Implementing an Academic Detailing Program with Massachusetts ACOs:

Program Experience and Summary Results from adviseRx

APPENDICES

Alosa Health

MASSACHUSETTS HEALTH POLICY COMMISSION

TABLE OF CONTENTS

APPENDIX 1.
FINAL ADVISERX APPLICATION

APPLICATION TO PARTICIPATE IN HEALTH POLICY COMMISSION ADVISERX PROGRAM

PROGRAM OVERVIEW

The Health Policy Commission (HPC) is partnering with Alosa Health to offer an opportunity for HPC-certified accountable care organizations (ACOs) to participate in an evidence-based pharmaceutical education program called adviseRx. ACOs selected to participate will identify up to two clinical staff to receive training and support from Alosa Health to provide outreach and education to ACO clinicians regarding evidence-based prescribing to treat type 2 diabetes.

The adviseRx program components are as follows:

1. Training: Participating ACO staff will receive training from Alosa Health through:
   - Clinical content modules for independent study
   - Three 60-90 minute webinars led by subject matter experts
   - One two-day, in-person, basic skills training
2. Program Implementation and Monitoring: Participating ACO staff will conduct educational outreach to ACO clinicians; Alosa Health will provide ongoing program consultation (i.e. mentoring, clinical consultation, monthly conference calls). Participating ACO staff and the clinicians to whom they conduct educational outreach will be eligible to earn continuing education credits (AMA PRA Category 1 CreditsTM).
3. Program Evaluation: The HPC and Alosa Health will work with participating ACOs to identify appropriate metrics to monitor program implementation and assess impact. Participating ACOs will track and report on these metrics.

The program will require participating ACO staff to dedicate approximately half of their time over approximately nine months.[i] For more information about the program, please visit: https://www.mass.gov/info-details/opportunities-for-hpc-certified-acos

APPLICATION PROCESS

HPC-certified ACOs that would like to be considered for participation in adviseRx must complete the application below. Please type your answers directly into this document, and then submit it to the HPC at hpc-certification@mass.gov. **The deadline to submit a complete application is August 23, 2019 at 5:00 pm.**

The HPC anticipates selecting five or more HPC-certified ACOs to participate, up to the maximum program capacity of 10 ACO staff (no more than two staff per participating ACO). The HPC will use the following criteria to evaluate ACO applications and select ACOs to participate:

1. the quality and strength of the ACO's statement of purpose (see question 1);
2. capacity for collecting and reporting data to monitor program implementation and impact (see question 2), and;
3. identification of an internal Champion likely to support implementation within the ACO (see question 3).

If you have any questions about the adviseRx program or the application process, please contact Courtney Anderson and Mike Stanek at hpc-certification@mass.gov.

---

i Please note that HPC will not provide funding for ACO staff time.

ACO Name: _____

ACO Address: _____

Contact Name: _____

Contact Title: _____

Contact Phone: _____

Contact Email: _____

1. Statement of purpose: Please describe in 500 words or less why your ACO is seeking to participate in adviseRx. In your response, please describe:

   a. Your ACO's specific goals for participating in adviseRx, including any metrics you propose to track to monitor your progress toward those goals.

   b. How improving evidence-based prescribing and pharmacy management, particularly for type 2 diabetes, aligns with your ACO's overall strategic goals for the coming year, including:

      - how your ACO's ongoing cost containment or quality improvement initiatives align with this program;
      - how participating in adviseRx would align with or further your ACO's specific prior or ongoing experience conducting evidence-based pharmaceutical outreach to providers.

   c. Your ACO leadership's interest in and support for participating in adviseRx.

2. ACOs selected for participation in adviseRx will work with Alosa Health and the HPC to collect data and report on key metrics related to program implementation and impact. These metrics may focus on clinician prescribing patterns (i.e. number of prescriptions written), patient adherence, utilization of health care services, and/or laboratory results. Please describe your ACO's capabilities for collecting and reporting metrics in these areas, including:

   d. Examples of specific metrics that the ACO could collect and report on, and

   e. Any limitations to the ACO's data collection and reporting capabilities on metrics in the areas described above.

3. Please briefly describe the ACO clinical staff (including role and/or title) that you propose to dedicate at a half-time rate to participate in adviseRx. Please specify whether you request participation of 1 or 2 ACO clinical staff.

4. Please identify and briefly describe the individual who will serve as the internal "Champion" to spearhead your ACO's participation in adviseRx. This person should be a leader within the organization who will actively support its success, including ensuring that the participating ACO staff are appropriately dedicated to the program and are able to conduct the educational outreach with ACO clinicians following the training.

   - Champion Name:
   - Champion Title:
   - Champion Contact Information (email, phone number):
   - Brief description of the Champion's role within the ACO, relationship to the staff who will participate in adviseRx, and qualifications or abilities to help ensure the successful implementation of adviseRx within the ACO:

5. By typing my name below, I certify that to the best of my knowledge and belief the information I have submitted is accurate and complete:

_____ Date of submission: _____

APPENDIX 2.
TRAINING AGENDA & PARTICIPANT SURVEYS

SCHEDULE: DAY 1

TIME	SESSION	PRESENTER/FACILITATOR
8:30 am	Welcome & Introductions	Paul Fanikos
8:45 am	Introduction from the Massachusetts Health Policy Commission	Michael Stanek
9:00 am	Clinical Review	Marie McDonnell, MD
10:00 am	**Break**	
10:15 am	Evidence based medicine & the case for Academic Detailing	Paul Fanikos
10:30 am	Practice detail	Mary Lou Woodford, Mary Liz Doyle Tadduni
11:00 am	Structure and planning of a visit	Mary Lou Woodford, Mary Liz Doyle Tadduni
11:30 am	Using educational materials wisely	Mary Lou Woodford, Mary Liz Doyle Tadduni
12:00 pm	**Break**	
12:45 pm	Clinical materials review	Ellen Dancel
2:00 pm	Introductions [15 min], Needs assessment [45 min]	Breakout groups
3:00 pm	**Break**	
3:15 pm	Features, benefits and key messages [45 min]	Breakout groups
4:00 pm	Barriers & enablers of key messages [45 min]	
4:45 pm	**Wrap up and close**	

