Anna: *You're listening to Changing Minds: Transformative Talks for Healthcare Improvement. Grab a coffee or tea and join our team as we chat with leaders in the academic detailing space. For more information on academic detailing, visit us at narcad.org.*

Anna: Welcome back to *Changing Minds*. I'm your host, Anna Morgan-Barsamian, and I'm joined today by the one and only Dr. Mike Fisher. Mike is the Founder and Director of NaRCAD, as well as the Chief of the Section of General Internal Medicine at Boston Medical Center.

Mike, welcome to the podcast and happy new year! I'm thrilled to have you on today to kick off 2025.

Mike: Absolutely delighted to be able to spend some time with you and it is a wonderful way to start a new year.

Anna: It certainly is. Let's dive right in. As the founder of NaRCAD, what inspired you to establish this national resource center and how did you envision its role in advancing academic detailing?

Mike: I'm not sure inspiration is the right word as much as a really fortunate combination of experiences and circumstances. And I should say right at the outset that originally I co-founded NaRCAD along with Dr. Jerry Avorn, who people who've been part of the NaRCAD and the academic detailing community know, wrote the original papers on academic detailing back in the late 70s and the early 80s. So, we founded NaRCAD in 2010 and the experiences that had led to that were work in academic detailing on an intermittent basis over the years with Jerry on programs in a couple of places, one in Pennsylvania and a few others. And some programs we were doing at Brigham and Women's Hospital where we both worked at the time.

Combined with the fact that we were hearing from more individuals, health professionals, organizations who were interested in getting programs of academic detailing going, they had maybe read Jerry's original papers or they had heard a little bit about some of the work that we were doing, but they didn't really have the expertise.

They weren't sure how to get a program started and so on. So that was sort of the experiences that we were having. And then the opportunity was around 2009, there were a set of requests for proposals from AHRQ, the Agency for Healthcare Research and Quality, that was looking for innovative approaches to get the best evidence that was out there into practice.

It was based on the recognition that there was a lot of federal funding for medical research, lots of important findings but it wasn't clear that that evidence was making it to the bedside, to the patients that we all try to help. Well, that's really what's at the core of academic detailing. And so this was a great opportunity at the right time.

So Jerry and I together with some colleagues wrote a proposal to create a resource center to engage with healthcare professionals, with organizations, with programs that were trying to figure out could they use academic detailing to improve care wherever they were located for whatever population they were serving. And if so, how would they implement it? And so what we wrote in that original proposal contained a lot of the seeds of what NaRCAD is today. And so our hope was to serve as an activator to get a lot of those other organizations started with programs of academic detailing that we would make possible for them but that they would be the ones who would really take it forward. So that was the opportunity.

And then in the second half of 2010, the grant was successful. We received funding and we launched NaRCAD at that time. So just over 14 years ago. And then it's really, and I'm sure we'll talk about this in the rest of our conversation today, it's grown since then to evolve from that original vision that we put forward in that first grant proposal.

Anna: I'm sure Mike that you didn't think NaRCAD would look like it does now, 15 years later. So it's very exciting where things have been going in the NaRCAD world and the NaRCAD community. How has NaRCAD supported adaptations of the AD model for diverse audiences and settings over the years?

We've just seen the academic detailing model continue to adapt and programs have been so innovative in the ways that they're implementing their AD projects. So, I'd love to know how NaRCAD has supported these adaptations over the past 15 years.

Mike: It's a great question and it's been a fascinating process. I mean, you're right that when we got that original grant award and started NaRCAD, I certainly didn't imagine that a decade and a half later we would still be doing it. And initially as we were getting the first sort of few cycles of training and support for programs figured out, we really were providing support for implementing academic detailing very close to the model that was originally studied in the original research papers, and that makes a lot of sense.

As we worked with programs, as we worked with a wider and wider range of individuals over the years, we saw that there was a tremendous diversity in the kinds of healthcare settings in which people thought about adapting the principles of AD and applying academic detailing as a way to improve care. They might be in a different part of the country, in a different type of care delivery environment working with a different payment model, or different patient populations, or different types of clinical decisions.

And that's just a sampling. There are many other dimensions across which any given situation could vary. And the more we worked with individuals and programs and organizations, the more we realized that for our work as NaRCAD to be effective and for the academic detailing efforts of the folks we were working with to be effective, we needed to have that flexibility.

We needed to be able to be that supportive resource. I mean, it's why we're called a resource center that could teach people about those underlying principles of academic detailing that had the experience and the deep knowledge of both the theory and the practice, but that also could understand and learn back from the folks we were working with to see what they needed in their context. Maybe they didn't need every element of the original model and by working with them to adapt what they needed, we could be responsive and we could hopefully increase the reach and the impact of academic detailing.

Anna: Thanks, Mike. You started to talk about this at our NaRCAD2024 conference we had back in November. If you're interested, listeners, to listen to Mike's talk, you can find that at narcad.org on our conference hub. And I'll put it in the show notes as well. But Mike, why do you believe adaptation and innovation are cornerstones of successful academic detailing programs? What's so important about that?

