Academic Detailing During a Pandemic: What Works?

Washington OD2A Peer-to-Peer Webinar Series

Key Learnings / February 22, 2022

Bevin Kathleen Shagoury, Deputy Director, National Resource Center for Academic Detailing (NaRCAD)

Laura-Mae Baldwin, MD, MPH, Professor, Department of Family Medicine, University of Washington

Adrienne E. Butterwick, MPH CHES, Senior Improvement Advisor, Patient Safety, Comagine Health

Panel Discussion Highlights (View Recording Here)

What is Academic Detailing (AD) and who does it?

Bevin Shagoury: Academic Detailing is a direct communication approach in which an educator or detailer walks into a clinician's space where they practice. We've noticed in our community of detailers that there is a strong concentration of public health departments who connect us with potential detailers. This could be an epidemiologist with an MPH, a nurse practitioner, or a retired MD. It needs to be someone with the clinical prowess and communication skills to have a persuasive communication that allows the clinician to feel empathized with and respected to build a trusting relationship in which evidence-based care and tools can be woven into their practice.

How can AD be tailored into our virtual environment?

Bevin Shagoury: We have seen that AD can work as well as an in-person approach, and in some instances, it may be more successful. In some instances, it may be less successful. Folks in our community were prepared to adapt and be creative in how they have adapted to AD work.

Can you think of an example of AD being adapted to a virtual environment?

Bevin Shagoury: The Oregon Education and Training Center does incredible work on HIV prevention detailing. They have found ways to save money on materials and turn these into electronic materials. These colleagues were able to find the invitation to participate a little easier and they did this through great technology like Calendly, a scheduling application.

You've described the principle about engaging clinicians individually. Have you seen it used with non-clinicians, where you're engaging other people?

Bevin Shagoury: We have not heard of successful approaches with non-clinicians. However, we have seen adaptations in which fusion approaches could work, and multifactorial approaches can work. For example, a clinician and law enforcement may partner to address the use of Naloxone and harm reduction. This approach allows us to consider if we are in our own bubble as clinical educators or are we stepping back and talking with

others, and considering how the patient is informed? Academic Detailing programs can partner with other community programs to ensure messaging is consistent, so the patient is getting what they need from multiple angles.

Can you tell us about the academic detailing you worked with cardiovascular risk with primary care clinics?

Laure-Mae Baldwin: This AD outreach program was part of Healthy Hearts Northwest, a clinical trial in Washington, Idaho, and Oregon to support 200 small medium size clinics over 15 months on approaches to help patients reduce their cardiovascular disease risk. All practices had a facilitator to support them in their QI, and to provide educational outreach. We focused on cholesterol management because there was a large pocket of people between the ages of 40-75 years of age who had not been identified as high risk but there was now a calculator to help providers identify those individuals. This is the group we were targeting and provision of statin medication and lifestyle modifications. The project was based in Seattle at Kaiser Permanente and partnered with sites, some over 800 miles away. We believed that the clinical team was an important piece of making these kinds of changes in the practice. We had five educators that offered a single educational outreach visit per month to the clinic leaders. That single visit was then supported by a clinic facilitator visit monthly.

Were there adaptations that you had to make to make the outreach successful?

