

# Rx Watchdog Report

Shining a light on the cost and quality of prescription drugs

## Academic Detailing: An Interview with Jerry Avorn, M.D.



Jerry Avorn, M.D., is a professor of medicine at Harvard Medical School and chief of the Division of Pharmacoeconomics at Brigham and Women's Hospital, and author of *Powerful Medicines: The Benefits, Risks, and Cost of Prescription Drugs*. An internist, he has worked as a primary care physician and geriatrician and has been studying drug use and its outcomes for over 25 years.

Dr. Avorn, known as the "father of academic detailing," devised the approach when he and his colleagues showed that such programs could improve prescribing decisions and reduce costs by correcting improper medication expenditures. Today, programs based on his work are in place in the U.S., Canada, Europe, Australia and the developing world.

### Where and how do you see academic detailing fitting into the overall health care reform debate?

The way things are shaping up at the national level will leave a larger role for academic detailing because two big ingredients missing now, which will emerge later on, are ensuring that doctors

know what works best, and addressing physician incentives. The current plans in Congress do not seem to take on these issues effectively as we have seen in Massachusetts. Just guaranteeing access to health insurance, without managing the cost of care being delivered, is just asking for a bigger problem down the road. Making sure that physicians have the information they need to make the best and most cost-effective decisions will be necessary if we are to have quality, affordable care.

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Academic detailing can't fix the incentives problem of fee-for-service reimbursement. But academic detailing can help address what doctors know. If we could combine that increased base of knowledge about prescribing with the proper incentives, this would be an even better way to improve quality and contain costs. But even in the current system, equipping doctors with better knowledge about drugs has been shown to change our

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## Academic Detailing in Practice: A Tale of Four States

Frustration has reached a boiling point with governments, the public and lawmakers over the negative effects of the pharmaceutical industry's marketing practices. Spending on marketing and promotional goods, including drug samples, is estimated at nearly \$30 billion (according to the *New England Journal of Medicine* article, "A Decade of Direct-to-Consumer Advertising of Prescription Drugs," Donohue, 2007), with \$7.2 billion targeting physicians. The industry employs approximately 90,000 pharmaceutical sales representatives, which average out to about one for every five doctors. With scores of conflict of interest issues abounding between the industry and physicians, and the number

### What Is Academic Detailing?

Academic detailing is a service offered to prescribers that sends trained clinicians to the prescribers' offices to present the best available, objective scientific evidence on prescription drugs (prescribers include physicians, nurse practitioners, physician assistants—those authorized in the respective state to prescribe). The clinicians—often pharmacists, physicians and nurses—have face-to-face discussions and answer any questions prescribers may have on the topic presented. Many times, and at the prescriber's request, the clinicians make follow-up visits to discuss the overall patient practices and the use of those drugs, and/or make another presentation to discuss another class of drugs.

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prescribing for the better.

**We understand academic detailing is much more than saving dollars, but can you speak to saving the states money, especially because they are currently in such financial distress? And also how do states get funding for academic detailing programs?**

Fortunately, three of the programs we're working with were up and running before the economic meltdown. The granddaddy program—in Pennsylvania—was started in 2005 because Governor Rendell and Tom Snedden, director of the state's Pharmaceutical Assistance Contract for the Elderly (PACE) program, reasoned that it would be plausible to spend 1/20th of 1% of their drug expenditures in order to improve the way doctors use those drugs. They spent a tiny fraction to help doctors make smarter prescribing decisions.

But even in this current economic climate, Massachusetts as well as the District of Columbia found modest amounts of money to fund their programs in 2009. Massachusetts is contemplating a tax on drug companies associated with the state's new gift ban legislation, in order to help fund the academic detailing program they already have in place. D.C. has proposed a fee on drug company sales reps to fund their academic detailing program.

States are having a hard time funding their prescription programs, but if they can get an academic detailing program in place, it could help contain those medication costs. Several programs have found that if you can educate a doctor to use a \$50 per year generic medication to treat hypertension or diabetes instead of a \$1,000 per year brand-name medication that may be no better, or not even as good, that can improve care as well as saving costs.

