Day 2 field presentations

U.S. Department of Veterans Affairs

Providers' perception after implementation of academic detailing on opioid overdose education and naloxone prescribing at the Veterans Health Administration

12 November 2018

Mark Bounthavong, PharmD, PhD
National Clinical Program Manager
VA Pharmacy Benefits Management
National Academic Detailing Service

Disclosures and disclaimers

The author have no relevant financial or nonfinancial relationships to disclose. During the development, analysis, and preparation of this presentation, the author was an employee of the US Veterans Health Administration, Department of Veterans Affairs.

The views and opinions expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of any agency of the US government. Assumptions made within the analysis are not reflective of the position of any US government entity.

Outline

Introduction

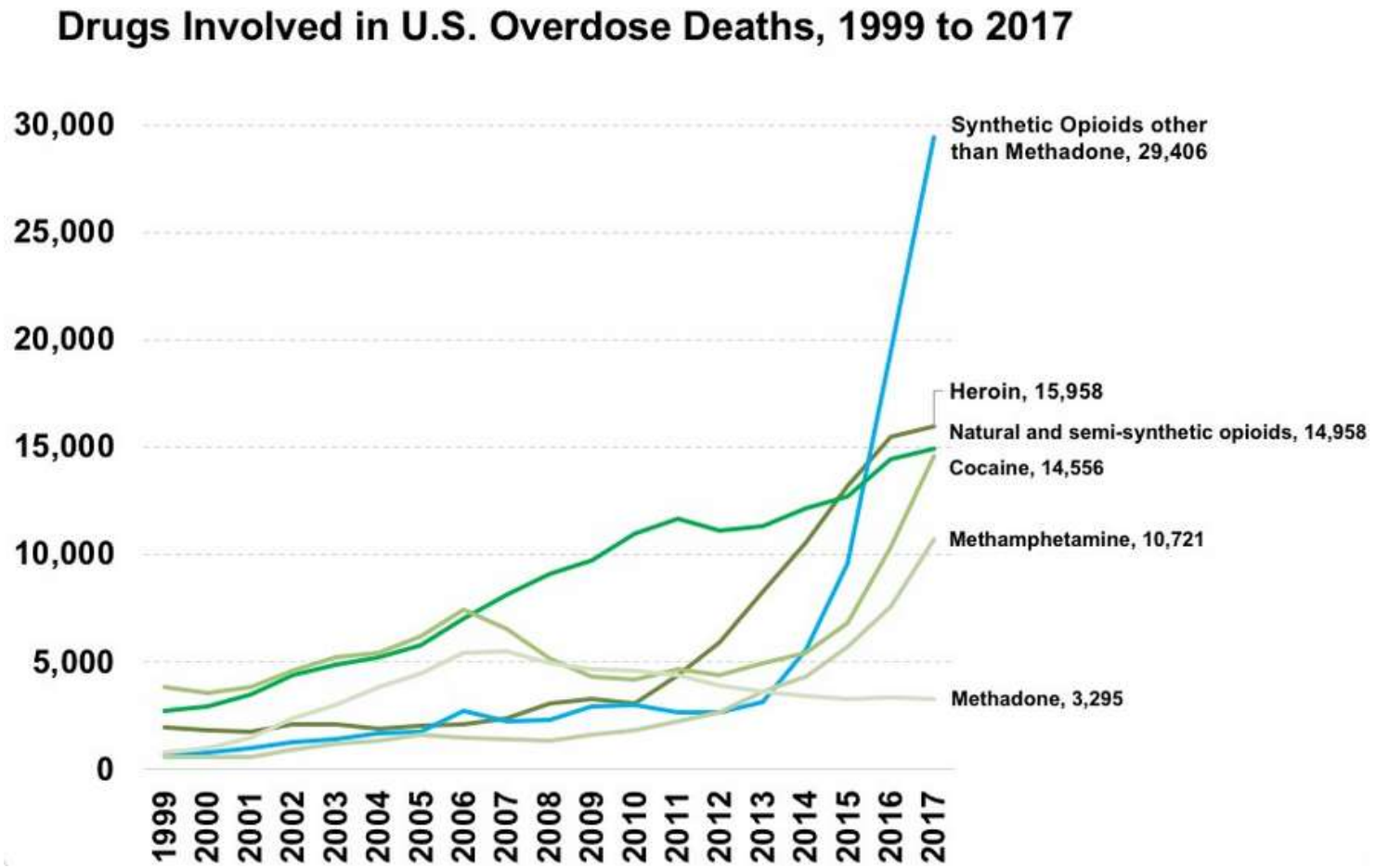
Objectives

Methods

Results

Questions

Background



https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

VA policies surrounding naloxone

Prior to 2014, VA did not have a distribution program

Naloxone was only available as an injectable solution

Naloxone kits and autoinjector was added to the VA formulary in 2014; intranasal was added in 2016

The VA Opioid Education and Naloxone Distribution (OEND) was implemented nationwide in 2014

VA National Academic Detailing Service is the main instrument to carry out the OEND's goals

Academic detailing was associated with an increase in naloxone prescribing

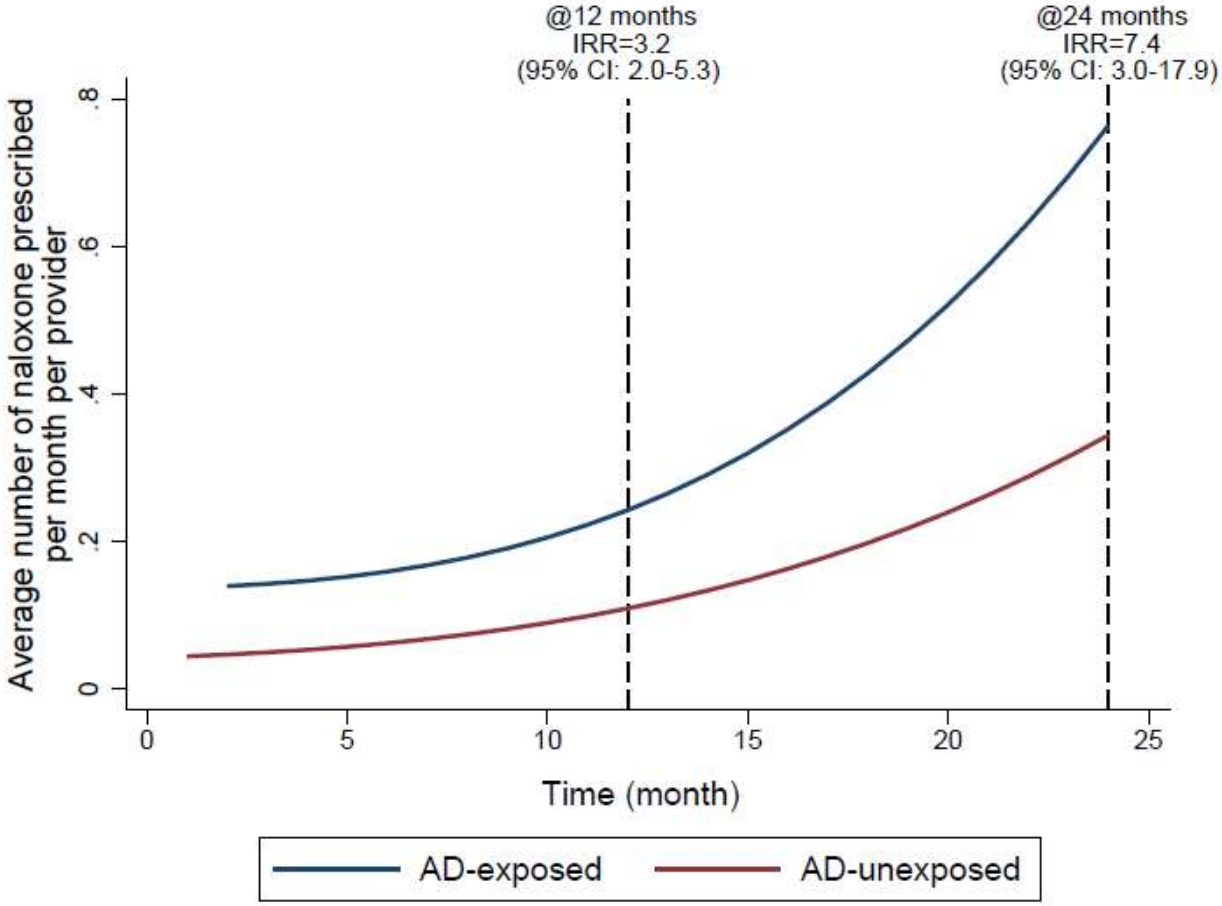


Figure 1. Naloxone kits monthly prescribing rates from October 2014 to September 2016.

Objectives

Although academic detailing appears to improve naloxone distribution, it was unclear whether this was driven by improvements in providers knowledge, attitude, or perceived barriers

Explore elements of academic detailing associated with naloxone prescribing

- **Evaluate providers' perceptions about naloxone and academic detailing**
- **Identify facilitators and barriers to successful adoption of naloxone prescribing guidelines from the perspectives of the providers**

Study Design

Prospective, mixed methods design using a survey and semi-structured interviews

Part I: Cross-sectional Survey

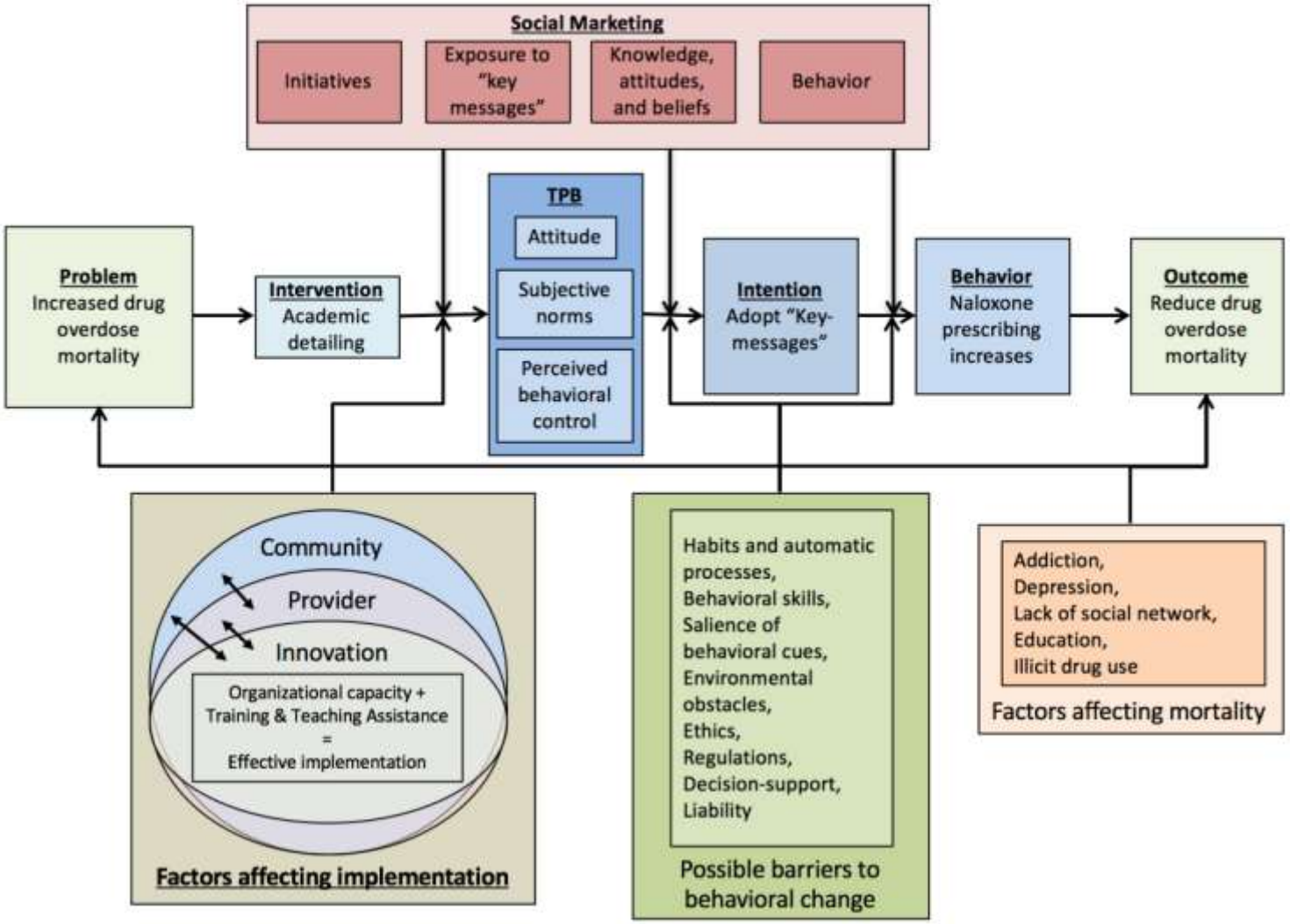
- Capture perception about naloxone and academic detailing
- Identify constructs associated with self-stated changes in naloxone prescribing

Part II: Semi-structured interviews

- Identify facilitators and barriers to adopting academic detailing key messages regarding naloxone and prescribing changes

Conceptual framework

Figure 1. Conceptual framework of the effect of academic detailing on naloxone prescribing.



