Academic Detailing for the Opioid Epidemic

DON TEATER

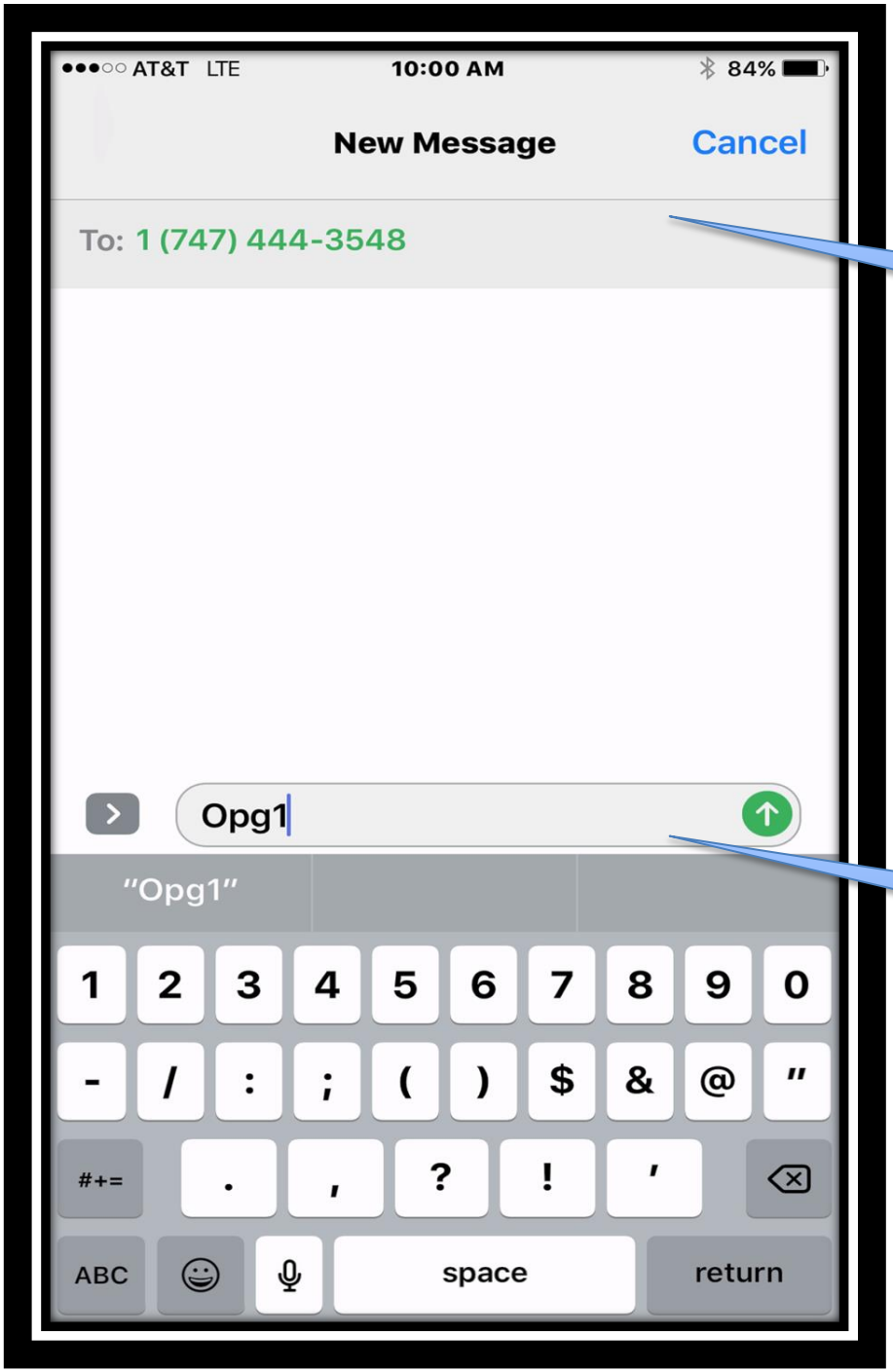
NADEJDA RAZI-ROBERTSON

SKYE TIKKANEN

ALETA CHRISTENSEN

NaRCAD's International Conference on Academic Detailing

November 7th, 2017



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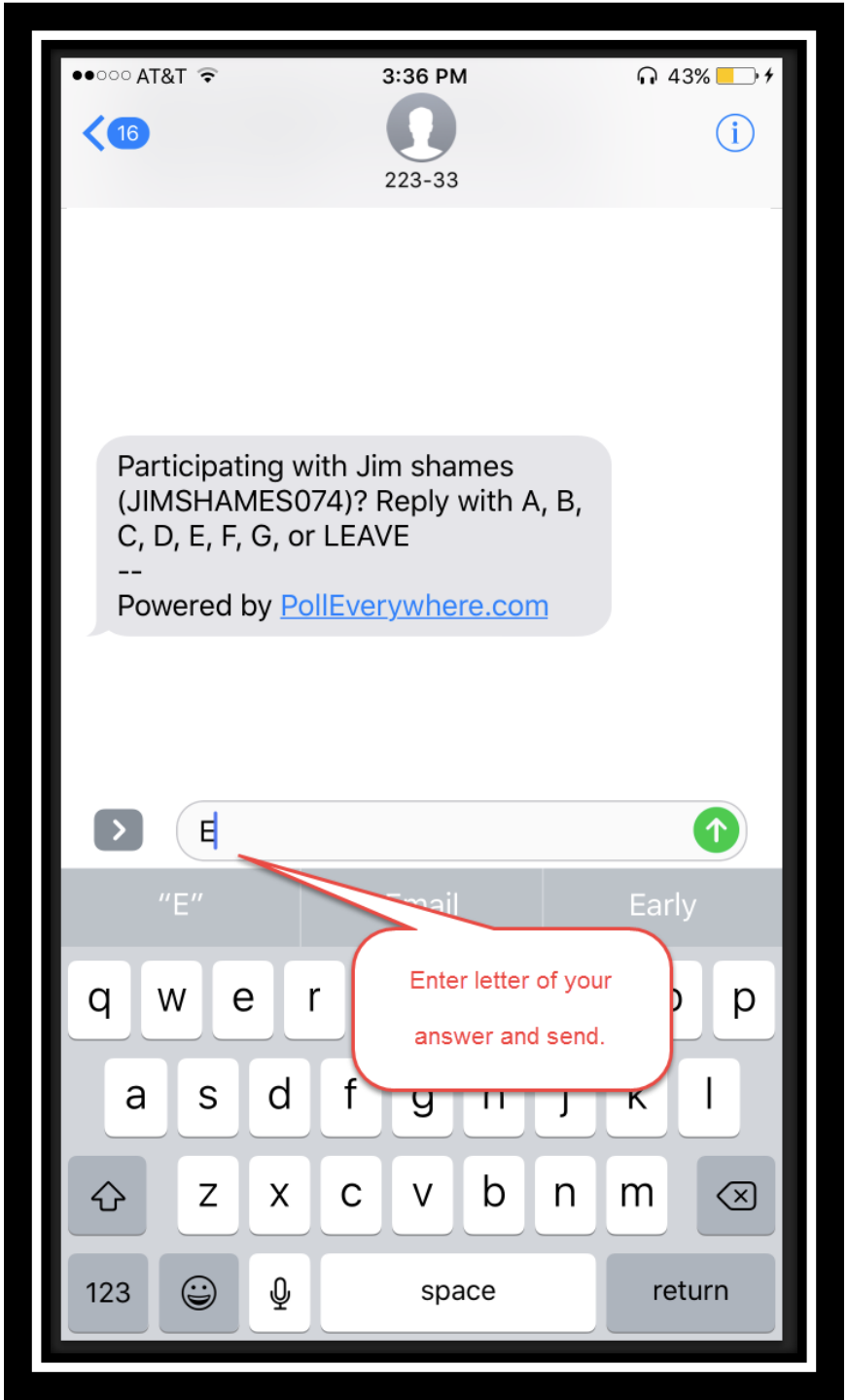
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any times have you attended NaRCAD's confe

First time!

2 previous conferences

3 previous conferences

4 previous conferences

Never missed one!

Start the presentation to activate live content

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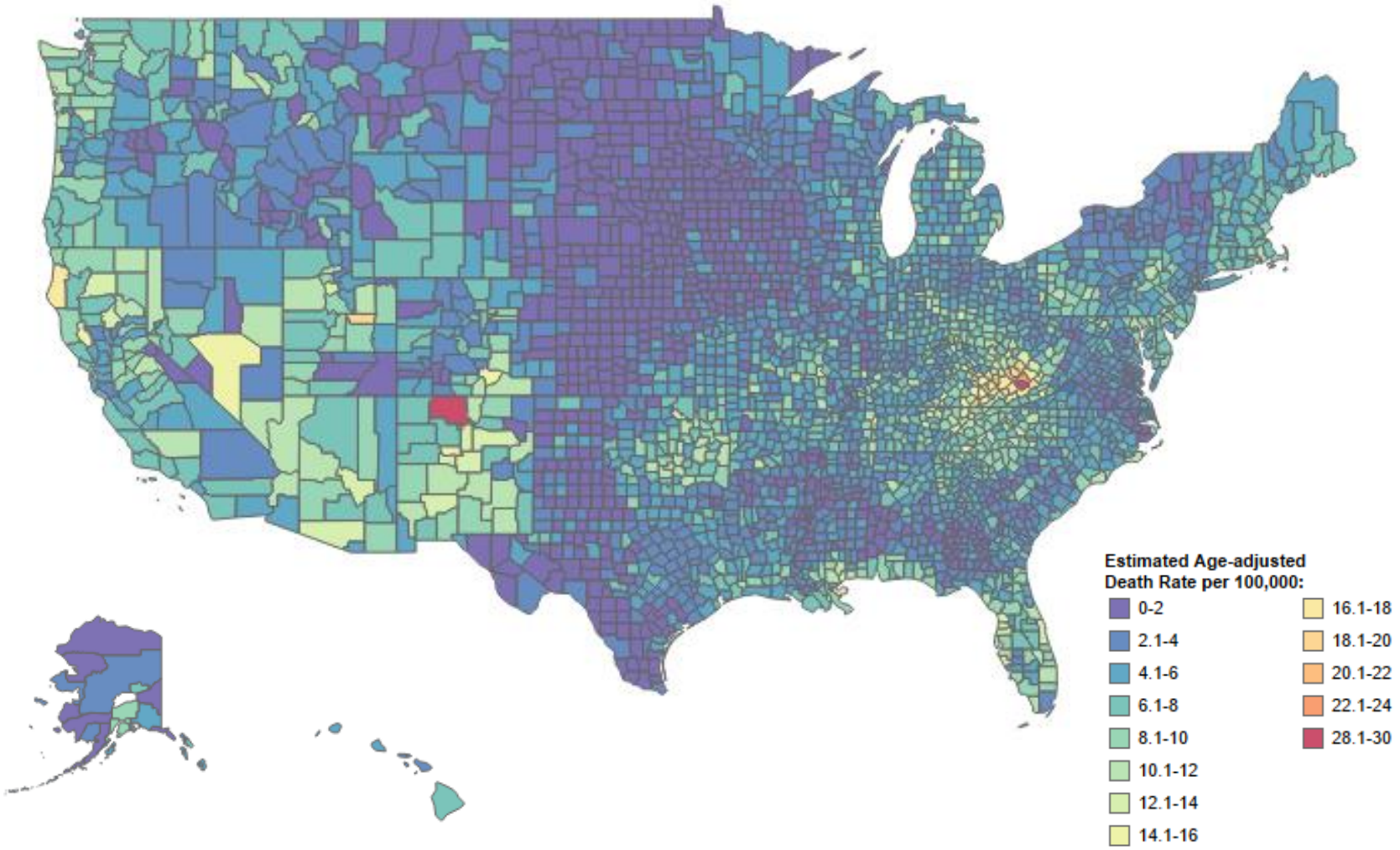
The Opioid Epidemic in the United States