There is also some "poetic justice funding" that has been made available for this work. When Pfizer had to pay \$430 million to settle litigation over off-label marketing of Neurotin, the attorney generals managing the case decided to take on the problem of misleading marketing by using some of the settlement funds to fund programs that teach physicians and

medical students about evidence-based prescribing. I hope this recent settlement with Pfizer (regarding Bextra and other drugs for non-approved off-label use) does the same.

The poster child for what NOT to do with the settlement money from the pharmaceutical companies is the tobacco settlement. Much of that went to general state revenues or to repair state highways instead of to deterring smoking. Similarly, I hope the settlement dollars from the pharmaceutical manufacturers don't get poured into general funds, but instead are used to undo the problem that gave rise to the settlements and for academic detailing programs. Doctors often rely on pharmaceutical sales reps to shape their drug choices, so the more we hear about intentional misinforming of physicians, the more we understand the need to get them evidence-based and objective information.

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**So, are there studies about evidence-based research resulting in better outcomes for patients, in addition to cutting costs?**

In the early 1980s, after conceiving the idea of academic detailing, I wanted to test the concept, so conducted a large multi-state randomized trial involving over 400 doctors in four state Medicaid programs. As Steve Soumerai and I reported in the *New England Journal of Medicine*, 92% of the doctors who were offered this service accepted it, and those who were randomized to the academic detailing group significantly improved their prescribing. In a formal cost-benefit analysis, we found that such a program

could save \$2 for every \$1 it cost to run. This was not a surprise; it is how the drug companies move prescribing in the direction they want. They know exactly what they are doing.

And evidence-based recommendations do save money. My Harvard colleague Michael Fischer, M.D., and I studied 133,634 patients treated for hypertension in a state pharmaceutical assistance program who filled 2.05 million prescriptions. In a paper we published in the *Journal of the American Medical Association*, ("Implications of Evidence-Based Prescribing for Hypertension") we found 815,316 prescriptions (40%) for which an alternative regimen appeared more appropriate, according to evidence-based recommendations. Such changes would have reduced the costs to payers in 2001 by \$11.6 million (nearly a quarter of the program spending was on antihypertensive medications), as well as being more clinically appropriate overall. Nationally, that would come to over \$1 billion. Use of pricing limits, similar to those in the Medicaid program, would have resulted in even larger potential savings of \$20.5 million in just that one state (42% of program costs).

So, we found if you could get doctors to treat hypertension using evidence-based recommendations, it would not only improve outcomes, but it would save costs. If doctors prescribe according to the very best available evidence, it will bring about the best outcomes and also reduce costs—we can have both, and we don't have to choose.

**Since the academic detailing program in Pennsylvania got started in 2005 and has been so successful, have other states moved the dial on similar programs?**

There is now a critical mass of academic detailing programs around the world and growing in the U.S. The non-profit Alosa foundation is the group that funds some of these programs and allows us to provide the clinical content to states including Massachusetts and Pennsylvania, as well as D.C.

There are also academic programs

in South Carolina, New Hampshire, Vermont, Maine and a large program in New York. Alosa provides training and the educational materials to these states as well. In the U.S. some integrated health care systems—particularly Kaiser—have mounted their own academic detailing services. Several Canadian Providences run academic detailing programs; Ontario soon plans to launch the largest academic detailing program in North America. Additionally, European countries, the Netherlands and Australia have some excellent academic detailing programs. Some of our colleagues from Australia have worked with us here in the U.S. My hope in the next calendar year is to continue building a critical mass and have a world-wide meeting so we can share programmatic and clinical experiences and learn from each other.

**Why is it so challenging for physicians to get the best information on which medicines to prescribe?**

I practiced for many years on the front lines, and I know how hard it is to get this information without spending hours reading journals. Getting information from a pharmaceutical representative is problematic, since you know darn well it's just a sales line. But academic detailers can provide a concise, 20-minute, boiled down discussion that reviews all the latest data on managing diabetes or depression, for example. Doctors find that to be terribly useful information.

Now the doctors ask the academic detailers, "When can you come back? Can you give grand rounds at our hospital?" Once they know the valuable information is out there—that is evidence-based and that we are not just pushing products—they all want more of it.