5-MINUTE
Q & A

Ontario's Academic Detailing Service

Lindsay Bevan, Manager
Victoria Burton, Coordinator

Centre for Effective Practice
Toronto, Ontario, Canada

Disclosure

Lindsay Bevan

- No conflicts of interest to disclose
- Financial relationships: employee of the Centre for Effective Practice

Victoria Burton

- No conflicts of interest to disclose
- Financial relationships: employee of the Centre for Effective Practice

CEP Centre for Effective Practice

Building our service in Ontario

500

Family physicians visited in 8 months

CEP Centre for Effective Practice

Service overview

Visit topics

Visit 1	Visit 2	Visit 3	Visit 4 +
Mar – Jul 2018	Aug – Dec 2018	Jan – Apr 2019	May 2019 +

Visits 1-3 – Supporting physicians care for their patients living with CNCP:

- currently on opioid therapy
- considering opioid therapy
- and problematic opioid use

Visit 4+ To be informed by primary care provider priorities

CEP Centre for Effective Practice

Local innovations and adaptations

Reflecting compassion for the current opioid context

Centre for Effective Practice

Local innovations and adaptations

Helping physicians lead successful patient discussions

Why set goals?

- You and your doctor will be "on the same page" about what you hope to gain from the treatment.
- You'll have a better idea of what's realistic and when to expect changes to happen.
- You'll make faster progress in improving your quality of life.[1,2]
- You and your doctor will be able to see if your treatment is working and when it might be time to switch to another treatment.

Talking Points

Provide information about why a taper might be needed:

- "Chronic pain is a complex disease and opioids alone cannot adequately address all of your pain-related needs."

Talking Points

Provide information about why a taper might be needed:

- "I think it is time to consider the opioid dose you are on and its risk of harm. The risk of overdose and the risk of dying from overdose go up as the dose goes up."

Getting back on the road of life

It can be helpful to think of chronic pain as a car with four flat tires.[1]

We may be looking for a single treatment, like medication, to manage pain, but this would be like putting air in only one tire.

You need to fill the other three tires to get where you want to go. There are lots of different ways to fill up the tires. Most of these involve taking an active role in your treatment. Keep your goals in mind so you know what you are working towards.

Local innovations and adaptations

Connecting physicians with local patient supports

Resources* for Chronic Non-Cancer Pain
LHIN 7 - Toronto Central

The inclusion of these resources does not entail endorsement by the Centre for Effective Practice, the Ontario College of Family Physicians, the Nurse Practitioners' Association of Ontario or LHIN 7 - Toronto Central. This document is a list of all resources located in your LHIN and it is up to you as a provider to determine the most appropriate resource to refer your patient to.

Chronic pain management clinics

1 Allevio Pain Management Clinic — **Location(s)**

This evidence-based multidisciplinary pain management clinic provides interventions (e.g., nerve blocks, epidurals), pharmacotherapy, psychological therapies (e.g., CBT, mindfulness, psychotherapy), naturopathic services, osteopathic services, chiropractic services, acupuncture, massage therapy, nutritional counseling, and occupational health assessments.

North York

http://allevioclinic.com/

2 Altum Health Pain Management Program — **Location(s)**

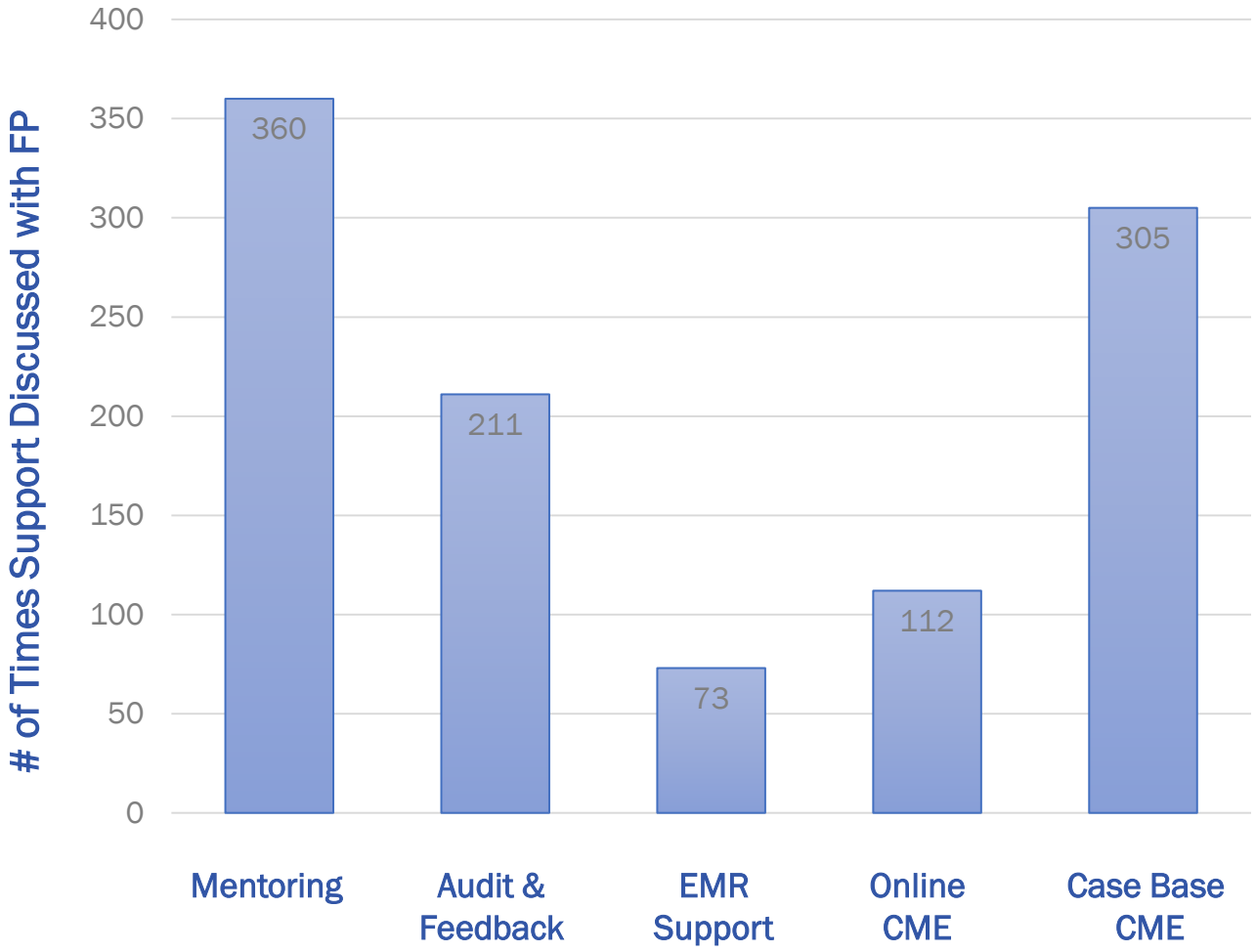
Altum Health's Pain Management Program provides an interdisciplinary approach to chronic pain management for those that have not returned to work within usual course of recovery (more than 6 months from time of injury or accident) or those struggling while at work. The program is time limited and goal directed, with a cognitive behavioural and functional restoration focus.

Toronto

http://www.altumhealth.com/pain-management/

Local innovations and adaptations

Connecting physicians with local provider supports



CEP Centre for Effective Practice

Local innovations and adaptations

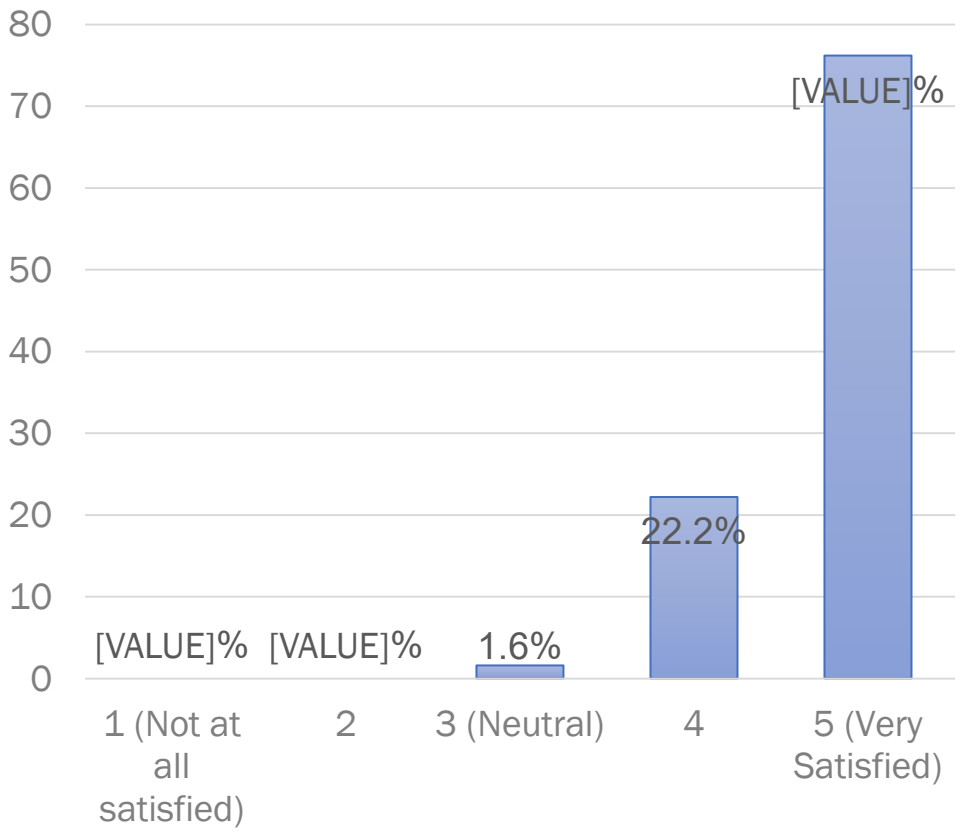
Imbedded care team detailers

- Lessons learned
  - Leveraging existing physician-pharmacist relationships makes it easier to get in the door
  - Provide financial means to increase capacity/scope of participating pharmacists
  - Provide connection to an experienced embedded detailer for additional support
  - Detailing increases referrals for clinical pharmacy services