SCHEDULE: DAY 2

TIME	SESSION	PRESENTER/FACILITATOR
8:30 am	Debrief Day 1	Mary Lou Woodford
8:45 am	Objections [30 min], Summary, gaining commitment, and closing [30 min]	Breakout groups
9:45 am	Preparing for the visit [15 min]	Breakout groups
10:00 am	**Break**	
10:15 am	First role-play of an educational visit [50 min]	Mary Lou Woodford
11:05 am	Collaborative practice detail session	Breakout groups
12:05 pm	**Break**	
1:00 pm	Individualized detailing and coaching sessions with physicians	Breakout groups
4:15 pm	Group discussion and debrief	
4:30 pm	Administrative meeting	Daniel McMahon & Mackenzie Rowe
5:00 pm	**Next steps and group departure**	Mary Lou Woodford

AD POST-TRAINING ATTENDEE SURVEY RESULTS

COURSE EVALUATION	Strongly Agree (7)	Agree (6)	Agree Somewhat (5)	Undecided (4)	Disagree Somewhat (3)	Disagree (2)	Strongly Disagree (1)	Avg. Score
The training course was well-organized	6							7.0
Role playing was an effective way to improve my academic detailing skills	6							7.0
My questions were answered to my satisfaction	6							7.0
The pace of the training was conducive to learning	6							7.0
Enough time was spent on discussing topics important to me	5	1						6.8
Too much time was spent discussing topics NOT important to me		1		1		1	3	2.5

OVERALL SATISFACTION	Totally Adequate (7)	Very Adequate (6)	Barely Adequate (5)	Borderline (4)	Inadequate (3)	Very Inadequate (2)	Totally Inadequate (1)	Avg. Score
How would you rate this training OVERALL?	6							7.0

ADS TEAM EVALUATION	Strongly Agree (7)	Agree (6)	Agree Somewhat (5)	Undecided (4)	Disagree Somewhat (3)	Disagree (2)	Strongly Disagree (1)	Avg. Score
The instructors were well organized	6							7.0
The instructors were concerned with how well the trainees were learning	6							7.0
The instructors presented the material well	6							7.0
The instructors provided valuable feedback	6							7.0

KNOWLEDGE, SKILLS AND ATTITUDES	Strongly Agree (7)	Agree (6)	Agree Somewhat (5)	Undecided (4)	Disagree Somewhat (3)	Disagree (2)	Strongly Disagree (1)	Avg. Score
I am going to apply the academic detailing skills I've learned within the next week	2	1	1		1		1	4.8
I am going to apply the academic detailing skills I've learned within the next 2 weeks **one trainee did not respond*	3	1		1				6.2
I am going to apply the academic detailing skills I've learned within the next 4 weeks **one trainee did not respond*	2	2		1				6.0
I am going to apply the academic detailing skills I've learned within the next 3 months	5	1						6.8
I am confident about using the academic skills that I've learned	4	1	1					6.5
I believe that academic detailing can align providers to best practices	4	2						6.7
My local colleagues have been successful with academic detailing **two trainees wrote N/A*				4				6.0
Local providers have a positive opinion about academic detailing **two trainees wrote N/A*				4				6.0
My local facility supports academic detailing	2	2		2				5.7
I know how to access academic detailing resources	3		3					6.0
I feel confident that I can change a provider's behavior	1	3	2					5.8

OVERALL ATTENDEE COMMENTS:

Thank you for very useful information!!

The providers were a great part of training. They provided practical, helpful tips.

Very good training.

Clinical content was presented in a way that was conducive to learning. Webinars were a great resource! Printed materials were great and tools are organized well.

Great learning activities. Thank you. Very well done!

Safe, caring environment.

This has been a wonderful experience for me and has exceeded my expectations. The clinical information and academic detailing methods I have learned will certainly be applied to my daily work. Thank you for all of your help and experience! It was a pleasure!

Thank you!! Excellent content. Trainers and guest providers provided valuable feedback.

APPENDIX 3.
EVALUATION RESULTS BY ACO

SIGNATURE HEALTHCARE (N=24)

	Avg. Response
The adviseRx educator presented tools to assist with diet and lifestyle education for patients with prediabetes and diabetes.	4.88
The educator presented factors that drive medication selection, including the evidence on the cardio-vascular benefit of select glucose-lowering medications.	4.88
The educator described a strategy for reducing treatment burden for patients on insulin.	4.75
As a result of this visit, I will simplify insulin regimens in patients who are having recurrent hypoglycemia.	4.63
The adviseRx educator provided current, non-commercial, evidence-based information that will enable me to improve patient care.	4.79
The information provided will impact the way I make clinical decisions in caring for my patients.	4.79
Information provided by the adviseRx educator will benefit the well-being of my patients.	4.88

BETH ISRAEL LAHEY HEALTH PERFORMANCE NETWORK (N=2)

	Avg. Response
The adviseRx educator presented tools to assist with diet and lifestyle education for patients with prediabetes and diabetes.	4.0
The educator presented factors that drive medication selection, including the evidence on the cardio-vascular benefit of select glucose-lowering medications.	5.0
The educator described a strategy for reducing treatment burden for patients on insulin.	4.0
As a result of this visit, I will simplify insulin regimens in patients who are having recurrent hypoglycemia.	4.0
The adviseRx educator provided current, non-commercial, evidence-based information that will enable me to improve patient care.	5.0
The information provided will impact the way I make clinical decisions in caring for my patients.	5.0
Information provided by the adviseRx educator will benefit the well-being of my patients.	5.0

