Academic Detailing | Program Management Breakout Session

For many organizations, the active educational outreach performed by an academic detailing program represents a unique paradigm for their organization. Through the understanding of important managerial aspects of academic detailing programs, and sharing insights from managers of other academic detailing programs this session will help managers explore ways to address critical challenges.

Overview:
- Provide training and advice to managers of current or planned academic detailing programs, as well as for those who are contemplating starting programs on important managerial aspects of academic detailing.

Structure:
- A combination of brief presentation/outlining of discussion areas, audience discussion, breakout groups and question and answer formats will be used

Outline:

1. Introductions   5 minutes

2. Staffing an Academic Detailing Service
    a. Models of hiring   20 minutes (MLC)
    b. What to look for in an academic detailer   10 minutes (LDR)
    c. Code of Conduct for Academic Detailing (CADC)   5 minutes (LDR)

3. Training Academic Detailers
    a. Basic Training in Academic Detailing   15 minutes (MLC,LDR)
    b. Ongoing Topic Training/Upskilling   15 minutes (LDR,MLC)

4. Anticipating and Answering Skeptics Questions   20 minutes (LDR)
    a. Who says we need this? Who are you?
    b. Around Evidence
    c. Around Guidelines
    d. Around Industry
    e. Around Government
    f. Other

5. Evaluation   25 minutes (MLC)
    a. Methods / Options
    b. Pressures
    c. Best Practice versus Best Performance Reporting
        i. (patient outcomes versus computer reports)

Models of hiring   **20 minutes (MLC)**
Hiring Staffing Models for Academic Detailing:

Academic Detailing interventions, within government, insurance programs, academic affiliated programs and private companies providing consultation to stakeholders are all faced with the process of selecting the staffing model that meets their needs with the allocated resources they have available.

Consulting as an academic detailer for these individual entities may allow for discussion on management of programming from different perspectives of payer, patient centered (advocate groups), societal perspectives, and clinicians receiving the behavioral change interventions.

Following a successful 3 year pilot targeting use of Mental Health Evidence Based Treatment recommendations, VHA has had an active year of hiring and training new academic detailers for national implementation. This commenced more rapidly following the interim Under Secretary for Health recommending all VA Healthcare Networks facilitate the infrastructure for delivering academic detailing. This came on the heels of congressional testimony noting Academic Detailing as an intervention utilized to address opioid prescribing.

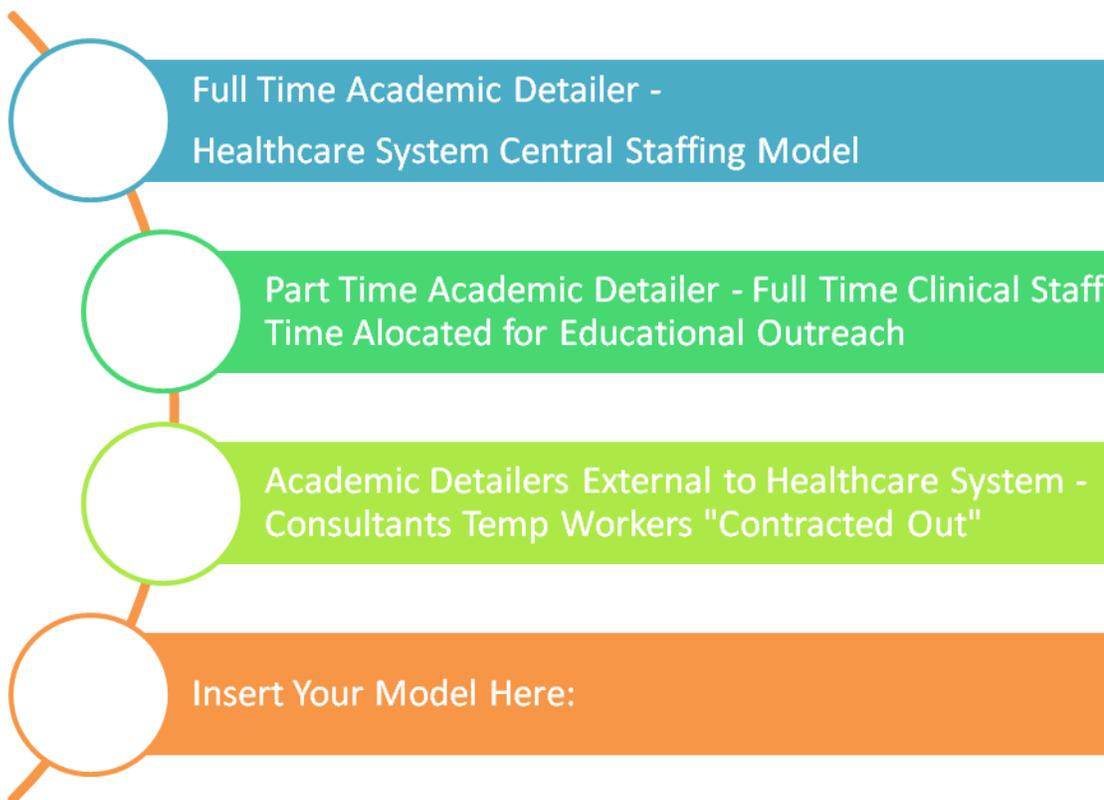Fill in other options you have used for implementing staff models of Academic Detailing