CDC Response

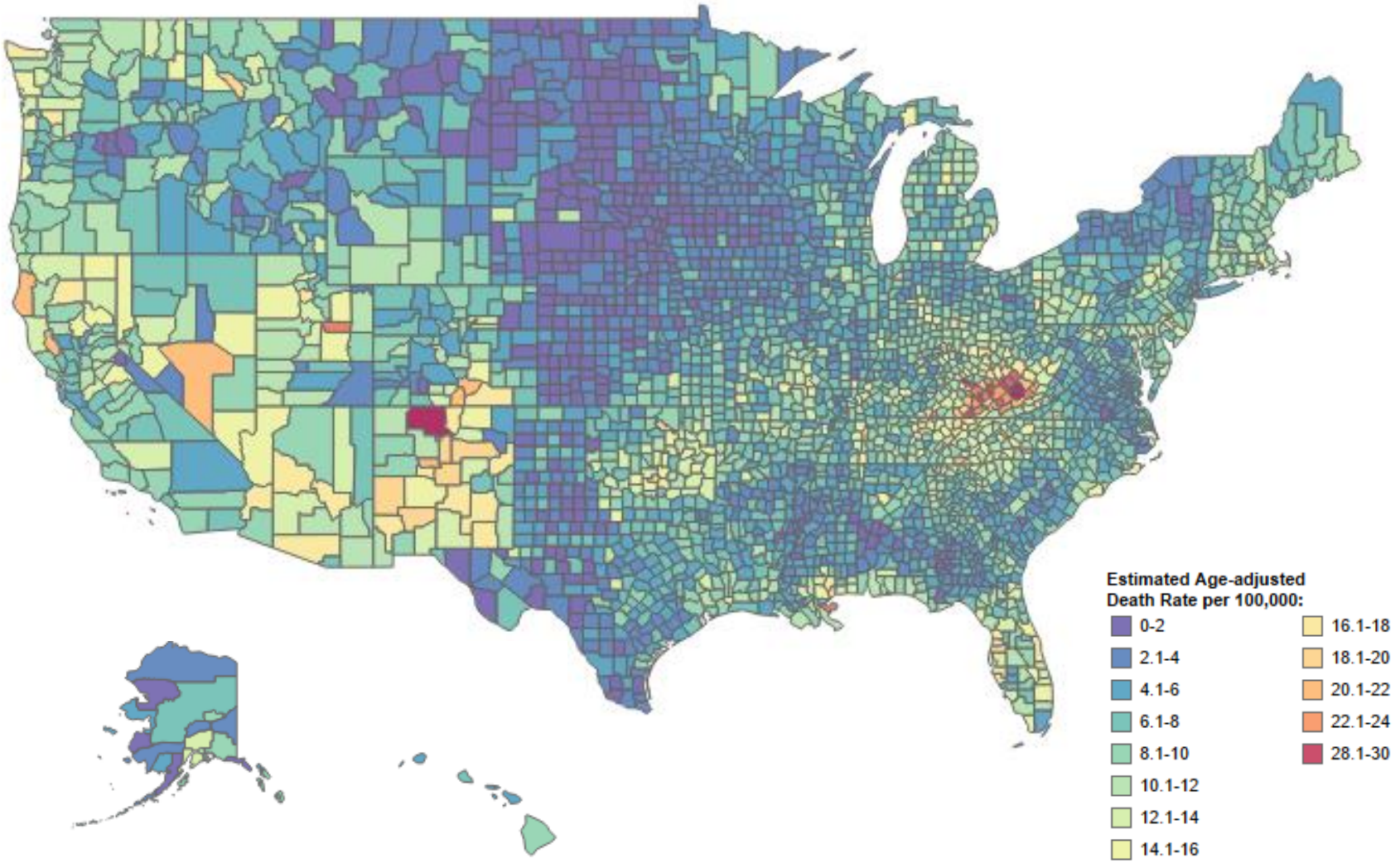
Aleta Christensen, MPH
Behavioral Scientist
Unintentional Injury Prevention

