Anna: *You're listening to Changing Minds: Transformative Talks for Healthcare Improvement. Grab a coffee or tea and join our team as we chat with leaders in the academic detailing space. For more information on academic detailing, visit us at narcad.org.*

Anna: Hello and welcome back to our podcast, *Changing Minds*. I'm your host, Anna Morgan-Barsamian, Senior Manager of Training and Education at NaRCAD. I'm joined by my fabulous colleague and our Deputy Director at NaRCAD, Bevin Amira. Bevin, welcome! How are you doing today?

Bevin: I am doing great. I'm so excited to chat about AD and get to say hello for the first time to our podcast listeners. So, hey, thanks for joining us.

Anna: Awesome. Thanks, Bevin. Today I really want to create a space on our podcast for us to chat about NaRCAD and our academic detailing community. I want this to be for new and veteran detailers and people that aren't even part of the AD community quite yet. Let's start off by doing some level setting. If you were describing AD to someone new, what would you say?

Bevin: So, luckily I do this all the time with varying levels of success - when you meet new folks and one of the inevitable questions they ask is what do you do for work? What I try to do is talk about the strategy itself. It's a quality improvement strategy and it's all about relationship building.

What I love to talk about with academic detailing is I describe it as a conversation between an educator who's trained in clinical content and a clinician themselves. It could be a pharmacist, it could be a nurse, it could be a doctor. What that educator does is they go in with the best, most up to date evidence. That evidence could be about best prescribing or deprescribing or screening tools or ways in which you can have conversations with patients about challenging things like substance use disorder.

Educators, most of whom are from public health departments across the states, they go into that clinician's own space. They ask a lot of really great questions to understand what that clinician goes through every day and then they work together in partnership. AD is all about collaboration to figure out how to put new things in place that also fit within a very stressful day-to-day profession of being a clinician and make things easy for that clinician to provide the best possible care for that patient.

It's usually around myriad topics, but what we notice here at NaRCAD, and Anna, I know you know this, is that a lot of areas of care focus around, you know, public health crises, like the opioid crisis, all kinds of substance use challenges, HIV prevention, and other infectious diseases. Academic detailing is really a cool way to get clinicians to think differently and act differently. The interactive piece is so great because no one is going to change their behavior if they sit and watch a training video, right?

Anna: No, not a chance - that's why I love academic detailing. Another thing I really love about it is the domino effect. Our team at NaRCAD trains and supports detailers to educate and support clinicians who then provide care and support to patients so that they can live healthy lives. Sometimes it's hard to see that impact on patients, but when you think about it like that and take a step back, it's really a beautiful sentiment.

Bevin: It's a support chain really. It's really kind of a trickle sideways effect and a lot of people want to know where does the impetus for this come from? I just wanted to throw in Anna, you know, that a lot of times organizations like the CDC will say, "hey, we have data that shows there's a major challenge for patients in a certain area and we have money. So, let us give it to, you know, state and local public health departments." They then come knocking on our door at NaRCAD and say, "can you teach us how to talk to clinicians about this challenge?"

Here at NaRCAD, what we love to do, and I know you and I love this in particular, is train those educators on how to confidently go in, talk to clinicians, and use a structured approach to holding space for that clinician to talk about what he, she, or they really deal with on the day-to-day and what they see with their patient population and how that population struggles with whatever clinical topic is up for discussion.

I would say, you know, we're really a support group in a way, and we provide technical assistance and so many opportunities for these educators to sharpen their skills at drawing out clinicians knowledge, their attitudes, their behaviors, and really kind of do some detective work to figure out, okay, how do I get this clinician to adopt this practice so that their patients are less likely to, for instance, contract TB. What we do is really powerful. How would you kind of describe who we are and what we do for those educators?

Anna: I would describe the NARCAD team as small, but mighty. We're cheerleaders and coaches for the AD community. We are the only resource center for academic detailing, but at our core, we're here to build a community and support the detailers. As you said, Bevin, in an often isolating field, we connect the detailers and detailing programs to others working on similar topics, facing similar challenges, or looking to celebrate the small wins. Our team offers events and trainings to network and learn from one another. Our goal really is to get out of the way and create a learning environment for detailers to connect and do the important work that they're doing.

Bevin: I know you and our colleague Aanchal run an amazing Peer Connection Program where detailers from say, you know, someone from Alaska can talk to someone in LA about how hard it is when you walk in to meet with a clinician who says, "I don't have time to meet with you." What do you do there? They can share strategies because they're the ones with boots on the ground.

The team at NaRCAD is sort of a home base. They can come to us and get new information, try new things and ask questions, and even practice a conversation with us where we will role play with them and pretend to be a persnickety clinician, a busy clinician, or a stressed clinician. Then they get to go back in the field and try it out. As you said, we step out of the way, they do what they do best, and they come back and tell us how it's going and what else they need. I would definitely agree with you. We are cheerleaders. We'd love to see detailers build their confidence and know they can go in and have challenging conversations and be the igniter for a series of behavior change. We love our work if you can't tell by the tone in our voice.