Full Time Academic Detailer -
Healthcare System Central Staffing Model

Part Time Academic Detailer - Full Time Clinical Staff Time Alocated for Educational Outreach

Academic Detailers External to Healthcare System - Consultants Temp Workers "Contracted Out"

Insert Your Model Here:

Figure 1 Hiring and Staff Models for Academic Detailers

These staffing models have pro's and con's worth discussing for considering how program managers may want to approach your strategies for establishing a workforce.

Mixed models are also for consideration where funding allows for some full time positions to partner with existing staff clinicians working collaboratively on the programming initiative.

A. Full time hired academic detailer: Most of these positions for our government program deployment are designated as clinical pharmacists many of which practice in VHA as prescribers and offer complex medication management services. Their clinical privileges offer expertise and experience in complex treatment areas within primary care, mental health, pain management, and various other chronic disease management models. A minimum hour of clinical practice may be carved out for the full time academic detailer to continue to use these skills they were notably recruited to have as an asset to the programming intervention. Typical time with patient care is ½ day to 1 day per week.

Pros:
1) Detailers demonstrate insight, are familiar with ordering/procedures and patient care culture, if recruitment allowed for identification of full time clinician within healthcare system.
2) "common ground" Additional active experience in practice allows for personal examples, so continuing to see patients but on a more limited scale has an organic aspect to shared experiences, while allowing for time to outreach to the clinicians.
3) Full time position allows for clear focus on mission with limited competing priorities
4) Time Flexibilities – with full time dedicated staff, allows for scheduling flexibilities with servicing clinicians to minimize conflicts in scheduling for face to face encounters. Additionally allows for time to travel to outlying community based clinics where longer time commitments may be required and with competing patient care priorities on a daily basis this could prevent outreach to further distance locations from detailers origin.
5) These staff have dedicated time in as a full time position to address barriers and provide resolution and follow up to the clinicians they are servicing. To proactively offer enablers the AD staff can work on implementing and resolving identified barriers and conduct for practice facilitation to assure this is a solution for the individuals' practice.
6) Doing it full time means you at times get better at this skill over time and have more practice at it, rather than performing It more infrequently, this is true in theory, but there is consideration to investment in ongoing skill development and coaching.

Cons:
1) Lower number of FTEE is assigned due to the financial commitment thus individuals are covering a larger territory, perhaps higher travel costs associated by using one lower number of staff.
2) Staff turnover with high amount of travel, typical healthcare practitioners in these positions may not be accustomed to the travel demands and the assigned workload with large catchment area of clinical staff. May be challenging to sustain individuals in this position over time.
3) Hiring within the system works well, but if externally recruiting you may find getting these individuals up to speed with the clinical demands of the job for their assigned time servicing patients, may be a larger investment initially. External candidates may not already have existing relationships and the start up time to gain access needs to be accounted for in delivery of time to change behavior
4) Start-up time to get clinical assignment if you choose to use this model and work through system requirements and training with infrequent clinical practice times can be something the employee has challenges adapting to and perhaps orientation and training may need to have more consistency to accommodate this for mastery of electronic medical record and procedures required in the patient care encounters.
5) Establishing performance metrics to determine programming success needs to be based in advance so outlining for these positions how much time is required for face to face visits versus the time they are resolving system barriers identified in their encounters. Expectations need to be clear so FTEE time is capitalized for face to face visits, otherwise this may be a management challenge.