**Why is the approach to academic detailing more effective than say, a Web cast or a taped lecture?**

We academics tend to stay up in our ivory towers and lecture from there—that is, we talk at physicians, not with them. There is good evidence this method does not change behavior.

By contrast, academic detailing is based

on the same idea that drug companies take advantage of to change behavior; that is, they know how to engage you, interact with you, and learn about your beliefs and attitudes, and have a very clear objective: "Dr. Avorn, I want you to put your patients on xyz medication." Plus, the drug companies have the additional advantage of having access to what the doctors are already prescribing—since they buy that data.

**If doctors prescribe according to the very best available evidence, it will bring about the best outcomes and also reduce costs—we can have both, and we don't have to choose.**

So then I wondered what would happen if we could take this interactive adult learning exchange and use it in the context of conveying evidence based on rational prescribing. This explains how we do academic detailing. Avorn also added the academic detailers are physicians, nurses, pharmacists – they are health care

professionals that are not out to make a profit, versus the drug company sales representatives that are solely there to sell their company's drugs and make a profit, which dictates what kind of subjective information they will present to the physicians.

**I noticed at my doctor's office at Johns Hopkins they no longer allow pharmaceutical sales representatives. They do allow for academic detailers, right?**

Yes, that is interesting and I believe you are correct. Academic detailing is not just a "say no to drugs" program. It begins with the assumption that prescribing is one of the most useful and challenging things we doctors do, and we crave accessible, unbiased data about the drugs we prescribe. If war is too important to be left to the generals, then drug information is too important to be left primarily to the pharmaceutical industry. I think of getting good, current, non-commercial, evidence-based information to doctors as an important public good—like good roads, primary-school education and clean air.

For more on academic detailing visit the website [www.rxfacts.org/](http://www.rxfacts.org/). ■

**State Advocacy Update**

States are facing dramatic fiscal pressures as revenues decline and the demand for state services remains high. Policy makers are not expected to have much appetite for expanded funding of state programs, and will be looking to cut state expenditures wherever possible.

In this environment, AARP needs to combat short-sighted efforts to reduce or eliminate state-funded State Pharmaceutical Assistance Programs, which often supplement the coverage available under Medicare Part D. While these dollars can be cut without sacrificing federal funds, this risks incurring the much higher cost of treating unmanaged chronic conditions.

For more information on threats to State Pharmaceutical Assistance Programs, read the March 2009, Issue 2 of *Rx Watchdog*: [www.aarp.org/health/conditions/rx\\_watchdog/](http://www.aarp.org/health/conditions/rx_watchdog/)

We are also expecting AARP offices in a number of states to promote academic detailing programs. While the purpose of these programs is not to decrease costs, it is a likely "side effect" of providing physicians and other prescribers independent, unbiased information about prescription options in order to counter the efforts of brand pharmaceutical manufacturers who encourage the use of their products, which are many times the latest, least tested, and most expensive drug therapies. ■

# Pharmaceutical Giant Pfizer Off-Label Marketing Settlements

## Is It Enough to Deter Others?

The world's largest pharmaceutical company—which just got even larger due to a recent approval to buy Wyeth in a \$68 billion deal—recently settled a criminal case with the Department of Justice (DOJ) by agreeing to pay the government \$2.3 billion in fines, which is the largest single fine ever extracted by the DOJ from a single defendant.

This is not the first time, nor the second, that Pfizer, Inc., has paid millions of dollars in fines paid out for the same allegations. They have been found marketing off-label uses of prescription drugs, which is illegal.

**“Although it is legal for physicians to prescribe off-label uses of drugs that are not approved by the U.S. Food and Drug Administration (FDA), it is illegal for drug manufacturers to market such usages without the approval of the FDA.”**

Although it is legal for physicians to prescribe off-label uses of drugs that are not approved by the U.S. Food and Drug Administration (FDA), it is illegal for drug manufacturers to market such usages without the approval of the FDA. The rationale for this distinction is that physicians may become aware of the beneficial therapeutic effects. An example would be aspirin: physicians many prescribe it for reducing the onset of heart disease.