MASSACHUSETTS
HEALTH POLICY COMMISSION

Alosa Health

Balanced information for better care

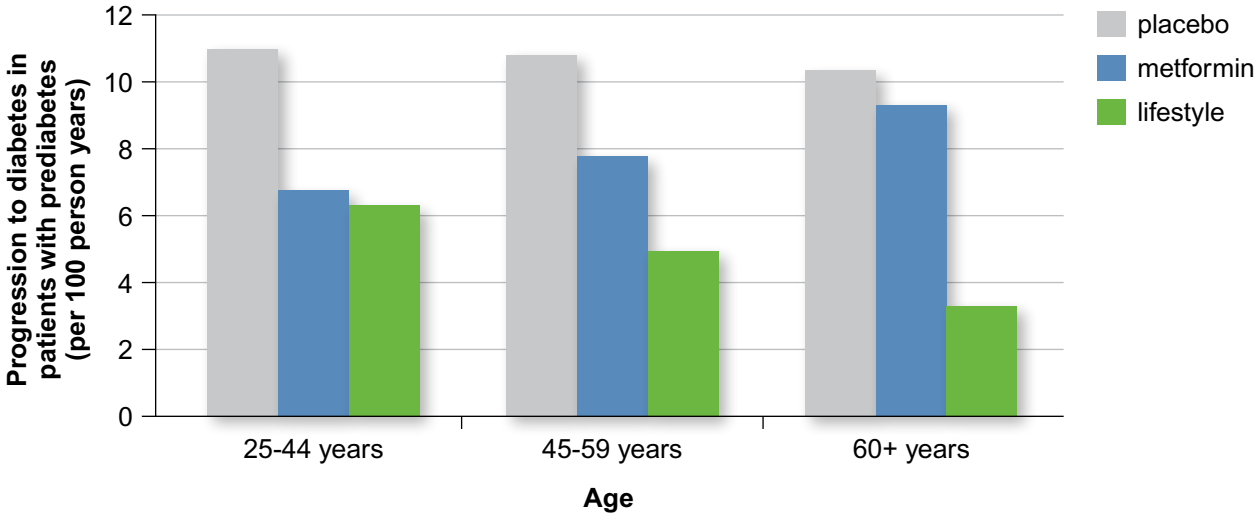
Managing type 2 diabetes

New trials and guidelines are transforming medication use

Type 2 diabetes is common, but its risk can be reduced with lifestyle changes

Prediabetes (HbA1c 5.7-6.4%) affects more than 80 million people.[1]

FIGURE 1. Diet and exercise can reduce or delay the progression from prediabetes to diabetes, especially in older adults.[2]



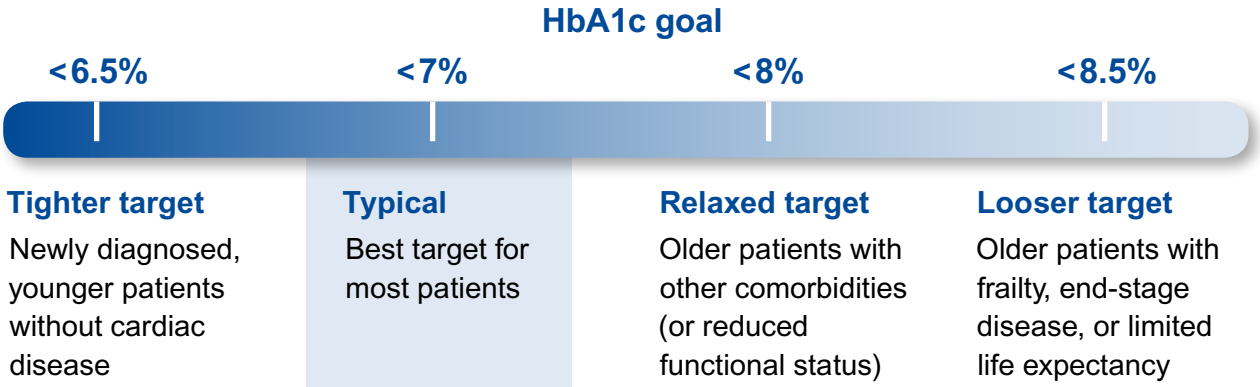
Diabetes Prevention Programs

DPPs support lifestyle changes in patients with prediabetes through exercise and wellness programs certified by the CDC. To learn more about referring patients and to find programs in your area, visit **AlosaHealth.org/Prediabetes**.

Over 30 million Americans have diabetes (HbA1c ≥6.5%),[1] including more than 8% of adults in Massachusetts.[3]

Select HbA1c goal based on patient characteristics

FIGURE 2. For most adults, the HbA1c target is <7%. But the proper goal can change as patients age, especially in older adults with comorbidities, cognitive decline, or frailty.[4]



Begin with lifestyle changes, adding metformin if needed.

FIGURE 3. Diet and exercise are a central component of management; medications such as metformin will be needed if greater HbA1c lowering is required.

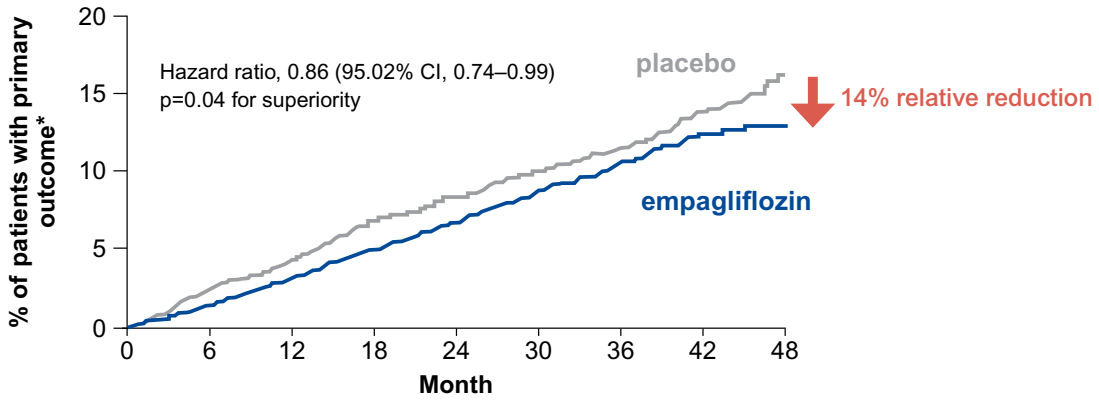
Diabetes self-management programs can help patients make lifestyle changes. So can other members of the healthcare team, including diabetes educators, nurses, pharmacists, and nutritionists. Links to diabetes education resources are at **AlosaHealth.org/Diabetes**.