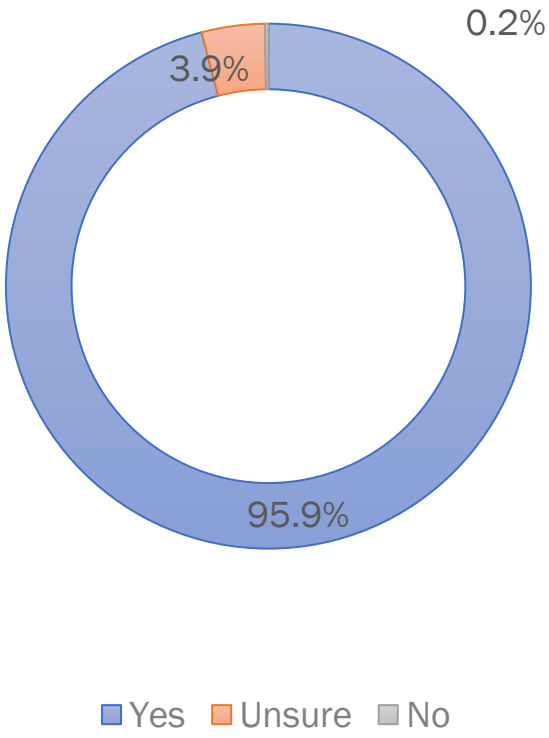
CEP Centre for Effective Practice

Successes so far

Satisfaction with the service (n=454) (n=440)



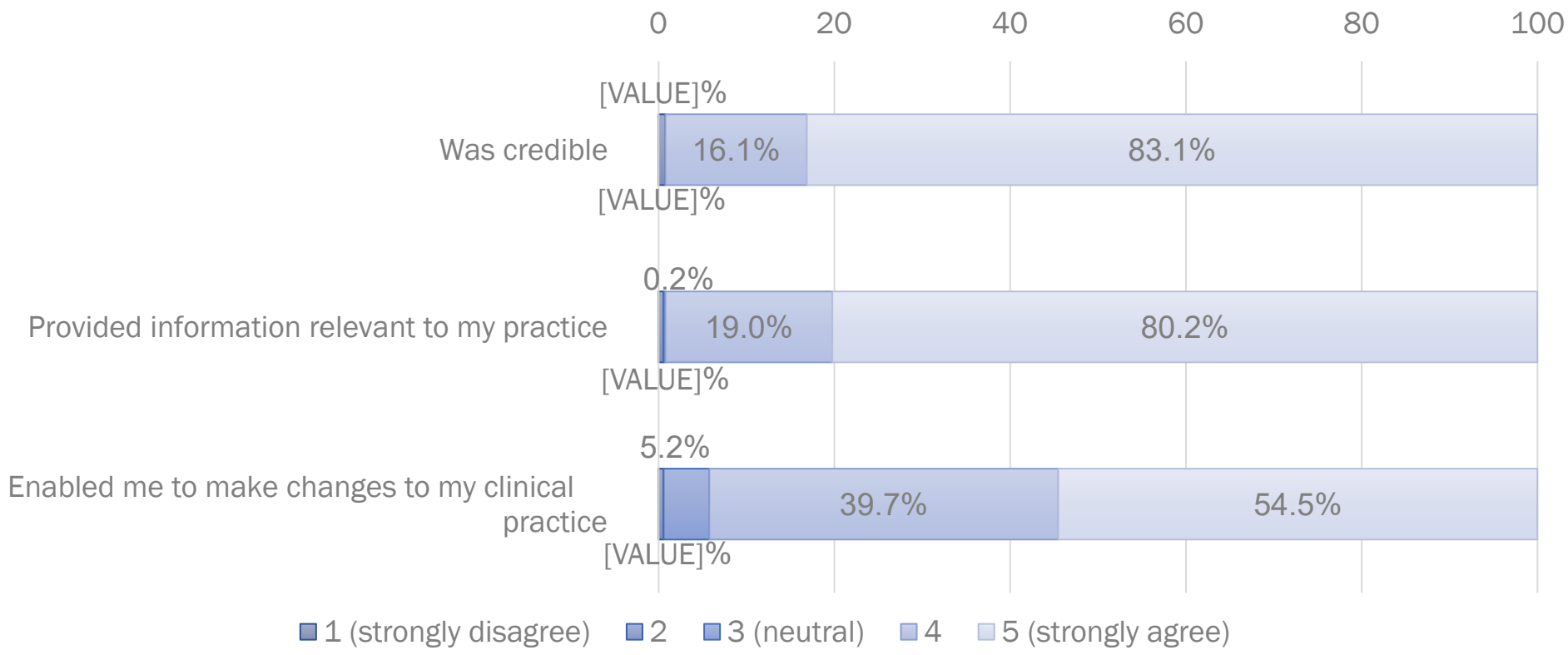
Interest in future visits



CEP Centre for Effective Practice

Successes so far

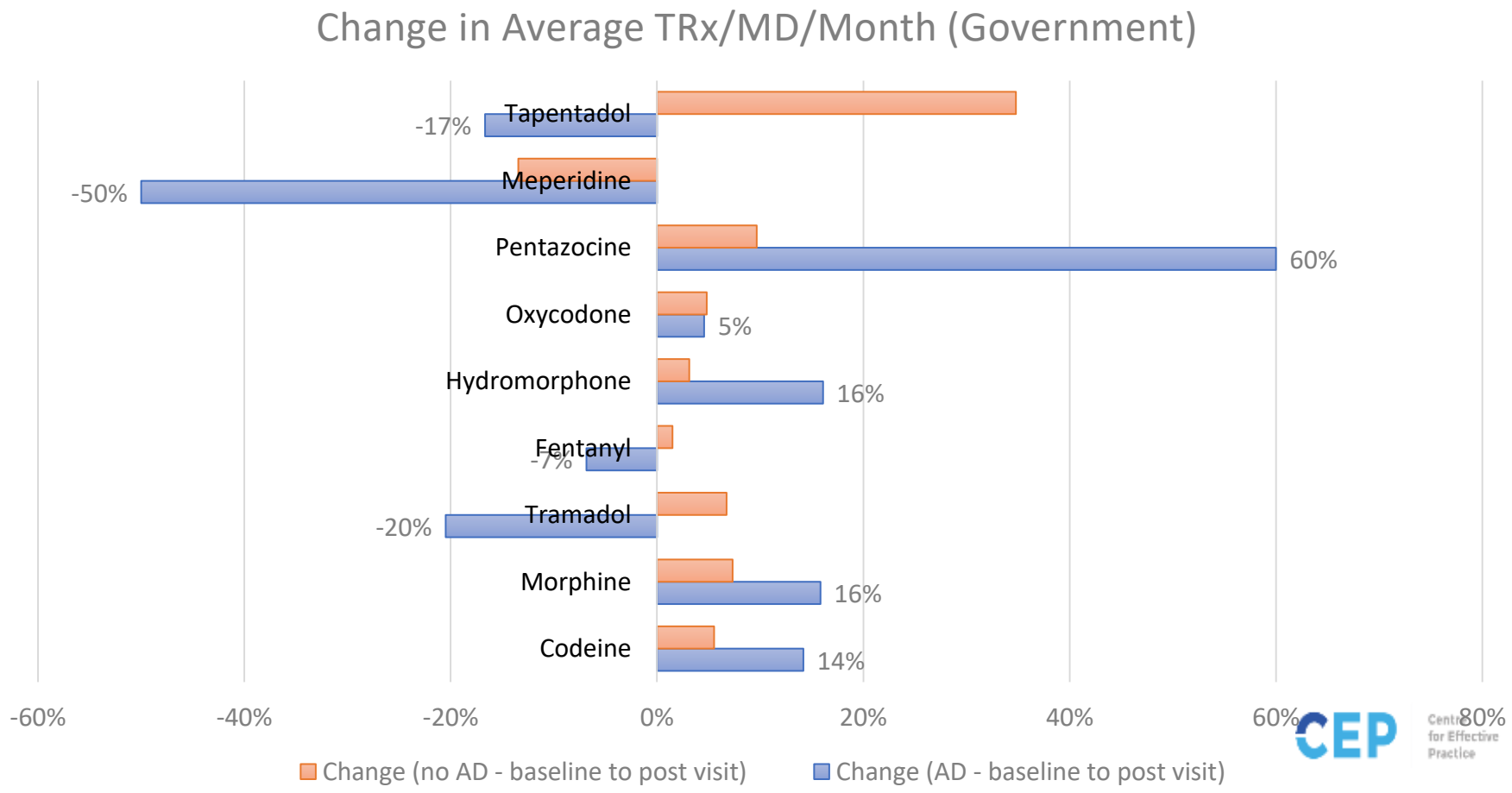
Perception of academic detailers (n=457)



