrollees
- Multi-day training sessions provided by Harvard Medical School faculty
- regular follow-up teleconferences for updates, feedback
- Quarterly one-on-one visits, establishing ongoing relationships with prescribers

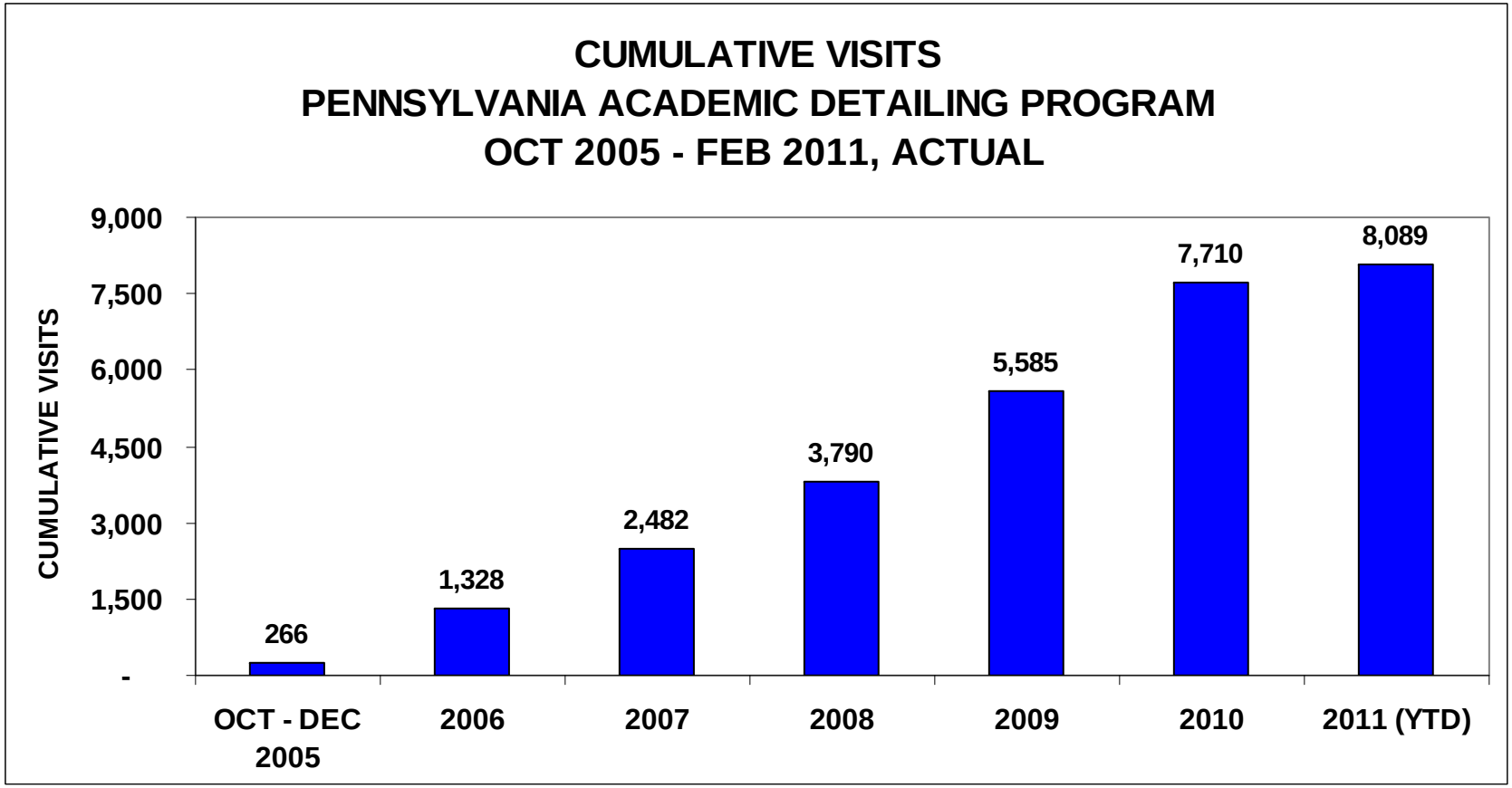
The Harvard/Brigham Connection

- Systematic review of current medical literature → evidence-based synthesis
- Development of user-friendly materials
- Follow-up, consultant support
- Responses to clinical questions
- Fiscal management
- Program evaluation
- Web presence – **RxFacts.org**

TOPIC VISITS
PENNSYLVANIA ACADEMIC DETAILING PROGRAM
OCT 2005 - FEB 2011




ANNUAL VISITS
PENNSYLVANIA ACADEMIC DETAILING PROGRAM
OCT 2005 - DEC 2011 (EST.)
VISITS PER YEAR
2,500
2,000
1,500
1,000
500
-
266
1,062
1,154
1,308
1,795
2,125
2,339
OCT - DEC 2005
2006
2007
2008
2009
2010
2011 (EST.)