In patients with cardiac disease, newer glucose-lowering drugs prevent CV events

All these studies were conducted in patients already taking metformin.

Sodium-glucose cotransporter-2 (SGLT-2) inhibitors or 'flozins'

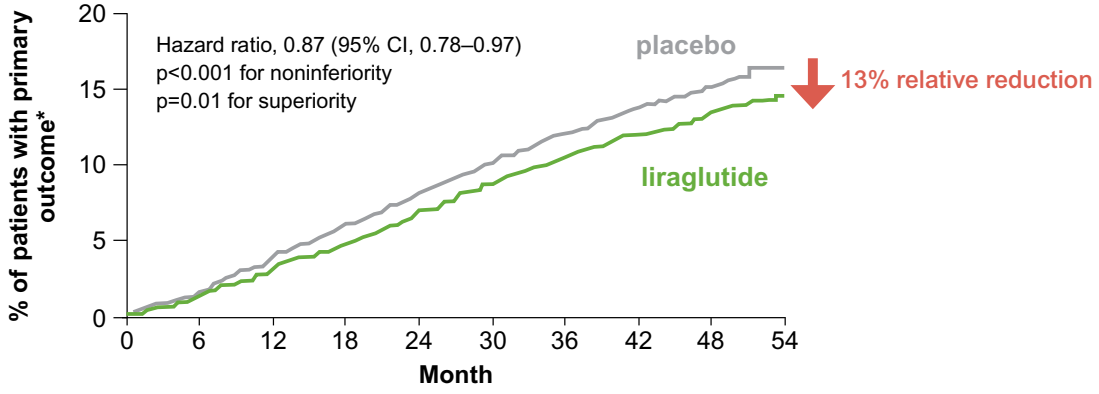
FIGURE 4. The EMPA-REG trial showed that empagliflozin (Jardiance) reduced the risk of cardiovascular events more than placebo.[5]



Canagliflozin (Invokana) also provided CV benefit over placebo. The effect of dapagliflozin (Farxiga) was mixed.[6,7]

Glucagon-like peptide-1 receptor agonists (GLP-1)

FIGURE 5. Liraglutide (Victoza) reduced the relative risk of CV outcomes 13% more than placebo in the LEADER trial.[8]



Not all GLP-1s have been shown to reduce CV outcomes. Semaglutide (Ozempic) and dulaglutide (Trulicity) reduced CV events more than placebo (relative reduction 26% and 12%, respectively), but exenatide (Bydureon) and oral semaglutide (Rybelsus) were no better than placebo.[9-12]

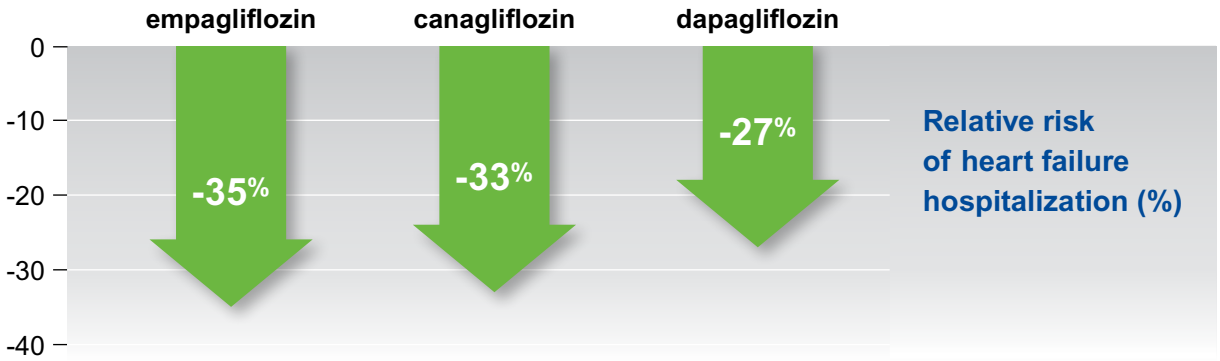
Management of hypertension and cholesterol can also reduce CV risk.

* Primary outcomes were CV death, non-fatal myocardial infarction, and non-fatal stroke.

Newer medications can also reduce heart failure and renal damage

Hospitalization for heart failure

FIGURE 6. All SGLT-2 inhibitors (flozins) studied significantly reduced the risk of heart failure hospitalization compared to placebo.[5-7]



However, GLP-1s did not differ from placebo in preventing heart failure outcomes.

Progression of nephropathy

TABLE 1. GLP-1s and SGLT-2 inhibitors (flozins) significantly slowed decline in renal function compared to placebo.[7-10,13,14]

Class	Drug	Worsening renal function		Relative risk reduction
		On Medication	On Placebo	
SGLT-2 inhibitors	empagliflozin (Jardiance)	13%	19%	39%
	canagliflozin (Invokana)	7%	10%	34%
	dapagliflozin (Farxiga)	2%	3%	47%
GLP-1	liraglutide (Victoza)	6%	7%	22%
	semaglutide (Ozempic)	4%	6%	36%
	dulaglutide (Trulicity)	17%	20%	15%