CEP Centre for Effective Practice

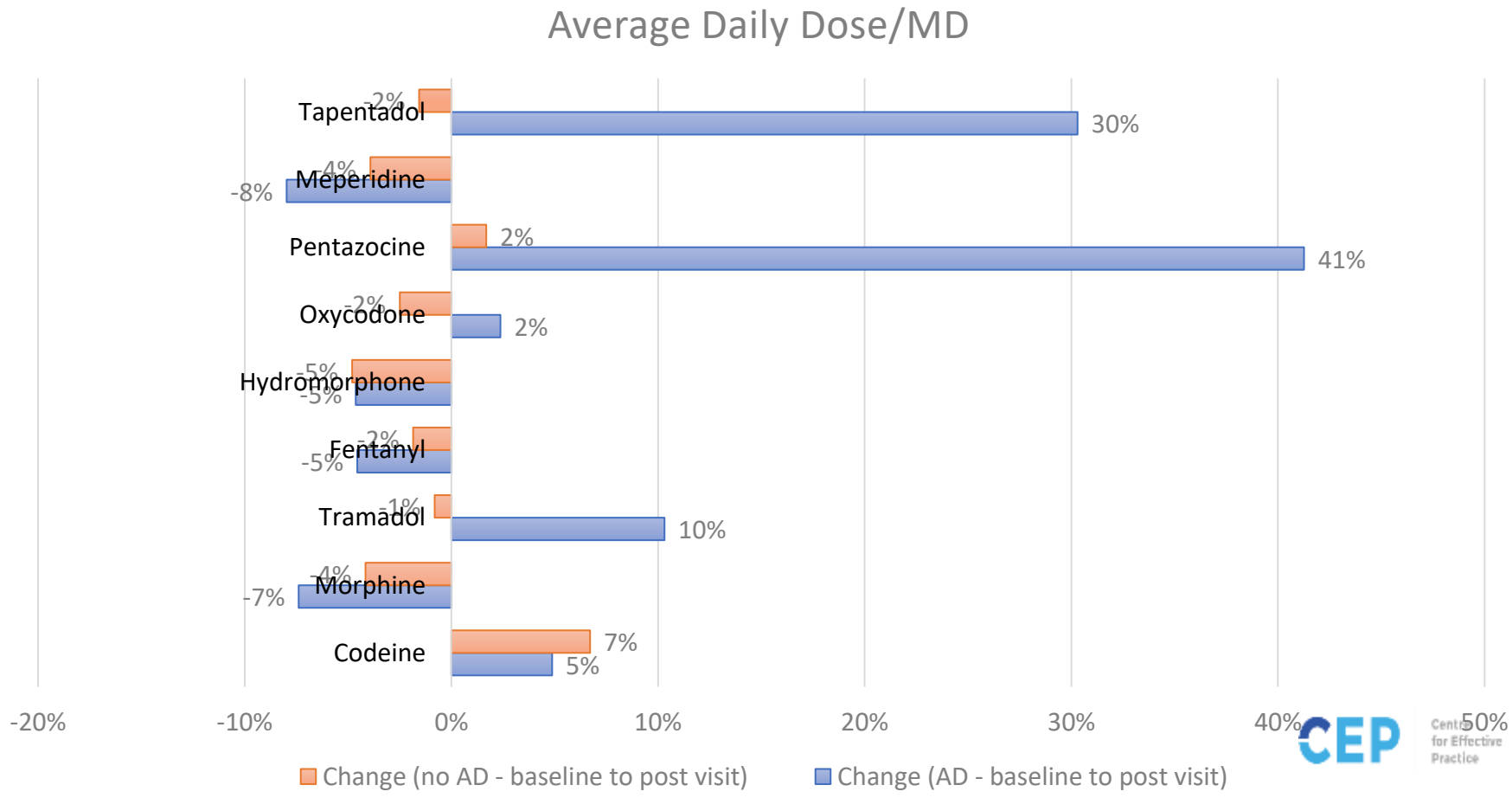
Successes so far

Behaviour change



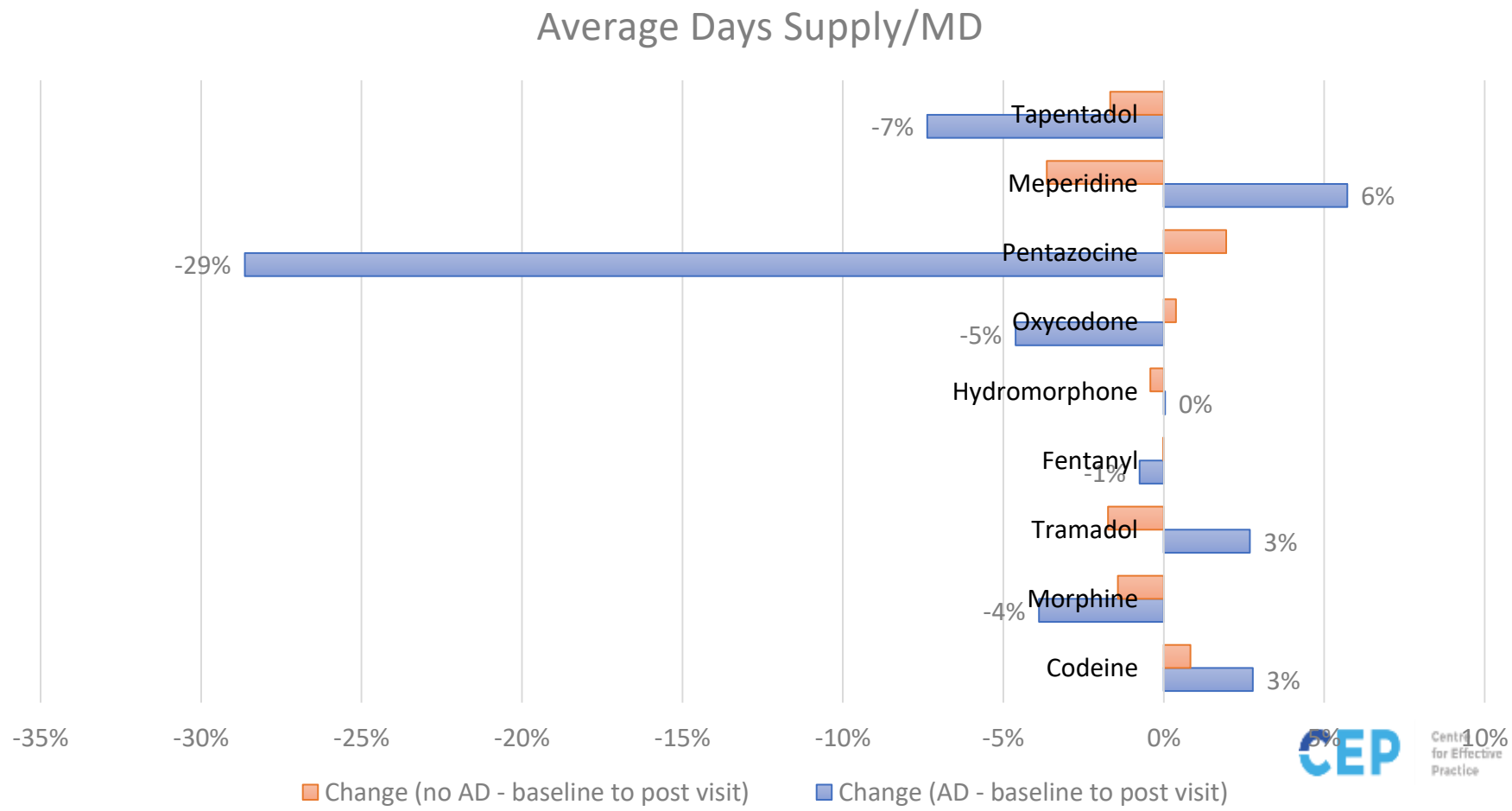
Successes so far

Behaviour change



Successes so far

Behaviour change



Future plans

Continuing to build off of participant feedback

I hope this will be available for nurse practitioners.

This was an excellent opportunity to engage, ask questions and learn.

It would be great if we could discuss a specific case anonymously

What a great service. I am so impressed. Thank you.

Would also appreciate the opportunity for a group learning experience with the doctors in our family health organization.

Excellent! I hope this program continues and expands.

Case presentations might be useful

Excellent, looking forward to the next one

I think a small group of same professionals would be equally effective and better use of time.

It is a shame not to target NPs

CEP Centre for Effective Practice

Thank you

5-MINUTE
Q & A

Improving Pneumococcal Immunization Rates through Academic Detailing

Kimberly McKeirnan, PharmD, BCACP
Clinical Assistant Professor
Washington State University College of Pharmacy and Pharmaceutical Sciences

Karen Colorafi, PhD, MBA, RN
Assistant Professor
Washington State University College of Nursing

College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

Financial Disclosure

- This research was funded by a generous grant from Pfizer's Independent Grants for Learning and Change (2015-2018)

College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

Need for change

- PPSV23 immunization rates were 6.9% and 2.2%, respectively (8/13-7/14).
- PCV13 rates were 0.4% and 4.7%, respectively (8/14-7/15)
- Herd immunity requires 93% of the population to be vaccinated
- WA generally has strong immunization rates but rural counties face challenges

- Pneumococcal Polysaccharide Vaccine (PPSV23)
- Pneumococcal Conjugate Vaccine (PCV13)

College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

Barriers to completing the pneumococcal vaccination series

Barrier
Lack of awareness of disease among vaccine candidates
Lack of awareness of disease among healthcare providers
Failure of providers to assume responsibility for vaccination
Competing priorities during office visit
Lack of documentation of previous vaccinations
Lack of coordination of adult immunization activities
Lack of patient knowledge
Lack of provider recommendations for immunization
Financial impediments to vaccinations
Lack of access to, and utilization of, health care services by adults
Lack of utilization of reminder or assessment systems
Racial/ethnic disparities
Health literacy
Concern about adverse events

Preparation

- Grant proposal submission and approval
- Recruitment of our interprofessional team
- Attend NaRCAD training
- Recruitment of medical clinic sites
- Regional needs assessment*
- Development of interprofessional academic detailing material

College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

Interventions

- Physician champion interviews
- EHR workflow assessment
- Developed and presented tailored acader
  - In-services at all-staff meetings
  - Slide decks about pneumococcal vaccinations targeted to specific audiences
  - Exam room poster
  - Nurse station handouts
- On-going data collection
- Presentation of workflow results to leadership

College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

Work plan table

Visit Number	Month/Year	Audience	Purpose	AD Team
Detailing Visit 1 (Clinic 1 and 2)	June 2016	Physician leaders at two separate medical clinics	Enrollment in project, determine what kinds of AD material would be helpful	McKeirnan, Panther, Colorafi
Workflow Assessment (Clinic 1 and 2)	July and August 2016	Shadowed clinicians (doctors, nurses, PAs, NPs)	Shadowed clinicians in two clinics to document immunization practices	Colorafi
Detailing Visit 2 (Clinic 1 and 2)	September (Clinic 1), November (Clinic 2) 2016	Medical clinic all-staff meetings	30-minute academic detailing presentation about pneumococcal immunization use	Interns, McKeirnan, Panther
Detailing Visit 3 (Clinic 1 and 2)	June 2017	Physicians and nurse managers	Follow up to see how implementation is working; ask what other resources would be helpful	McKeirnan, Panther, Colorafi
Detailing Visit 4 (Clinic 1 only)	July 2017	Physician leader	Discussed best practices for using EHR to identify needed immunizations at the request of physician leader	McKeirnan, Panther, Colorafi
Detailing Visit 4 (Clinic 2 only)	July 2017	Physician leader and nurse manager	Discussed best practices for using EHR to identify needed immunizations at the request of physician leader	McKeirnan, Colorafi
Detailing Visit 4.2	September 2017	Clinic medical assistants	Provided 30-minute academic detailing presentation to clinic medical assistants at the request of physician leader	McKeirnan, Panther