2000 Rapid Increase in Drug Overdose Death Rates by County



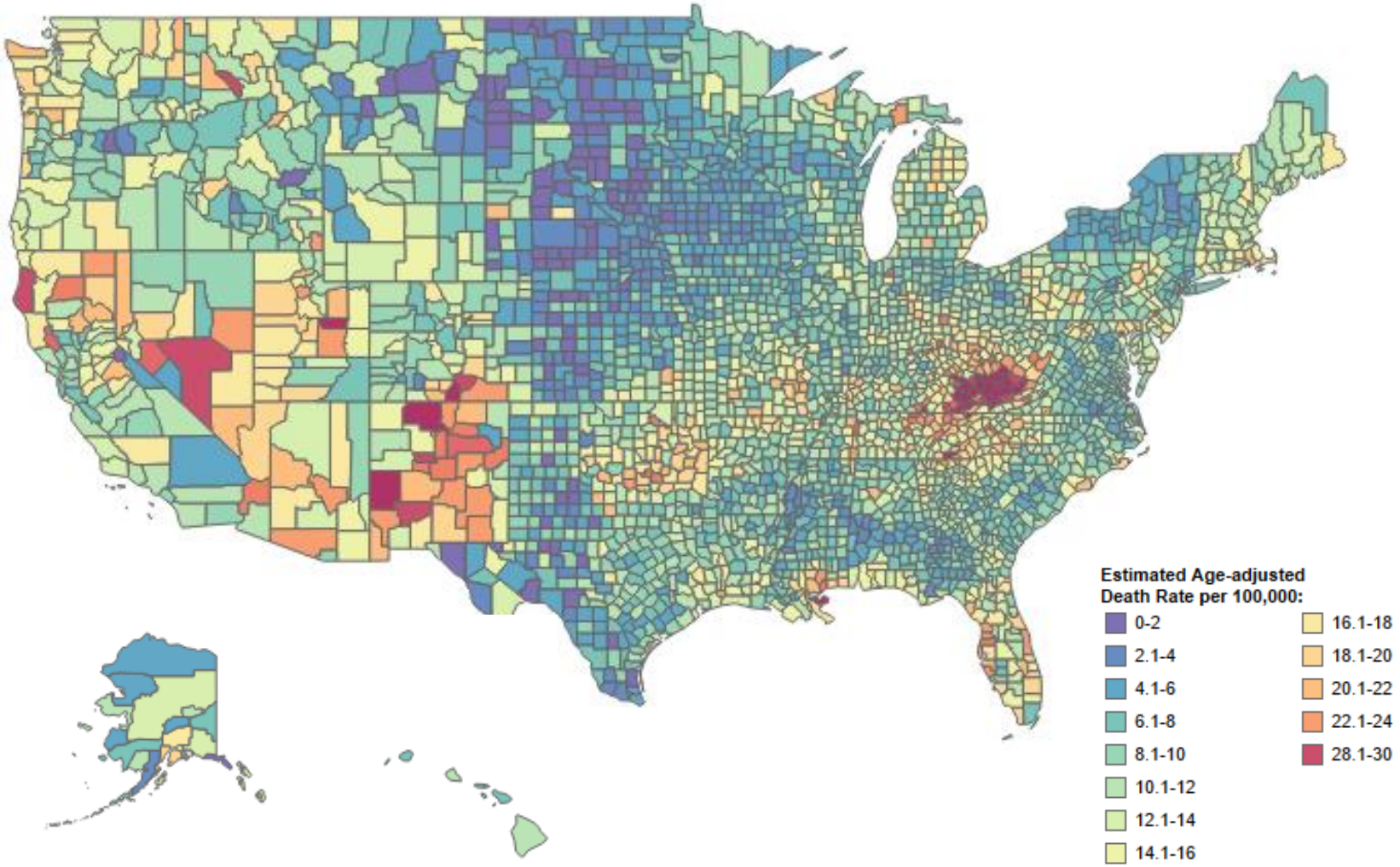
SOURCE: NCHS Data Visualization Gallery

2005 Rapid Increase in Drug Overdose Death Rates by County



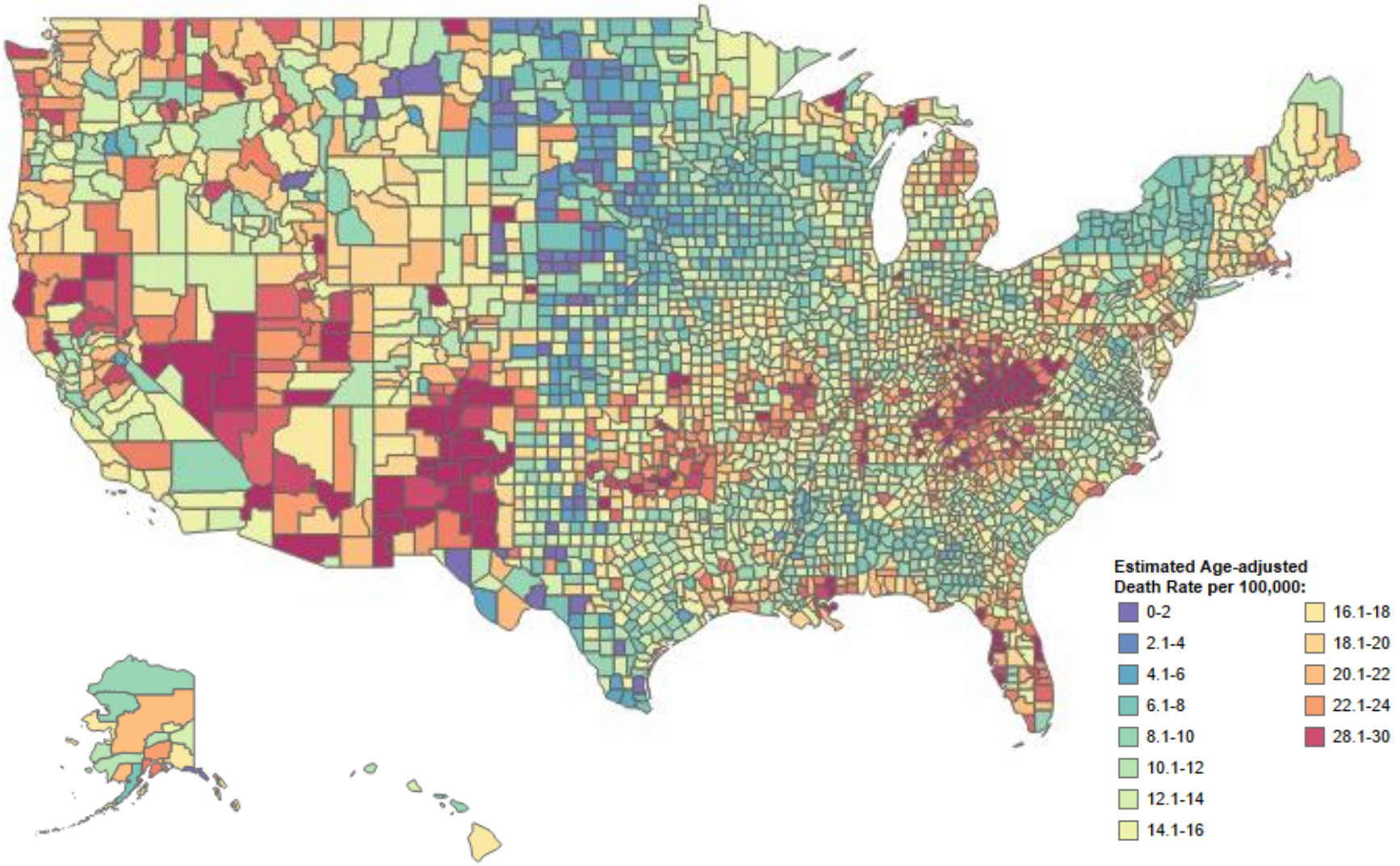
SOURCE: NCHS Data Visualization Gallery

2010 Rapid Increase in Drug Overdose Death Rates by County



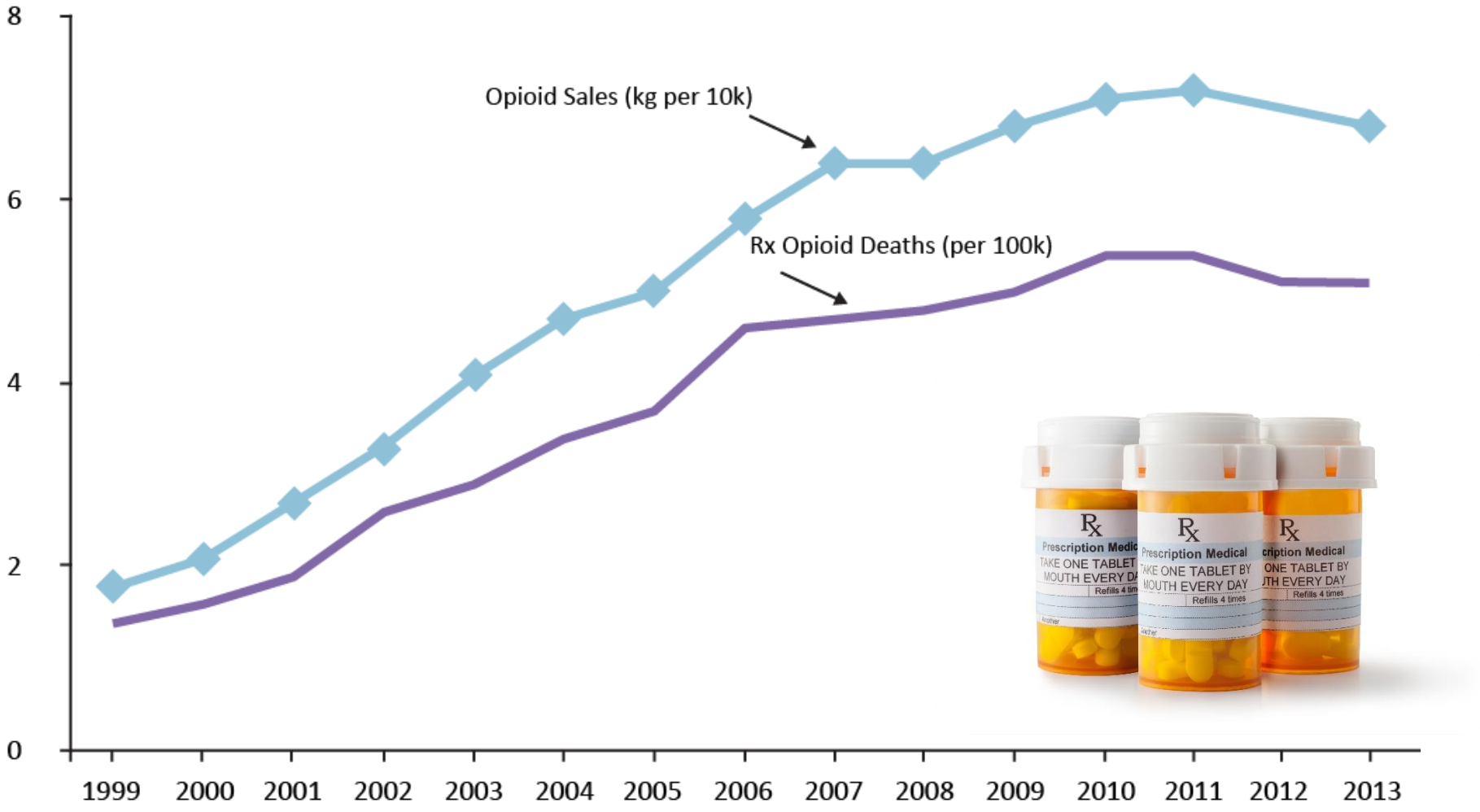
SOURCE: NCHS Data Visualization Gallery

2015 Rapid Increase in Drug Overdose Death Rates by County



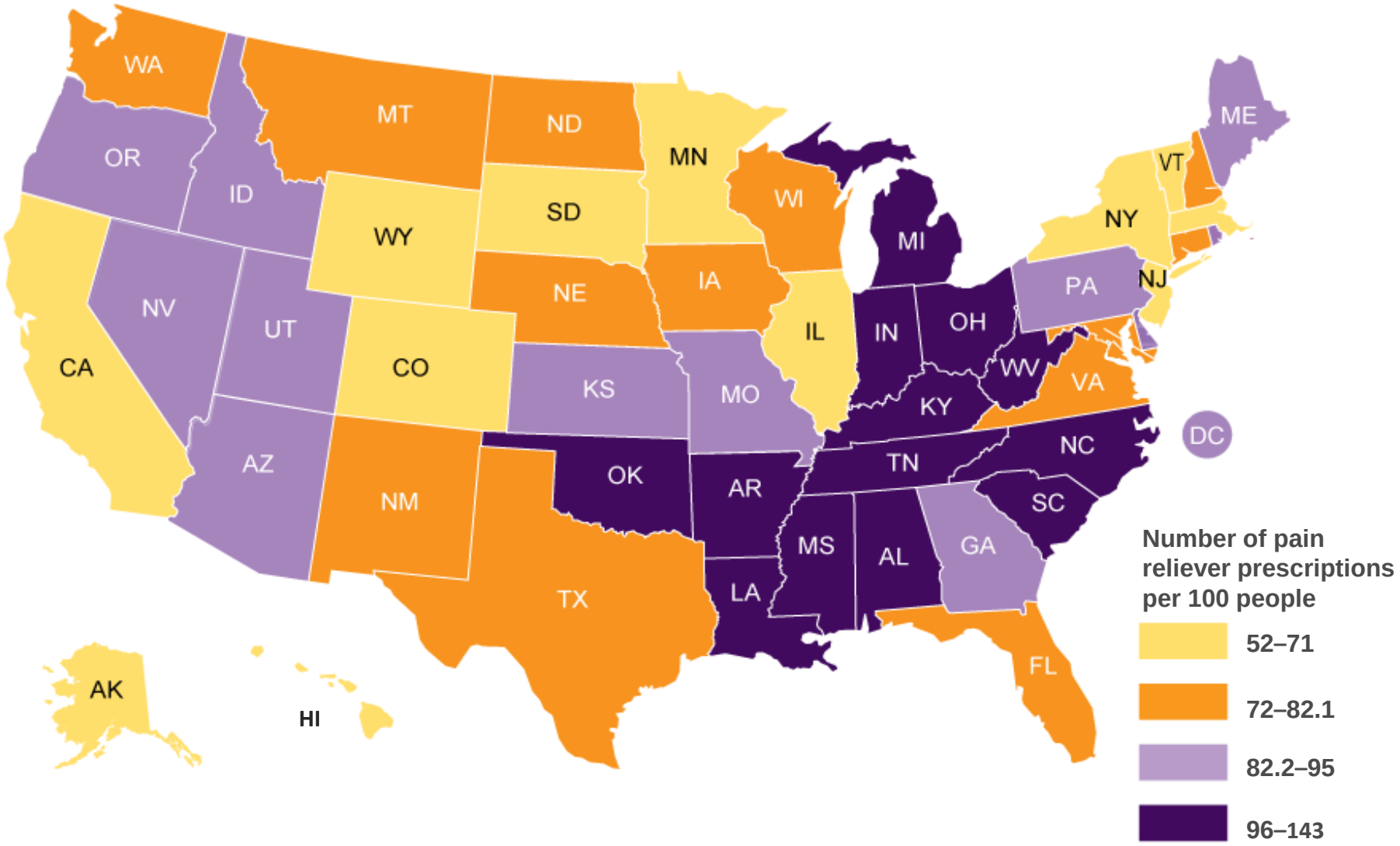
SOURCE: NCHS Data Visualization Gallery

Sharp increases in opioid prescribing coincides with sharp increases in Rx opioid deaths



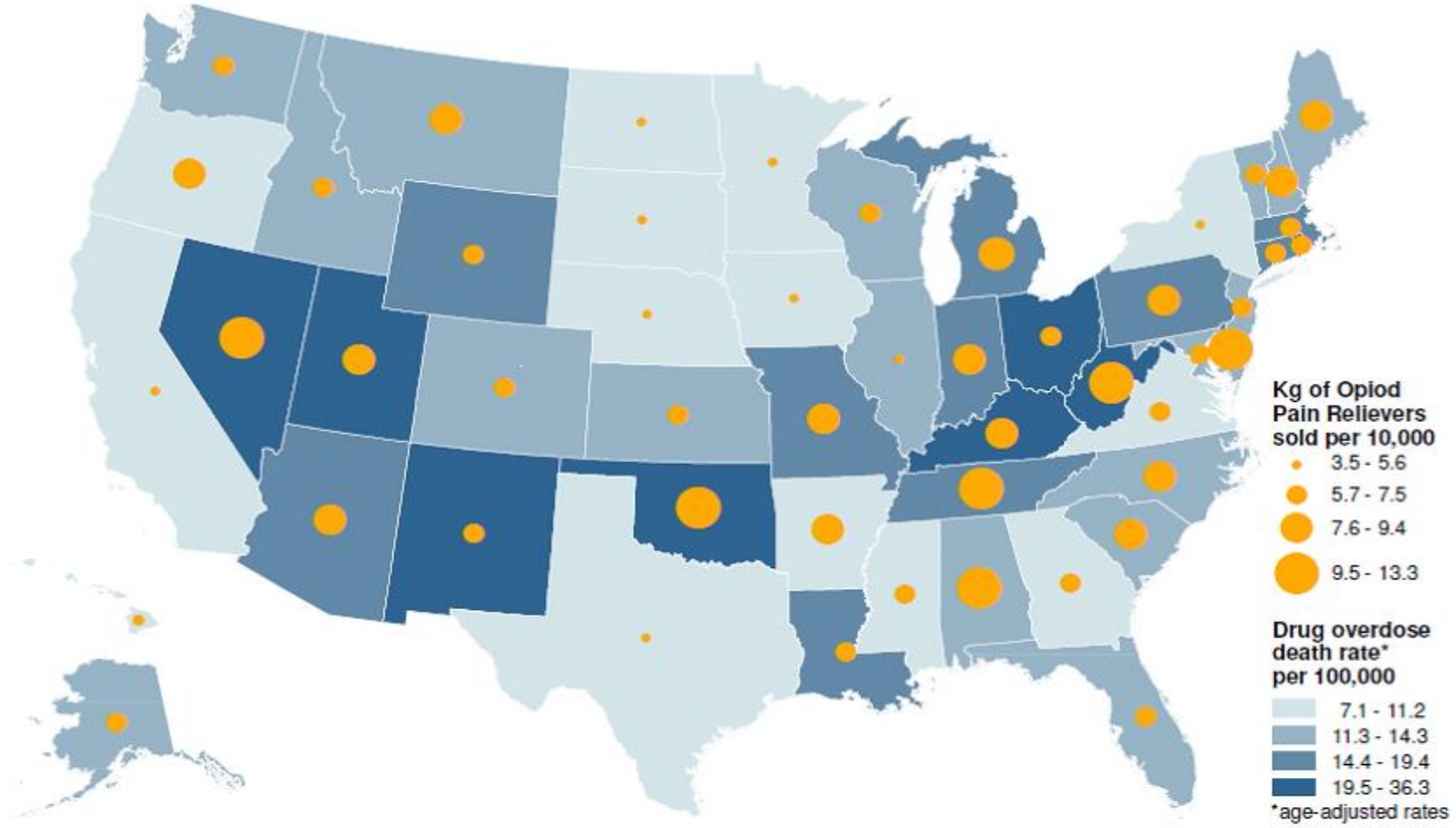
National Vital Statistics System, DEA's Automation of Reports and Consolidated Orders System

Opioid prescribing can vary 3-fold across states



Paulozzi et al. (2014) MMWR 63(26), 563-8.

States with more opioid pain reliever sales tend to have more drug overdose deaths



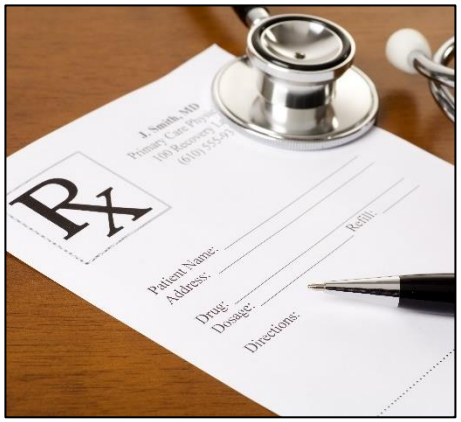
Death rate, 2013, National Vital Statistics System. Opioid pain reliever sales rate, 2013, DEA's Automation of Reports and Consolidated Orders System

GRASP

specific strategy that is being used in respon
opioid crisis.