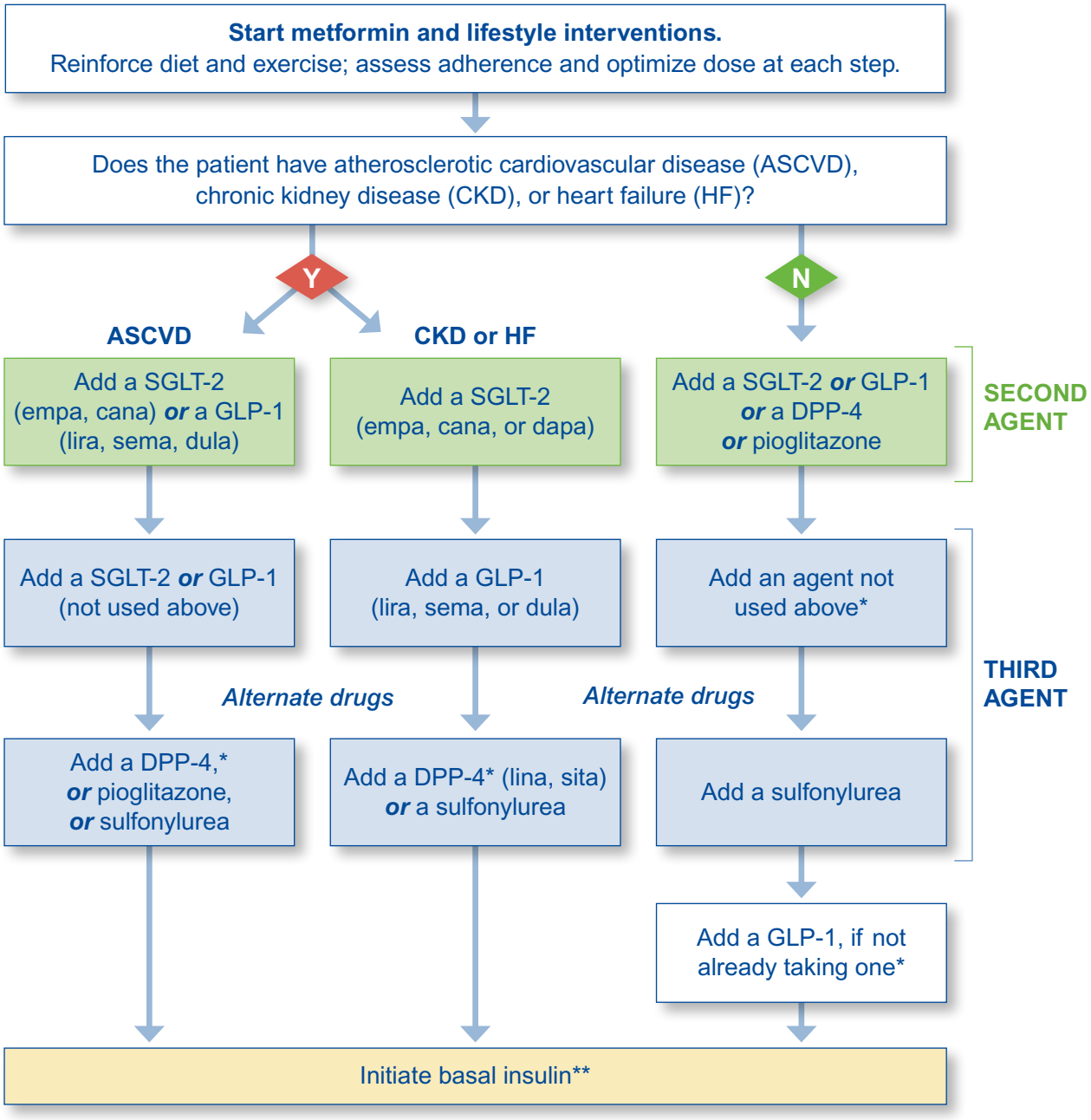
Thresholds for defining new or worsening renal function decline varied slightly between studies, generally including persistent worsening eGFR, need for renal replacement (e.g., dialysis), or renal death.

The cardiovascular and renal benefits of these drugs are independent of their glucose-lowering effects.

Moving further toward the HbA1c goal

What to do when lifestyle and metformin are not enough

FIGURE 7. Treatment paths for patients who are not at HbA1c goal. Use patient characteristics, preferences, and insurance coverage to select the best regimen.[4]



* Avoid prescribing a DPP-4 and GLP-1 together.

** **Basal insulin can be initiated if needed at any point.**

Select drug based on patient factors

TABLE 2. Medication effects and considerations for prescribing

Class / medication	CV outcome: ASCVD	CV outcome: HF	Worsening nephropathy	Weight change	Hypoglycemia	Precautions
biguanide metformin (Glucophage)	**benefit**	*	*	**loss**	**no**	GI intolerance (start with low dose to minimize)
SGLT-2 inhibitors (flozins) canagliflozin (Invokana) empagliflozin (Jardiance)	**benefit**	**benefit**	**benefit**	**loss**	**no**	UTI, ketoacidosis, genital infections, hypotension, fractures (cana), amputation (cana)
dapagliflozin (Farxiga)	**neutral**					
ertugliflozin (Steglatro)	*	*	*			
GLP-1 receptor agonists liraglutide (Victoza) semaglutide† (Ozempic) dulaglutide† (Trulicity)	**benefit**	**neutral**	**benefit**	**loss**	**no**	GI side effects common pancreatitis
exenatide† (Bydureon) lixisenatide (Adlyxin) semaglutide (Rybelsus)§	**neutral**	**neutral**	*			
exenatide (Byetta)	*	*	*			
DPP-4 inhibitors (gliptins) linagliptin (Tradjenta) sitagliptin (Januvia)	**neutral**	**neutral**	*	*	**no**	joint pain, pancreatitis
alogliptin (Nesina) saxagliptin (Onglyza)	*	**potential risk**	*	*		
thiazolidinediones (TZD) pioglitazone (Actos)	**benefit**	**increased risk**	*	**gain**	**no**	bone fractures, bladder cancer
sulfonylureas glyburide (DiaBeta, Glynase) glimepiride (Amyarl)	**neutral**	*	*	**gain**	**yes**	
glipizide (Glucotrol)	*	*	*			
insulin lispro, aspart, glulisine, regular, NPH	*	*	*	**gain**	**yes**	
glargine, degludec, detemir	**neutral**	*	*			

*no data available; †given weekly; §oral formulation

Renal dose adjustment is required for metformin, GLP-1s, and SGLT-2 inhibitors.

