

VA Academic Detailing Implementation Guide

**U.S. Department of Veterans Affairs
Veterans Health Administration**

**Created by:
VA PBM Academic Detailing Service**

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VA Academic Detailing Mission Statement

To enhance Veteran outcomes by empowering clinicians and promoting the use of evidence-based treatments using the intervention of Academic Detailing by clinical pharmacy specialists.

Preface

The following VA Academic Detailing Implementation Guide is largely based on prior experiences through the VISN 21/22 Academic Detailing Pilot Program and is intended to assist new programs and detailers with implementation of academic detailing. Except where citations are provided, the content reflects the opinions of the VA PBM National Academic Detailing Service (ADS).



*Real Provider Resources
Real Patient Results*

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Part 1. Academic Detailing Code of Conduct

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

- As an academic detailer, you have the opportunity to improve the care of thousands of Veterans; treat this responsibility with the respect it deserves.
- Be prepared to provide accurate, informative, practical and balanced information.
- Do not push resources or information the provider does not see a need for or value in. This will lead to provider frustration and most likely not lead to behavior change. Instead, discover what they value and need while advocating for the best care for our Veterans.
- Seek first to understand, empathize and be respectful of differences of opinion. Keep in mind that as an academic detailer you are an optional service available to providers; meeting with you is not mandatory.
- Be attentive, responsive, and follow up as necessary in a timely manner.
- Be responsible, reliable, respectful of time and commitments, and thank him or her for their time.
- Always maintain confidentiality and respect the privacy of providers, patients and other healthcare team members.
- Celebrate success; change is hard. Encouragement, acknowledgement, and praise are critical elements for sustaining change. Be accountable and report back not only the success of the behavior change, but also on the improved health outcomes.
- Last but not least, we all make mistakes and no one is perfect! With a commitment to persevere through frustration, rejection and discouragement, detailing skills will improve and evolve over time. When you have an outreach visit that doesn't go well, frame this experience as a learning opportunity, learn from your mistakes, collaborate with and learn from your peers, and be open to feedback.

Modified from:

*Terryn Naumann, BScPharm, PharmD
Director, Evaluation/Coordinator of BC PAD service
BC Ministry of Health,
New Westminster, British Columbia, Canada
Code of Conduct; November 9, 2015*

Part 2. Overview of Academic Detailing (AD)

I. What is AD?

AD is a service for clinicians, by clinicians, that provides individualized, face-to-face outreach, to encourage evidence-based decision making to improve Veteran health outcomes. It is a scholarly approach that uses direct one-on-one social marketing techniques to provide service-oriented outreach for health care professionals using balanced, evidenced-based information. The overall goal of ADS is to improve evidence-based delivery of health care, disease management and preventative services nationally by resourcing front-line clinicians. Academic detailers use real time data and interact with front-line providers in order to understand the barriers to implementation. Detailers target educational outreach to where there is need and are able to tailor solutions and resources available to address the barriers applicable to each facility, clinical team and provider. Academic Detailing uses a strategic intervention to promote evidence-based treatments, improve quality of care, assess delivery models and resources which results in improvements for the healthcare system. The information is provided interactively so the detailer can: understand where the provider is coming from in terms of knowledge, attitudes, and behavior; modify the discussion appropriately; engage the provider; and conclude the visit with specific practice-change action items¹. Over time, the goal is for the detailer and provider to develop a trusted and synergistic relationship.

In March 2015, the Interim Under Secretary for Health (IUSH) issued a memorandum requiring implementation of AD programs throughout the VHA².

II. Why is AD needed?

Analysis of various prescribing practices reveals a significant gap between the evidence and current practice in some areas. VHA has utilized various training interventions to address safe medication use and training for clinicians for improving use of pharmaceuticals and increasing use of effective, under-utilized treatments through policy development, mandatory chart reviews and national response to poly-pharmacy, national webinars, continuing medical education, and collaborative councils. Outcomes of these broad programming efforts have not sustained change consistently.

Contributing to the gap between the evidence and current practice is the continuous growth of scientific literature. As of 2014, this rate of growth was estimated to be 8-9% from World War II to 2012, which corresponds to a doubling of scientific literature every 9 years³. Simply attempting to remain well versed in all aspects of medical improvements is undoubtedly becoming more difficult with time.

III. Is AD effective?

Academic detailing has been studied extensively over the last 25 plus years, and a 2007 large systematic review of 69 studies confirmed the ability of Academic Detailing to improve medical practice. Results varied based on type of outcome being assessed and type of interventions performed (e.g. outreach visits alone vs a multifaceted approach)^{4,5}.

Other research has published results indicating high MD acceptance rates from cold calls (92%), significant reductions in inappropriate prescribing (14%) and cost savings (\$2 saved for every dollar spent)^{6,7}.