Mike: There are a couple of ways in which adaptation and innovation are so important. We talked about at the conference in that session that you mentioned, the idea that when you think about implementation, a lot of what we do as NaRCAD is help organizations implement academic detailing. And in implementation science, there's a line from a paper that I really liked that says all implementation is adaptation. And that's because each context, each

situation is unique. One of the reasons that I think adaptation and innovation are cornerstones as you said, Anna, goes back to the fact that we didn't think NaRCAD would be here 15 years later, or maybe we thought, but we didn't really believe it at the time. And we don't work in a static environment. The healthcare landscape, the organization of health insurance and healthcare delivery, and even just how people get information now at the beginning of 2025 is really different from what it was in 2010.

If we said we're going to use exactly the same approach as we did in 2010, let alone the same approach that was in the original papers of academic detailing from 1979, 1980, 1983, the original studies there, they might and very likely would not be a great fit for the challenges that we now face. And so that adaptation and innovation, that thinking about how we take those principles that underlie academic detailing around changing behavior, around how we learn and incorporate new information, around how we improve the quality of care, and figuring out what sort of adaptations are needed to make that work in the era of the 2020s, now halfway through the 2020s and the beginning of 2025, where information travels in different ways, where the way that medical care delivery is structured is somewhat different.

If we don't adapt and if we don't innovate, and if we don't get adaptive and innovative ideas from the community, then we'll be delivering an intervention that's not going to be as effective as it could. That's what's so interesting. I think if we didn't do that, we wouldn't be reaching our potential. But also frankly, it keeps the work really interesting and fun because we're learning from our colleagues who are out there trying new ideas, figuring out which of these adaptations and innovations are the ones that are going to make an impact as we all move forward.

Anna: Mike, we often hear from detailers and program managers that they're hesitant to move away from that core model of AD, that 1:1 model, because that's what's been studied in the past. So what role does NaRCAD play in maintaining the balance between fidelity to the core model of that 1:1 education, and the flexibility that's needed for implementation of these programs that vary so much?

Mike: It's a great question, Anna and a big part of what we as NaRCAD can do is help the groups that we're supporting and that we're partnering with approach that question in a rigorous way.

I like that instinct to that sort of cautionary note of saying, let's start with the original model, and let's start with the assumption that we should stick with that original model because it's what was tested rigorously in randomized control trials back in all the original papers that, as I'm sure you remind people on the podcast, they can find on the NaRCAD website and so on. That's what's been well-established. And so we start with that, and then we sort of almost put the burden of proof, if you like, on ourselves to say, okay, let's look at that core model.

We as NaRCAD can help organizations think about that really carefully. Now, are there elements of it that we just can't quite make work in our local circumstance whether it has to do with the geography and challenges of travel, whether it has to do with the kind of practice environment you're in and how you get access to those frontline clinicians to whom you're going to deliver the detailing intervention? Whatever those challenges might be, to think about those so that the default is you stick with the original model whenever possible, but you know that the original model isn't necessarily going to fit in every circumstance.

So you've asked the question, you've partnered with us, our NaRCAD team and the great community we have of our facilitators, the experts who come to our conference, everybody in this larger sort of NaRCAD universe to think carefully through that question and then to say,

okay, here's an area where we need some flexibility for this to be practical to implement locally. If we're too rigid about this element, we just can't get it done in our local setting. So we're going to be flexible there. That's where we're going to adapt. That's where we're going to innovate. Then you can think clearly about, okay, here's what's the original component. Here's what we're adapting. Now let's observe carefully and see what works.

Sometimes that'll be in the setting of doing a new trial. We're doing something that's different enough that we actually want it to be a research study. And as you know, and as many of our listeners know, we sometimes partner with members of our community on research studies, but sometimes it's simply an adaptation and we monitor to see, are we able to make this work in our current setting? And that's where we like to partner with people to help them do that adaptation while not losing sight of the evidence-proven approaches that make up the foundation of what we're doing here.

Anna: That's great advice, Mike. We've seen so many innovative ways that people have approached AD, especially when they present at our conferences and our summits. I hope that folks feel that they are able to innovate and adapt and we're okay with that. And we're here to support all of our listeners in doing that as well. I want to take a step back and think broadly for a moment about public health.

What are the most valuable lessons you've learned about adaptation and innovation in achieving public health goals, whether that's through your role at NaRCAD or your role as a primary care provider or your role as a chief?

Mike: Yeah, I think when I think about a question like this and I think about the ways in which academic detailing is a good model from which to think about other elements, so many of the lessons that I've learned about where to be flexible and where to be a bit more of a stickler when you're thinking about public health goals, whether for sort of a larger program that might be across a region or a whole organization or smaller initiatives that might be more at the level as you said, as a primary care doctor. It really is that when you come to that adaptation and innovation, you need to have a clear understanding in your head of what your goals are. What goals are you working towards? You need to understand the tools you're using.

