

Communication Challenges, Opportunities & Strategies in Pharmacies – The Flu Season Experience

May 2019

NAIIS Conference

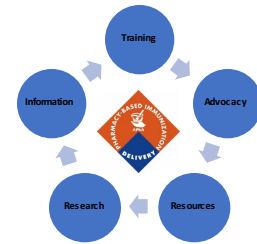
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Chief Strategy Officer
American Pharmacists Association

Focus of Discussion

- 1) Discuss current and future needs regarding messaging by pharmacists and the immunization neighborhood regarding influenza vaccination.
- 2) Discuss the importance of unity and consistency in communications within the immunization neighborhood.

Vision for Immunizing Pharmacists

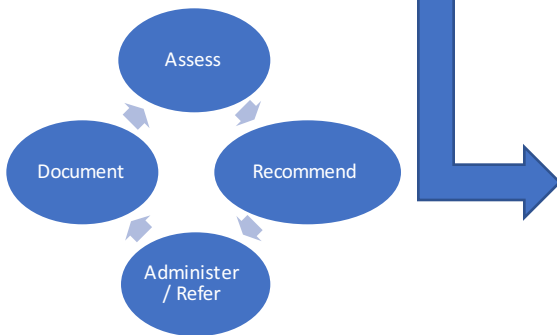
Pharmacists are an **accessible, valued and recognized** member of the immunization neighborhood who is **authorized and compensated** for providing immunization service related to **ACIP recommended vaccinations** that improve public health.



Immunization Neighborhood

Collaboration, **C**oordination, and **C**ommunication among immunization stakeholders dedicated to meeting the immunization needs of the patient and protecting the community from vaccine-preventable diseases.

Coined by APhA in 2012



NVAC Adult Immunization Practice

Standards

Calls to action for healthcare professionals

Assess immunization status of all patients in every clinical encounter.

Strongly **Recommend** vaccines that patients need. **Administer** needed vaccines or **Refer** to a provider who can immunize.

Document vaccines received by patients, including entering immunizations into immunization registries.



Timing of Vaccination

Balancing considerations regarding the unpredictability of timing of onset of the influenza season and concerns that vaccine-induced immunity might wane over the course of a season, it is recommended that vaccination should be offered by the end of October. Children aged 6 months through 8 years who require 2 doses (see Children Aged 6 Months Through 8 Years) should receive their first dose as soon as possible after vaccine becomes available, to allow the second dose (which must be administered 2-4 weeks later) to be received by the end of October. Community vaccination programs should balance maximizing likelihood of persistence of vaccine-induced protection through the season with avoiding missed opportunities to vaccinate or vaccinating after onset of influenza circulation occurs. Revaccination later in the season of persons who have already been fully vaccinated is not recommended. Vaccination should continue to be offered as long as influenza viruses are circulating and unexpired vaccine is available. To avoid missed opportunities, vaccine health care visits and hospitalizations.

Optimally, vaccination should occur ... vaccination should be offered by the end of October. Onset, peak, and decline of influenza activity varies, the ideal time to start vaccinating cannot be predicted each season. Moreover, more than one outbreak might occur in a given community in a single year. In the United States, localized outbreaks that indicate the start of seasonal influenza activity can occur as early as October. However, in 75% of influenza seasons from 1982-83 through 2017-18, peak influenza activity (which often is close to the midpoint of influenza activity for the season) has not occurred until January or later, and in 58% of seasons, the peak was in February or later (7,8).