Pillars of CDC Activity

- **Improve data** quality and track trends
- **Strengthen state efforts** by scaling up effective public health interventions
- **Supply healthcare providers with resources** to improve patient safety
- **Partner** with public safety
- **Raise awareness** about risks of opioid misuse and abuse





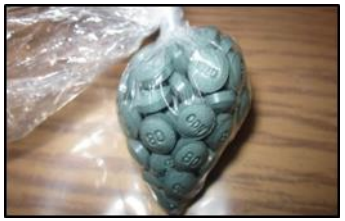
Enhanced State Opioid Surveillance (ESOOS)

- 33 state health departments

- Strategy One: increase timeliness of non-fatal opioid overdose reporting
  - Emergency department and discharge data (ED)
  - Emergency Medical Services (EMS) data
  - Three indicators: suspected all-drug, opioid, and heroin

- Strategy Two: increase timeliness of fatal opioid overdose reporting
  - Death certificate and Medical Examiner/Coroner (ME/C) report abstraction

- Strategy Three: widespread dissemination



Data Driven Prevention Initiative (DDPI)

- **Awarding $18 million over a 3-year period to 13 states and District of Columbia* to:**

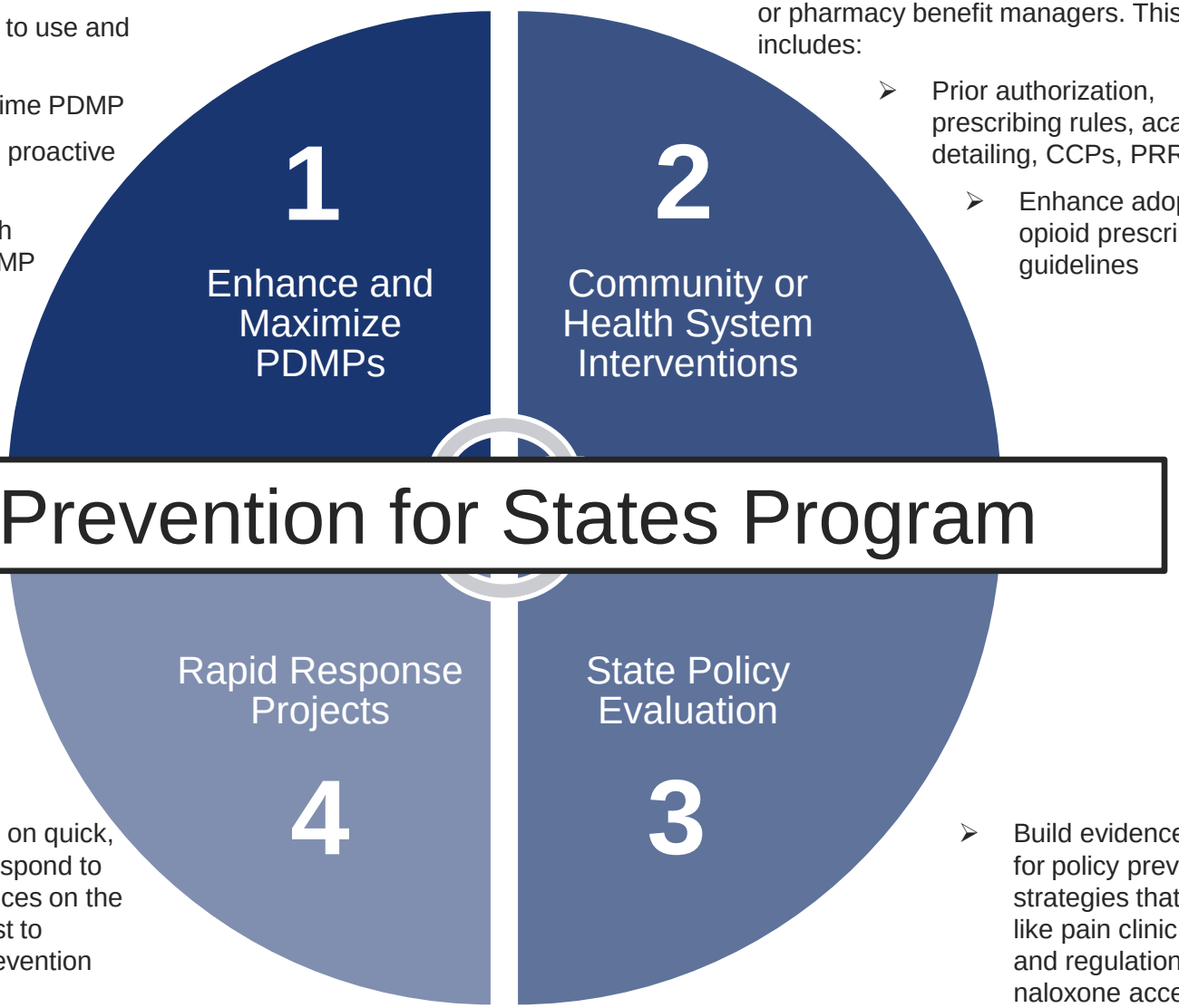
  - Improve data collection and analysis around opioid misuse, abuse, and overdose.

  - Develop strategies that impact behaviors driving prescription opioid dependence and abuse.

  - Work with communities to develop more comprehensive opioid overdose prevention programs.

*Alaska, Alabama, Arkansas, Georgia, Hawaii, Idaho, Kansas, Louisiana, Michigan, Minnesota, Montana, New Jersey, and South Dakota, Washington D.C.

Prevention for States Program



- Move toward universal PDMP registration and use
- Make PDMPs easier to use and access
- Move toward a real-time PDMP
- Expand and improve proactive reporting
- Conduct public health surveillance with PDMP

- Implement or improve opioid prescribing interventions for insurers, health systems, or pharmacy benefit managers. This includes:
  - Prior authorization, prescribing rules, academic detailing, CCPs, PRRs,
  - Enhance adoption of opioid prescribing guidelines

- Allow states to move on quick, flexible projects to respond to changing circumstances on the ground and move fast to capitalize on new prevention opportunities.

- Build evidence base for policy prevention strategies that work like pain clinic laws and regulations, or naloxone access laws

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 1
March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

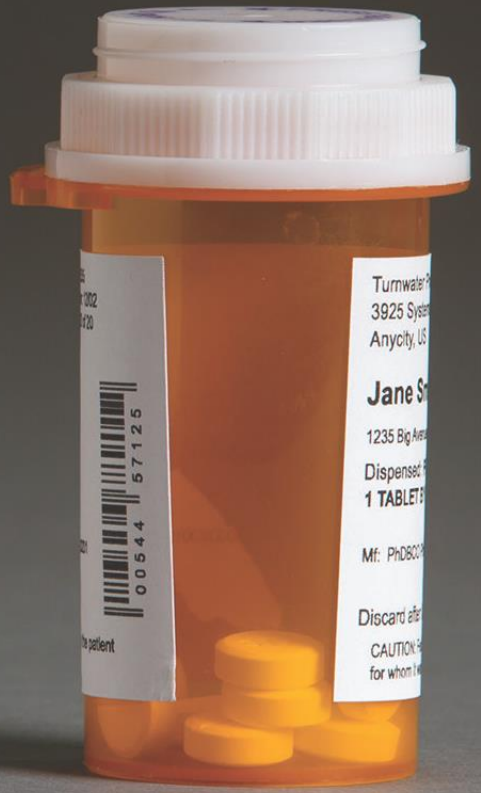
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

www.cdc.gov

CHANGE YOUR COMMUNITY'S FUTURE FOR THE BETTER

TAKE PART IN THE CDC Rx AWARENESS CAMPAIGN.

Get ready-to-use, tested campaign materials and tips in the CDC *Rx Awareness Campaign Toolkit.*



Trailer

Opioid Detailing

DON TEATER MD, MPH

ould you describe a patient/individual on lon opioid therapies in one word?

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Why opioid detailing?

- Prescribers get little education on diagnosing or treating pain.
- Prescribers get little education on the efficacy or side effects of opioid pain medications.
- Prescribers do not understand addiction.
- Small changes can make a big difference.
- It’s a public health emergency!

at kind of interaction do you have with patie

I am a clinician.

I detail clinicians.

I supervise clinicians or detailers.

I am a patient.

other

Start the presentation to activate live content

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Case presentation:

37 y.o. female

- Patient presents with concerns of chronic pain, pounding heart, shortness of breath, migraine, and fatigue.

Case presentation:

Medical history

- Patient has a history of IV heroin and cocaine use
- History of frequent office visits for similar symptoms

Case presentation:

Social history

- Patient works but has frequent absences from work due to health concerns.

What is your first impression?

Start the presentation to activate live content

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Case presentation:

Current problem list:

- 300.02 Generalized Anxiety Disorder
- 309.81 Post Traumatic Stress Disorder
- F11.20 Opioid Use Disorder
- F14.20 Cocaine Use Disorder
- R53.83 Fatigue
- 338.29 Other Chronic Pain
- 346.90 Migraine Unspecified

What is your clinical impression?

..elapse of substance use

Acute anxiety with generalized anxiety disorder

Histrionic personality disorder

Someone that I really don't want to see today!

Other diagnosis...

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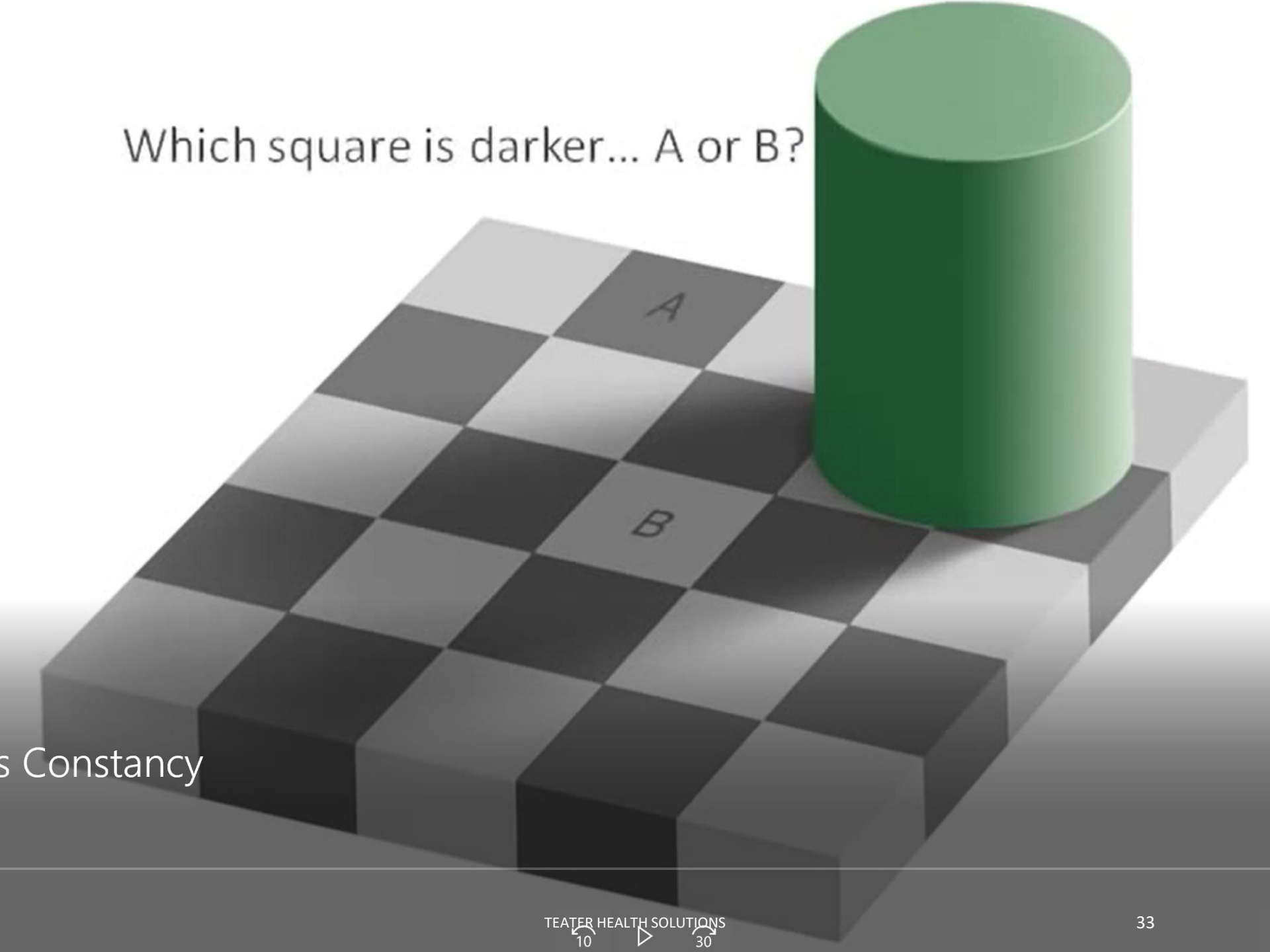
Why do we have stigma?

Our brains compartmentalize life in ways that we can understand it.

Why do we have stigma?