So again, using academic detailing as an example, when I think about the things we've been discussing in our time together today about flexibility and adaptation and innovation, that only works when we have a clear understanding of the goals we've set out for improving clinician behavior by educating them with the best information about decisions that are relevant to their practice and to the patients and communities that they serve. And a similarly clear understanding of academic detailing, what it is, what it isn't, where it's been proven, then having those as sort of, as I said, as your North stars, the thing you're pointing towards, also having the flexibility to be able to say, okay, now, is this working? And again, where I said academic detailing is a good model to think about other kinds of public health interventions.

One of the things I really enjoy about being in healthcare, both as a frontline clinician, but also in our shared work at NaRCAD or in the work we do here at Boston Medical Center as a safety net hospital with a large primary care practice is that it's very practical and pragmatic.

We're researchers, we're academics, we care about the evidence, but at the end of the day, we are trying to help patients and help populations. And we ask very practical questions about, is what we're doing with this adaptation or this innovation - are we able to get more of our patients the treatment that they need? Or if we're doing it on a more of a public health level, are we able to help this community get the resources they need, maybe improve the

delivery of a given service or a given health intervention? And to me, that combination of having those principles that you really are committed to and nailed down, but the pragmatism that focuses on how can we make a positive impact, that to me is the valuable piece. It's really a framework for thinking about how to do the work we do, how to meet the goals we set.

And especially I think is key in terms of keeping us humble, that we keep learning about ways to adapt and innovate, which means all the things that we thought we knew 100% a few years ago, maybe need to be questioned. And bringing that humility to our collaborations is really important for getting the new ideas that can help us move forward.

Anna: Thanks for sharing that, Mike. I love how your perspective bridges your multiple roles, each offering unique insights into public health. So thanks again for that. I want to wrap up with one more question.

How do you envision NaRCAD evolving in the next decade to address emerging public health challenges and reduce health disparities through AD?

Mike: That's such an interesting question because we talked at the outset about the idea of how much has changed in the 14 coming on 15 years that we've been doing this work at NaRCAD. So imagining what the next five to 10 years will hold is an interesting thought exercise and one where I'm sure I could make some predictions that would be flamboyantly wrong, but I do have a few thoughts about how we will evolve.

I think there is an ongoing challenge for all of us at NaRCAD, both in our core team and in the larger community, to understand the new ways in which information is delivered, is disseminated, and is taken in by individuals, individual healthcare providers, but also by the larger community that we really need to incorporate into our work.

This isn't sort of a rant about media of the 2020s or social media, but rather that it's simply a fact that information travels very quickly right now. There are real challenges sometimes in identifying which is the most accurate information and thinking about how we as NaRCAD and the larger academic detailing community can help clinicians and via clinicians, their patients and the communities that those patients are a part of, recognize where the best evidence is, incorporate it into practice in a way that's helpful. That won't necessarily look exactly like AD has looked in the past.

And so that's an area where I think we're going to have to evolve and be innovative is how do we stay current and be as impactful as possible in this changing media environment. And then I think also there will be challenges we don't anticipate. We've started talking about the role of artificial intelligence at our last couple of conferences on and off. None of us really saw that coming a few years ago. And I don't think we know how that's going to be a part of our work going forward.

So I think for all of us at NaRCAD, it's that openness to seeing what will change to engaging with our larger community to identify solutions or potential solutions to test them out and to figure out how we can implement them. When it comes to reducing health disparities, I think a lot of that is for us to think about how can we, as we adapt to these new channels of communication, try to make sure that the messages are delivered everywhere and are delivered evenly everywhere, but not identically everywhere, that we get quality information to all the groups and communities that need it, but in a way where each group and each community can access it and can incorporate it into practice.

I think it's going to be an exciting next few years. There's a lot of uncertainty in front of us, and that can be scary. But I also think it creates opportunities for us to see where we can go.

And I said in response to your very first question that NaRCAD was really here because there was an opportunity that came up with that first request for proposals, and it turned out that we wrote the grant that turned into NaRCAD, and now we've gone on for a decade and a half. I don't know what that next opportunity will look like, but I think for all of us to be open to it and to know that over the last 15 years, we've built a community around us that will be ready to respond actively to those challenges, that's what excites me. That's what gets me feeling that the future for NaRCAD is just as promising as the years that are in our rear view mirror have been.

Anna: I agree, Mike, and it's so exciting to consider how academic detailing and our entire NaRCAD community can continue to evolve to meet these emerging challenges in the healthcare landscape. This conversation has been so inspiring for our 2025 work. A big thank you to you, Mike, for sharing your expertise today. And of course, a big thank you to all of our listeners. We'll catch you all next month. Bye, Mike, and thank you so much again for joining.

Mike: Absolutely, and I thank you for doing this wonderful podcast series, and best wishes to everyone in our community for an exciting and innovative 2025.

Anna: Thanks, Mike!