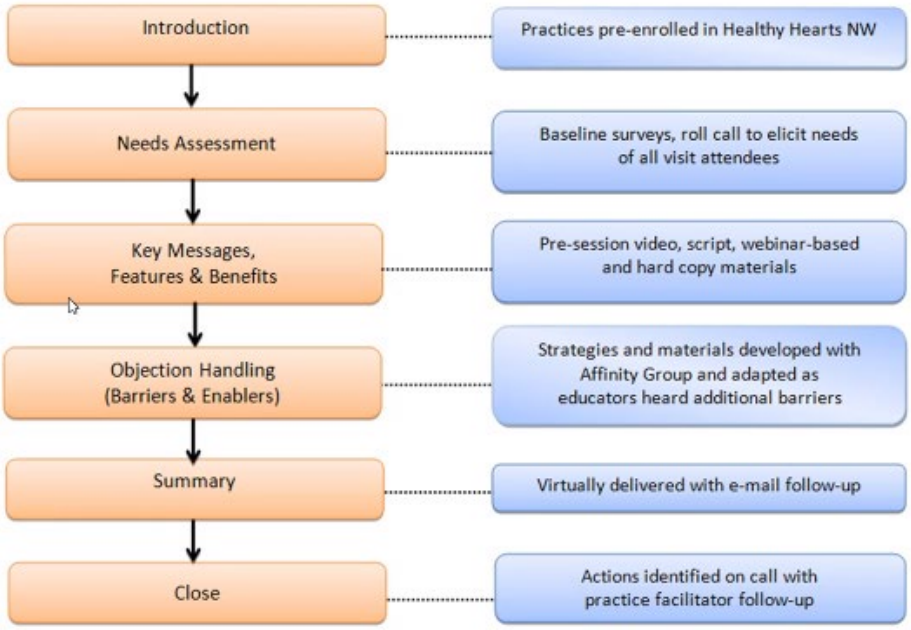
Laure-Mae Baldwin: It was a short period of time that our educators had with our team at the site. There are components that take place over time, but we had to offer these in different ways. In traditional AD, there is an introduction, a needs assessment, key messages tailored to that practice, and addressing barriers or objections to practice change. We had to take a number of those pieces and offer them in different ways. Prior to the launching this work, we consulted with a group of clinicians who helped us understand objections and barriers and assisted us in the development of materials and potential solutions ahead of time. There was some knowledge of clinicians in these practices and their use of cardiovascular measures. We brought together whoever the clinic chose to be the leaders (physicians, pharmacists, nurses, medical assistants) in the program. During the visit we tried to economize. Since we only had 30 minutes, we used Zoom chat and assessed the needs of role representatives on the call. We also had an educational video we sent out ahead of time that had the same key messages that we provided during the visit. We consulted with NaRCAD.

You might have a clinician, along with their medical assistant, a nurse, an office manager on the call?

Laure-Mae Baldwin: Yes, in some practices it would be the medical assistant that would do the cardiovascular risk assessment ahead of time. They could do it and tee it up for the provider and they were important constituents in this process. In some ways, the medical assistant might have needed the academic detailing more than the clinician.

Bevin Shagoury: We built this process together (NACaRD and Healthy Hearts Northwest Team) and the visual below illustrates the pre-session video, the script and the adaptations developed for this project.

Key Learnings Shared by Participants



Can you describe your academic detailing experience?

Adrienne Butterwick: I am based in Salt Lake City and started our academic detailing work with dentists through an OD2A grant with the Utah Department of Health in May 2019. This was our first phase in specific geographic regions of our state due to high rates of opioid prescriptions and overdoses. In February 2020 we branched out to reach a larger number of individuals. We had to pivot to virtual in 2020 due to the pandemic and did not see many changes. It is beneficial to be in person, but does help when you're talking about something as serious as overdose deaths. Unfortunately, we don't have that in today's world and a virtual approach allowed us to work with a high number of participants.

Can you describe your experience detailing primary care physicians vs. dentists?

Adrienne Butterwick: It is different. Our experience with targeting dentists was due to a high number of adolescents being prescribed many opioids for wisdom tooth extractions and common procedures that take place during those years. Dentists may not be affiliated with large health networks and there is large competition between dentists, so they are not a group you can necessarily partner within groups. We found in general they have more questions about screening and were less aware of resources such as Screening Brief Intervention and Referral to Treatment (SBIRT). We found that partnerships with your community programs are very helpful to partner with others around measures such as naloxone distribution, disposal sites, and we provided information within the dentist's geographical area. Dentists shared that individuals tend to be more anxious coming into procedures and dentists were concerned that patients may pre-medicate themselves. Having naloxone on-site is incredibly helpful, as well as assessing who on your team is trained in Narcan. We saw a lot of very favorable responses to screening in SBIRT.

Key Learnings Shared by Participants

If you could give one piece of advice to someone preparing to launch AD program in the current environment?