The following slides give us a visual experience of how our brains compartmentalize our perceptions.



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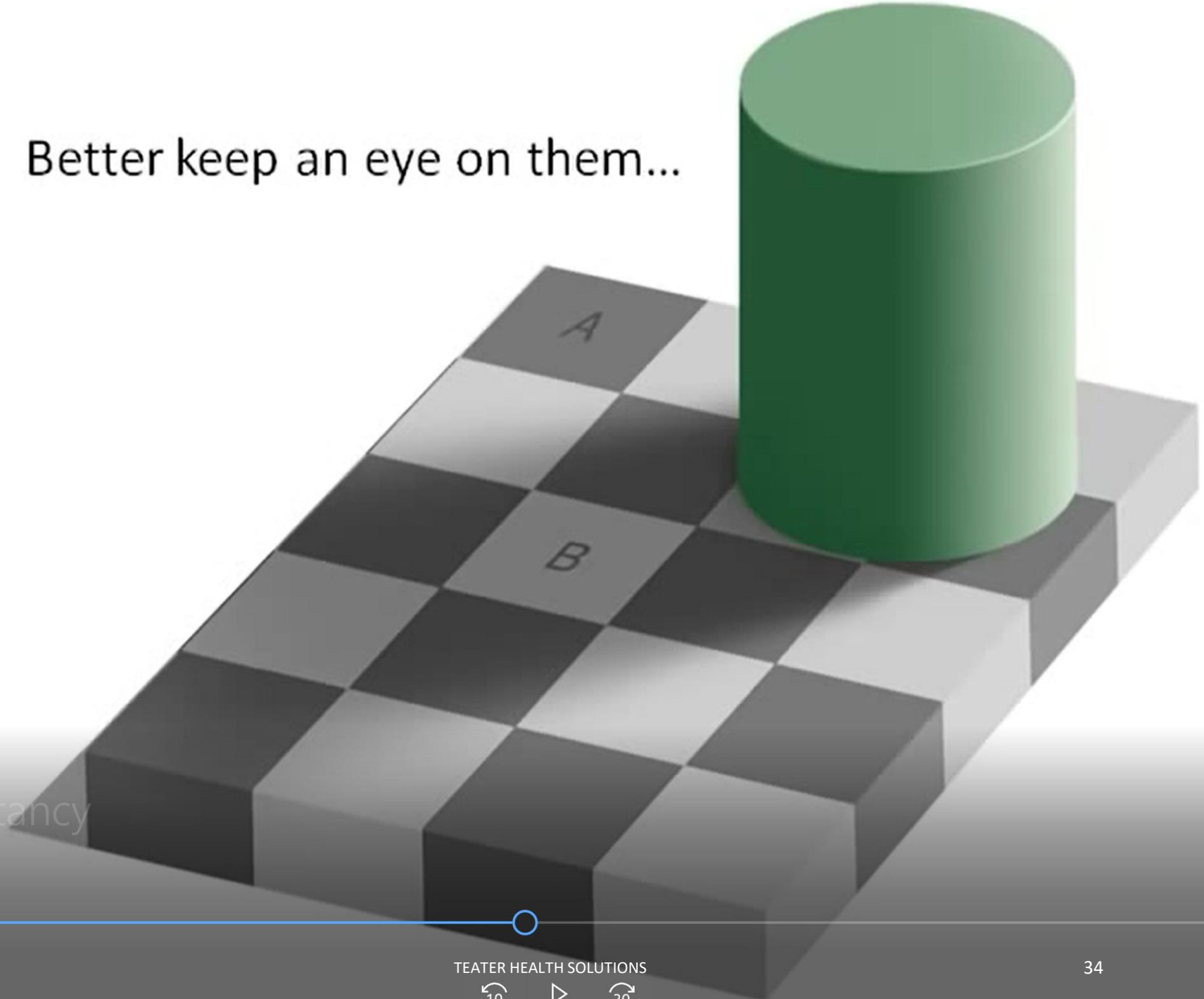
Better keep an eye on them...



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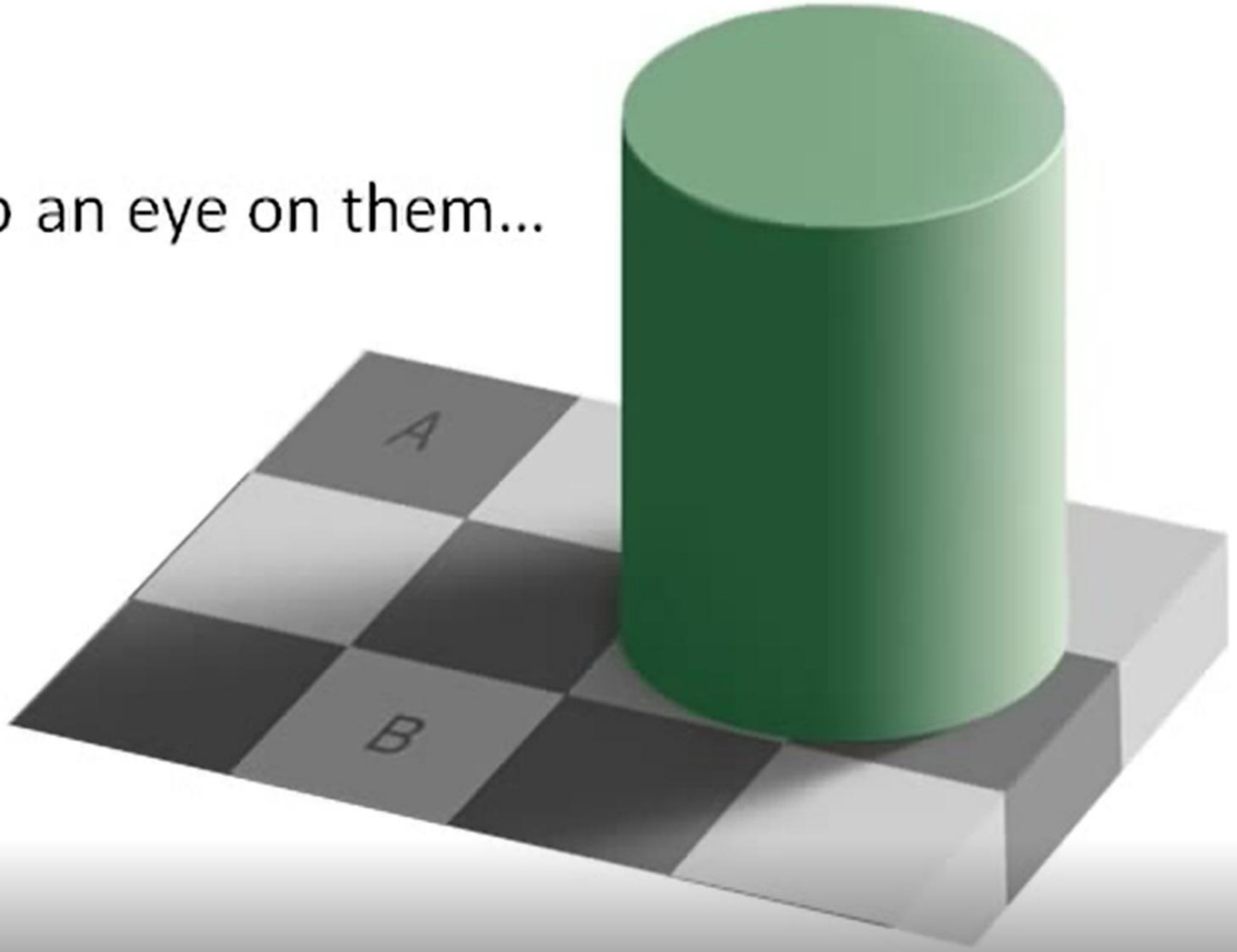

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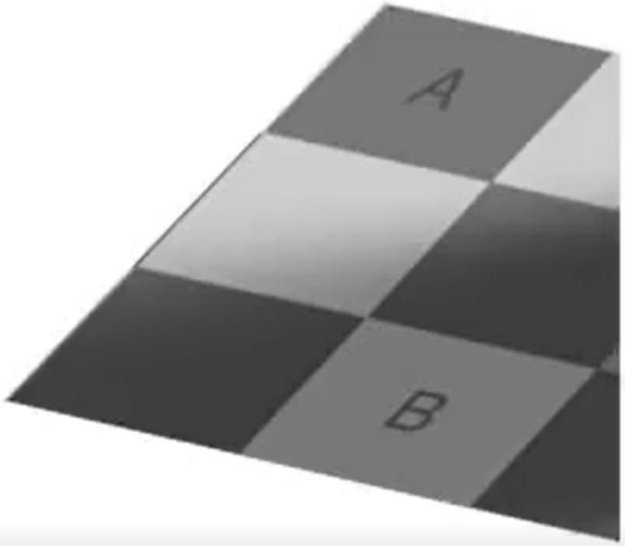

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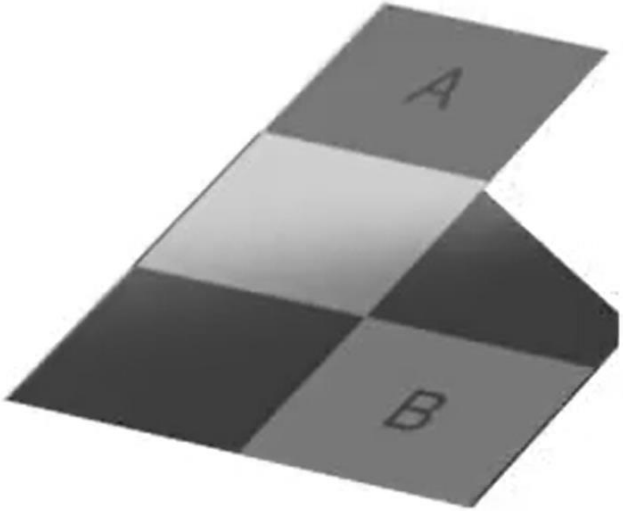

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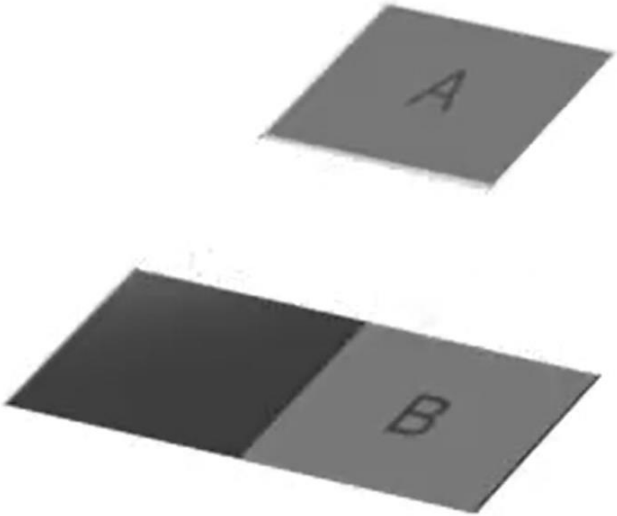

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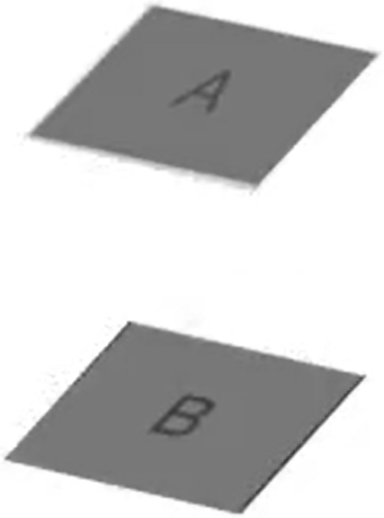
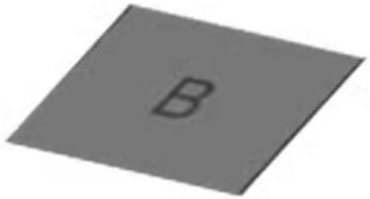


s Constancy

Better keep an eye on them…

Pretty cool, huh?



“Lightness Constancy”

s Constancy

Stigma: definition

Stigma is the situation of the individual who is disqualified from full social acceptance. The stigmatized individual is reduced in our minds from a whole and usual person to a tainted, discounted one. (Goffman, 1963)

Stigma vs. Prejudice

Prejudice:

- Exploitation and domination (Keeping people down)

Stigma:

- Norm enforcement (keeping people in)
- Disease avoidance (keeping people away)

In reality, these terms are often used interchangeably.