The other 'resistance': starting insulin

Many patients can successfully achieve their HbA1c target with basal insulin (e.g., NPH, glargine) combined with other non-insulin agents.

FIGURE 8. If insulin is required to reach the HbA1c goal, initiate basal insulin first, adding mealtime doses as needed to achieve goal.[4]

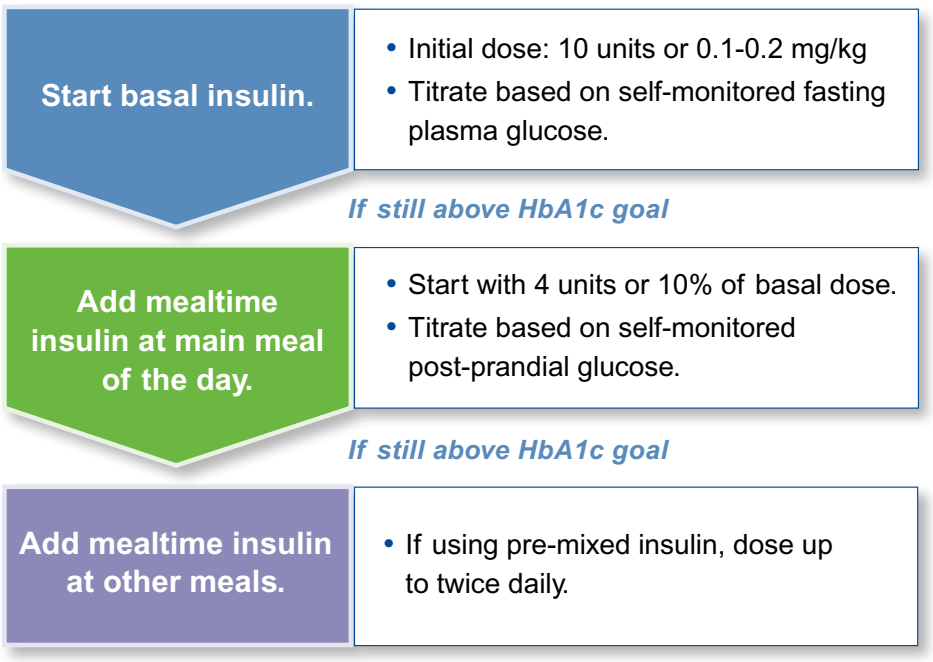


TABLE 3. The "Treat to Target" criteria provide an evidence-based approach to increase insulin doses in patients without frailty or cognitive impairment.[15]

- Start with 10 units of **basal** insulin (either intermediate or long-acting insulin) at bedtime.
- Adjust insulin dose every week, based on the mean self-monitored fasting blood glucose (FBG) values from the previous 2 days.

If mean FPG is:	Increase insulin by:
100-120 mg/dL	2 units
120-140 mg/dL	4 units
140-180 mg/dL	6 units
≥180 mg/dL	8 units

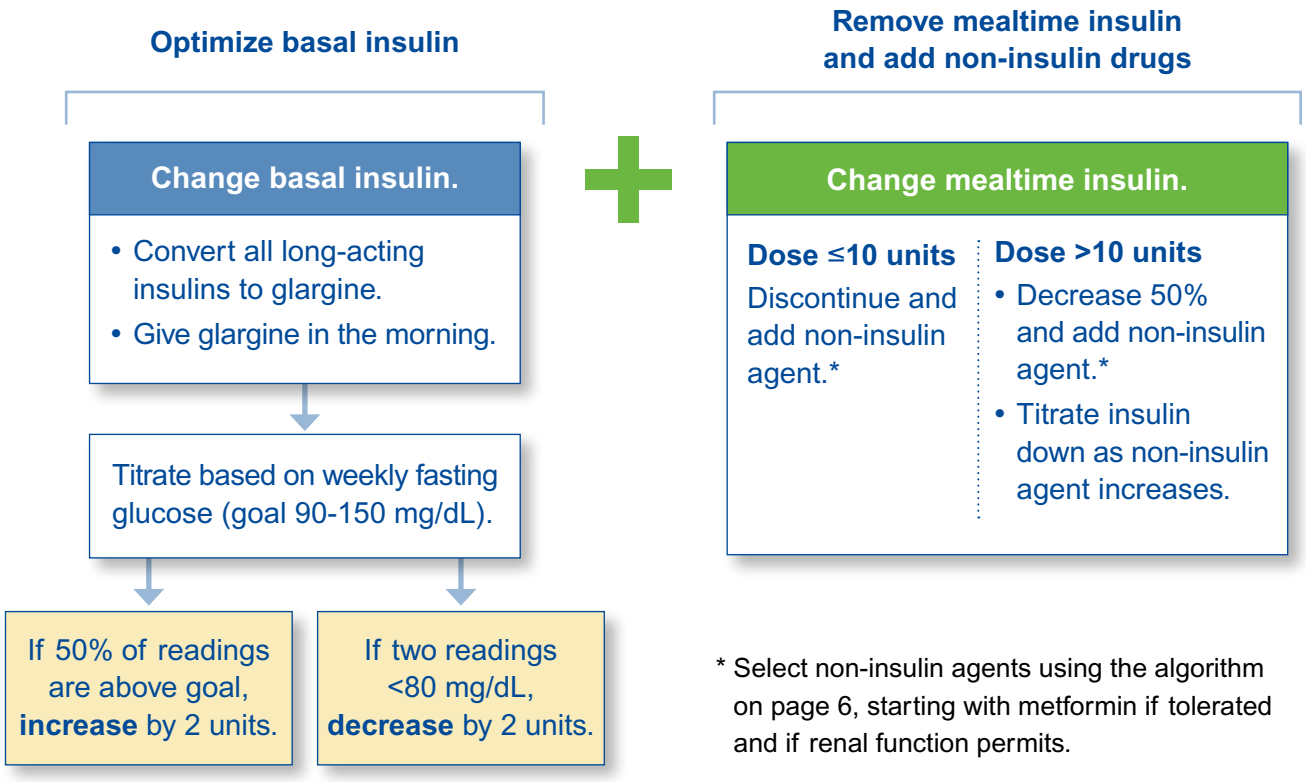
A slower, more gradual titration may be required for older adults to avoid hypoglycemia.