Anna: Yes, we do. It's important to me and I know it's important to the rest of our team as well. Bevin, I want to shift gears and talk a little bit about where NaRCAD started and where it is now and how it's evolved. And not just NaRCAD, but also the AD field in general - how has it evolved over the years.

Bevin: Yeah, 100%. The original studies were done by Dr. Jerry Avorn in the early eighties in nursing homes to really test out, does this approach work, you know, and it really came from a space of thinking you can throw a bunch of doctors and nurses and pharmacists in a huge lecture hall and lecture at them, but they're very unlikely to do new things.

We all know that when we're trying to learn something new, whether we're trying to change our behavior around healthy exercising routines, we are more likely to do it if we have things like support, if we have people at our side, if we have tools that help us like an app that says you've got a three-day streak, you know, keep at it.

Dr. Avorn really wanted to look at how can we get away from this passive model of learning and really make it interactive and hands on because that's what's going to change behavior. When you think about how little kids learn in preschool, no one's lecturing at little kids, right? We know folks need to get their hands on stuff. They need to be able to ask questions. And that's true through the lifespan. We all as lifelong learners need to be able to ask questions and have someone ask us questions. What are we thinking? What are we feeling?

So that original model is having somebody who has a lot of the same skills as a pharmaceutical detailer, but they're going in and meeting with clinicians, not with the goal of commercial sales as the end point, but the goal is to get that really good evidence from the best resources out there and get the cream off the top of so much literature out there every single day and give it to that clinician in a really easy, practical, usable format. So that's the original model and the focus was very much on prescribing or de prescribing.

What we've really seen that is so exciting and I want to turn it to you to talk about your own excitement about this, Anna, as a nurse and just as a public health specialist and a geek about harm reduction is we're starting to see these conversations really go in the direction of seeing clinicians as people who not only can monitor or change prescribing or make different recommendations or offer new screening tools, but detailers can teach clinicians how to have challenging conversations with their patients in order to build more trust. And harm reduction as a topic is blowing up. I'll turn it to you to talk a little bit about what we've seen there.

Anna: I think a lot of it goes back to what you're saying about the key messages. What are detailers asking clinicians to do differently. When I first started at NaRCAD, these key messages were around prescribing like, “start low and go slow when prescribing opioids.” Now with the harm reduction work, we're seeing more key messages like, “talk to your patients in a non-stigmatizing way” and detailers providing scripting tools and language for clinicians and providers to use.

That's been really exciting for me because it's definitely a shift in the field and shift from the original model. That's not to say that people still aren't having the prescribing messaging in their detailing visits. Of course, that's an important part of academic detailing, but we are seeing the messaging expand beyond that.

Bevin: I'd love to piggyback on that and just add that the opioid crisis has become something where five, six years ago, or actually, I guess it's eight years ago, which is blowing my mind. In 2016, the CDC came out with prescribing guidelines for clinicians. At this point, there's so many folks using drugs not via prescriptions. Rather than saying, “hey clinicians, you don't have to worry about this because it's not coming from your prescriptions” to say, “hey, you may have patients who are using drugs that weren't sourced via a prescription and you can still help

them." You can, as Anna just said, have a conversation that helps assess whether they may need anything from treatment to medication for opioid use disorder to a syringe, a safe syringe site, a safe injection site. Being able to go to clinicians and say, "there's a range of things you can offer your patient beyond altering their prescribing that can really keep them safer and save a life."

Really looking at clinicians as folks who, especially in primary care, often are the only access point for patients seeking care and really can be that trusted space that can help patients feel like, it's okay for me to talk to my clinician about what's going on for me.

It is really exciting to be able to expand that model and see the ways that detailers can help clinicians think differently about what their role can be about how to build really trusting relationships with their patients.

Anna: They can empower the clinicians too to expand beyond just prescribing, as you were saying. I think it's really important that the field is moving in this direction. Why do you think the field is evolving?

Bevin: Well, I think folks are really looking across public health, across health care, even in, you know, psychiatry, looking at the whole patient is this sort of buzz phrase we hear a lot about and really what it's looking at is that there are myriad factors that make up clinical challenges. When you have, for instance, someone who's elderly, who is depressed, you can't just treat somebody with prescriptions or looking at one piece of the puzzle. You want to look at the whole puzzle, which may in the instance that I just brought up include, well, is this patient socially isolated? Might they need an antidepressant and might we need to work with them to figure out how can we get them social supports? How can we make sure they're interacting with family more?

So again, I think the fact that people are really interested in an integrated approach and trying to figure out how to support patients through a multifaceted lens means that we can go to clinicians and say, "hey, in this instance, all you have to do is ask a couple of questions." That really help open up that patient's ability to share with you. So that's an instance where looking at a whole patient, looking at how clinicians can do so much more than just provide medications, they can really be a safe space for patients to talk about what's up for them.

That's what I'm seeing. I know that you may have different ideas around that, Anna, because there's so many reasons that things take on new shapes. So, what's sort of your insight on that?