Pfizer is racking up significant fines due to the illegal use of off-label promotion for several prescription products. In September 2009, they settled a criminal case with the DOJ by agreeing to pay the government \$1.3 billion in fines for marketing off-label uses for Bextra-

Vioxx “cousin” pain reliever (both were removed from the market due to safety concerns). As part of the same settlement, Pfizer paid another \$1 billion to settle whistleblower cases alleging marketing off-label use of Zyvox (an antibiotic), Geodon (anti-schizophrenia and anti-mania), and Lyrica (fibromyalgia and nerve pain). Combined, the fines totaled the historical \$2.3 billion dollars.

In another settlement involving marketing of Geodon, Pfizer agreed to pay \$33 million to 42 states and the District of Columbia to resolve civil consumer protection claims.

In 2004, Pfizer paid \$430 million to settle allegations of marketing off-label uses

of Neurotin, originally approved for anti-seizure use in patients with epilepsy. A portion of this settlement helped to fund over two dozen prescriber education grants to help increase professional awareness of pharmaceutical influences, including off-label prescribing. Last year, Consumers Union received a \$4.4 million grant from the same settlement to raise consumer awareness about similar issues. Details can be found at [www.consumersunion.org/pub/core\\_health\\_care/005581.html](http://www.consumersunion.org/pub/core_health_care/005581.html).

As always with legal actions against drug makers, it is unclear whether even such a massive fine will deter similar behaviors from other drug makers, given the economic power of the drug industry. ■

## AARP Federal Advocacy

Right now Congress is grappling with how to overhaul our nation's health care system. AARP is fighting to guarantee all Americans have access to affordable, quality health coverage. For our members with Medicare coverage, the doughnut hole stands out as a major affordability concern and a real barrier to access. That's why AARP is fighting to ensure that Congress closes the doughnut hole.

More than 3 million people fall into the doughnut hole each year, and millions more live in fear of reaching this dangerous gap in coverage. Research shows that people who have trouble paying for their prescription drugs are more likely to skip doses or stop taking medications altogether, which can lead to more serious health problems and higher long-term costs for both them and for our health care system.

In addition to closing the doughnut hole, AARP is also working on several other prescription drug issues, including:

- Fighting to bring less costly generic versions of biologic drugs (typically very expensive drugs made out of living organisms and tissue, and that treat diseases such as cancer, multiple sclerosis and rheumatoid arthritis) to market in a safe and timely way;
- Pushing for measures that allow for the safe and legal importation of lower cost prescription drugs from abroad;
- Advocating that the Secretary of the Department of Health and Human Services be given the power to negotiate with the pharmaceutical companies for lower prescription drug prices.

For more information on AARP's health care reform effort, please visit [www.aarp.org/health/articles\\_health\\_reform\\_get\\_the\\_facts.html](http://www.aarp.org/health/articles_health_reform_get_the_facts.html). ■

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of lawsuits and safety issues with some drugs—the Vioxx debacle, for example—the momentum is growing for objective, evidence-based methods of getting accurate information into the hands of physicians and other prescribers. One strategy that has shown particular promise is academic detailing.

### Cost-Savings for States

The good news for state policy makers is that academic detailing is not only good for prescribers and their patient's health outcomes but it is cost effective too. While not originally designed to do so, these programs may produce substantial savings for Medicaid programs and other large purchasers, such as Kaiser Permanente, which has its own academic detailing program.

By one estimate, every dollar spent on an academic detailing program returns two dollars in reduced drug costs. This estimate, reported by the Pew Prescription Project, was developed from an economic model by researchers at the Harvard Medical School and Brigham and Women's Hospital, and published in the *New England Journal of Medicine*.

Another analysis was done in Pennsylvania's academic detailing program, within their Pharmaceutical Assistance Contract for the Elderly Program (PACE). The analysis was done by the Independent Drug Information Service, which is affiliated with Harvard Medical School, on the information on several classes of drugs. One preliminary economic analysis—for just one drug class—focused solely on an acid-reflux medication and its cheaper equivalent. They found reduced drug costs of approximately \$120 per doctor per month.

According to the Pew Prescription Project's report, *Cost-Effectiveness of Prescriber Education ("Academic Detailing" Programs)*, the heaviest prescribers showed a reduction of \$378 per month. Worth noting is that the savings shown is just for one single class of drugs and only for those in the PACE program, who

make up just a fraction of the caseload of any physician.