Preventing hypoglycemia in frail older adults

Reassessing insulin regimens can:

- avoid hypoglycemia, which can cause poorer outcomes in older adults.
- reduce treatment burden and the number of injections required each day.

FIGURE 9. A small pragmatic implementation study in older people with diabetes used an algorithm to simplify the insulin regimen.[4,16]



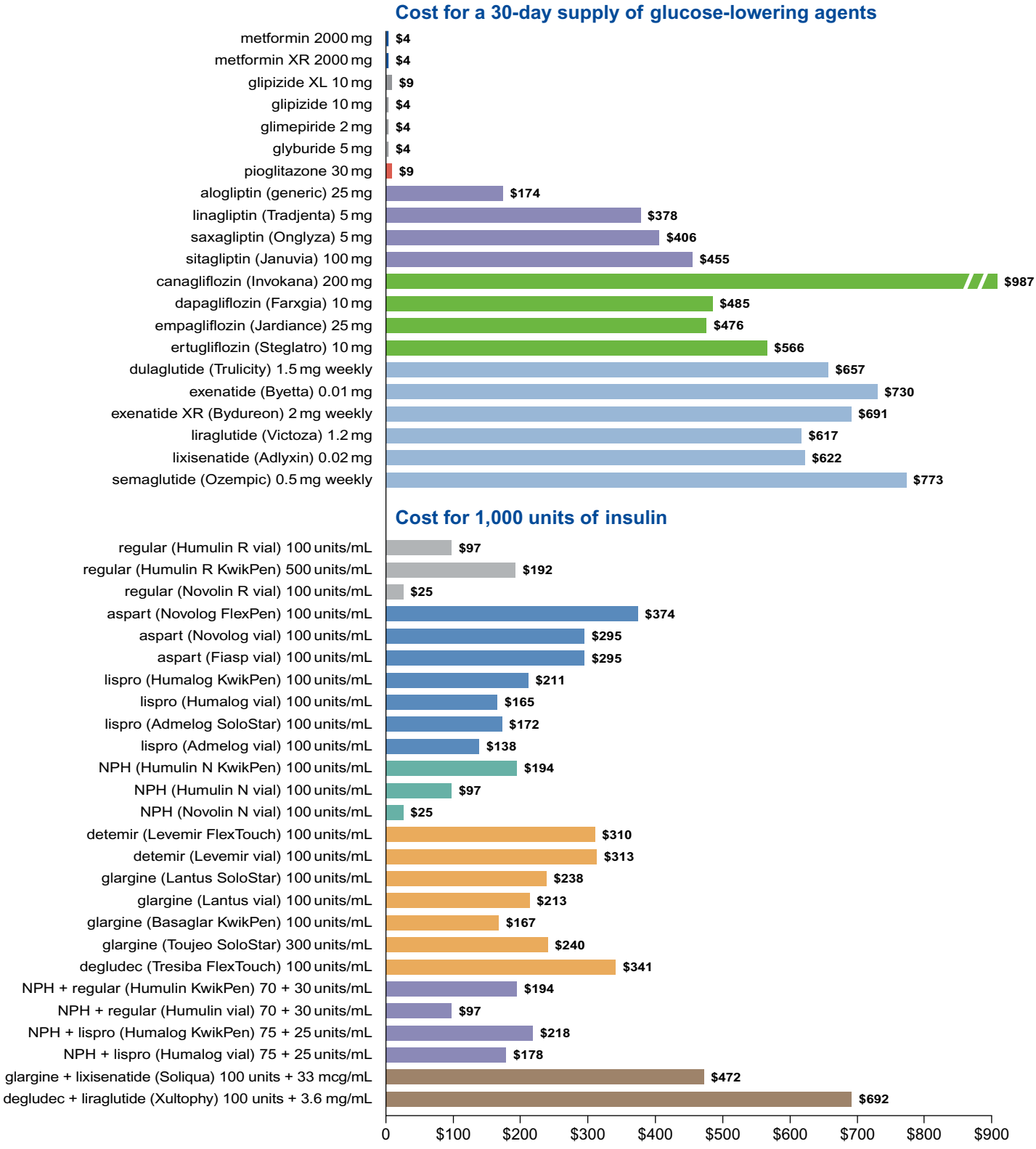
* Select non-insulin agents using the algorithm on page 6, starting with metformin if tolerated and if renal function permits.

Insulin simplification:[16]

- ✓ lowered time in hypoglycemia nearly 3-fold,
- ✓ reduced insulin injections from almost 4 injections to 1 per day, and
- ✓ did not change HbA1c control.

Costs

FIGURE 10. Price of agents used to treat diabetes



Prices from goodrx.com, January 2019. Listed doses are based on Defined Daily Doses by the World Health Organization and should not be used for dosing in all patients. All prices shown are for generics when available, unless otherwise noted. These prices are a guide; patient costs will be subject to copays, rebates, and other incentives.