B. Part Time Academic Detailers/ Full Time Clinical Staff

In this scenario assignments of allocated hours per week may be quite variable from week to week and position to position, if this is not preset as a condition of performance appraisals. Practicing clinicians with vested position in the healthcare system are identified as peer champions and conduct academic detailing at their local clinics and healthcare systems.

Pros:
1) Often already on the teams the campaign is intended to impact; rapport /relationship may already be an asset we have in place.
2) Clear insight into what the clinicians are dealing with and may bring additional experience identifying enablers they have tested and implemented in their own practice successfully.
3) Insider Knowledge to approach: Have the history on what has been tried, what was successful, and allows for further understanding and target on what to prepare for with objections clinicians may raise in discussion.

Cons:
1) Scheduling Issues: amount of time dedicated may now allow for flexible scheduling with 2 busy, practically full time healthcare providers
2) Carry over of patient care issues, and difficult to find an open spot for time to meet. 3)
3) Personalities and history with individual if servicing the broader team, may have baggage to deal with and can get in the way of the intervention
4) Challenging to see the person in another assign responsibility and time with provider gets redirected to other work they have together, off topic.
5) Even though time "dedicated" other assignments/workload in patient care take priority, and staff is pulled to cross cover or has too high of work load to carve out the educational outreach. (Scheduling system may prevent this if there is a way to make appointments in the same system, workload is more accounted for, but cancelled education vs. cancel patient, will still trump time/attention to patient care, and perhaps not actually do needed amount of detailing.
6) Barrier resolution, carve out for this is likely even less, so messaging occurs but barriers remain without dedicated resources to accomplish this
7) Existing staff assigned may not have the characteristics/talent you are recruiting for to accomplish this mission, a mismatch of talents and tasks assigned, skills may improve this but entirely solve to the point that recruitment would have allowed for with selection of candidates.

C. Consultants/Temp Workers/Clinical and Nonclinical Educators
Based on program design these hiring and staff model may be project based for minimum term commitment with pre – identified targets/goals/deliverables if set forth in the contract agreement. High likelihood the individuals will be outside of system and have outside supervision, with stakeholders requesting AD service as the customer of the consultant.

Pros:
1) One other model is to consider these positions as contracted out. No clinical assignments, only competing customers, motivated to satisfy the customer, focused on mission and reaching deliverable for incentives built into contracting agreements
2) May have contract based on incentives and allows for payment per hourly rate or built in accomplishments deliverables with productivity of executed educational outreach as well as metric based with noted rx changes accomplished.
3) Client base of clinicians, perhaps are curious to what this outside resource is offering them, lessons learned from other healthcare systems, new information sharing
4) Performs or Perish: may be a selling point for year to year funding that can be agreeable to payer stakeholders who want for flexibility for funding resources and priorities can shift from year to year.

Cons:
1) Temporary Staff/Consultants are outside hires, at times not vested by the system or managed by the system, steep learning curve to adapt to healthcare system they are servicing and may have delays with gaining access and following requirements for appointments.
2) Skill development and accountability investing in staff for training when consultant external to the system may not be executed.
3) Limited control on selection of consultant for best fit candidates, recruitment and hiring may be outsourced by contractor.
 4) Turnover could be higher; if contractor is not able to maintain same consultant, you may have challenges

Discuss in small groups what models/strategies you prefer for hiring and building of programming.

All of these hiring models discussed are based on programmatic design further points of consideration is type of education and experience of your detailer, healthcare discipline vs education and behavioral modification, criteria and qualifications you are searching for in an academic detailing team.

Influencers when Building your Team:

Strategies: Use of Peer to Peer Champions, Emphasis on Drug Experts, Team member to Team Member for leveraging existing staff.

