Module 10: Academic Detailing as a Quality Improvement Tool

Introductory Guide to Academic Detailing

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Academic Detailing Visits

Academic detailing is interactive educational outreach to physicians to provide unbiased, non-commercial, evidence-based information about medications and other therapeutic decisions, with the goal of improving patient care. It is usually provided to clinicians one-on-one in their own offices. The approach is based on the effective communication/behavior change/marketing approach that is used so powerfully by pharmaceutical industry sales reps ("detailers") to increase use of a company's products. However, academic detailing puts this approach solely in the service of providing practitioners with neutral, rigorous information to optimize their clinical decisionmaking.

Like most human interactions, each academic detailing visit is a unique and potentially unpredictable encounter. This is especially true during the first meeting with a clinician. The flow and course of the discussion depends on the particular skills and personality of the detailer, as well as the clinician's specialty, practice patterns, attitudes, personality and mood. A series of common steps can help take an encounter successfully from the pleasantries of hellos to the communication and acceptance of specific evidence-based practice recommendations.

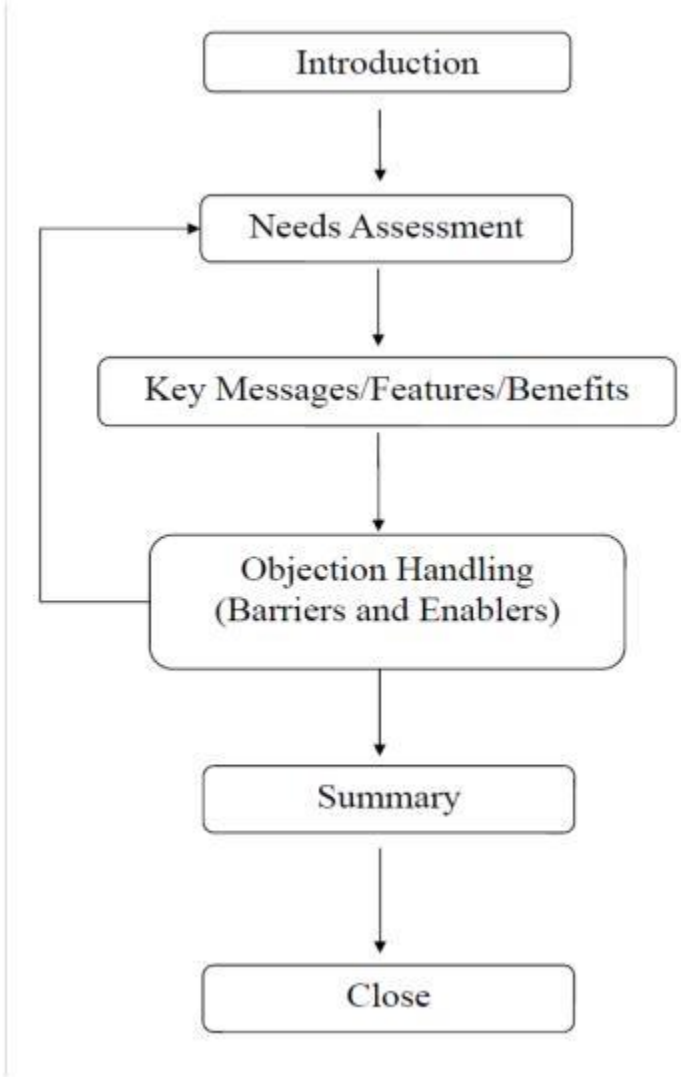
The steps include:

1. The Introduction
2. Needs Assessment
3. Key Messages/Features/Benefits
4. Understanding Barriers and Enablers
5. Identifying and Handling Objections
6. Summary
7. Close

The following pages will cover each of these key steps, and give a sense of how the elements fit together. It is important to understand that a successful academic detail is a conversation, not a checklist. The conversation should flow naturally from the subject matter itself, the focus of the

clinician's medical practice, and the goal of successfully changing attitudes and behaviors in order to improve patient care.