IV. How is AD different from existing clinical pharmacy services?

In the VA, clinical pharmacy specialists performing AD are trained on the skills of Academic Detailing which requires a complex combination of knowledge, attitudes, specific communication skills, and personal values that reflect a high level of tacit learning. The academic detailer brings the best available evidence to the place at which care is delivered and tailors the interaction to the level of knowledge, interest, and responsibility of the provider being visited. The interaction between the detailer and the provider moves beyond communicating information and focuses more on understanding existing behaviors, motivations, and perceived barriers through discussion. The detailer encourages and facilitates change as the provider voluntarily decides to make a change in his or her practice. Change in practice is achieved through voluntary action by providers, not via coercion or policy enforcement.

Clinical pharmacy specialists (CPS) utilize education to influence patient care but this often occurs on a case-by-case basis via specific medication management or treatment recommendations for an individual patient. In contrast, an academic detailer focuses on population management with providers and cultural change within the facility. It is designed to empower the clinician to utilize evidence-based medicine and support providers, including CPS's, to overcome barriers to implementation of evidence-based practice.

Part 3. Developing an Academic Detailing Program

I. Various AD Program Models

- a. VISN-level consolidated work units (CWU) – *Recommended* model for VA

Example: 3.0 FTEE assigned at the VISN level to perform AD activities throughout the VISN

The VISN 21/22 AD Pilot CWU model was comprised of 5.0 clinical pharmacist academic detailers FTEE covering 2 VISNs along with 1.0 clinical pharmacist FTEE to serve as an AD Program Director. (Of note, the AD Program Director was assigned two duties: 1. Manage and prioritize VISN 21/22 AD Program activities and 2. Perform academic detailing activities in the assigned territory.) Based on the success of the VA pilot program, the VISN-level CWU is currently the recommended model for VA AD programs.

The CWU allows for a more flexible, proactive and coordinated approach to AD when managed by an AD Program Director. The AD team can shift focus from one area to another under the guidance of the AD Program Director. The CWU also allows AD programs to prioritize efforts on long-term program goals rather than the immediate needs at any one facility which promotes standardization and reduces variability amongst facilities in the VISN. In addition, it provides a more consistent linkage with all involved program offices, committees, and resources at various levels. The efficiency gained from centralizing AD functions and access to resources via a CWU will reduce staff needed to provide this service and improve the ability to deploy national resources and achieve goals across VHA.

- b. De-centralized staffing model

Although the IUSH memorandum mandated establishment of Academic Detailing Programs with 3.0-7.0 FTEE per VISN, additional funding was not provided. One method VISNs have opted for was to integrate Academic Detailing activities with their existing Clinical Pharmacy Specialists by providing them time to perform Academic Detailing.

Example: Multiple pharmacists responsible for detailing at one facility (1 FTEE spread amongst the various pharmacists)

- c. Hybrid staffing model

Example: 3.0 FTEE distributed among 15 pharmacists belonging to various facilities throughout the VISN; 2.0 FTEE for two VISN Academic Detailers responsible for the VISN.

II. Discipline/specialty of detailers

Various national and international programs have used pharmacists, nurses, physician assistants and physicians as Academic Detailers; however, the VA PBM ADS selected pharmacists to serve as academic detailers given the current national focus on various medication safety initiatives.

It is imperative that the Academic Detailer has the qualifications and expertise necessary to educate clinical personnel. Without this expertise, it is difficult to obtain provider buy-in due to a lack of credibility and as a result, behavior change will be less likely to occur.

Pharmacists currently serve as the drug information experts for patients and health care teams and are not only valued across specialties for their refined knowledge of medication management, but they also have the capacity to recommend non-pharmacological evidence-based treatments. Using drug information experts as Academic Detailers also allows them to serve as a resource for more complex patient cases.

The following are reasons for the decision to select pharmacists as the preferred health care professionals to serve as Academic Detailers in VA:

1. Properly trained clinical pharmacy specialists currently work alongside physician colleagues and have been shown to make a substantial impact on patient care in a variety of practice settings.
2. Pharmacists are important partners to physicians in implementation of medication use programs.
3. Pharmacists provide recommendations via a chart note to change or discontinue medications according to current evidence-based treatment guidelines and local policies. This allows easy transition to an Academic Detailing interactive model which allows the intervention to impact more than one patient.
4. Restricting use of certain medications is usually assigned to pharmacy and requires a large personnel commitment and also raises issues related to prescriber autonomy. Pharmacists functioning as Academic Detailers can be used to supplement these policies thus using pharmacists' time more efficiently, reducing provider frustration and improving patient outcomes.
5. Pharmacists already have collaborative agreements under a scope of practice with prescribing privileges to provide medication-related treatment as CPS and clinical pharmacy specialists also work in a collaborative relationship to give recommendations to providers about adjusting medications according to evidence-based treatment.
6. Inclusion of pharmacists in the treatment decision reduces medication errors and improves prescribing; prescribers are used to pharmacists functioning in this capacity.
7. Pharmacists are trained to gather and assess applicable primary literature and must demonstrate the ability to accurately interpret the significance of study results and make appropriate medication use recommendations to providers.
8. Pharmacists review current primary literature on a regular basis and prepare reference materials and patient education. This makes them well suited to function as Academic Detailers as the development and use of comprehensive educational resources is a core component of the Academic Detailing educational outreach visit.
9. Pharmacists often serve as drug information resources to the physician. As an Academic Detailer the pharmacist still functions as the provider of balanced evidence-based information.