Considerations for building team:
- Resources: What can we afford?
- Define your needs
- Do you have a need for high level of navigation from topic to topic?
- Are you deploying detailers for one topic mission for performance improvement? or
    - Is this an investment for sustained programming over time for quality improvement efforts?

Setting Performance Standards for Academic Detailers

Discussion questions
Do you set performance standards for number of minimum encounters of educational outreach sessions with priority clinical staff?
If yes, how do you determine the goals?
    Tracking Metrics/ Widgets on workforce platforms:
    Types of Academic Detailing Visits
    Repeat Visits
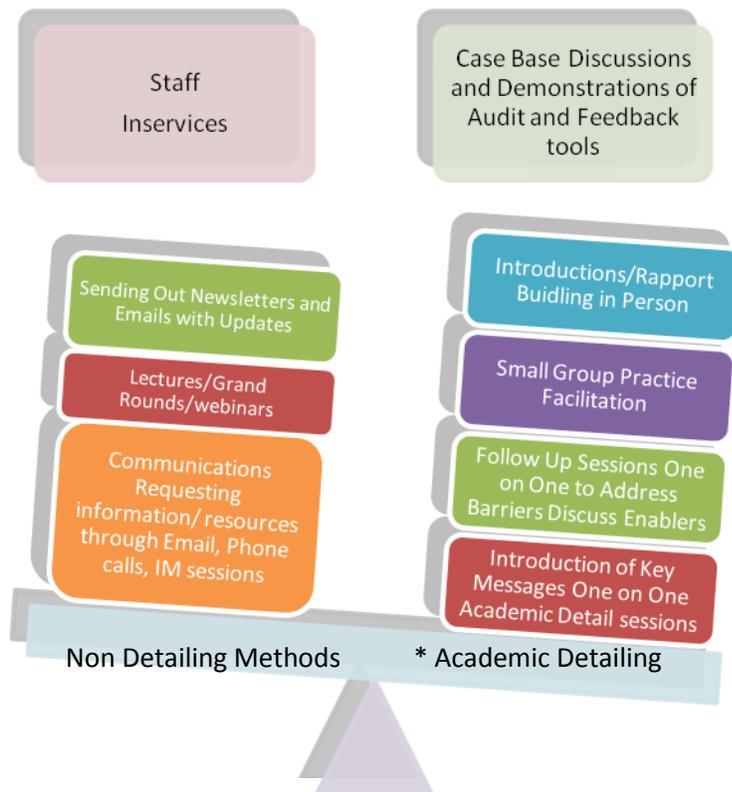   % of priority clinicians reached (goal setting?)
    Duration of visit
    Quantity of time in face to face one on one visit versus other type of educational programming

How do you manage/balance the propensity for staff to use non detailing methods to invite and build relationships to eventually engage staff in detailing interventions?
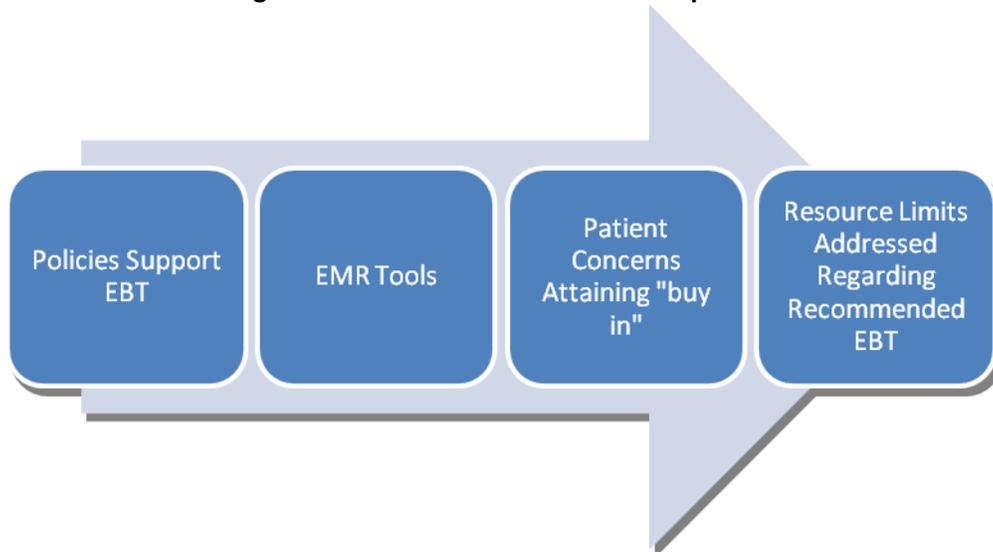
Discuss in your groups:
Who are key members to include when building your academic detailing team?