Flow of an Academic Detailing Visit



The Introduction

The introduction is generally brief, but it forms one of the most important parts of an academic detailing visit. It sets the tone of the visit, conveys a sense of purpose, and can lay the foundation for future visits.

If you have previously called on the clinician, your introduction will be a brief reacquainting, since you have laid the groundwork during your previous visits and have already established a relationship. In many cases, you will be calling on someone for the first time and will need to build the relationship from scratch. An important challenge is that while nearly all prescribers know about pharmaceutical company sales reps, most may never have heard of academic detailing—public-service health educators whose job is to communicate unbiased summaries of evidence, rather than to promote sales of particular products. Thus, most initial visits require

explaining the nature of the program and making it clear that it is not just another industry-sponsored promotional program, nor an intervention to cut costs without regard for clinical quality.

The introduction needs to effectively communicate:

Who you are:

Name, title, brief occupational background as relevant.

Where you are from:

The agency or group that you represent, or are funded by, a brief background on your organization if it might be unknown to the clinician.

What the academic detailing service is:

Why the sponsoring group has established the program.

Why you are there and what benefit will you deliver:

What is your purpose for calling on this clinician? How will your visit benefit the clinician?

Example:

"Hi my name is Sally Markinson. I am an academic detailer and a nurse practitioner by training. I'm here as part of a new service supported by the State Department of Health to provide practitioners with summaries of the most current evidence about medications you are currently prescribing [modify as needed for other interventions]. Our goal is to provide you with up-to-date and useful information to help you in managing your patients."

Check for acceptance: Time is precious for a clinician. You want to make sure that you ask for the time you need in a respectful fashion and that the clinician agrees that it will be worthwhile to talk with you. Emphasize that this is a *service* being offered to the physician, and convey the idea that it can actually be a highly *efficient* use of his/her time to receive a condensed overview of the most recent literature on a given topic.

Example:

"I was hoping to discuss the care of patients with Type 2 diabetes. It should take about 15-20 minutes of your time, in which we can discuss this overview of the most recent clinical literature about the risks and benefits of common approaches to treatment; I believe you'll find it very informative. Would now be a good time for us to talk?"

"Is this still a good time for us to talk? When would you like me to finish by?"

Note: You need to use your judgment. Does it seem like there is a big backlog of patients? Might another time be better? Is it office policy that visits must be scheduled in advance? Can you get by with just 5 or 10 minutes? If you don't meet now will you get another chance?

Needs Assessment

To be effective as an academic detailer you need to understand the clinician, his/her practice, beliefs, attitudes, issues, and concerns. This way, you will be able to tailor your visit to address that practitioner's specific situation and needs. This *interactivity* makes it possible for you to adjust your presentation to each of the above elements, rather than delivering a canned one-size-fits-all lecture.

After the introduction, you will need to *bridge* to your intended topic and ask probing questions to assess the perceptions and needs of the clinician.

Note: Needs assessment begins as soon as you walk in the door of the office. How busy is it? What types of patients are in the waiting room? Are patient guides on display? What topics do these guides cover?

Bridge

The bridge is a straightforward way to move smoothly from the introduction to the conversation.

> *Example:*
>
> "As you know, undiagnosed or uncontrolled diabetes is becoming a major public health problem. I want to talk with you about the care of your Type 2 diabetes patients…"
>
> "Many of the doctors I speak with say that the care of their diabetes patients is a real challenge; I would like to talk with you about your care of Type 2 diabetes patients."

Open-Ended Questions

The goal of the needs assessment is two-fold. You want to understand more about the clinician's practice and attitudes regarding your chosen topic and you want to get thoughtful participation by the doctor in the conversation.

Questions like "Do you see many diabetics?" "How many of your patients are on insulin?" are considered *closed-ended*. While they might be useful in gaining some information, questions that can be answered with yes or no or simple replies do not lead into deeper conversation. These questions might be used to gather specific, relevant information, but you need to rely on more thoughtful questions to really learn about the clinician's practice and to establish an engaging interaction.