Other savings in using academic detailing include the increased use of generics (underuse of generics cost the U.S. health system an estimated \$8.8 billion each year). In looking at hypertension, for example, the evidence shows that for most patients the first drug of prescribers' choice would be inexpensive thiazide diuretic instead of one of the several new more expensive, heavily marketed drugs. The estimated savings is \$433 million a year, according to a study cited by the Pew Prescription Project.

### States' Experiences

#### Pennsylvania

Not everyone likes to boast about cost savings. Tom Snedden, director of Pennsylvania's PACE and academic detailing program, doesn't want to even know how much money the state saves, he says. "Once you start putting a lot of numbers out there, and you measure your success that way and publicize it, you just end up alienating the physician community. Then docs think it is all about saving money," Snedden said.

**"What I find is many states don't optimize the use of their resources to control the misutilization of drugs. They need to be more assertive and take a closer look at their processes."**

Snedden said it was never about the money when he developed both the academic detailing and the PACE program. "Never in the 18 years did we look back to see what it saved. Did it save us money? Undoubtedly yes. But if they are taking medications that are going to kill people or harm them, who is thinking about the money? And if it is keeping people out of hospitals and I know it

is, then I know we are saving Medicare and Medicaid money. I bet the savings is astronomical," Snedden said.

Snedden's advice to other states, as he often gives regarding academic detailing, is to complement academic detailing with other approaches. "You can't expect academic detailing to be a panacea as the biggest cost saver—it needs to be coupled with other strategies," Snedden said. He recommends strategies like drug utilization and using an online real-time adjudication process. "What I find is many states don't optimize the use of their resources to control the misutilization of drugs. They need to be more assertive and take a closer look at their processes."

#### South Carolina

"I wasn't sure about their goals when they first approached me, maybe a little reticent about it, but I liked their approach towards education and utilization of a given topic of the class of drugs," said Internist Irwin Linton, M.D., of Charleston, South Carolina. And now I find it extremely helpful and convenient for my schedule."

Dr. Linton is referring the academic detailers who have visited him to present evidence-based research and useful information on mental health drugs. "The primary difference between these pharmacists/academic detailers and pharmaceutical sales representatives is that the academic detailers pose questions, help resolve problems and have a scope of knowledge that is broader and more in-depth. They discuss the pros and cons to each of the drugs and bend over backwards to make sure we know they were not promoting any agent in a drug class," Linton said. "The more education we physicians can receive, the better. Our belief that we can master the intricacies of all the pharmaceutical agents is just not possible. I also have problems with computerized programs that spit out interactions and information—it may be pertinent to some of my patients, but not others. And I can't ask it questions and it doesn't help me problem solve. And I

don't have time to do all this because I'm so busy seeing patients."

South Carolina is unique in that most of the academic detailing programs originated and are located in the northeast part of the U.S. "Kudos to Medicaid for their forward thinking," said Sarah Ball, director of the South Carolina Academic Detailing Program, and assistant professor at the South Carolina College of Pharmacy.

"Medicaid, in looking at their data, saw there was a need to improve the mental health of the beneficiaries and heard about academic detailing. "It is a research and operationally validated tool for achieving better outcomes and value from medical care, as a way to make that happen. The South Carolina Department of Health and Human Services subsequently entered into a contract with the College of Pharmacy to develop and implement academic detailing services," Ball said.

It is too early into the program to decisively tell whether the program has saved Medicaid any money, but Ball said "the focus is on making the best choices for the patients and what we know is if you get someone mentally well, the cost savings is tremendous."

Ball is hoping that supplemental funding can be found to continue and expand the academic detailing program. There are

currently federal grants and other sources available and she said she is "anxiously confident and remains optimistic."

#### **Idaho**

There is a lot of territory to cover in Idaho, but in the academic detailing pilot project, it is getting done by just three people covering two large regions of the state. Tami Eide, Idaho's Medicaid Pharmacy Unit supervisor, and a pharmacist all said they wanted to concentrate on mental health drugs. Their program is unique in that they only meet with nurse practitioners—who in Idaho, are licensed to prescribe drugs without the oversight of a physician, and who see the majority of patients on Medicaid.