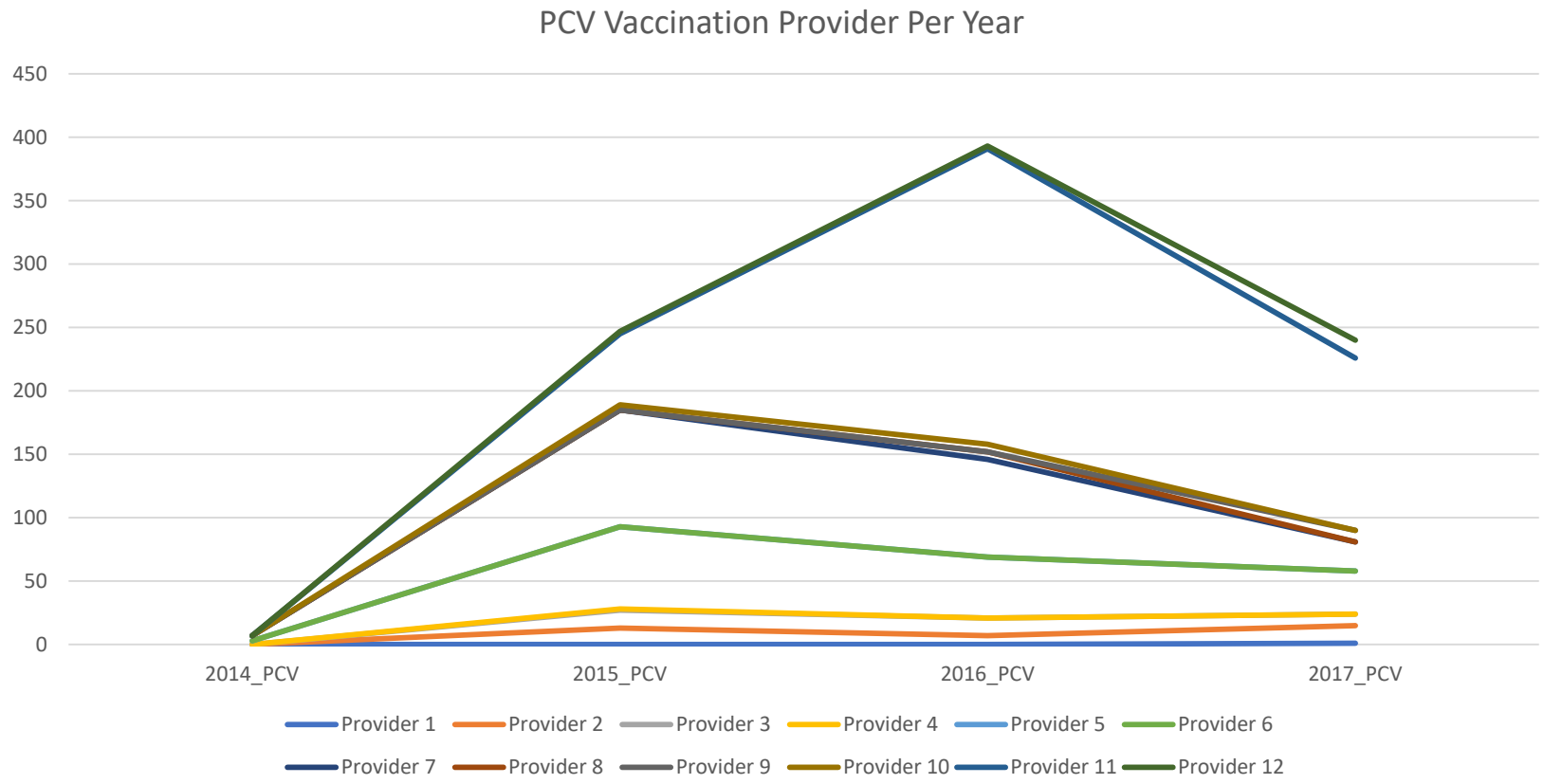
Pharmacy and Pharmaceutical Sciences

Washington State University

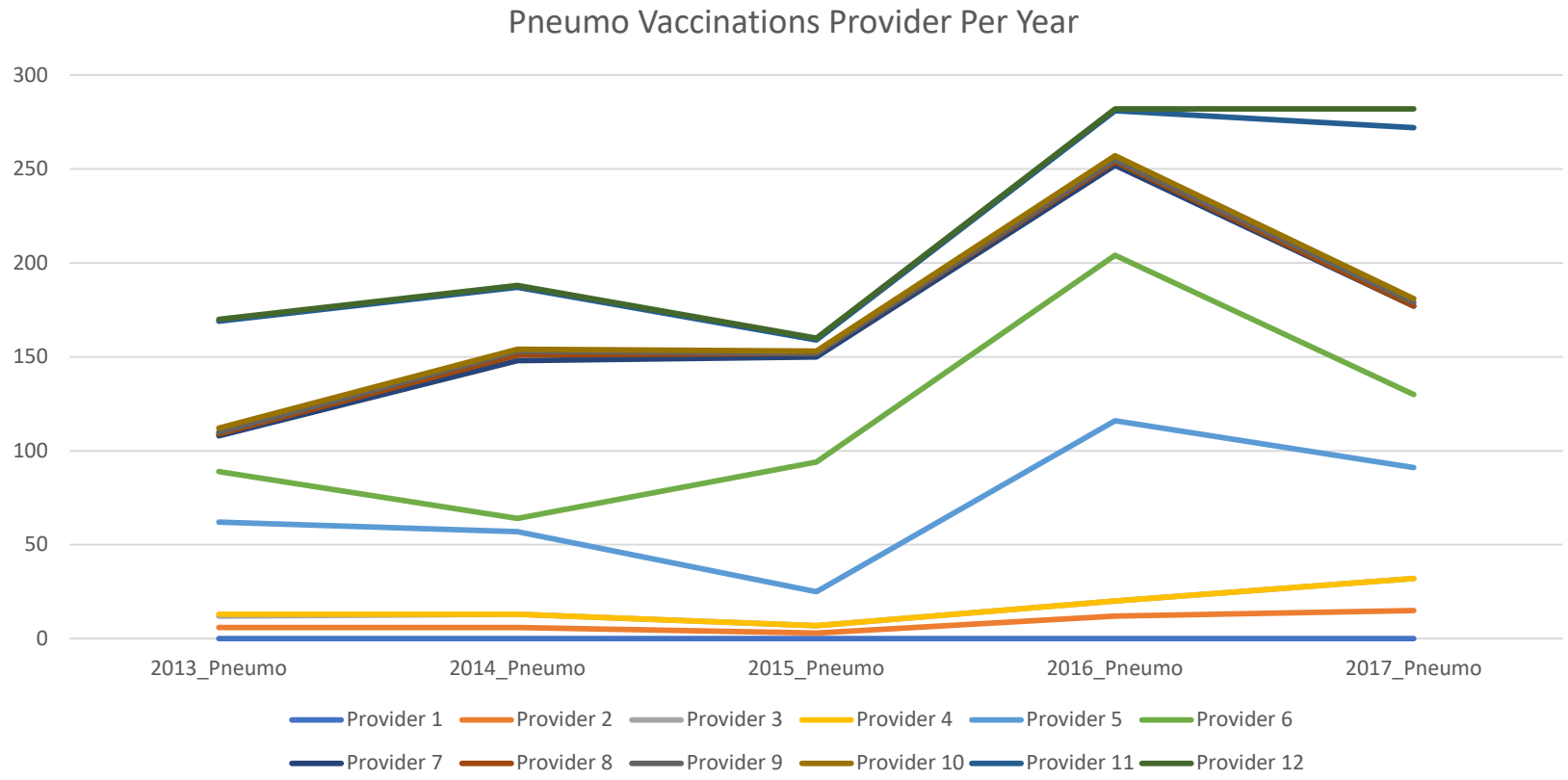
Preliminary Results (Site 1)

Site 1	Pneumovax	PCV
Year 1 (2013-2014)	121/1639=7.4% (baseline)	not available
Year 2 (2014-2015)	151/1559=9.7%	7/1677=0.4% (baseline)
Year 3 (2015-2016)	60/1448=4.1%	243/1712=14.2%
Year 4 (2016-2017)	161/1379=11.7%	399/1447=27.6%
Year 5 (2017-2018)	242/1335=18.1%	243/1172=20.7%

College of Pharmacy and Pharmaceutical Sciences
Washington State University



College of
Pharmacy and
Pharmaceutical Sciences
Washington State University



College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

General impressions

- In-services were well received
- Site 2 asked us for a repeat presentation for all nursing staff
- Re-print needed for exam room posters
- “I have really enjoyed having those posters. It adds a bit of credibility to when I tell my patients about pneumococcal vaccination. What I have found is that if I advocate for imms, most of my patients just do them -- they say something like "do you think I should?"; I respond with "yep" and that is almost always the end of the conversation. Even with kids. I found this really works. Odd, huh? Who would guess that is all it takes?”

Limitations

- Previously vaccinated patients (prior to year 1) in denominator
  - % vaccinated could be artificially low
- Does not account for vaccinations given outside the clinic
- Observation does not equal correlation
  - Hawthorne effect (observation improves results)
  - Not all physicians attended in-services
  - Workflow vs. training vs. exam room poster – which intervention was impactful?

College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

Successes and Challenges

Successes:

- Interprofessional team
  - Relationships and projects
  - Co-precepting and teaching students
- Exam room poster
- Physician champions
- Opportunity for student involvement
- Road trips

Challenges:

- Site recruitment
- Data availability
- Hubris
- Difficult personnel
- Road trips

College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

Our Interprofessional Team

Karen Colorafi, PhD, MBA, RN
Assistant Professor
Washington State University College of Nursing

John McCarthy, MD
Assistant Dean for Rural Programs
Professor
University of Washington School of Medicine

Kimberly McKeirnan, PharmD, BCACP
Director, Center for Pharmacy Practice Research
Clinical Assistant Professor
Washington State University College of Pharmacy

Shannon Panther, PharmD, BCACP
Pharmacist
Kaiser Permanente

Darryl Potyk, MD
Chief of Medical Education
Professor
University of Washington School of Medicine

Dillon Gasper, MD Candidate 2019
University of Washington School of Medicine-Gonzaga

William Knott, PharmD Candidate 2018
Washington State University College of Pharmacy

Shauna Leggett, PharmD Candidate 2018
Washington State University College of Pharmacy

Jessica Martin, MD Candidate 2019
University of Washington School of Medicine-Gonzaga

Sarah Temple, BS in Nursing Candidate 2017
Washington State University College of Nursing

Zuan Sun, Health Analytics PhD Candidate 2019
Washington State University College of Business

College of
Pharmacy and
Pharmaceutical Sciences
Washington State University

5-MINUTE
Q & A

HEALTHY HEARTS NORTHWEST

An EvidenceNOW Project

Scaling up academic detailing in primary care with limited resources and broad geographic reach

Leah Tuzzio, MPH
Research Associate
Kaiser Permanente Washington Health Research Institute
MacColl Center for Health Care Innovation
Seattle, WA

Michael Parchman, MD MPH; Laura-Mae Baldwin, MD MPH; Jennifer Powell, MPH; Erika Holden; LJ Fagnan, MD; Jeff Hummel, MD MPH; James Ralston, MD MPH

KAISER PERMANENTE®

ORPRN Oregon Rural Practice-Based Research Network

QUALIS HEALTH

ITHS Institute of Translational Health Sciences

Disclosure Statement

I have no conflicts of interest.

This project is supported by grant number R18HS023908 from Agency for Healthcare Research and Quality (AHRQ). The content is solely the responsibility of the authors and does not necessarily represent the official views of AHRQ.

Today's presentation

- AHRQ's EvidenceNOW Healthy Hearts Northwest pragmatic trial
- The design process for the virtual educational outreach intervention
- The adaptations to traditional academic detailing to accommodate challenges
- Next steps

The team

The research and implementation team included health services researchers and practice facilitators in WA, OR and ID, and consultants.

- Kaiser Permanente WA Health Research Institute, MacColl Center for Health Care Innovation
- University of Washington, ITHS
- Oregon Health Sciences University, ORPRN
- Qualis Health
- Quality improvement and clinical consultants

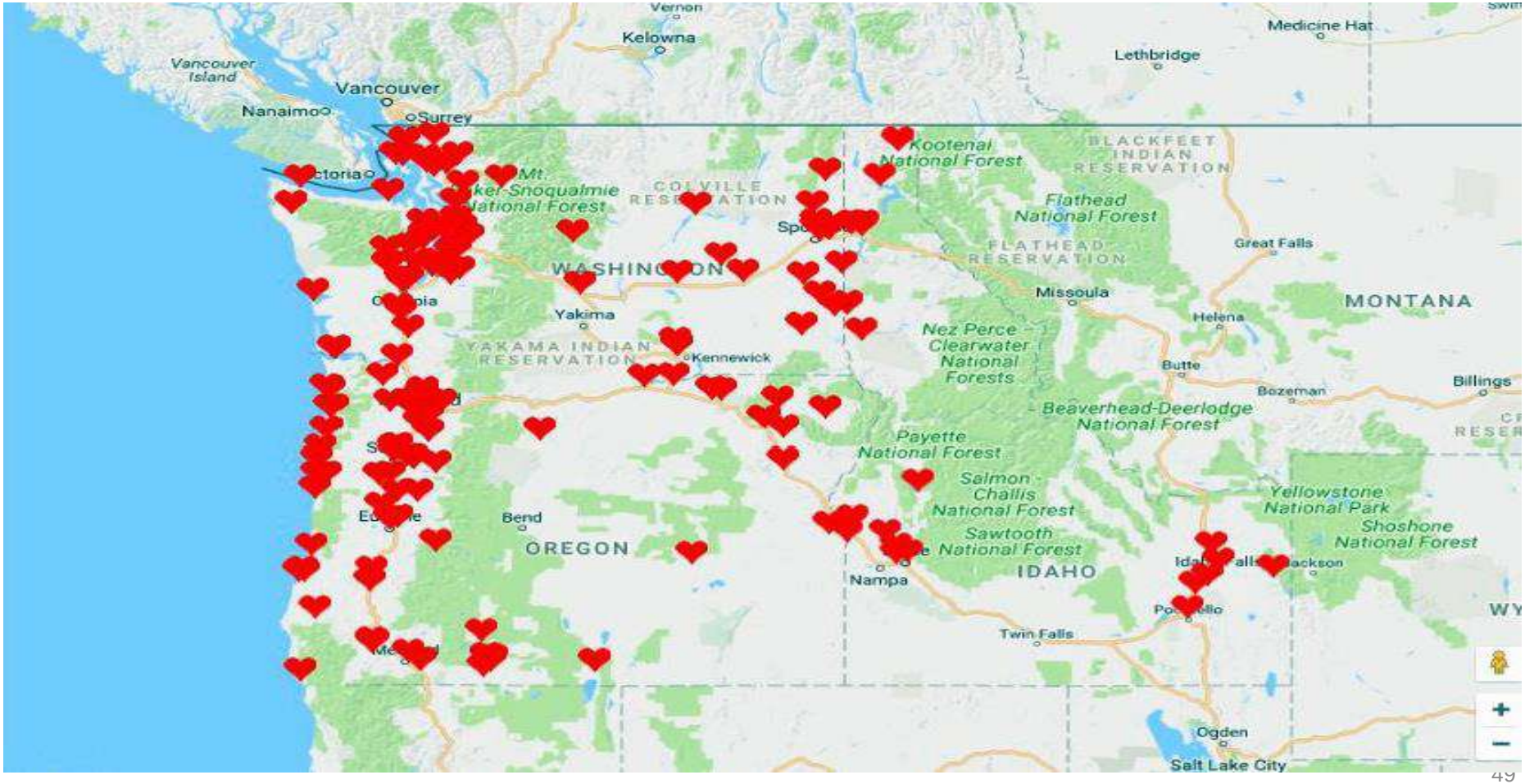
Healthy Hearts Northwest (H2N): an AHRQ EvidenceNOW Cooperative

4-arm pragmatic trial evaluating the addition of educational outreach and shared learning to practice facilitation aimed to improve the adoption of cardiovascular quality measures.