Stigma and AD development

Consider stigma impact:

- Language used
- Program development
- Clinical decisions of detailees
- Self-reflection

Stigma and language

- Addicts
- Drug abusers
- Babies born addicted
- Doctor shoppers
- Substituting one addiction for another
- Clean vs. dirty

Stigma and program development

- Consider language used during development
- Are all solutions/outcomes on the table?
  - Harm reduction
    - Naloxone availability
    - Needle exchange
    - Safe injection sites
  - Treatment
    - Are all treatments considered
- "Safe prescribing" messages

Stigma and clinical decisions

- Identification of those with OUD and referral for treatment
- Initial prescribing of opioids to “good” people

Stigma and self-reflection

- We must all consider how we stigmatize others

Self-stigma

- When we stigmatize ourselves
  - Very common in addiction treatment
- May interfere with optimal outcomes

eople/groups do you believe are affected by s

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People groups who are commonly victims of stigma:

- Those with substance use disorder
- Homeless
- Mental Illness
- HIV/AIDS
- LGBTQ
- Racial/ethnic
- Those living in poverty

Case presentation

- Patient has been in recovery for over 14 years.
- She is a Master's level therapist and community activist for people in recovery. She has two beautiful children that light up her life.
- She was diagnosed with
  - Ehlers-Danlos Syndrome
  - Postural Orthostatic Tachycardia Syndrome (POTS)
  - Mast Cell Activation Disorder
  - Gastroparesis.
- In the 14 + years of her recovery the only time that she took an opioid was when she had an emergency C-section and then only when in the hospital.
- She will be speaking to you in just a few minutes…

Addressing Complexity in Changing Opioid Prescribing & Treatment of Chronic Pain

Nadejda Razi-Robertson

Plum Consulting, LLC

A little about me …

Nadejda Razi-Robertson

Licensed Clinical Social Worker
Doctor of Behavioral Health

Steering Committee, Oregon Pain Guidance Group
Practice Facilitator, Oregon Health Authority
Behavioral Health Consultant, Primary Care, Oregon
Therapist, Private Practice

Plum Consulting, LLC

Who is the OPG?

OPG
OREGON PAIN GUIDANCE

"Improve the quality of life in our communities through the understanding, evaluation and application of best practices for the treatment of complex chronic pain."

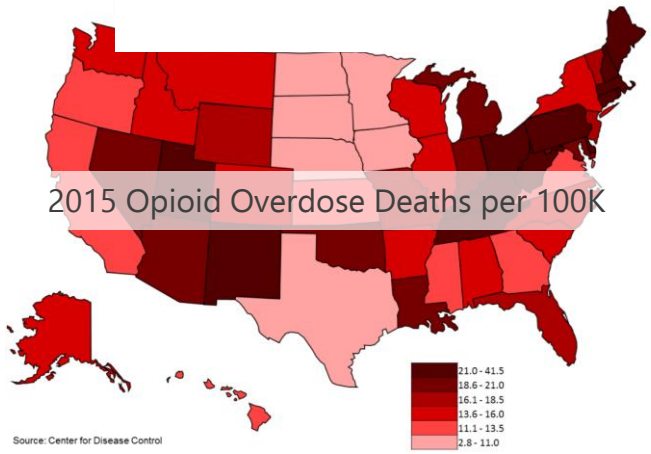
- Developed Opioid Safety Prescribing Guidelines in 2012
- Hosts monthly meetings with more than 70 Healthcare professionals around the state
- Developed website that offers support & guidance for patients, families & doctors looking for solutions for chronic pain & opioid dependence
- Founders are consultants with the CDC and the OHA

Sources: OPG, Plum Consulting

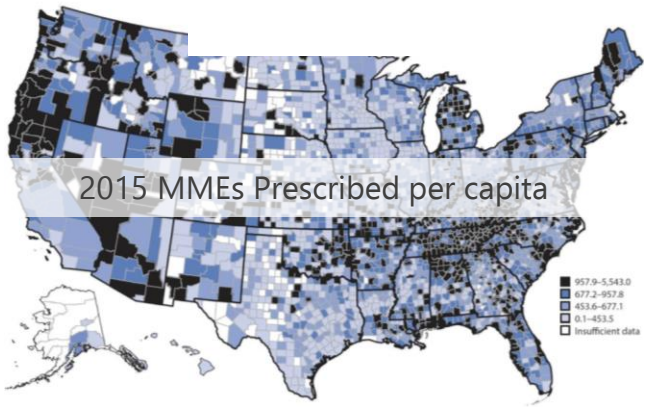
State of the Union….

The national numbers you know…

- ✓ 11.8 million Americans misused opioids in the past year … 11.5 million, misused **prescription pain relievers**.
- ✓ **1 in 4 patients** treated with long-term opioid pain therapy struggle with **opioid addiction**
- ✓ **91 Americans die everyday** from opioid overdose
- ✓ 50,000 died in 2015, 2016 likely to top 60,000 (CDC)



Sources: CDC, Oregon Health Authority, The Oregonian

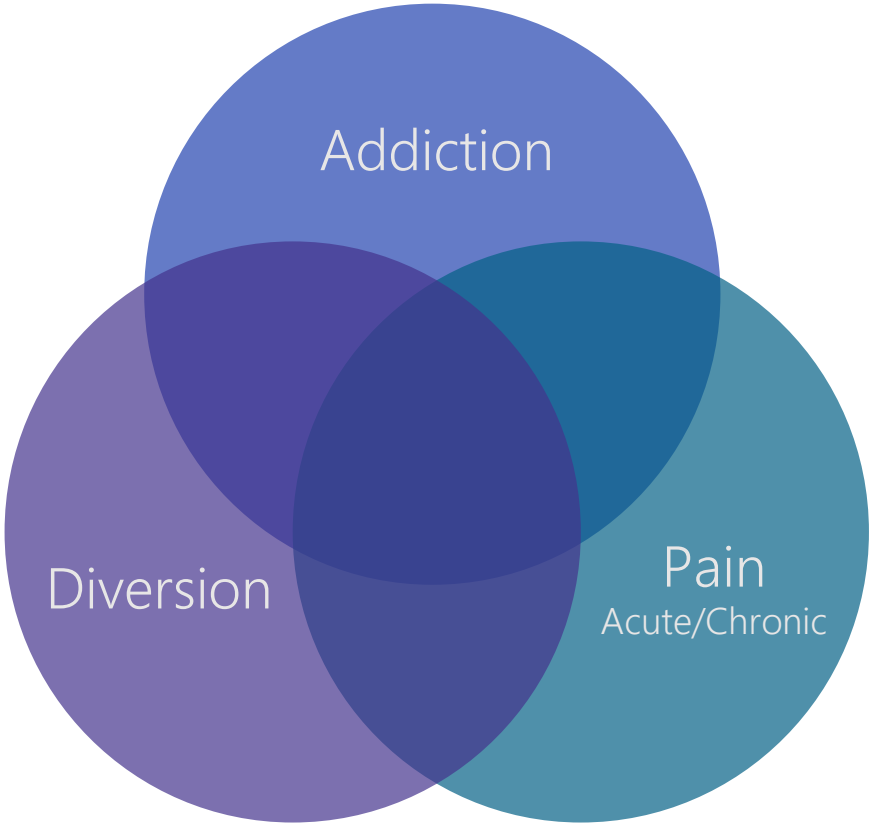


… The state of our state.

- ✓ Southwest Oregon remains in the **CDC's highest dose per person category for opioids.**
- ✓ Oregon has one of the **highest rates of prescription opioid misuse** in the nation.
- ✓ An average of **3 Oregonians die every week** from prescription opioid overdose. Many more develop opioid use disorder.
- ✓ More drug poisoning deaths involve prescription opioids than any other type of drug.

Plum Consulting, LLC

What makes this so complex?



Sources: OPG, Plum Consulting

Cultural Humility & Educational Outreach

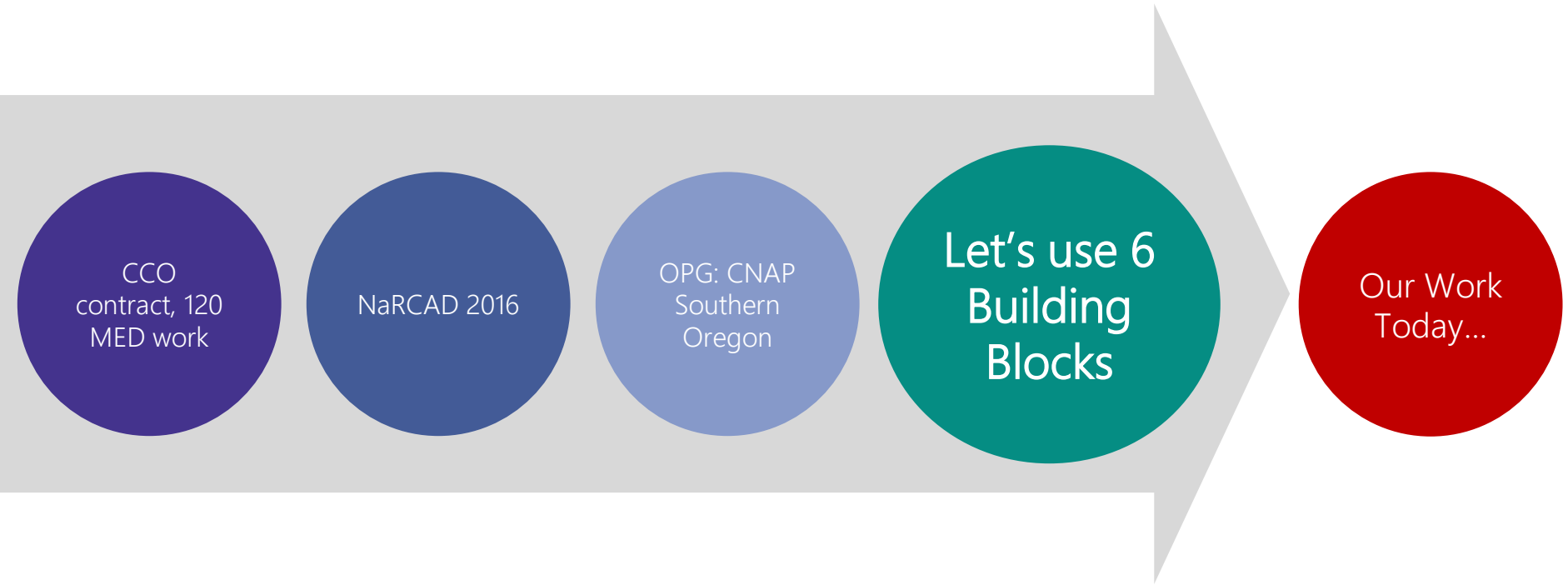
"Teach us about where you are so we know how to support you…."

Micro

Mezzo

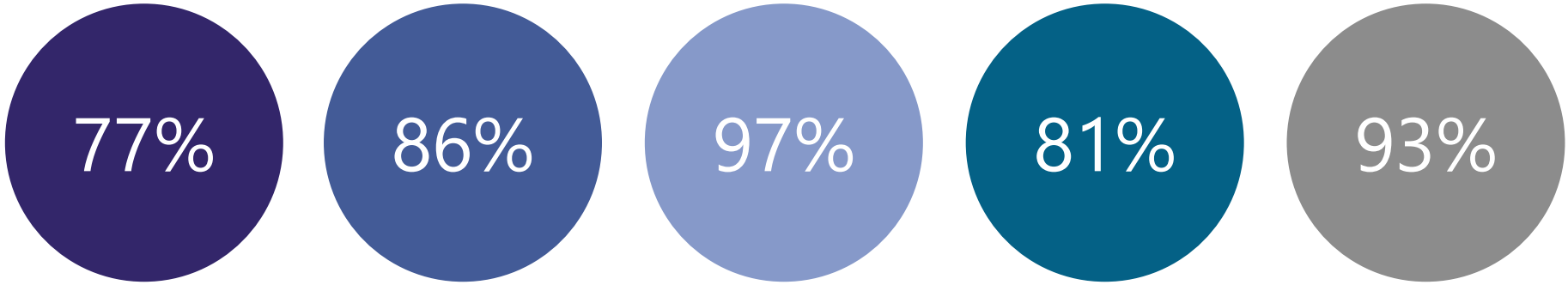
Macro

Developing our Educational Outreach Program…



Sources: Plum Consulting

Some interesting numbers…



Feel they lack necessary skills to work with patients who have chronic pain

Need more behavioral health support in order to reduce opioid dosages

Need increased access to alternatives to opioid treatments

Believe that LOT for CNCP is harmful

Believe patients' functioning will improve on doses >120 MED

Sources: "Barriers Related to use of LOT for CNCP" by Nadejda Razi-Roberston

A brief history of the 6 Building Blocks

Development → The 6 Blocks → Adapt for PDO & CNAP

MacColl Center
for Health Care Innovation

KAISER PERMANENTE

UNIVERSITY of WASHINGTON

Funding comes from AHRQ

Michael Parchman, MD, MPH

Director, MacColl Center for Innovation
Group Health Research Institute

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

Brooke Ike, MPH
Project Manager and Practice Facilitator, UW

David Tauben, MD
Chief of Pain Medicine, UW

Goal: Improve safe prescribing and reduce the risk of death for non-cancer opioid patients

- MacColl CenterTeam from UW developed the blocks as part of *team-based opioid management project*
- 3-year research study with 20 rural & rural-serving clinics in Idaho & Washington

Sources: Kaiser Permanente, MacColl Center, 6 Building Blocks

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What are they?