"We felt mental health drugs were not being used as appropriately as they could be—we were not looking to save money so much as we were to find ways to approach prescribers and get them to change their prescribing behavior versus having them use a preferred drug list. With mental health drugs, prescribing issues are not as clean cut as they are with other drugs. There is a lot of patient variability. Examples include using some of the drugs off label despite lack of good evidence suggesting it, using higher doses than recommended, etc. Our feeling is if we get the prescribers to use the best evidence-based drugs more effectively, we will save money," Eide said.

"We heard about academic detailing at a conference about drug utilization sponsored by the Community Catalyst and we read the Drug Effectiveness Review Project (DERP) guidelines and it seemed like a good way to approach this group of drugs," Eide continued. (see links below for more information on Community Catalyst and DERP).

Eide said after each visit, like most academic detailers, they do an evaluation and gain feedback from the prescribers to learn how they can improve their presentation or materials, find out if the physicians found it helpful and so forth.

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The feedback, Eide said, has been very positive. Idaho's program includes plans to finish these modules, measure the effort to see if they have changed prescribing behavior, and then possibly look at DERP's reviews on diabetes and asthma drug classes for future work.

#### **Maine**

Maine's academic detailing program is unique primarily because the Maine Medical Association (MMA) manages the program. Gordon Smith, the executive director of the MMA, said the association really embraced the program. "I think the state could have done a competitive contract, but because academic detailing was so new [state officials] wanted us [to manage the program] because they assumed physicians will take the information better from other physicians—they were worried otherwise they wouldn't get through the door," Smith said.

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### **Resources and Information on Academic Detailing**

Independent Drug and Information Service  
[www.rxfacts.org/](http://www.rxfacts.org/)

Prescription Policy Choices  
[www.policychoices.org](http://www.policychoices.org)

Prescription Policy Choices Academic Detailing Toolkit  
[www.policychoices.org/AcademicDetailingToolkit\\_000.shtml](http://www.policychoices.org/AcademicDetailingToolkit_000.shtml)

Drug Effectiveness Review Project  
[www.ohsu.edu/ohsuedu/research/policycenter/DERP/](http://www.ohsu.edu/ohsuedu/research/policycenter/DERP/)

Community Catalyst  
[www.communitycatalyst.org/about\\_us/](http://www.communitycatalyst.org/about_us/)

Community Catalyst: The Pew Prescription Project  
[www.prescriptionproject.org/](http://www.prescriptionproject.org/)

# Prescriber Education Program

## Maine (since 2009)

**Structure:** 2007 legislation mandated DHHS establish a program; DHHS has contracted with the Maine Medical Association and GHS Data Management; the MMA is subcontracting with the Independent Drug Information Service (iDiS) for training and materials; 2 detailers (both PAs)

**Topics:** Type 2 diabetes, anti-platelet therapy

**Budget:** The budget for 2009 is approximately \$150,000, raised from fees of \$1000 assessed on pharmaceutical manufacturers and labelers who market their products in the state of Maine (small, one-product companies are excluded from fee).

[www.mainemed.com/academic/index.php](http://www.mainemed.com/academic/index.php)

## Vermont (since 1999)

**Structure:** The Dept. of Health directs the program in collaboration with the AG, the Univ. of VT AHEC program and Office of Vermont Health Access; recently expanded from 2 to 4 detailers (PharmD and MD)

**Topics:** Insomnia, depression, hypertension, cholesterol, heartburn

**Budget:** 2007 legislation enables Vermont to assess a 0.5 % fee on what the Office of Vermont Health Access spends on each manufacturer's or labeler's products. \$200,000 of these fees is directed toward academic detailing. (PhRMA filed an unsuccessful challenge to this fee in 2007. In 2009, a Vermont District Court upheld the law enabling Vermont to collect the fee.)

[www.med.uvm.edu/ahec/TB1+BL.asp?SiteAreaID=290](http://www.med.uvm.edu/ahec/TB1+BL.asp?SiteAreaID=290)

## Massachusetts (since 2009)

**Structure:** The Dept. of Public Health directs the program in cooperation with Commonwealth Medicine; contracts with the Independent Drug Information Service (iDiS); 2 detailers (BSN/MPH, MD/MPH)

**Topics:** Type 2 diabetes

**Budget:** Massachusetts passed legislation on academic detailing in 2008, appropriating \$500,000 from its general fund that was later cut to \$200,000 due to budget constraints.