Staff Inservices

Case Base Discussions and Demonstrations of Audit and Feedback tools

Sending Out Newsletters and Emails with Updates

Lectures/Grand Rounds/webinars

Communications Requesting information/ resources through Email, Phone calls, IM sessions

Introductions/Rapport Buidling in Person

Small Group Practice Facilitation

Follow Up Sessions One on One to Address Barriers Discuss Enablers

Introduction of Key Messages One on One Academic Detail sessions

Non Detailing Methods   * Academic Detailing

Productivity Data: Program Managers approach to addressing when this is heavy on the non-detailing methods "efficient methods to blast email, not necessarily effective". What approach works best to keep this balance? How do performance metrics contribute to this balance?

Allocating Time to Address Barriers & Develop of Enablers:

Policies Support EBT

EMR Tools

Patient Concerns Attaining "buy in"

Resource Limits Addressed Regarding Recommended EBT

Hiring: **What to look for in an academic detailer:**

What do you think are the most important qualities to look for in an academic detailer? (breakout)

1.

2.

3.

4.

5.

Honorable mentions:

What are some barriers and enablers to obtaining suitable detailers?

Canadian Academic Detailing Collaboration Revised - June 2014

This *Code of Conduct* recognizes the need for a commitment to excellence in the delivering of academic detailing as a professional service. Through such service, valued and effective relationships are built, and evidence informed, patient-oriented therapeutic decision making is enhanced.

1.   Be prepared to provide accurate, informative, practical and balanced information

2.   Be responsible, reliable and respectful of time and commitments

3.   Seek first to understand and empathize

4.   Be respectful of differences of opinion and hold them in good faith and confidence

5.   Be attentive and responsive

6.   Follow up as necessary in a timely manner

7.   Remember to be thankful and express it

8.   Always maintain confidentiality and respect the privacy of physicians, patients and staff

9.   Remember, you are a guest of the person(s) you are visiting

Observations from Physicians

1) *You ask a couple of good questions and you're right, I have seen 4 different people but I have to say that all were excellent so I don't really have a 'poor model' for comparison. I think what each of these 4 had to offer that was particularly impressive was a very thorough understanding of each topic and an in-depth knowledge of the literature. For most of us, we have limited time and want to hear about what is new and up and coming in trials that we might not have time to access ourselves. I have always found the detailers to be very flexible and interactive in their approach to sessions and able to focus on the interest of the particular physician while still doing a good overview of the topic as a whole, I think that is 'what makes a session work'. On the rare occasion that I have had a question that the detailer couldn't answer they were always willing and eager to look it up and provide me with a timely answer which is great. For physicians new to the program (like my colleagues here in Calgary) I think it is important in the first sessions to go over how the program works and particularly how to use the charts. There is so much good info there and once you know all the symbols and how they are laid out it is easy to access but I know that my new colleagues find it a bit intimidating. Providing info on local resources is also very useful where applicable. The thing that I really appreciate about the program is the fact that it is non-biased and provides info about a topic as a whole and all of the drugs used in that particular area rather than the shotgun, biased approach used by conventional detailers. I know I can trust the info I get from you guys!!*

Hope that wasn't too much of a ramble and gives you some useful info. Thanks again for pioneering such a great program!

2) *I like your service. You're not out to sell me anything, but I don't feel you're out to slap my hands either!*

3) *I felt I wanted to incorporate the recommendations into my practice, rather than I had to.*

Basic Training in Academic Detailing
Our experiences with basic training

Melissa	Loren

New Onboarding Process
 	
Minimum Level of Training:
   1. Two day workshop on basic skills with interactive practice sessions
   2. Required readings establishing methods, evidence behind intervention and results achieved
   3. Review of Topic Content on Active Campaigns for Deployment and mastery for engaging key messaging.
 	