To establish a productive conversation, primarily use questions that are *open-ended* and give the clinician an opportunity to say what is on his or her mind. These are typically "how" or "why" questions.

> *Example:*
>
> "I hear from a lot of doctors that compliance is a big challenge. How do you deal with compliance problems among your diabetic patients?"
>
> "Why do you start most of your patients on long-acting insulin?"

"What typically is the trigger that makes you decide to add insulin to the regimen for a particular patient? Why is that?"

Key Messages

In an academic detailing visit your goal is to bring about behavioral change in keeping with the best evidence to improve patient outcomes. You have a limited amount of time to achieve this goal, so it is important to know what the key messages that you need to deliver are. These messages need to be planned and thoroughly understood well in advance of your visit.

Key messages are a limited number of important points that are relevant, compelling, and succinct, and are generally specific practice recommendations. Your clinician must understand and accept these messages before any action can be expected. If at the end of your conversation your clinician will remember only a few points, what would you like them to be? Those few things are your key messages.

Key messages are linked to the materials you share with the clinician. Depending on the topics and the clinician, some messages may be more impactful and better accepted than others. In some discussions you may choose to stress specific messages more than others, as the circumstances dictate. Your ultimate goal is to help the practitioner accept as many of the messages as possible. If multiple visits are planned with the same clinician, you might limit the key messages you focus on during each visit.

Examples:

Good key messages:

- Target HbA1c levels to below 7% for most patients with diabetes.
- Initiate insulin therapy as promptly as possible when oral agents are not effective.
- Use metformin in most cases as the preferred oral antidiabetic starting treatment.

Ineffective key messages:

- HbA1c levels are indirect measures of glucose levels.
- There are over 63 different oral antidiabetic agents to choose from.
- Sulfonylureas work to increase cellular sensitivity to insulin.
- A meta-analysis of all oral agents showed that they were all equally effective.

Note: Just because something is not a key message does not mean it should not be mentioned or shared. It just means that the delivery of that message is not the ultimate goal. Such information may help to support the delivery and the acceptance of your key message, but delivering that information alone does not guarantee that you successfully deliver your key messages.

Features and Benefits

Any product, service or proposed action can be presented as a series of features. *Features* are facts or details that describe a product. A drug may be designed to be taken once a day, or a

guideline can consist of 7 easy-to-follow steps. While it is important to identify the features, the discussion cannot be left there. *Benefits* must also be discussed.

A *benefit* is how a feature meets the needs of the clinician; it has a clear and direct impact. It provides the "what's in it for me?"

Example:

"A once-a-day drug will be easier for your patients to take and will increase their compliance. That means you don't have to worry as much about the risk of noncompliance."

"Following this 7-step guideline will enable you to deliver improved care and save you a lot of time."

If you are not sure if something is a feature or a benefit, just ask yourself the question, *"So what?"* If you still need further explanation to answer the "So what?" question, then you are still describing a feature and haven't yet gotten to the benefit.

Example:

"X has no known harmful drug interactions." *(feature)* **So what?**

"…so that when you initiate therapy with X you won't have to make changes to any of the other medications your patients are already taking." *(benefit)*

In an academic detailing visit, you should always connect a feature with a benefit. The benefit motivates people to change their opinions or behaviors.

Features and benefits are often linked by words such as "therefore," "because," "so that," "which means," etc.

Examples:

"Metformin and sulfonylureas work by different mechanisms; therefore, you gain additional HbA1c control by adding a sulfonylurea to a patient inadequately controlled with metformin."

"The ADA recommends that if the HbA1c level is still above 8% after the use of two oral antidiabetic agents, insulin therapy should be initiated, which means you do not need to worry about the cost, risks, and complexity of adding another oral agent and can get adequate control sooner."

Barriers and Enablers

When examining your features, benefits and key messages, it is important to plan ahead and anticipate potential challenges you may encounter, as well as potential responses to these challenges. We call these *barriers and enablers*.