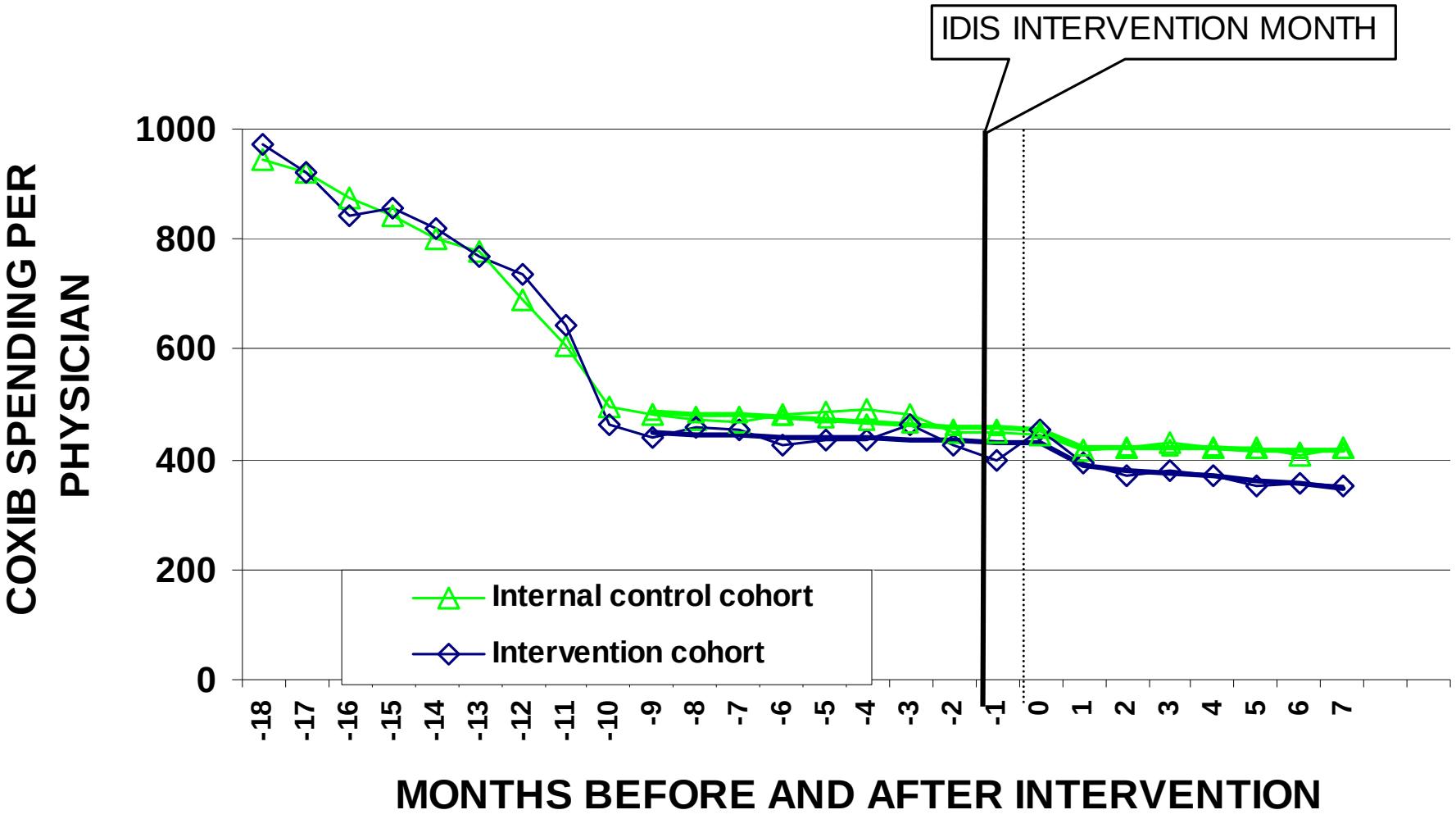

CUMULATIVE VISITS
PENNSYLVANIA ACADEMIC DETAILING PROGRAM
OCT 2005 - FEB 2011, ACTUAL
CUMULATIVE VISITS
9,000
7,500
6,000
4,500
3,000
1,500
-
266
1,328
2,482
3,790
5,585
7,710
8,089
OCT - DEC 2005
2006
2007
2008
2009
2010
2011 (YTD)

PHYSICIAN SURVEY (n=180, OCT 2009 – SEP 2010)	MEAN ± SD
1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree	
The program provides me with useful information about commonly used medications.	4.7 ± .4
The content represents unbiased and balanced information about drugs.	4.8 ± .5
The program provides a perspective on prescribing that is different from what I get from other sources.	4.3 ± .8
My Drug Education Consultant is a well-informed source of evidence-based information about drugs I prescribe.	4.8 ± .4
I find the patient materials useful in my practice.	4.6 ± .5
Being able to get Continuing Medical Education credits from Harvard is a valuable component of the service.	4.5 ± .7
It makes sense for the Commonwealth of Pennsylvania to devote resources to this activity.	4.6 ± .6
I would like to see this program continue.	4.8 ± .4
The program has provided me the information that will help me in the care of my patients.	4.7 ± .5

Effect on Prescribing

- Cox-2's
- PPI's

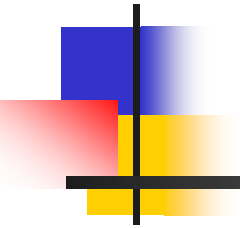
EFFECT ON DRUG UTILIZATION AFTER COX-2 / NSAID MODULE



PPI COST SAVINGS ANALYSIS

PRESCRIBING STRATUM	PHYSICIANS	6-MO. PPI SAVINGS
Very low (≤ 19 PPI scripts in past year)	60	$23,436
Low (20 – 40 scripts)	68	$53,285
Medium (41 – 75 scripts)	71	$69,197
High (76+ scripts)	92	$139,983
6-mo. total, weighted by distribution)		$285,901

http://www.rxfacts.org/pdf/iDiS%20eval_PPI_2007%2010%2004.pdf



Questions / Comments