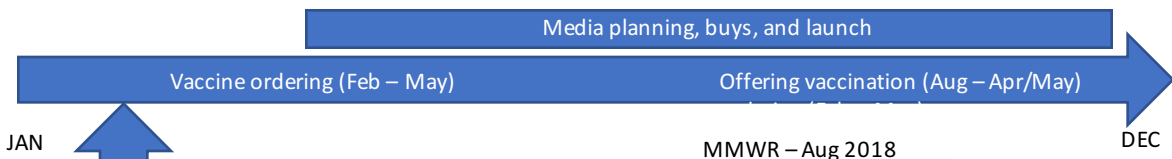
A number of observations in a single influenza season, with observed declines in protection less well-matched to the season, also vary with recipient age. In a multiseason (2011-12 through 2013-14) study, VE remained greater than zero for at least 5 to 6 months after vaccination. An analysis from the 2011-12 through 2013-14 seasons noted protection ranging from 54% to 67% during days 0 through 180 postvaccination (20). A third multiseason analysis (2011-12 through 2014-15) conducted in Europe noted a decline in VE to 0% at 111 days postvaccination for A(H3N2) viruses. VE against B viruses declined more slowly and VE against A(H1N1) viruses remained roughly stable at 50-55% through the influenza season (27).

Variable data concerning the presence and rate of waning immunity following influenza vaccination, coupled with the unpredictable timing of the influenza season each year, prevent determination of an optimal timing (e.g., in July and August) might result in greater potential waning of immunity. Although delaying vaccination might result in greater immunity later in the season, deferral also might result in missed opportunities to vaccinate, as well as difficulties in vaccinating a population within a more constrained time period. Efforts should be structured to optimize vaccination coverage before influenza activity in the community begins.

Vaccination efforts should continue until February or March. Providers should offer influenza vaccine routinely, and organized vaccination campaigns should continue throughout the influenza season, including after influenza activity has begun in the community. Although vaccination by the end of October is recommended, vaccine administered in December or later, even if influenza activity has already begun, is likely to be beneficial in the majority of influenza seasons.

Source: MMWR Aug 2018 - <https://www.cdc.gov/mmwr/volumes/67/rr/rr6703a1.htm>

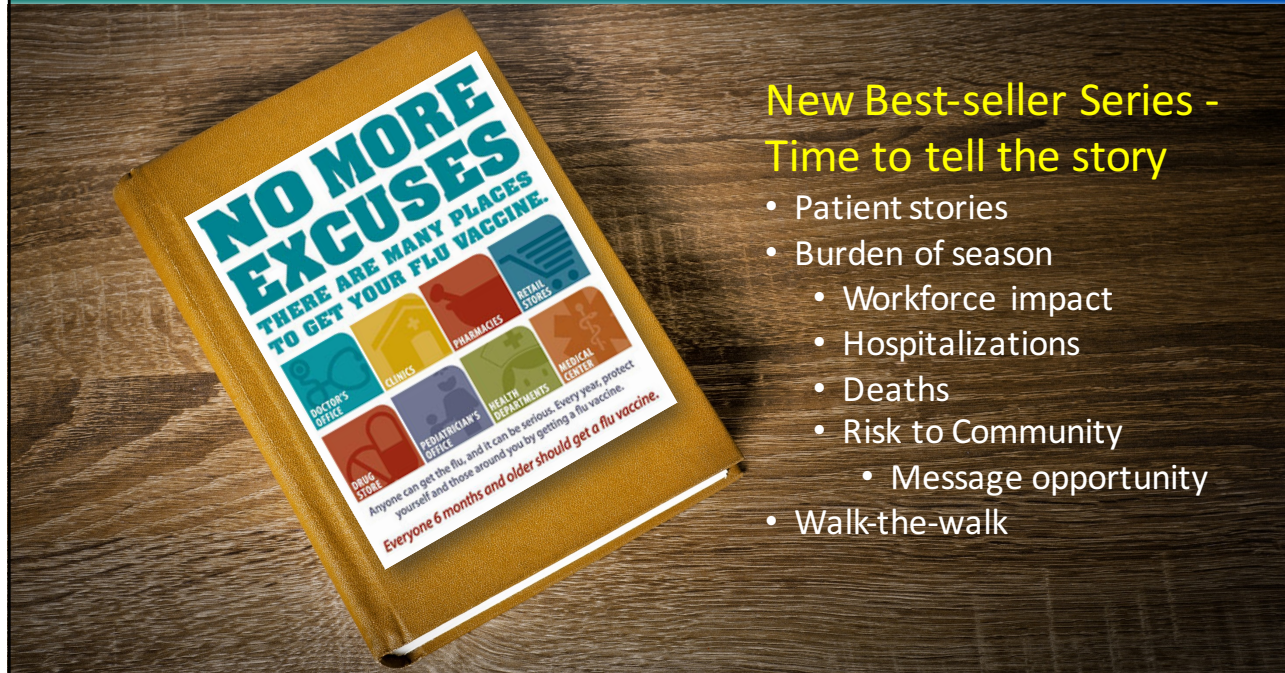
- Need clarity, consistency and understanding in regarding to timing for vaccine administration
- Communication between members of immunization neighborhood
 - Is there a preferred timing of vaccination within the community or a practice's patients?
 - Has the practice communicated to their patients their preference for timing?
 - How would primary care providers like to be informed of vaccinations?
 - Is everyone reporting to and accessing IIS?