Building Block #1
Leadership, goals, & Assigned Responsibilities

Building Block #2
Produce policies, workflows, treatment agreements, patient education materials

Building Block #3
Identify the patient population and develop ways to track progress

Building Block #4
Planned, patient-centered visits

Building Block #5
Caring for complex patients

Building Block #6
Measuring success

Sources: Kaiser Permanente, MacColl Center, 6 Building Blocks

Simplified Self-Assessment for Workshops

Measure Description	Level 1	Level 2	Level 3	Level 4
Description of the measure if fully implemented.	Very little has been done on a clinic basis. No clinic wide documentation exists. Some prescribers may implement parts, but most do not.	Some clinic policies have been documented and some prescribers are following them. Implementation is fragmented.	Clinic policies are well-defined and documented. The majority of prescribers understand and follow the policies. However, progress and compliance is not monitored.	Clinic policies are fully implemented. All prescribers and clinical staff support and follow policies. Compliance is monitored monthly or quarterly with follow-up on any variances.

Click Here: Full Survey

Sample question:

Co-Prescribing Benzodiazepines	1	2	3	4	Please describe briefly what your clinic is currently doing on this measure.
Clinic policies discourage co-prescribing of opioids and benzodiazepines (or other medications such as z-drugs, carisoprodol, etc.) Existing patients on both are being tapered to safe levels defined in the policies. Behavioral health or other specialists are consulted when indicated.		X			We have identified all patients who are co-prescribed opioids and benzos. Memo sent to all prescribers on risks of co-prescribing. Prescribers are now discussing tapering with patients. Some patients are being tapered.

Sources: OPG, 6 Building Blocks

How can they help?

Six Building Blocks are a helpful tool for clinics, practice coaches, and regional leadership to:

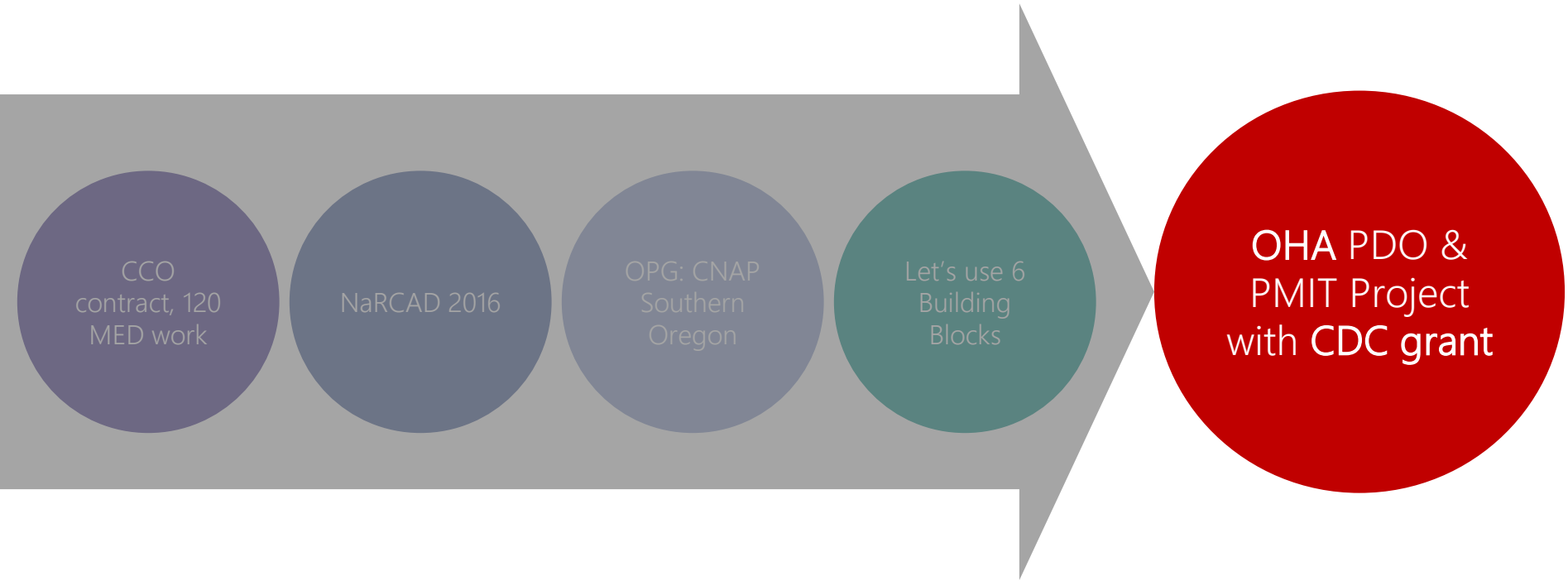
- Assess current status & baseline for measuring progress
- Help decide where to focus efforts
- Identify clinics with areas of excellence
- Facilitate communication & exchange between clinics
- Develop a common framework for implementation

"Physicians can and should depend on the **support of the entire clinic team** and on the backing of a **clinic-wide consistent approach** to providing care to opioid patients …The six building blocks **provide a roadmap for this team process**…and creates a sense of **'we are all in this together.'**"

– Dr. Parchman

Sources: Kaiser Permanente, MacColl Center, 6 Building Blocks

What we're working on today…



Sources: Plum Consulting

Project Review: CDC prevention for State grant

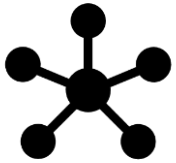
Develop tools and trainings for implementation of Opioid Prescribing Guidelines

Metrics-based toolkit

Systems framework (6 Building Blocks), PMIT

EHR integration package

MED calculator



OR Pain Guidance website

OR Pain Commission training module enhancements

Extend UW Tele-Pain to Oregon

Regional opioid summits (OrCRM)

Sources: CDC, OHA, Plum Consulting

6 Buiding Block Project Steps 1-5…

1. OHA IDENTIFIED 9 HIGH RISK REGIONS

2. HEALTH SYSTEMS THAT WANTED TO PARTICIPATE WERE IDENTIFIED IN 6 OF THE 9 REGIONS

3. PARTICIPATING HEALTH SYSTEMS ARE TASKED WITH IDENTIFYING AN IMPLEMENTATION TEAM AND COMPLETING THE 6 BUILDING BLOCKS SURVEY (NEEDS ASSESSMENT)

4. DATA IS ANALYZED AND FINDINGS ARE USED TO DESIGN A WORK PLAN THAT ADDRESES THE SPECIFIC NEEDS OF EACH HEALTH SYSTEM

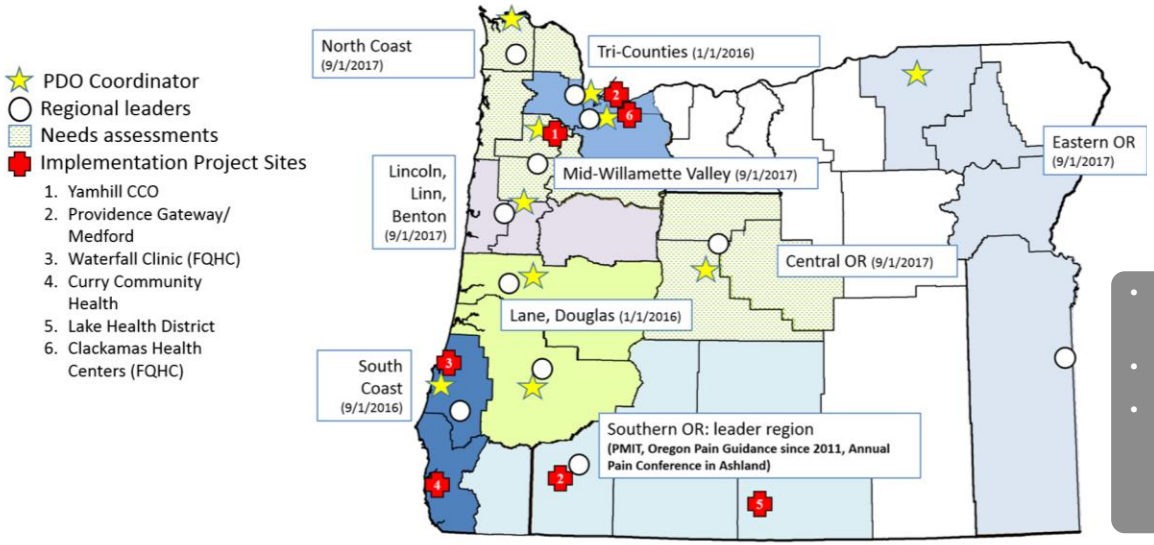
5. HEALTH SYSTEMS RECEIVE SUPPORT INCLUDING PRACTICE FACILITATION, EDUCATIONAL OUTREACH, EMR INTEGRATION, & ACCESS TO STATE WIDE RESOURCES

PDO Project & PMIT

PMIT = Oregon's Pain Management Improvement Team

Multidisciplinary team of SME from the OPG

9 PDO regions ⇨ 6 Implementation Project Sites ⇨ 3 regional needs assessments



PMIT: Pain Management Improvement Team


Jim Shames, MD


Laura Heesacker, MSW, LCSW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Simon Parker-Shames

- Work with **6 health care organizations**, in top **9 PDO regions**, using **team-based approach** to pain/opioid management
- **3 regions** will receive a needs assessment and funding
- Assessment leverages evidence-based *Six Building Blocks* framework to:
  1. Assess the organizations current state then
  2. Tailor solutions based on identified needs

Phase 1 CNAP → **Phase 2** – Goal-setting → **Phase 3** - Bring in Academic Detailing / "Educational Outreach" as needed

Sources: OPG, OHA

Academic Detailing/Educational Outreach

EDUCATIONAL OUTREACH IS TAILORED TO EACH INDIVIDUAL CLINIC BASED ON OUTCOMES OF THE 6 BUILDING BLOCK ASSESSMENT

EDUCATIONAL OUTREACH-Case Examples….

NALOXONE	(Building Block #5)
SUBOXONE	(Building Block #5)
POLICIES AND PROCEDURES	(Building Blocks #1-2)
CURRENT EVIDENCE-LOT FOR CNCP	(Building Block#1)
BEHAVIORAL HEALTH	(Building Block #5)
DIFFICULT CONVERSATIONS	(Building Block#4)
MEASURING SUCCESS	(Building Block #6)
IDENTIFYING PATIENT POPULATION	(Building Block #3)

EDUCATIONAL OUTREACH: LESSONS FROM THE FIELD

Providers who have been sanctioned by the board wish they had known how to…

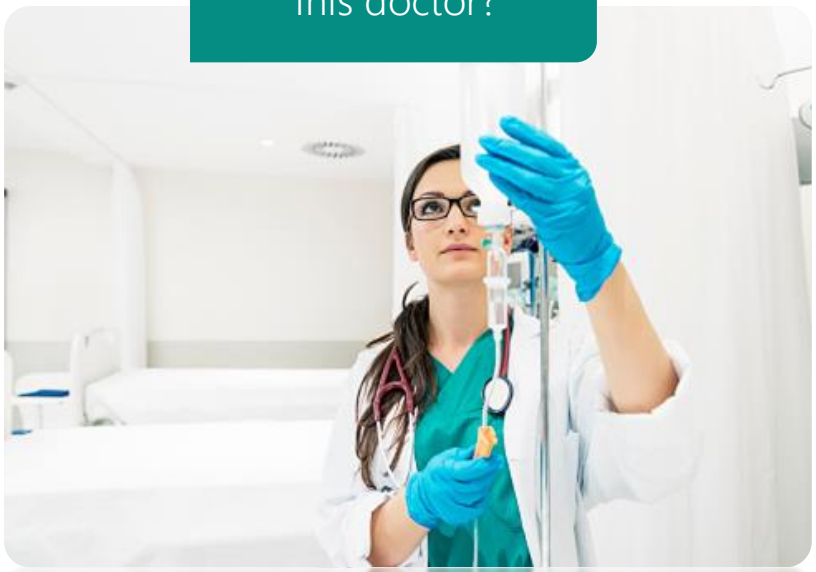
474 × 721 - pinterest.com

1. Say "no" and maintain relationship with their patients
2. Recognize that the relationship is medicine
3. Be with their patient's pain without needing to take it away
4. Have difficult conversations – (redefine "success")

"Changing how I prescribe opioids meant changing myself. This was the hardest lesson to learn, but it changed my life-for the better."-a provider who was sanctioned by the Oregon Medical Board

What do these two individuals share in common?