Barriers are potential obstacles to acceptance of key messages that clinicians may perceive. These most often appear in the form of an *objection* (see next section). *Enablers* are parts of your key messages; they are benefits and features that might address the concern.

For each key message you should be ready to identify the potential barriers and what enablers might be useful in addressing those barriers.

Examples:

Key Message: "If two oral agents do not control glucose levels, insulin therapy should be added to the regimen."

Possible Barrier: "My patients don't want to be on insulin. So I think it is best to add a third oral agent."

Possible Enabler: "It is common for patients not to want to be on insulin. That is why the ADA recommends waiting until two agents don't work. But after that, the data shows that the delay can have a negative impact on the patient's long term health outcomes, and that is why it is so important to start insulin early."

Key Message: "If two oral agents do not control glucose levels, insulin therapy should be added to the regimen."

Possible Barrier: "I actually prefer to replace the oral agents with insulin alone. It is cheaper and requires less work for the patient to only take one medicine."

Possible Enabler: "Data shows that combining oral agents with insulin actually works better. It provides better glucose control and weight control, and can reduce the likelihood and severity of side effects. Since your patient is already familiar with their routine in taking their oral medicine, the addition of insulin will also create the least disruption."

Handling Objections

As acknowledged in the review of barriers and enablers, clinicians will not always accept the messages you are delivering or agree with the information you share. These *objections* may be direct ("I don't agree that I should be monitoring my patients that often") or they may be indirect ("I don't see that as a problem in my practice"). It is therefore very important to use your communication skills to understand what the true *barrier* is behind the stated objection.

Encountering objections should not be considered a sign of failure or a negative reflection of your skills as an academic detailer. In fact, an objection presented by a physician is a sign of participation and opens an opportunity for addressing an issue he or she sees as an important concern. Objections can also signal the need to better understand your clinician's situation and to provide more information. Objections could signal: a lack of understanding of the issue, a fear that change means more work, a lack of recognition of the need for change, a misunderstanding of what you communicated, or a genuine disagreement with the content of your message.

Overcome objections by having a positive attitude and avoiding an argument. Use the objection as an opportunity to further your understanding of your clinician and the barriers presented and to move the discussion forward. It may not be necessary to immediately respond to the objection with a counterargument. There are specific steps you should take to effectively manage objections.

Steps for handling objections:

1. **Probe** (ask questions) to clarify your understanding of the objection.

    - This is an opportunity to better understand your clinician's needs and attitudes.
2. **Restate** the objection to signal that you are being attentive to the clinician's concerns, and to confirm that you understand them and have identified the true barrier.
3. **Consider** whether you are prepared to address the objection then and there, or if you need more information and time to do so.
4. **Respond** to the objection, utilizing probing skills and relevant key messages, features/benefits, and enablers.
5. **Gain confirmation** that you addressed the objection successfully.

Objections will generally fall into one of four categories:

1. **Stops:** A disagreement with your key messages and rejection of your call to action.
   "I don't think approach A is better than approach B because it is more time consuming."
2. **Stalls:** A deferral of decision on your call to action.
   "We have a staff meeting next week and we will discuss the situation and make a decision."
3. **On the fence:** An indication that the clinician is open to your position, but just not completely convinced.
   "I understand how your approach could be useful, but I am worried we won't be able to implement it."
4. **Indifference:** A general lack of interest.

Stops

Stops are effectively no's. They can be based on:

- misunderstandings
- skepticism of clinical content
- valid concerns regarding drawbacks

For stops you need to get a better understanding of the concern by asking clarifying questions.

Misunderstandings or skepticism are the easiest to address. They require tactful provision of the correct information. For skepticism you may have to provide the source data or credible third party support for your position.

Valid concerns are sometimes the most challenging to address, since the objections are not over the facts themselves, but rather over the weighting of the facts and the identification of a

drawback. For such concerns you should acknowledge the concern and then reframe the issue so that it fits into the bigger picture, where the benefits outweigh the drawbacks.