Anna: I think zooming out a bit and thinking about the bigger picture of where AD fits with other community initiatives is helpful. AD is often implemented in public health departments, and we've seen a cross pollination of AD with other community interventions, which is, it's exactly what we want to see. We don't want AD to be an intervention on its own. It really makes the most impact when it's combined with other interventions. For example, a lot of the detailers that we work with, they wear many hats within their public health department. They're not just a detailer. They could be working on evaluation and surveillance and other projects as well. When they're out in the field with clinicians for academic detailing visits, they're able to reference and connect clinicians with other resources and projects available at the department, like free condoms or free naloxone so that patients have access to things that they need.

That's really what I've been seeing within our community is being part of these larger projects and having it be a vital part of those projects as well.

Bevin: I think it's important what you're saying, Anna, is very much about sort of what's the identity of the community and what do they need. What you're hitting on is so important because you're really talking about a patient's need isn't confined to that patient, right? Noticing trends beyond what data is saying of how someone may live in a very specific community that has its own unique identity and how does that community show up for a patient? It's so important that any intervention where clinician behavior change is necessary, that that's aligned with what the community is already trying to do.

I love that you brought that up and I think one thing that's really important too is to make sure we're working in the public health sphere, as you said, wearing many hats, or clinicians themselves really being curious about an entire patient's experience, or I should say a patient's entire experience. It's all well and good to prescribe something that could be beneficial to a patient, but if we don't understand that that patient has access barriers, you know, transportation issues and can't get to the pharmacy to get that filled or can't afford the co-pay, then that's something where we're not closing the loop.

Other community resources are so important. If a clinician says, "hey, I'd love to prescribe this" or "I'd love to try this, but I know that many of my patients can't afford it", being able to say, "I'm so happy to tell you about this community initiative that I learned about right here in your county where they are subsidizing access to XYZ." Something like free condoms or naloxone kits and really just looking at how can we connect the dots.

It's so, so exciting to just think about ways that we at NaRCAD have really changed shape over time. We're part of other collaborations. We're part of projects that are so much bigger than detailing. It makes us really proud to be part of that. Really, really great to talk about.

Anna: Talking about being excited, I'd love to hear your thoughts on any upcoming projects or collaborations that you're particularly excited about that we have going on here at NARCAD.

Bevin: Well, I love a project that we just are kind of starting to wrap up. I know you know what I'm about to say, Anna. It's the HRAD project, which stands for Harm Reduction Academic Detailing. It's a collaboration with NACCHO, the National Association for County and City Health Officials and what I think is so fabulous about it is it takes that persuasive conversational technique of AD and instead of just applying it with clinicians, they also have looked at, hey, how can we reduce harm for patients by talking to other folks who are key members of society, key members of the community, who would have a space to provide safety and opportunity for their patients?

We've been helping folks detail not just clinicians, but volunteer firefighters and faith leaders, you know, thinking about, hey, patients feel safe within maybe their faith communities, how can we make sure that faith leaders also can provide access to things like harm reduction and naloxone?

I know you're excited about that, too, if you want to talk a little bit more about some of the other subpopulations who are receiving detailing as part of this project and any other projects that you're excited about.

Anna: The project is definitely a favorite of mine. I mean, we're seeing people work with audiences from nursing students to pharmacists to clinicians to, as you mentioned, faith leaders and drag artists. It's a really cool project about how academic detailing can be applied to other audiences beyond just clinicians, again, thinking back to what we spoke about earlier with just expanding from the original model. That's really what this project has done, and I love to see that.

I also wanted to share about an event that I'm particularly excited about that we are doing at NaRCAD. We have our AD Summit coming up next month on June 26th and 27th, and it's a completely virtual event. Our theme is, "A Commitment to Inclusivity: Equitable Approaches to AD." We're going to be networking, creating resources, and sharing best practices with everyone in our community. I really encourage our listeners to join us. You can check out more on our website at narcad.org. You can look at our agenda and you can register for the event there. We'd love to have you all join us.

Bevin: We really would. We have some really awesome content this year. We'll be hearing from folks who share their own personal experiences and their own intersectional identities as detailers and what that feels like to be within that identity when meeting with clinicians. We're talking about everything from asking folks about their campaigns on criminal justice reform to gender affirming care to harm reduction. Really, really important topics.

And again, one thing I want to say, and this is just me really loving the work that we do, is when folks think about patient care, you know, they often think, what are the doctors doing? What are the nurses doing? What are the pharmacists doing? Folks don't often think, how are the doctors and the pharmacists and the nurses getting what they need? And that's, what is just so cool about academic detailing. Again, it's something where we are just so excited at NaRCAD to support these detailers who are all just such amazing people. They're very caring. A lot of them have backgrounds in social work, public health, and many of them are clinicians themselves, but no matter what their background, they are all really committed to helping clinicians do the best that they can with the best evidence and help their patients become healthier, safer, and hopefully happier. So, that's why we love what we do. Thanks so much Anna for inviting me to come onto the podcast!

Anna: Thank you, Bevin! Let's do this again soon.

Bevin: Okay, we will!