Academic detailing in a time of plague

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Disclosures

- I accept no personal compensation from any pharmaceutical company.
- Our research Division at Harvard/Brigham is funded primarily by federal grants, but does receive some industry research contracts through the Hospital to study specific drug adverse effects and other outcomes.
- Alosa Health is a non-profit organization that accepts no drug company support, and I receive no payment for any of my academic detailing-related work there.

The current context:
An unprecedented crisis

- Covid affects/afflicts most people on the planet, in many different awful ways
- Academic detailing: Whatever hassles we face, we are among the lucky ones.
- That said, there have been several major impacts to our model of:
  - ***face-to-face interactivity***
  - ***showing up at the office to find an opportunity to talk***
  - ***reviewing the materials in person with the practitioner***
    - **guiding the conversation, but responsively**

Solutions that are working

- Zoom / WebEx / Skype / etc. platforms
- This takes practice – like writing with the opposite hand
- Telemedicine has become a useful new habit for clinicians
  - practitioners are getting used to setting up appointments for computer-based interactions.
- As with classroom teaching, the goal is ***not*** to just replicate the usual behavior via a terminal
- e-detailing can actually offer important potential advantages:
  - conquering the tyranny and inefficiency of long distances
  - new approaches that can now be done easily
    - video clip: “What would you do for a patient like this?”
    - access to all the data in the universe: “Let’s see what that paper ***really*** reported…”

Additional chances for empathy

- Knowing and caring where a clinician is coming from knowledge-wise is best accompanied by asking how they're doing in the current crisis
- Can start e-encounter with a shared recognition of the pandemic tragedy
  - "How are you holding up these days?"
  - "Covid must really be impacting your practice a lot."
  - *Much better than:* "Is that a picture of your kid playing soccer?"

Using the materials:
An important dimension of The New Way

- Not a great idea: e-mailing materials in advance for the clinician to follow along with you
  - More work for the participant, may be hard to access and follow
  - Loses the opportunity to manage the flow of the interaction ***responsively***
- Re-format information for remote use, or work from PDFs of existing materials?
- In either case, the following still apply:
  - Keep control of the interaction, but react to the learner's needs and interests
  - Sounds contradictory, but it isn't.

For all these issues, the greatest expertise in the world exists among participants in this conference.

Kudos to NaRCAD for creating a community
that enables us to share with each other
the best insights and practices
in these changed times.

What about Covid as content?

- Not much prescribing impact yet, just a few key points
  - Hydroxychloroquine doesn't work, either as treatment or prevention.
  - The virus will not disappear, like a miracle, by Easter (last Easter).
  - Don't inject disinfectant.
  - UV light inserted into the body has not been subjected to RCT evaluation.
- That said, there is a great deal the primary care provider can do to educate patients.
  - Much can be accomplished by combatting the "infodemic" of bad ideas and ineffectual guidance that have made things so much worse:
    - For example, **Masks: Yes; washing surfaces: not really**.
    - Patients look to their health care professionals for guidance on this, in the face of so much silence and mis-information from authorities.

Inadequate transmission of evidence-based guidance:
Jerry washing food with Lysol Wipes early in the pandemic.

Coming soon: A Covid role for academic detailing?