Adrienne Butterwick: Maintain flexibility and commitment to find out what is needed, especially when addressing substance use. Be prepared to listen, offer more resources, and connect people to those with expertise.

Laure-Mae Baldwin: Think about how to reinforce the qualities of "in-person visits" if you must be virtual. Identify a central connector who can be your point of contact, develop materials you can provide between visits to build relationships in different ways, and make sure you know how providers like to receive information.

Bevin Shagoury: You can have great data and materials and that is critical, but you need to remember the clinician with whom you are visiting with is a human being. They may be stressed, have prejudices towards patients who are struggling with OUD is part of what you may be facing. The end goal is building a relationship that is genuine and people can tell when you are a genuine person as a detailer. You will be able to be more flexible if you remember the person you're serving is human and you're all on the same team.

How did you initiate detailing with dentists? Establishing relationships and trusts in daunting. I'm worried about the initial response to detailing.

Adrienne Butterwick: There was some recent legislative changes and the use of the Prescription Monitoring Program PDMP in Utah. We were able to combine our work with messaging around a new mandate. We located a champion who was a retired oral surgeon who connected us with dentists and dental hygienists. I would be more than happy to meet anyone who is interested and talk about different approaches, so please feel free to contact me at my email address abutterwick@comagine.org.

Bevin Shagoury: Don't get into academic detailing language but emphasize that you are available, the service is free, and you are with a reputable group to assist.

What challenges do you face regarding AD in your own programs?

- Getting the data on the impact of academic detailing work
- Having a team member provide outreach due to the high number of outreaches that are needed
- Negative attitudes toward individuals with addiction disorders
- Challenges related to COVID
- Dentists are hard to get ahold of, and many have no experience with AD
- Increased use of fentanyl and methamphetamines

What has been successful in your setting with AD that other programs might learn from?

- Addressing SDOH & stigma
- Use of the Logic Model
- Understand overprescribing based on local zip code that impacts risk level
- Find the right detailing team - the right people on board makes a great team
- Working with NArCAD is a best practice
- Consider use of American Dental Association membership

Key Learnings Shared by Participants

- Include provision of CME for the training
- Use individuals with lived experiences when possible
- Track recent legislative changes
- Leave the jargon at the door
- Utilize Materials Toolkit - NARCAD
- Outreach to pharmacy staff to train on naloxone (why to carry it and how to get reimbursed) and provide education to reduce stigma
- Work with the Hospital Association to engage surgeons and hospitals
- Inform high risk prescribers of AB 2760 (CA) to offer academic detailing on naloxone and opioid stewardship. AB 2760 is a new bill that requires naloxone is offered with any prescriptions at 90mme or higher.

Nikki Griffis, Program Manager, Montana Drug Registry, **Board of Pharmacy at State of Montana**

I am a pharmacist with the Montana Board of Pharmacy. I found it helpful to hear how you have used your mandatory use of PDMP as a gateway to get into academic detailing and your virtual tips. We are going to move forward with prescriber reports in the PDMP and looking forward to comparing peers to each other.

Cassie (Catherine) Harter, RDH, MPH, Health Promotion Coordinator, Tacoma Pierce County Health Department, Washington.

We started with the OD2A grant with plans of performing AD in primary care and other medical settings, but since COVID-19, our nurses, who were originally our trained detailers, were activated in COVID response and could no longer do so. The team decided to pivot to dentistry as the audience for our AD work. That's when I came in and we're only in the beginning stages of getting it off the ground. My supervisor and I attended NaRCAD training in 2021. We're bringing the idea of academic detailing to an oral health-focused collective impact network in Pierce County and hoping to expand the practice beyond just the health department and identify local champions interested in helping develop the program, so it has wider reach and more equitable impact.

Ret. Captain Felix Pacheco III, *Northern Peer-to-Peer Learning Coordinator, Newark, NJ 07102*

We have a program run out of the Attorney General's Office called Operation Helping Hand which is a training for first responders to promote understanding of addiction and an overview of the program. It allows us to address the negative perception that law enforcement may have of a person suffering from substance abuse disorder. We train law enforcement, first responders and recovery coach specialists throughout the state.