		Shared Learning Opportunities (Site Visits)	
		No	**Yes**
Educational Outreach (CV Risk Calculator)	**No**	Practice Facilitation (PF) alone	PF + Shared learning
	Yes	PF + Educational Outreach	PF+ Educational Outreach + Shared Learning

Geographic spread across 3 states

We randomized 209 small- to medium-sized primary care practices in rural and urban WA, ID, and OR



Characteristics of 104 practices randomized to an educational outreach visit (EOV)

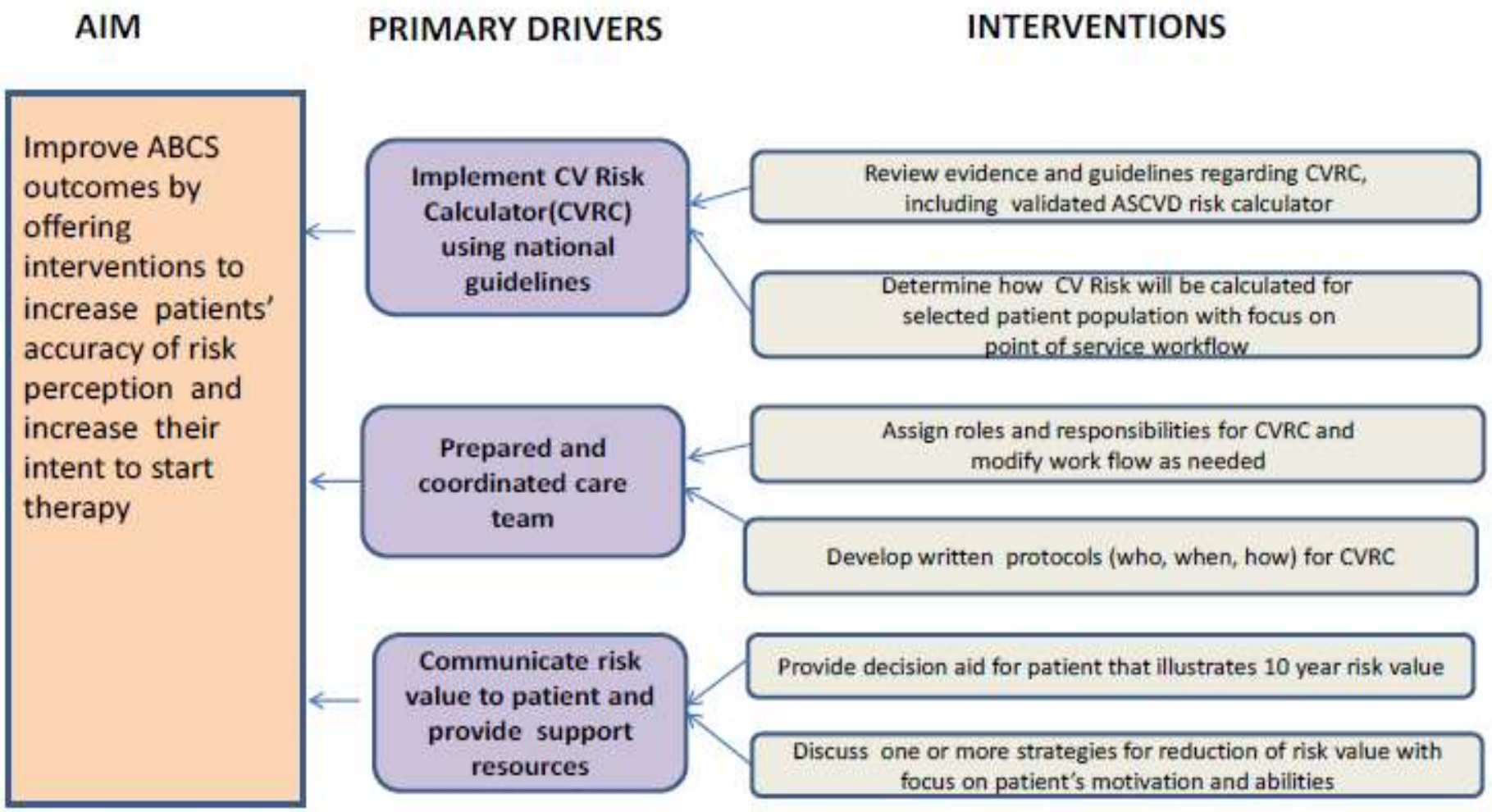
Practice Characteristics	No EOV Participation (N = 60)	EOV Participation (N = 44)
Size		
Solo	10 (17%)	7 (16%)
Small (2-5 providers)	36 (60%)	19 (43%)
Medium (6+ providers)	14 (23%)	18 (41%)
Location		
Rural	27 (45%)	17 (39%)
Urban	33 (55%)	27 (61%)
Type		
Federally Qualified Health Center	4 (7%)	5 (11%)
Hospital/Health System	28 (47%)	19 (43%)
IHS/Tribal Health Clinic	3 (5%)	3 (7%)
Independent	25 (42%)	17 (39%)
Specialty		
Family Medicine	52 (87%)	37 (84%)
Internal Medicine	2 (3%)	2 (5%)
Mixed	6 (10%)	5 (11%)

Known challenges to designing our intervention

Traditional, in-person academic detailing is effective. But, for our study we knew it required some adaptations if we wanted:

- To scale across 3 states in 4 months
- To work with the 5 study team physician educators rather than hire external consultants
- To deliver the intervention to a clinical care team, not only to a lead clinician

EOV design roadmap



Traditional academic detailing program structure

- In-person visits
- Lead clinician-only audience
- One-to-one visits
- Extensively-trained detailer
- Multiple visits

Structural adaptations in H2N

- In-person visits
  - Virtual 30-minute “visits” (conversations) facilitated by webinar technology

Structural adaptations in H2N

- One-to-one visits

- Fit “visit” into existing meeting to support team attendance.
- Developed short educational video on cardiovascular risk calculator in prep for the call and for care team members not attending visit.

Structural adaptations in H2N

- Lead clinician-only audience

  - Invited a clinical care team (e.g., clinician, medical staff, quality coordinator), as appropriate for the practice's context.

Structural adaptations in H2N

- Extensively-trained detailer

  - Developed “detailing” training program and resources (NaRCAD-vetted). Key messages developed in collaboration with Affinity Group and content expert in cardiovascular risk reduction.

Structural adaptations in H2N

- Multiple visits
  - Summary of call emailed to practice and copied their Practice Facilitator who followed up on practice change ideas.

Traditional elements of academic detailing

- Introduction
- Needs assessment
- Key messages, features, benefits
- Handling objections and enablers
- Summary

H2N adaptations: *Prior to the EOV*

- Introduction
  - Sent e-mail to clinical contacts with a copy to their Practice Facilitator to introduce the EOV and included a link to pre-visit video.

H2N adaptations: *During the visit*

- Needs assessment, key messages, handled objections

  - Did a roll call to engage all “visit” attendees.
  - Summarized and checked on barriers and enablers mentioned in H2N baseline practice survey.
  - Used a script, but educators tailored content and the tools they offered based on needs assessment and information shared during “visit.”
  - Discussed next steps and commitments team wanted to take after “visit.”

H2N adaptations: *After the EOV*

•Summary

- Sent an e-mail to “visit” attendees and copied their Practice Facilitator. E-mail included a summary of the call, commitments the attendees expressed and electronic copies of materials discussed or requested.

Process evaluation

- Educators took field notes during calls on practices':
  - Experience using a cardiovascular risk calculator
  - Barriers and facilitators to implementing a calculator
  - Commitments for next steps in implementing a calculator
- Interviews with the educators about which tools and elements of the call they thought worked well and what they would change.
- Interviews with affinity group members about the design process.

Identified 13 barriers to cardiovascular risk calculator implementation

- **Calculator-related**
  - Risk calculator: limited access/no EMR integration
  - *No or little calculator training*
  - *Different results for different calculators*
- **Practice-related**
  - Lack of documented workflow
  - No or little team communication (e.g., huddles)
  - *Time constraints*
  - *Lack of buy-in from providers/staff*
  - *Lack of staff for calculator work*
- **Clinician-related**
  - *Clinician lack of trust in calculator evidence/guidelines*
  - No clinical champion
- **Patient-related**
  - Perception of inadequate patient population for using calculator
  - *Patient resistance/fears*
  - Cost of medications for patients

Conclusions

- We developed a virtual educational outreach program for geographically dispersed practices that can help overcome the limitations posed by more traditional resource-intensive academic detailing programs.

- The process evaluation suggests additional adaptations for future virtual EOVs.

Next steps

- Understand why some practices participated and others did not.
- Analyze cardiovascular outcomes to understand effectiveness of virtual EOVs.
- Develop more tailored approaches to using educational outreach combined with other strategies to overcome the barriers to implementing cardiovascular risk calculators.

HEALTHY HEARTS NORTHWEST

An EvidenceNOW Project

For more information:

Visit www.healthyheartsnw.org

Contact Leah Tuzzio at Leah.Tuzzio@kp.org

This project is supported by grant number R18HS023908 from the Agency for Healthcare Research and Quality (AHRQ).
Healthy Hearts Northwest is a cooperative of AHRQ's EvidenceNOW initiative to advance heart health in primary care.

KAISER PERMANENTE®

ORPRN Oregon Rural Practice-Based Research Network

QUALIS HEALTH

ITHS Institute of Translational Health Sciences

5-MINUTE
Q & A

ACADEMIC DETAILING TO REDUCE SEDATIVE HYPNOTIC PRESCRIBING IN OLDER VETERANS

Addison Ragan, PharmD, BCPS
Academic Detailing Program Director
Veterans Health Care Administration (VHA)
Atlanta Network (VISN 7)

VISN 7 Academic Detailing Service

The author has no relevant financial or nonfinancial relationships to disclose. During the development, analysis, and preparation of this presentation, the author was an employees of the US Veterans Health Administration, Department of Veterans Affairs.

The views and opinions expressed in this presentation are those of the authors and do not necessarily reflect the official policy or position of any agency of the US government. Assumptions made within the analysis are not reflective of the position of any US government entity.