This doctor?

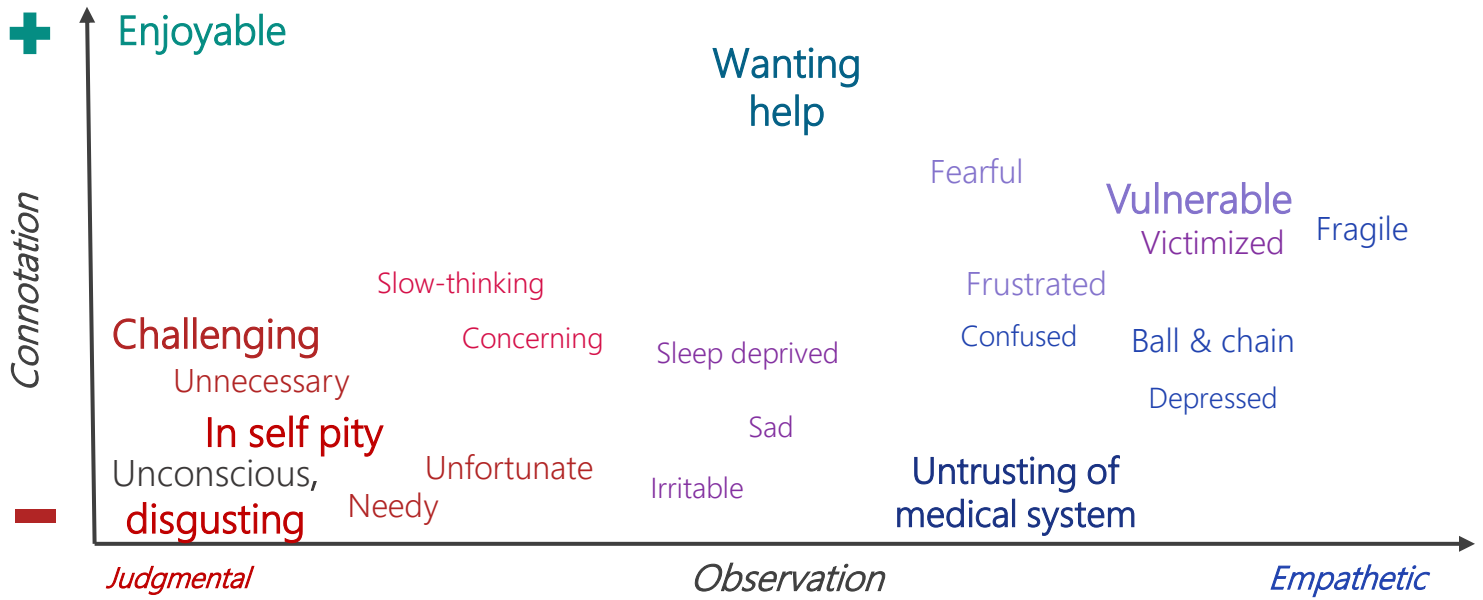


This man?

Sources: Plum Consulting

How would you describe patients on long-term opioid therapy?

"I don't want to attract more of <u>those kinds of people</u>"



Sources: Plum Consulting

Questions?

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Plum Consulting, LLC

Appendix

Provider confidence *is* a widespread issue

Detailed results from "Provider Barriers Related to Use of LOT for CNCP" :

Table 1. *Provider Responses about Confidence*

	Provider Response # (%)					
Confidence Questions	Never	Almost Never	Sometimes	Almost Always	Always	% at "3" or lower
Skills	14 (27%)	20 (39%)	3 (6%)	14 (27%)	0 (0%)	73%
Enjoy Working	10 (19%)	26 (50%)	11 (21%)	2 (4%)	2 (4%)	90%
Want to Specialize	24 (46%)	10 (19%)	7 (14%)	8 (15%)	2 (4%)	79%
Feel Successful	2 (4%)	32 (62%)	7 (14%)	10 (19%)	0 (0%)	80%

Note. n= 51

Table 2. *Provider Responses about Behavioral Health Support*

	Provider Response # (%)					
Behavioral Health Questions	Never	Almost Never	Sometimes	Almost Always	Always	% at "3" or lower
BH Support	16(31%)	28(55%)	5 (10%)	2(4%)	0 (0%)	90%
Assess for Risk	0 (0%)	6 (12%)	39(76%)	4(8%)	2 (4%)	88%
PDMP Helpful	0 (0%)	0(0%)	45(88%)	4 (8%)	2 (4%)	88%
Access to alt TX	16(28%)	32 (63%)	3 (6%)	0 (0%)	0 (0%)	97%

Sources: OPG, Plum Consulting

The Oregon Opioid Initiative

Aim: Reduce deaths, non-fatal overdoses, and harms to Oregonians from prescription opioids, while expanding use of non-opioid pain care

1

REDUCE RISKS TO PATIENTS BY MAKING PAIN TREATMENT SAFER AND MORE EFFECTIVE, Emphasizing non-opioid and non-pharmacological treatment

2

REDUCE HARMS FOR PEOPLE TAKING OPIOIDS AND SUPPORT RECOVERY FROM SUBSTANCE USE DISORDERS by making naloxone rescue and medication-assisted treatment (MAT) more accessible and affordable

3

Protect the community by REDUCING THE NUMBER OF PILLS IN CIRCULATION through implementation of safe prescribing, storage, and disposal practices

OPTIMIZE OUTCOMES BY MAKING STATE AND LOCAL DATA AVAILABLE for monitoring, evaluating, and informing policies and targeted interventions 4

Sources: OHA

Academic Detailing on Safe Prescribing of Opioids

Skye Tikkanen
Drug Poisoning Prevention Manager

BeSafe!

Plan for Academic Detailing in WI

- Began with pilots in Dane County
  - Round 1: 3 Health Care organizations
  - Round 2: 4 Health Care organizations
- RFPs for additional communities in WI
- National Resource Center of Academic Detailing (NaRCAD) to provide training in WI (24 participants)

Getting Buy-in

- Health Care Task Force on Safe Opioid Rx
  - Joint multi-disciplinary training, but gap with primary care involvement
- Approached CMO/CEO of 4 health care organizations (Co-chair of HCTF) to get commitment
- HC leaders identified staff within their organizations to plan

Developing and Determining Plans

- Set up planning teams (appointed)
  - Pharmacists, prescribers, nursing, admin, pain specialist
  - Invited guests – Addictionologist
- Arranged planning meetings
  - What is already happening? What are you most proud of? What do you want to reinforce?
  - Determined goals, identify target group and plan
- Provided training on Academic Detailing process through NaRCAD (Boston)

Developing and Determining Plans

- Set the stage
  - Developed process and tools
    - Smart sets, smart phrases – make as easy as possible
  - Addressed stigma
    - Invited person in recovery to give perspective through a variety of approaches
- Finalized plans
  1. Co-prescribing naloxone
  2. Co-prescribing with person in recovery
  3. Promote Medical Examining Board guidelines

Developing Materials

- Literature review on best practice and tools
- 2 HC organizations utilized already existing materials (thanks to CA)
- 1 HC organization developed own teaching materials to reflect the MEB guidelines

Innovative Aspects

- Addressing stigma and detailing team includes a person in recovery
- Policy and systems change ahead of beginning AD so recommendations can easily go into effect
- Detailer was chosen from within the system
  - Already established relationships
  - Understanding about what would work
  - Ongoing relationship and support

Results

●SSM Health focused their efforts on their pain clinic and then moved on to primary care, with a goal of every patient that is at high risk of overdose based on the CDC and MEB guidelines being co-prescribed naloxone in addition to their opioid prescription.

○3 MD, 2 NP/PA, 6 RN staff the pain clinic and all were detailed.

■100% are registered for the new ePDMP

■100% of prescribers detailed were more likely to prescribe naloxone

○Over 400 primary care physicians were taught the detailing material through large departmental meetings

■100% are registered for the new ePDMP

○System wide results from date of completed detailing 02/2017 through 07/2017

■8% decrease (425) in patients on chronic opioid therapy

■35% increase in completed pain agreements

■12.3% decrease (40) in patients receiving methadone for pain

■No significant change in co-prescribing of benzodiazepines and opioids

Results

●UW Health focused their efforts on detailing primary care physicians with a goal of every patient that is at high risk of overdose based on the CDC and MEB guidelines being co-prescribed naloxone in addition to their opioid prescription.

○138 staff detailed, 66 pharmacists, 25 RN, 40 MD/DO, 7 other

■100% are registered for the new ePDMP

○System wide results from pre-detailing 01/17-03/17 vs post-detailing 04/17-06/17

■17.7% increase in naloxone prescribing from MD/DO

■333% increase in naloxone prescribing from pharmacists using standing order

■Consistent increases in knowledge of what patients are considered high risk and should be co-prescribed naloxone.

■Participants (61.9%) would like to continue academic detailing in small group format

Results

●UPH Meriter focused their efforts on detailing primary care physicians with a goal of training staff on the new Wisconsin Medical Examining Board Guidelines on Safe Opioid Prescribing. They focused specifically on compassionate tapering and referral to substance use disorder tapering.

○32 staff detailed, 23 MD/DO, 5 NP/PA, 2 other

■100% are registered for the new ePDMP

○System wide results from pre-detailing 01/17-03/17 vs post-detailing 04/17-06/17

■86% of those detailed were able to write a care plan that meets MEB guidelines and understand when to refer to SUD treatment

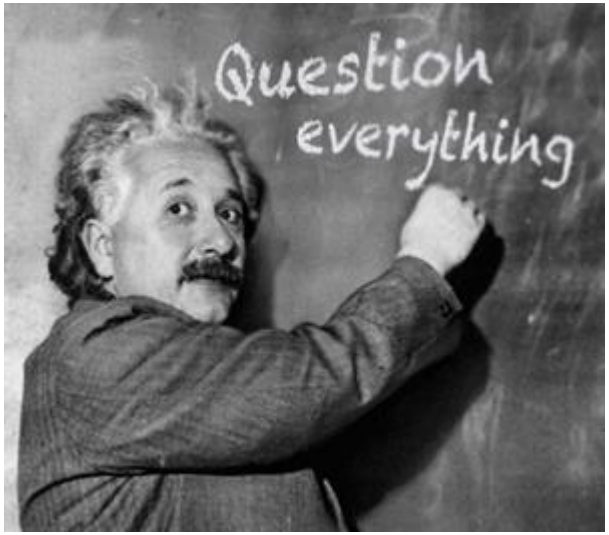
■ 88% of respondents were willing to titrate a patient on chronic opioid therapy based on the MEB and CDC guidelines

■74% of respondents felt capable of doing this

■84% of those detailed stated that they will change their practice based on this training

Successes and Lessons Learned

- Successes:
  - Buy-in from the top
  - Buy-in from prescribers and nursing staff
  - Ongoing relationships with detailers
- Lessons Learned:
  - Put on hold if there are leadership changes (6X)
  - Avoid starting if a health care organization is in the middle of merging
  - Individualize for each health care organization to encourage enthusiasm and systems change



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BeSafe!

Discussion with Panelist

QUESTIONS?

ways have you heard our panelists describe h
om the traditional academic detailing model

Start the presentation to activate live content

If you see this message in presentation mode, install the add-in or get help at PollEv.com/app

t other detailing topic areas does stigma nee addressed?

Start the presentation to activate live content

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