## New York (since 2008)

**Structure:** Department of Health directs the program in cooperation with the State University of New York (SUNY) and the Univ. of Massachusetts Medical School; contracts with the Independent Drug Information Service; 20 detailers/8 FTEs (PharmDs)

**Topics:** Antibiotics, antipsychotics, hypertension

**Budget:** Supported by general funds offset by booked savings

[www.nyhealth.gov/health\\_care/medicaid/program/prescriber\\_education/presceducationprog](http://www.nyhealth.gov/health_care/medicaid/program/prescriber_education/presceducationprog)

## Washington, DC (since 2009)

**Structure:** Department of Health is contracting with the Independent Drug Information Service; 2 detailers (RN/BSN, MD/MPH)

**Topics:** Type 2 diabetes

**Budget:** 2008 legislation allocated \$500,000 from the general fund for implementation of SafeRx of which approximately \$450,000 is dedicated for academic detailing.

## Pennsylvania (since 2005)

**Structure:** Pennsylvania's drug assistance program (PACE) contracts with the Independent Drug Information Service (this is the original state contract for academic detailing with iDiS); 11 detailers/6.5 FTEs (RN, BSN, PharmD, MS, MBA)

**Topics:** Pain management, upper GI symptom treatments, anticoagulants, lipid-lowering therapies and blood pressure medication.

**Budget:** Pennsylvania's drug assistance program (PACE) supports its academic detailing program with a budget of \$1 million a year financed through state lottery funds (not statutory). The development of the program was supported in part with funds from a multi-state settlement with a pharmaceutical manufacturer (Neurontin Consumer and Prescriber grant program).

[www.rxfacts.org](http://www.rxfacts.org)

## South Carolina (since 2007)

**Structure:** South Carolina Medicaid program contracts with Univ. of South Carolina School of Pharmacy; 5 detailers/3 FTEs (PharmD and RPh)

**Topics:** Mental health focused (antipsychotics, antidepressants, and mood stabilizers)

**Budget:** Supported by a Medicaid grant of approximately \$1 million a year.

## Idaho (since 2009)

**Structure:** Focus is on clinicians serving large proportions of Medicaid patients; 3 detailers (PharmD, RPh)

**Topics:** Mental health drugs

**Budget:** This grant-funded pilot operates on a budget of \$50,000, which includes funding through Medicaid match. Court upheld the law enabling Vermont to collect the fee.)

## Oregon (since 2009)

**Structure:** Focus is on clinicians serving large proportions of Medicaid patients; 3 detailers (PharmD, RPh)

**Topics:** Mental health drugs

**Budget:** This grant-funded pilot operates on a budget of 50,000 which includes funding through Medicaid match.

## New Hampshire

**Structure:** 2008 enabling legislation empowered the New Hampshire Medical Society to spearhead the program in conjunction with the AHECs under the direction of DHHS; no state funds were allocated to support the program; NHMS is exploring potential funding mechanisms.

The MMA negotiated a contract with the state after legislation was passed and the funding was made available, set up an advisory committee, and worked with Prescription Policy Choices (PPC), a nonprofit organization with expertise in prescription drug policy. The detailers/clinicians received their training from the Independent Drug Information Service (IDIS) and use IDIS modules. The program began in August of 2009, according to Smith.

Other states have called on Smith seeking his advice on how to set up similar academic programs, and he tells them if it were not for the PPC, he doubts he would have done it. “Most medical societies don’t have the resources to put together

a robust program like this,” said Smith, adding “now health plans, which also benefit from academic detailing, should also be big supporters of these programs.”

#### **Federal Action**

There is federal legislation pending—The Independent Drug Education and Outreach Act of 2008 (IDEA Outreach Act of 2008)—that would establish federal funding in the form of grants for academic detailing programs offered to states. It is sponsored by Senator Kohl in the Senate and Representative Pallone in the House. If Congress took action on this legislation and it was passed into law, it would not affect existing or new state-based programs. ■



## **Rx Watchdog Report**

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