OBJECTIVES

- Why avoid Sedative-Hypnotics in Older Veterans?
- Campaign Implementation
- Study Design
- Impact of Academic Detailing Visits on Prescribing

VISN 7 ACADEMIC DETAILING (AD) PROGRAM

AD Program Director

5 Academic Detailers

0.25 Informatics Pharmacist

375,000 Patients Receiving Medications

WHY FOCUS ON OLDER VETERANS PRESCRIBED SEDATIVE-HYPNOTICS

- Sedative-hypnotics including benzodiazepines (BZDs) and benzodiazepine receptor agonist (BZD-RA) have been identified on the Beers Criteria for Potentially Inappropriate Medications (PIMs) in older adults
  - Cognitive Dysfunction
  - Falls
  - Sedation
- Sedative-hypnotics are intended for treatment of acute conditions, but are often times used chronically
  - Dementia

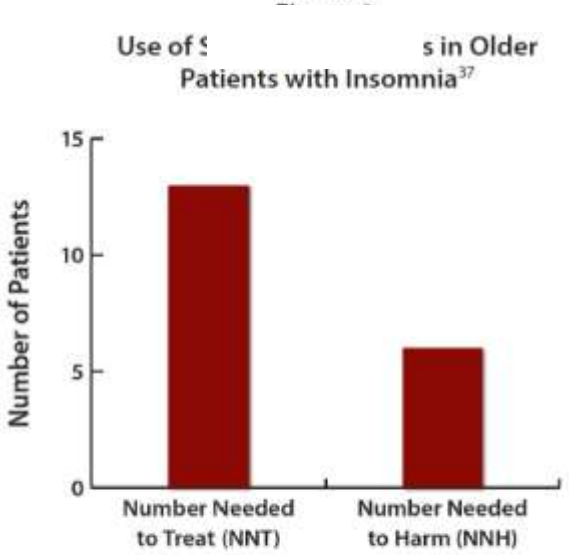
Benzodiazepine use in older patients is associated with at least 50% increase in risk of hip fracture

J Am Ger Soc. 2015;63(11):2227-2246
J Am Ger Soc. 2015;63(3):486-500

WHY FOCUS ON OLDER VETERANS PRESCRIBED SEDATIVE-HYPNOTICS

Sedative hypnotics for the treatment of insomnia have a small magnitude of effect and substantial risk in patients ≥60 years old.[37]

- → **MORE THAN TWO TIMES** as likely to be associated with adverse events than improved sleep[37]
- → **3-FOLD** increase in dizziness, loss of balance and falls[37]
- → **4-FOLD** increase in residual morning sedation[37]
- → **5-FOLD** increase in memory loss, confusion and disorientation[37]

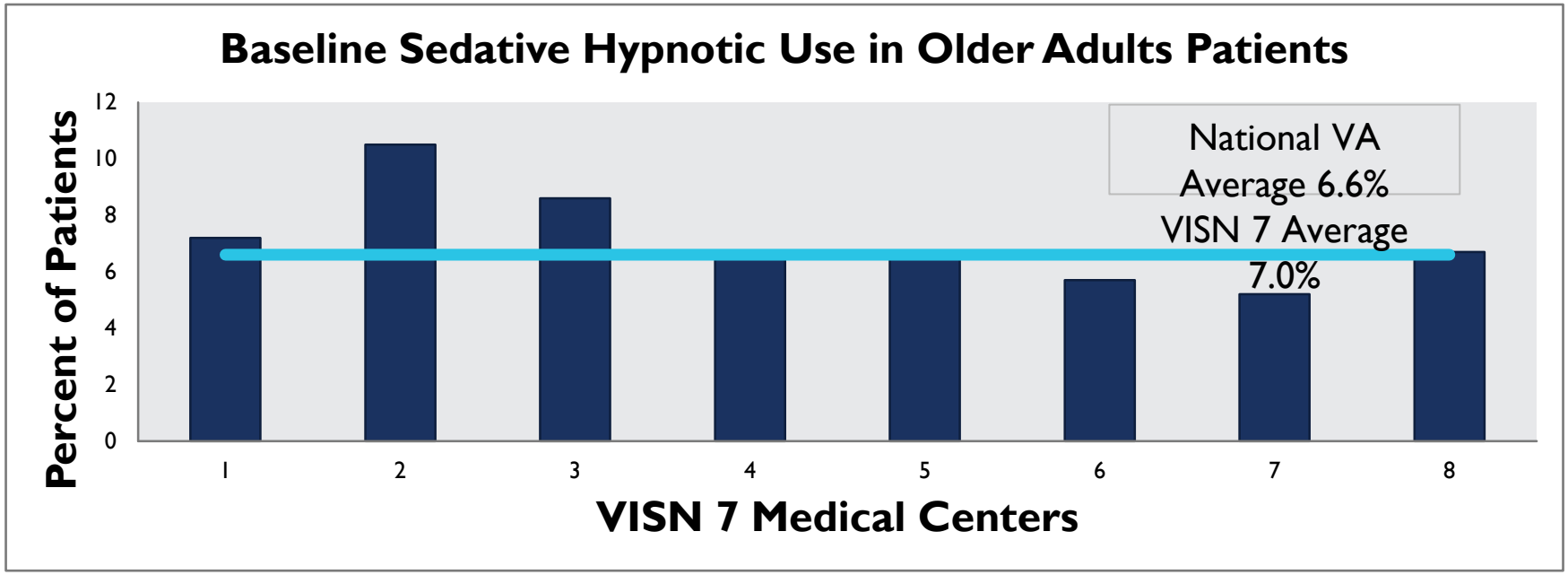


Meta-analysis of 24 studies with a total of 2,417 patients ≥60 years old who were prescribed a sedative hypnotic (benzodiazepines, non-benzodiazepine sedative-hypnotics, diphenhydramine) for sleep.

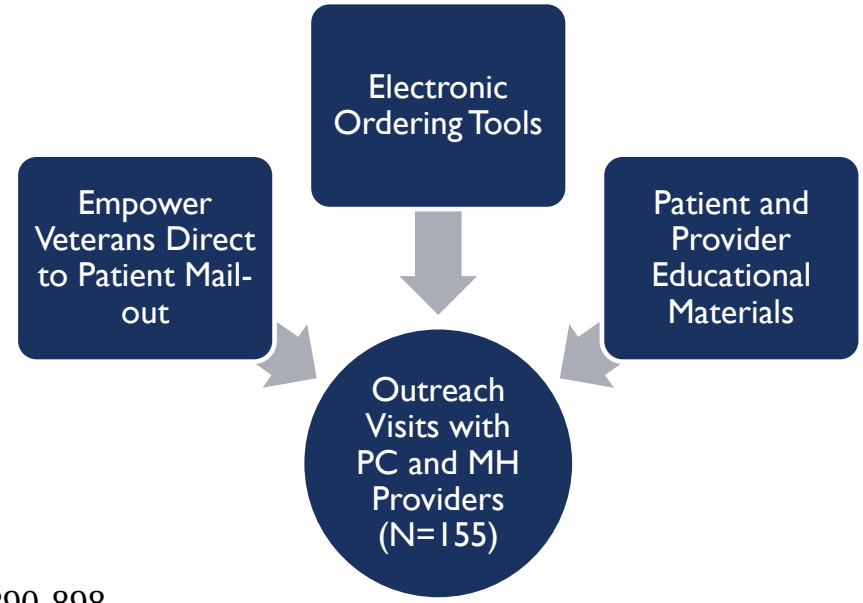
benzodiazepines CAN be successful

VA AD Provider Guide: Re-Evaluating the Use of Benzodiazepine; A Focus on High-risk Populations
BMJ, 2005. 331(7526): 1169

OPPORTUNITIES TO IMPROVE PRESCRIBING



AD CAMPAIGN INTERVENTIONS



JAMA Intern Med. 2014;174(6):890-898

OUTREACH VISIT KEY MESSAGES

Key Provider Messages for Re-Evaluating Sedative Hypnotic use in Older Veterans
Sedative Hypnotics are associated with significant risks in older Veterans (falls, sedation, hip fractures, and cognitive impairment)
Sedative Hypnotics for the treatment of insomnia have a small magnitude of effect and substantial risk in older Veterans
Lifestyle modifications and Cognitive Behavioral Therapy for Insomnia are effective and safe first line treatments
A slow benzodiazepine taper protocol (3 to 12 months) is preferred and has higher rates of benzodiazepine cessation.
First-line treatment alternatives for insomnia in the older veteran should be considered to include melatonin, trazadone, and mirtazapine.

STUDY METHODS

- Design: Retrospective with pre-post and interrupted time series analysis
- Setting: VISN 7 Medical Centers
- Measures: **Index Date:** Time when provider received an Academic Detailing Outreach Visits

  Time Frame: Monthly prescribing trends evaluated 18 month prior and after intervention

  Current Users: Patients > 75 yo with active BZD or BZD-RA, or alternative prescriptions

  New Starts: BZD, BZD-RA, or alternatives prescription fill without a fill in previous 180 days

  Discontinuations: BZD or BZD-RA prescription fill without a subsequent fill in the following 180 days

  Prevalence: Number of patients receiving treatment (BZD, BZD-RA or alternative prescription) per 1000 population aged 75 and older

BZD = Benzodiazepine
BZD-RA = Benzodiazepine Receptor Agonist (e.g. Zolpidem)
Alternatives = Melatonin, Mirtazapine, Trazadone

ANALYSIS PLAN

- Pre-post analysis by estimating the average number of prescription in the pre-intervention and post-intervention period
  - Student T test used to test the difference in the means
- Single-group interrupted time series analysis (ITSA) to compare trends of BZD, BZD-RA, and alternative prescription prescribing before and after the academic detailing intervention (difference in slopes) including the immediate impact of academic detailing (Intercept or level change)
- Alpha < 0.05 for statistical significance

RESULTS

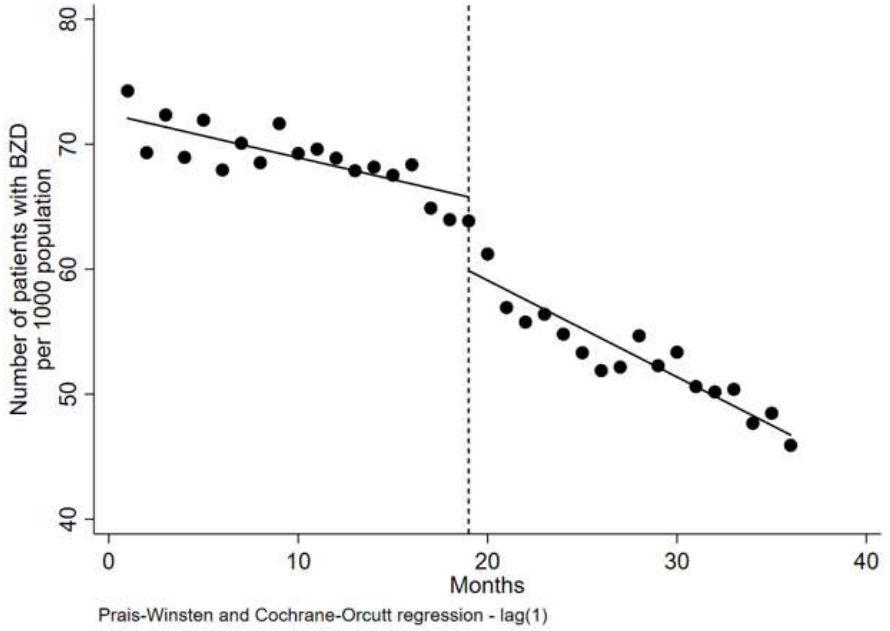
Table 1. Summary of pre-post analyses for all outcomes.