Advanced Level
   1. Workshop skill building in Practice Facilitation
   2. Coaching Mentoring through active detailers delivering services along with supervision.
   3. Outside programs for consultation – NARCAD
   4. Content Training didactic sessions with expert speakers allowing for open discussion on methods to address barriers and common questions for implementation in practice settings.
 	
Regional training in geographical territory
      Allows detailers to bring together larger groups of detailers to share best practices, covering advanced training topics, interactive involvement with journal clubs and practice sessions and including key provider champions within target areas for building strategies.
	New Onboarding Process
	
	Minimum Level of Training:
	
	Similar except
	- 2-3 day basic skills workshop
	- Intro to Academic Detailing - Webinar discussion
	- Shadowing academic detailer for 1-2 days with reflection and discussion of critical areas
	
	Advanced Level
	
	Similar except
	- Advanced workshops, with other Canadian Academic detailing groups – including tracks for topic preparation, and detailing

Academic Detailing Training - Practical Issues

Booking Visits

Who to start with
How to contact (Phone/Fax/Email)
How to try again
Receptionist's name
One on one versus small group visits

Pre-Visits

Confirm option
Promptness
Flexibility
Patience

Visits

◆Opening questions:
- Did you have a chance to read the newsletter?
- Did you have any questions about this area that have arisen from your practice
- To what extent do you deal with this topic area?

◆Opening offer:
- Do you have anything specific you would like to discuss or would you like me to highlight key points for you?

◆Time conscious- ASK – 15-20-30 minutes, body language, waiting room awareness
◆Know 2-3 key points to cover
◆Have something very new or unknown in your "bag" of info – for the Dr who knows it all
◆Invite feedback, questions, opinion, and diversity
◆Respect unique cases
◆Offer to follow up on items as necessary
◆Work for success & impact down the road

Post-Visit

How can you add value to the visit?
- Q&As
- Refs
- Info on other topics
- Thank you note
- CME documentation

Ongoing Topic Training/Upskilling

1) Background reading
    a. How much?
    b. Original literature?
    c. Upskilling evidence documents?

2) Input into topic materials

3) Webinars / Styles of Upskilling

4) In-person training
    a. Role of information expert
    b. Role of topic specialists
    c. Role of clinicians similar to target clinicians
    d. Ideas
        i. Debate
        ii. Mini-presentations
        iii. Critical appraisal
        iv. Devils advocate
    e. Role of "role play"
    f. Advanced Workshops – Around Academic Detailing Topics (see Appendix agendas)

5) Ongoing mentoring, networking, follow-up and support

Anticipating and Answering Skeptics Questions /Challenges

Who says we need this? Who are you?

Around Evidence

- Doesn't evidence change way too much to be trustworthy?
- What methodology did you use?
- How can you make a recommendation when the evidence is so weak?
- I believe in the "art" of medicine!

Around Guidelines

- Guidelines are just cook book medicine!
- Why do guidelines based on the same evidence differ?
- I've been burned by guidelines before so why should I follow them?

Around Industry

- What does industry think about you?

Around Government

- Does your funding come from government and if so, doesn't that result in a bias all of its own?

Constructing program evaluation plan may be approached or tailored to your stakeholders' requirements. What do your stakeholders want to know about the outcomes of this intervention?

1) Provider Response – What did they do, what is their feedback, what was their satisfaction, what was their participation?
2) Prescription pattern changes, timeline vs sustained
3) Patient Level outcomes – improvements achieved
4) What were the key influencers to responders vs non responders
5) What characteristics of campaign strategy influenced the impact the AD programming?
6) Cost-effectiveness Analysis – was there a return on investment

Designing evaluation up front for real time data collection
A) Workload Productivity Data –Managers may use this to understand what is working and not working to modify strategy mid campaign or redirect programming efforts.
   a. Tracking educational Outreach
   b. Tracking Costs
   c. Tracking Patterns and outcomes
   d. Tracking non outreach activities, barrier resolution
   e. Tracking non detailing actions

B) CRM – Customer Relationship Management System
   a. Broadly available technology consider investment and distribution to workforce
   b. Costs need to be considered and design impact on how this data and productivity is used
   c. Consider including data on distribution of provider and patient level resources to understand reach of programming
   d. Qualitative data on information identified through ad sessions may be analyzed although without a systematic collection process may be more challenging to draw conclusions.
   e. Additionally offers platform for information exchange – characteristics of healthcare system down to individual provider information to gain commitment to behavior change.