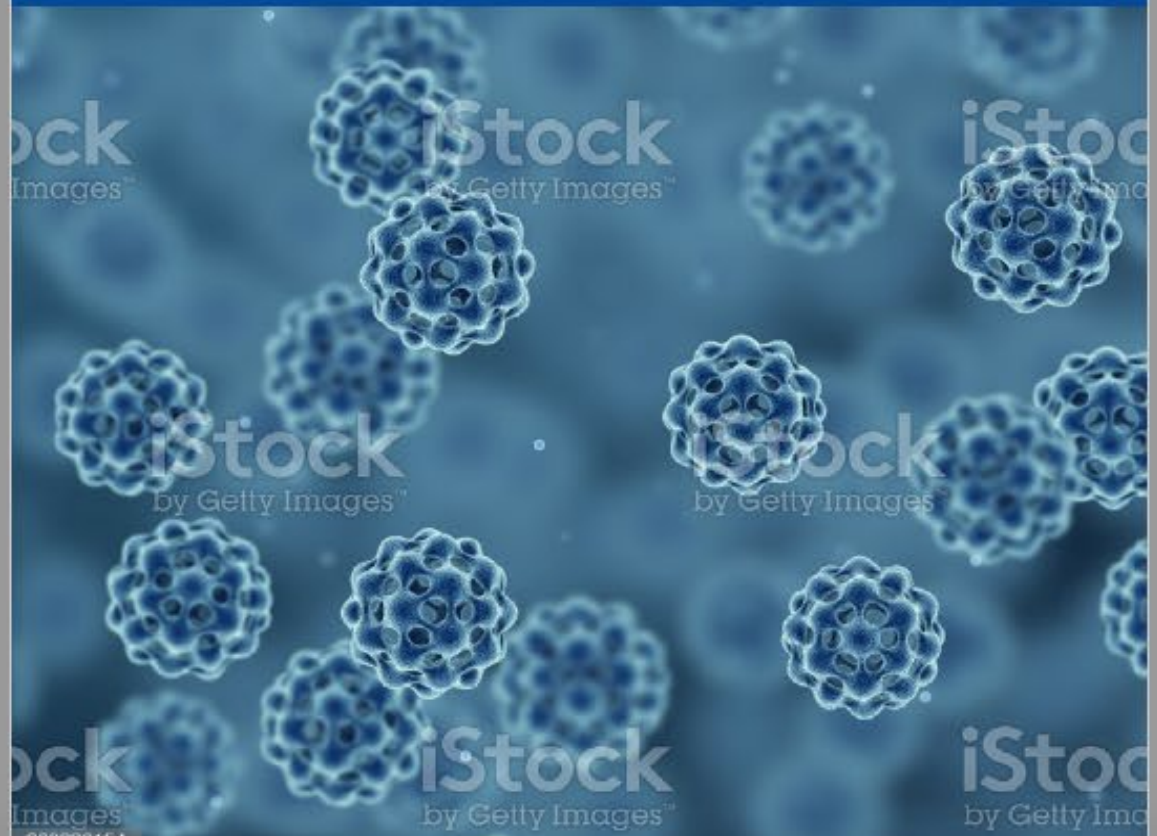
- Pretty soon we'll be facing a number of new vaccines, treatments, and preventive medications
  - as well as ongoing proliferation of numerous Covid tests, with varying properties
- Most of these will be laid at the doorstep of the primary care provider, with little or no educational outreach on their attributes
  - Vaccine A vs B vs C vs D
  - Test A vs B vs C vs D.
  - Evidence-based **behavioral** guidance, after 10 months of low quality and misleading communication
    - Masks, travel, family gatherings, Lysol on groceries, etc.

PACE Pharmaceutical Assistance Contract for the Elderly

Alosa Health
Balanced information for better care

Immunizing older adults

The latest recommendations for protecting against flu, pneumococcal pneumonia, shingles, and other preventable conditions



Influenza affects millions, with the greatest risk of death in older adults

FIGURE 1. The most recent flu season (2019-2020) sickened millions of Americans, resulting in substantial illness and mortality.[2]

Over 90% of influenza deaths occur in patients age 60 and over.[3]

Despite the proven efficacy of the flu vaccine and the risks from influenza, vaccination rates remain low.

FIGURE 2. Only about 40% of adult Americans receive the flu shot each year. Although those over 65 are covered best, only about 65% of them are immunized. (Averages based on data from 2010 to 2017.)[4]

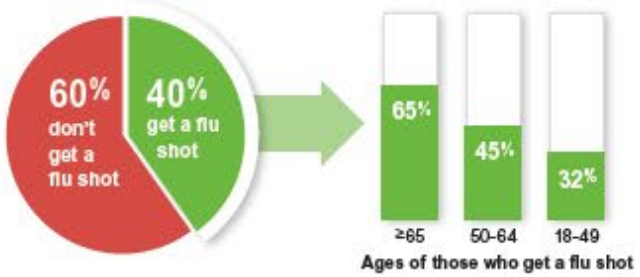
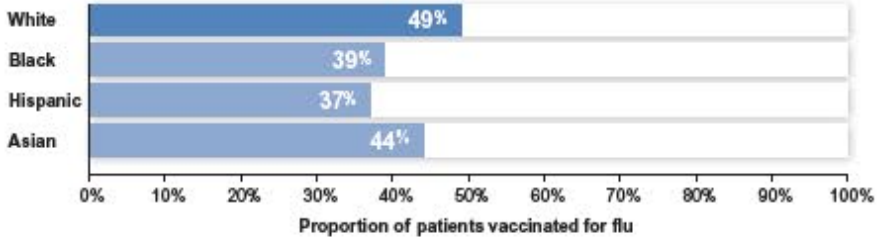


FIGURE 3. Black and Hispanic patients received flu shots at lower rates than white patients in the 2018-2019 flu season.[5]



Increasing adult immunization rates

Talk to patients about objections they may have.