Outcome variable	Pre-period (18 months before the intervention)		Post-period (18 months after the intervention)		% change	p-value
	Mean*	SD	Mean*	SD		
Benzodiazepines (BZD) Prescriptions	69.08	2.48	53.33	4.51	-23%	<0.001
BZD new starts	2.36	0.62	1.09	0.39	-54%	<0.001
Discontinue BZD	2.68	0.55	2.58	0.87	-4%	0.685
BZD-RA Prescriptions	18.07	0.63	15.38	1.08	-15%	<0.001
BZD-RA new starts	1.02	0.26	0.48	0.22	-53%	<0.001
Discontinue BZD-RA	1.08	0.34	0.87	0.27	-19%	0.053
Alternative Prescriptions	39.98	2.42	49.27	1.26	23%	<0.001

* Period prevalence, number per 1,000 population

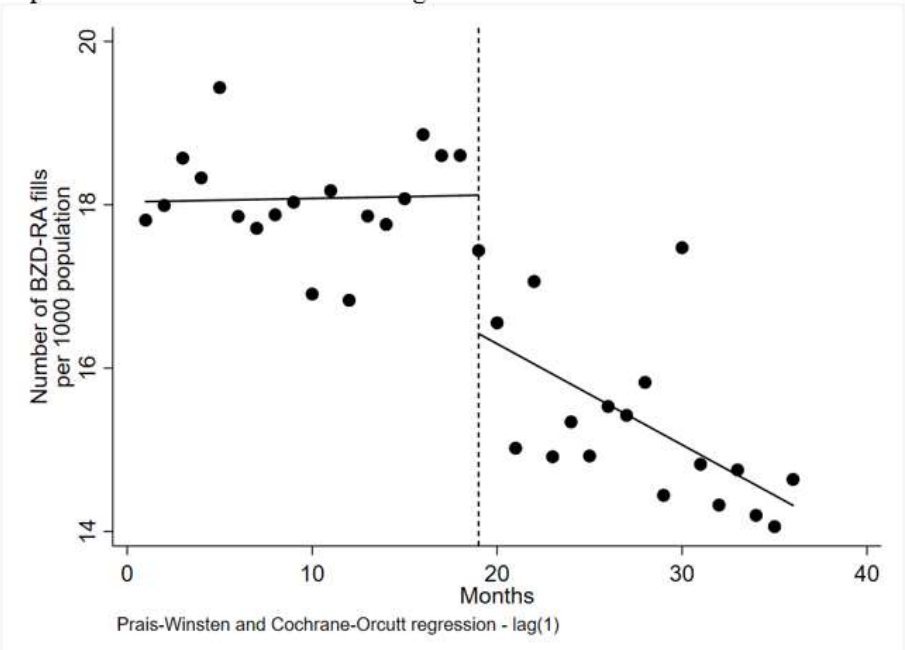
RESULTS

Figure 1. Prevalence of patients with all fills (BZD only) per 1000 population before and after implementation of academic detailing.



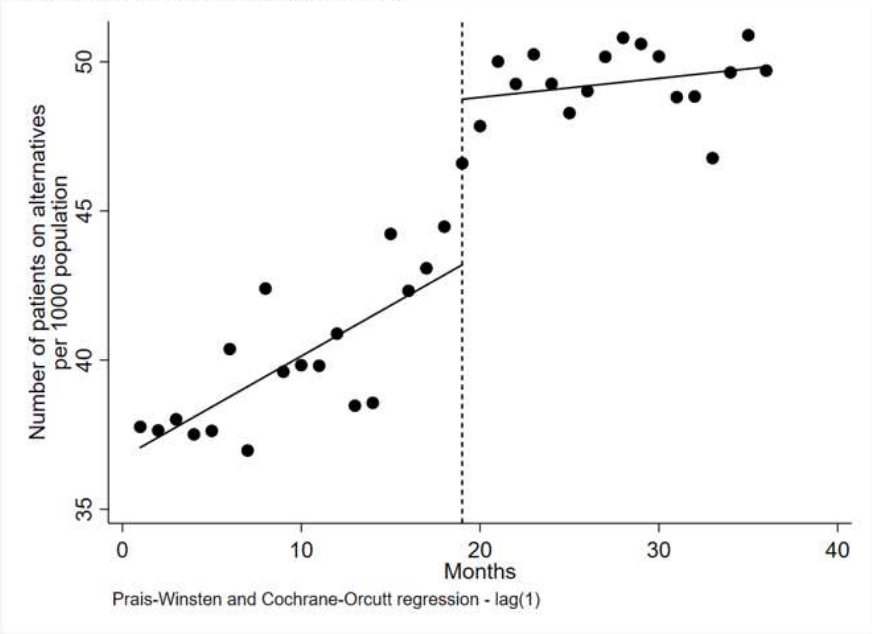
RESULTS

Figure 2. Prevalence of patients with all BZD-RA fills per 1000 population before and after implementation of academic detailing.



RESULTS

Figure 3. Prevalence of patients with Alternative fills per 1000 population before and after implementation of academic detailing.



DISCUSSION

- Academic detailing visits reduced overall prevalence of BZD prescriptions 23% and BZD-RA 15% for Veterans > 75 years old
- Large-level reductions were seen in both prevalence and new starts of BZDs, and BZD-RA and alternative prescriptions immediately following visits and continued 18 months after
- Academic detailing accelerated improvements in prescribing beyond normal trajectory
- A reduction in new starts accounted for most of change in prevalence. BZD were not replaced with BZD-RA

STRENGTHS & LIMITATIONS

Strengths

- Fluctuations in the number of older Veterans enrolled in VA care at these sites over time was controlled for by using the proportion of Veterans prescribed the drug of interest per 1000 Veterans enrolled for care in the VISN
- The patient population studied averaged around eleven thousand Veterans aged 75 and older each month
- The intervention by the trained academic detailing pharmacists was structured to allow uniformity of the education and key messages provided to each provider

Limitations

- Aggregate data does not reflect individual provider practice change
- Direct to patient education was potential confounder
  - 6.5% to 8.9% relative reduction in BZD prevalence attributable to direct to patient intervention

Federal Practitioner. 2018 September;35(9):36-43

Atlanta VA Geriatrician

- Anna Mirk

VISN 7 Academic Detailing Service:

- Kevin Brittain
- Bridget Roop
- Heidi Cantrell
- Callie Lavinghousez
- Heather Tanner
- Anishka Walker

VA National AD Program Office:

- Mark Bounthavong
- Melissa Christopher
- Sarah Popish
- Chad Kay

VISN 7 Pharmacy Executive

- Joette Lowe

Tuscaloosa VA Associate Chief of Pharmacy

- Garrett Aikens

5-MINUTE
Q & A

Beyond Traditional Academic Detailing: Trials and Tribulations of Using Web Conferencing for Academic Detailing

Colleen Donder, BSc(Pharm), ACPR

Academic Detailing Pharmacist

BC Provincial Academic Detailing Service, Island Health Authority, Victoria, BC

Knowledge Mobilization Officer

Canadian Agency for Drugs and Technologies in Health

Disclosures

Relationships with commercial interests

- None

British Columbia Provincial Academic Detailing (PAD) service

- Funded by B.C. Ministry of Health

Disclosures

- Canadian Agency for Drugs and Technologies in Health (CADTH) is funded by federal, provincial, and territorial ministries of health.
- Application fees for three programs:
  - CADTH Common Drug Review (CDR)
  - CADTH pan-Canadian Oncology Drug Review (pCODR)
  - CADTH Scientific Advice

CADTH Evidence Driven.

pad

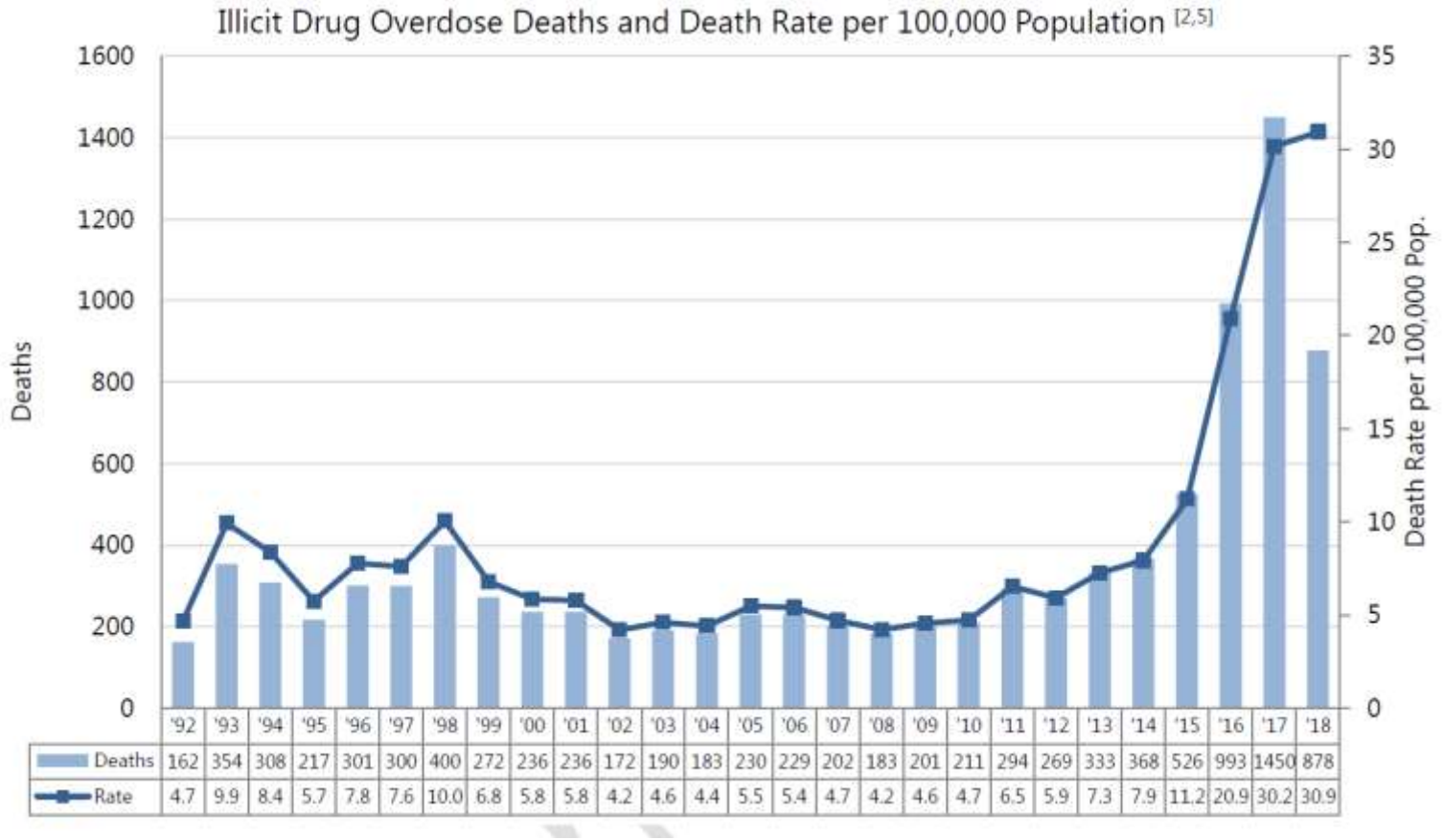
island health

Learning Objectives

- Discuss the advantages in providing academic detailing via web conferencing
- Explore challenges faced with technology
- Explore barriers posed by providing academic detailing via web conferencing

A tale from the BC Provincial Academic Detailing Service

- Buprenorphine/naloxone for opioid use disorder



https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf

A tale from the BC Provincial Academic Detailing Service

- Buprenorphine/naloxone for opioid use disorder
- First topic available exclusively via web conferencing
- Rationale for using web conferencing

Advantages of web conferencing

- Able to disseminate information quickly
- More flexible timing (no commuting necessary)

Challenges with technology

- Participant has not joined the conference after 15 minutes: are they just late or are they not showing up?

- What do you do if the web conferencing program does not work for the participant?

Barriers posed by web conferencing

- The participant is not contributing to the conversation, how do you handle this?

- A small group is attending the web conference and one person is hijacking the conversation, how do you ensure the other participants' learning needs are met?

Feedback

- Topic was well received
- Open to future topics via web conferencing

Moving Forward

- Web conferencing is an effective way to provide academic detailing when unable to provide in-person education

- Different challenges and barriers arise with web conferencing, anticipate and be prepared to manage these encounters

5-MINUTE
Q & A

Thank you,
day 2 field presenters