JAN
February
Begin planning
season plan
based on CDC rec
and other input

When will CDC
messaging and
guidance be provided
to practitioners?





New Best-seller Series - Time to tell the story

- Patient stories
- Burden of season
 - Workforce impact
 - Hospitalizations
 - Deaths
 - Risk to Community
 - Message opportunity
- Walk-the-walk

How do we communicate Vaccine Efficacy and Real-World Experience to overcome vaccine hesitancy?

- Many factors impact VE / Real World Experience
 - Double-edged sword: Percentages vs observational impact
 - VE numbers could be better and we can't sit back because
 - *as VE improves, burden of disease reduces, and importance of vaccination may be impacted*
 - Vaccine effectiveness 29% in acute MI prevention
 - "On par or better than accepted preventive measures [as] statins (36%), anti-hypertensives (15–18%), and smoking cessation (26%)"



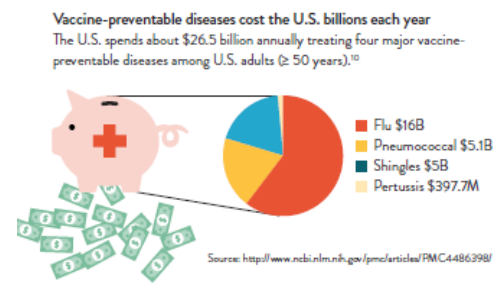
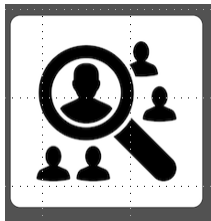
1. Barnes M, et al. Acute myocardial infarction and influenza: a meta-analysis of case-control studies. *Heart* 2015;101:1738-1747
 2. Udell JA, et al. Association between influenza vaccination and cardiovascular outcomes in high-risk patients: a meta-analysis. *JAMA* 2013;310:1711-20

Understanding how to communicate

Pharmacists are no different than any other providers

- **Challenged with understanding the data and how to communicate it effectively to the public**

- ❑ Consistent messaging across the immunization neighborhood is a necessity
- ❑ Put a face on the story for why people should get immunized (Reduces symptoms and illness length – Key messages)
- ❑ Education, repeat of messages, life experiences all influence health care providers



- ✓ All individuals who administer a vaccine should input data into the IIS, so that a full record is available for reference and unnecessary vaccine administration is avoided.
- ✓ As part of Pharmacists' Patient Care Process: proactively assess a patient's immunization history at any patient visit, and where available, assess data within IIS. **Requirements for reporting of vaccination data should be consistently applied across all immunization providers.**
- ✓ Pharmacists should continue educating patients about the importance of tracking their vaccine history and how their information may be stored electronically for other vaccine providers to access through an IIS.

Source: *Pharmacists: Advancing Core Elements of the Immunization Neighborhood and the Adult Immunization Standards*

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