Example:

"You are correct, Doctor Smith. Patients are often resistant to initiation of insulin therapy. But most patients with difficult-to-control diabetes will end up on insulin at some point, and data shows that late initiation can have negative long term consequences, including preventable progression of end-organ damage."

Stalls

A stall is usually a polite "no" or sometimes an avoidance of making a decision. The challenge with a stall is that it keeps you from knowing the clinician's true thinking. Use the opportunity to discover if a barrier exists behind the stall by asking direct questions.

Example:

Doctor: "Thanks for the information. We have a staff meeting next Friday and we will discuss it then."

AD: "Great! I will follow up on Monday." (accepted stall)

vs.

AD: "Based on the information we discussed today, what will your recommendation be at the meeting?" (probed for better understanding)

Depending upon what you discover, you may have to re-engage the stalling physician and handle the true barrier.

On the Fence

For those who are still on the fence, you need to better understand what benefit is missing for the clinician. What would be convincing? Were the benefits that you shared not significant enough? What needs are unfulfilled? Through open-ended probing questions you should be able to uncover what it would take to change their stance.

- Use open-ended probing to understand the nature of the remaining concern or hesitation or to discover what would be convincing.
- Offer information, features, and benefits related to your key messages to address the concern.
- Check to ensure resolution.

"What would convince you to choose another form of insulin for your patients?"
"What do you think is the most compelling clinical data for a product?"

Indifference

In addressing indifference, you need to ask questions to help the clinician see a bigger need.

- Acknowledge the clinician's point of view.
- Request permission to probe.
- Use closed-ended probes to create awareness of a need.
- Confirm the recognition of the need.
- Show how the need can be met.

Example:

"Have you had patients for whom it took unusually long to get their diabetes under control?"

"Did any of them have their cardiovascular or renal status deteriorate during this period?"

"Would it be beneficial to be able to avoid the problems associated with this disease progression?"

(Indifference is one of the times when using closed-ended questions can be very helpful.)

Note: Successful objection handling should ultimately conclude with the acceptance of a relevant key message through its features/benefits. This will enable you to successfully bring the objection to closure.

Summary and Close

The *summary* of an academic detailing visit should not take long. It is not a catalog of everything that was discussed. It is an overview of the key messages that the clinician agreed to and a general sense of where the conversation concluded. It includes checking to make sure that all key concerns have been covered. The role of the summary is to have the clinician acknowledge the key messages "bought into" during the discussion.

During a summary:

- Provide a brief review of the key messages, emphasizing those the clinician seems to have accepted.
- Ask if the clinician has any questions regarding what was covered.
- If further questions exist, use the opportunity to answer them.
- Do not repeat messages that were not well received.

Example:

"Dr. Jones, we discussed the comparative effectiveness data on oral antidiabetic medications and the ADA recommendations based on that data to initiate therapy first with metformin. In addition, we noted the evidence that when oral agents are inadequate to reach target A1c levels, moving to insulin therapy is too often postponed. The recommendations are that if greater control is needed after two oral agents are used, then insulin should be started. Do

those guidelines seem applicable in your practice? Was there anything important you feel I haven't answered or addressed about managing your patients with diabetes?"

After the summary comes the *close*, when you ask the clinician to implement some of the key messages/practice recommendations. From the flow of the conversation with the clinician and the acceptance or rejection of your key messages, you should have a good understanding of what changes he or she may be ready to accept. It is important, however, to get the clinician to own that change. Further, it is helpful to get them to visualize how the changes will be implemented.

Examples:

"I hope this information was helpful to you and that you find these suggestions easy to implement…."

"Will you be able to transition to this new guideline soon?"

"Do you already have patients in mind who might fit those criteria?"

"It's great that you are willing to try these recommendations. Can I check in with you next month to see if you've been successfully implementing the changes and answer any additional questions you may have?"

Note: The close is when you should take the opportunity to see if the clinician would be willing for you to meet with him or her again in the future to share more information.