Key messages

- **Diet and exercise** can slow the progression of prediabetes to type 2 diabetes, and can improve glucose control in patients with established diabetes.
- **Aim for a target HbA1c of 7% for most patients**, but modify the goal (to <8.5%) for many frail older patients in whom overtreatment can pose its own risks.
- **Use metformin as the initial treatment** for the vast majority of patients who require drug treatment.
- **Focus on adherence** before increasing doses or adding a new drug.
- **Intensify treatment with a second agent for patients who are not controlled on metformin.**
  - Choose a second-line treatment based on patient characteristics.
  - Prescribe a GLP-1 or SGLT-2 inhibitor for patients with ASCVD, heart failure, or CKD, based on trial data.
- **Add insulin promptly when other agents are not sufficient** to achieve HbA1c goal.
- In all patients with diabetes, **manage hypertension and hyperlipidemia** aggressively, and focus on smoking cessation when necessary.
- Continuously **promote weight control, exercise, and adherence to medications.**

More information is available at AlosaHealth.org/Diabetes.

References:

(1) Centers for Disease Control and Prevention. National diabetes statistic report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services;2017. **(2)** Crandall J, Schade D, Ma Y, et al. The influence of age on the effects of lifestyle modification and metformin in prevention of diabetes. *J Gerontol A Biol Sci Med Sci.* 2006;61(10):1075-1081. **(3)** Diagnosed Diabetes. https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html. Accessed 2 Oct 2019. **(4)** American Diabetes Association. Standards of medical care in diabetes-2019. *Diabetes Care.* 2019;42(Suppl 1):S1-S193. **(5)** Zinman B, Wanner C, Lachin JM, et al. Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes. *N Engl J Med.* 2015;373(22):2117-2128. **(6)** Neal B, Perkovic V, Mahaffey KW, et al. Canagliflozin and Cardiovascular and Renal Events in Type 2 Diabetes. *N Engl J Med.* 2017;377(7):644-657. **(7)** Wiviott SD, Raz I, Bonaca MP, et al. Dapagliflozin and Cardiovascular Outcomes in Type 2 Diabetes. *N Engl J Med.* 2019;380(4):347-357. **(8)** Marso SP, Daniels GH, Brown-Frandsen K, et al. Liraglutide and Cardiovascular Outcomes in Type 2 Diabetes. *N Engl J Med.* 2016;375(4):311-322. **(9)** Marso SP, Bain SC, Consoli A, et al. Semaglutide and Cardiovascular Outcomes in Patients with Type 2 Diabetes. *N Engl J Med.* 2016;375(19):1834-1844. **(10)** Gerstein HC, Colhoun HM, Dagenais GR, et al. Dulaglutide and cardiovascular outcomes in type 2 diabetes (REWIND): a double-blind, randomised placebo-controlled trial. *Lancet.* 2019;394:121-30. **(11)** Holman RR, Bethel MA, Mentz RJ, et al. Effects of Once-Weekly Exenatide on Cardiovascular Outcomes in Type 2 Diabetes. *N Engl J Med.* 2017;377(13):1228-1239. **(12)** Husain M, Birkenfeld AL, Donsmark M, et al. Oral semaglutide and cardiovascular outcomes in patients with type 2 diabetes. *N Engl J Med.* 2019;381(9):841-51. **(13)** Wanner C, Inzucchi SE, Lachin JM, et al. Empagliflozin and Progression of Kidney Disease in Type 2 Diabetes. *N Engl J Med.* 2016;375(4):323-334. **(14)** Perkovic V, Jardine MJ, Neal B, et al. Canagliflozin and renal outcomes in type 2 diabetes and nephropathy. *N Engl J Med.* 2019;308:2295-306. **(15)** Riddle MC, Rosenstock J, Gerich J. The treat-to-target trial: randomized addition of glargine or human NPH insulin to oral therapy of type 2 diabetic patients. *Diabetes Care.* 2003;26(11):3080-3086. **(16)** Munshi MN, Slyne C, Segal AR, Saul N, Lyons C, Weinger K. Simplification of Insulin Regimen in Older Adults and Risk of Hypoglycemia. *JAMA Intern Med.* 2016;176(7):1023-1025.

About this publication

These are general recommendations only; specific clinical decisions should be made by the treating clinician based on an individual patient's clinical condition. More detailed information on this topic is provided in a longer evidence document at AlosaHealth.org.

This material is provided by Alosa Health, a nonprofit organization which is not affiliated with any pharmaceutical company.

This material was produced by Marie McDonnell, M.D., endocrinologist and Director of the Brigham Diabetes Program at the Brigham and Women's Hospital and Lecturer in Medicine at Harvard Medical School; Michael A. Fischer, M.D., M.S., Associate Professor of Medicine (principal editor); Jerry Avorn, M.D., Professor of Medicine; Dae Kim, M.D., M.P.H., Sc.D., Assistant Professor of Medicine; Jing Luo, M.D., M.P.H., Instructor in Medicine, all at Harvard Medical School; and Ellen Dancel, PharmD, M.P.H., Director of Clinical Materials Development, Alosa Health. Drs. Avorn, Fischer, Luo, and McDonnell are physicians at the Brigham and Women's Hospital, and Dr. Kim practices at the Beth Israel Deaconess Medical Center and Hebrew Senior Life, both in Boston. None of the authors accepts any personal compensation from any drug company. An earlier version of this brochure was supported by the Pennsylvania Department of Aging through its PACE program.

Medical writer: Stephen Braun.

Development of this material and program were made possible by funding from the Massachusetts Health Policy Commission.

MASSACHUSETTS
HEALTH POLICY COMMISSION

APPENDIX 5. ALOSA TRAINERS

VIOLA PASCUCCI, PHARMD

Viola has 15 years' experience in academic detailing and education. She received her Pharm.D. from Northeastern University in Boston. She previously worked as a consultant at CVS Caremark, where she provided appropriate drug therapy and consulted in various disease states such as asthma, diabetes, dyslipidemia, mental health, gastroenterology and rheumatology. Viola has been a Clinical Educator with Alosa Health since 2014.

DAWN WHITNEY, MSN/ED

Dawn is a registered nurse with experience ranging from the bedside to curbside to the classroom. Passions include public health nursing and educating nurses of the future. In her free time Dawn can be found working with Boston's homeless community. Dawn holds the position of Lecturer within Northeastern University's graduate/ undergraduate Nursing department and University of Massachusetts Boston's College of Nursing and Health Sciences.