C) Comprehensive tracking for prescribing data trends, lab data, utilization of healthcare resources
   a. Many uses of this information from audit and feedback, to population management and further analysis of programming impact.
   b. Post campaign analysis – one approach is using a methodology of interrupted time series analysis to determine effect of intervention predefine metric of response.
   c. Post campaign analysis of patient reported vs chart/documented collected, may be more labor intensive and not always a part of typical and customary care.

D) Cost effectiveness analysis
   a. Design to answer common stakeholder questions: Was the investment in Academic Detailing Intervention worth it? What did we accomplish? What did that cost?
   b. These analyses can be costly, although are often desired by stakeholders for ongoing funding commitments. Often earlier surrogates with modeling are involved to identify if prescribing changes or practice changes implemented occurs does this translate into cost impact (cost avoidance/cost savings).

<div align="center">**Best Practices vs Best Performance Reporting**</div>

Best Practices:
- This can be an area with great opportunity to share programming successes. With various practice models across your healthcare system there is a lot to learn from provider to provider, and sharing this builds coalitions where others can draw on the lessons learned from others.

- Academic Detailers can share not only what they have found to be effective at influence behaviors, but additionally providers can share their application of the evidence based practices and how they successfully implemented the change in their own practice setting. These allows for breaking it down into tangible steps, and may enable you to overcome the feelings of being overwhelmed with the thought of starting a new approach/practice/drug therapy, etc.

- Markers to identify these best practices may be part of your program monitors. Whether that is trending individual providers prescribing trends or identifying patient laboratory results where improved responses/results are found, trending this data is the surveillance approach to identifying where to start to perhaps find a best practice.

- What's important is vesting those trends and having the detailed information on the methodology applied to impact trends. Depending on your campaign objectives it can be challenging to acquire these data points and either labor or resource intensive when building this into your surveillance plan.

Best Performance Reporting:
- Highlighting trends across your healthcare system is method applied in many AD programs. These tools can be used as an audit and feedback approach, for management review of impact and progress, as well as an influencer to academic detailers to keep their eye on the goal of achieving results driven outcomes.

- There are pitfalls at times that happen with setting arbitrary targets or data integrity concerns. These need to be addressed with stakeholders and customers to effectively use best performance reporting.
- Performance metrics aligned through leadership incentives (director bonuses) gain more attention with the carrot approach. This also creates pressure and there can be unintended consequence to change that occurs in perhaps an unsanctioned method leading to the opposite of an improved health outcome but a medication misadventure.

- Population management tools may be built into this performance reporting as additional tools for the medical home/ healthcare team to engage as a proactive model of change. Allowing for a more rapid uptake for proactive measures. Anticipating and creating strategies to reach patients for assessment shifts the focus from applying this evidence based recommendation only to those who you currently are scheduled to see, to optimizing available patient appointment slots and inviting the patient to review in a shared decision making approach the evidence based recommendation and what the next steps may look like if together they determine a change is needed.

Other Considerations Parking Lot Discussion:
- How do programs handle: New employee orientation?
- Virtual Management and Limited Travel Budgets
- Competing priorities – too many options of topics, and shifting quickly from introducing one topic before gaining results in achieving change in behaviors.
    - Assumptions: We commit to Opioid Safety for 18 months) – is this long enough to sustain change? How do we know this is long enough? Preset commitments vs ongoing surveillance.

- What is the amount (goal) visits for # of providers # of visits/provider you want to set for each campaign, how do you determine it varies based on topic, what is the criteria for this?
- Pressures to achieve results quickly versus building an investment in ongoing quality improvement.
    - Do we create system pressures to respond to programming with unintended consequences? How fast is too fast? How slow is too slow?

Co-Leaders Contact Information for Break-Out Session Program Management NaRCAD 2015

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