MYTH "I don't get the flu."

REALITY **Anyone can get the flu.**

Just because you haven't had a car accident before doesn't mean you shouldn't wear a seatbelt today. In addition to reducing mortality, the flu vaccine can prevent the major complications of getting the flu, especially for older adults.

MYTH "The flu shot gives you a case of the flu."

REALITY **Flu shot doesn't give you the flu**

- Most patients have very minor local injection site reactions, and that's all.
- All injectable flu vaccines are made from inactivated virus (other than Flumist, which is not recommended for older patients) and do not contain live virus, so they can't "cause the flu."
- The vaccine is administered at the beginning of cold and flu season, so many people contract viral upper respiratory infections around the time of flu shot administration. This is not a result of the vaccination, but of circulating viral illness in the community.

MYTH "In many years, the flu vaccine doesn't work well at all."

REALITY **The flu vaccine benefits patients, even though it is not 100% effective.**

- The efficacy of the flu vaccine varies year to year based on the composition of the vaccine and the strain of virus circulating in the community. Patients may be skeptical because the reported efficacy is often in the 30-50% range.[10] But even at this level, vaccination substantially reduces the risk of death, severity of illness, and length of hospitalization.[11]
- The flu vaccine is as effective as other treatments (e.g., statins) used frequently in primary care. Instead of daily use, flu vaccine is given annually and has less risk of side effects.

MYTH "The flu isn't that serious; it's just like a bad cold."

REALITY **Viral influenza can be a severe and sometimes fatal disease, especially in people over 65.**

Shifting gears:

Life (and death) continue unabated on other fronts, still

- Astonishing pubic ADD
  - Remember the other epidemic, of opioid misuse?
  - Did it just get resolved and I never noticed?
  - New highs in OD deaths
- Rather than going away, substance use disorders and mental health problems have gotten ***worse*** during the pandemic.
- And did people stop needing anticoagulants, hypoglycemics, BP meds?
- The Evening News syndrome
- Thank goodness for the programs, educators, clinicians, and funders that have kept their eyes on these balls, despite the pandemic.

Cosmic big picture thoughts

- *"Ah have always depended on the kindness of strangers."*
  - Blanche Dubois to her doctor, in "A Streetcar Named Desire."
    - Tennessee Williams, 1947; won Pulitzer Prize
    - Blanche probably suffered from schizophrenia.
    - She had been a prostitute.
- Like Blanche, academic detailers depend on the kindness of strangers.
  - We implicitly say this to the doctors who are good enough to see us.
  - This may often make us feel schizophrenic, or on a bad day, like (unpaid) sex workers.
    - Am I doing this for you, or are you helping me?
    - Yes.
- Getting serious about real incentives
  - Should clinicians spending time with an educator have to do so in their spare time?

Cosmic big picture thoughts, continued

- Might this change under Bidencare?
  - His Heath Policy Committee seemed open to many things.
  - Fostering more Accountable Care Organization-type system change could better integrate ongoing educational outreach into the fiber of health care.
    - Following the example of Kaiser, and the VA
- New categories of payment have been introduced before
  - SBIRT
  - End-of-life care
  - Annual physical
  - Why not a procedure code for participating in authorized academic detailing sessions?

In conclusion

- There will be a growing need to present evidence to clinicians about Covid treatments, vaccines, behaviors in an accuate, evidence-based, balanced way. ***(new approach)***
- None of the other conditions we address have gone away, and some – like opioid-related problems – will require even more communication.
- Academic detailing could emerge from this period with new and better tools for educational outreach.
- Governmental change in 2021 could make the health care system more open to active dissemination of medical evidence.
- 2020 will be over in 6 ½ weeks.

Thank you.

- Comments, objections, questions, discussion……