Pharmacists do not need to be a particular specialty (e.g. Mental Health, Pain, Ambulatory Care, etc.) to be an academic detailer. In fact, academic detailing programs often cover campaigns across several specialties and all detailers are expected to learn the content. If a VISN or facility knows it would like to focus on specific topic areas, then considering a specialist in that area may benefit the program.

III. Target FTEE per VISN

To provide coverage of VISN medical centers and clinics, it was mandated that a CWU with between 3 and 7 FTEEs be assigned these duties with sufficient travel funds to visit the associated VA Medical Center (VAMC), Community Based Outpatient Clinic (CBOC), or Department of Defense (DoD) health care settings. The expectation with this fixed academic detailing FTEE per VISN is that detailers are available to promote behavior change at the provider level rather than to focus on direct patient care activities. In most VISNs, these detailing FTEE positions would cover 1-3 VA facilities and their CBOCs.

ADS highly recommends assigning an AD Program Director FTEE to facilitate the AD team efforts as discussed in [Part 3.1.a](#).

ADS recommends that each Academic Detailer be assigned 0.5 FTEE or more. ADS discourages programs assigning AD FTEE allocations less than 50% per detailer due to the following concerns:

- Insufficient time available for academic detailing may mean the detailer is unable to complete follow-up visits with providers. Follow-up visits have been shown to be more effective than a single visit⁷.
- With only a small amount of time dedicated to academic detailing on a weekly or monthly basis, it will be challenging for the detailer to consistently practice and maintain or improve this complex communication technique.
- Scheduling time with busy providers will be increasingly difficult if the detailer's schedule is not sufficiently flexible due to existing non-AD or clinical duties. This will limit the detailer's ability to meet with providers during the provider's available time which results in a service less convenient for the provider.

IV. Hiring Process

Academic Detailers should be comfortable communicating with other health care professionals, be flexible, and persistent. Academic detailing may be more challenging for those pharmacists who do not enjoy face-to-face interactions using complex communication techniques. In addition to excellent communication skills, detailers need to be empathetic and attentive when interacting with providers. When making your selections, it is important to assess for comfort levels and abilities to communicate with others. Flexibility and persistence are also important attributes, since scheduling time to meet with providers can be challenging and detailers must be willing to work around a

provider's schedule in order to meet the needs of the provider. Detailers should also have confidence in their abilities and knowledge, which is vital to establishing a strong working relationship with providers. For more information on the hiring process, including example interview questions and example functional statements, please visit the National AD SharePoint: [Link](#)

Academic Detailers can be rated as Clinical Pharmacy Specialists (GS-13) or have equivalent work experience. ADS recommends pursuing GS-14 ratings for Academic Detailing Program Directors. Program Directors will include a supervisory role managing Academic Detailers assigned to multiple facilities. GS-14 ratings for academic detailers require additional language and boarding processes that can be identified from the [Pharmacy Program Manager Qual Standards](#). Please work with your local Human Resources Department to develop GS-14 positions as needed.

V. Labor Mapping

According to [VHA Directive 2011-009](#), there are four categories providers can be mapped under:

- 1) Direct Patient Care Time,
- 2) Administrative Time,
- 3) Education Time, and
- 4) Research Time.

Often times, academic detailers still may have clinical and direct patient care responsibilities, but the act of Academic Detailing does not fall under *Direct Patient Care*. If your academic detailers have clinical time, please consider this as you map the position.

Administrative time is defined as time spent on managerial or administrative duties, generally at the level of the department, service, medical facility, VISN, or nationally, both within and outside of VA. Examples of administrative time include: a) support of service wide administrative activities such as performance reviews, b) managing a program within a clinical department, service, or hospital, c) working on service committees, d) serving on state and national committees, advisory boards, or professional societies. Academic Detailers will likely be performing these duties in their day-to-day activities.

Education time is defined as time spent providing formal training (e.g. didactic education). This includes preparation as well as actual classroom or lecture time for educators or presenters. Academic detailers will likely be performing these duties in their day-to-day activities.

Research time is defined as time spent performing formal, approved health care research, or in activities in direct support of approved research. Formal, approved research is research that is approved through the hospital's research review process. Examples of research time may include: writing for publications or grants, supervising a student's, resident's or fellow's non-clinical research.

Below is an example of the labor mapping breakout of a typical full-time Academic Detailer:

- 0.2 FTEE as Direct Patient Care time for clinic day weekly
- 0.5 FTEE as Education time for outreach visit preparation, didactic lectures, and associated travel with an outreach visit
- 0.3 FTEE as Administrative time for outreach visits with providers and committee participation.

VI. Training recommendations for detailers

Academic Detailers need to utilize a specialized set of communication skills to effectively perform academic detailing:

- a. **Basic Skills Training (required for all academic detailers)**
ADS requires pharmacists who are assigned academic detailing duties obtain supervisor approval to attend Academic Detailing Basic Skills training. Basic Skills training provides information on academic detailing communication techniques and allows the academic detailer to practice the new skills. ADS currently provides three options for acquiring Basic Skills training. For more information on basic skills training, please visit our SharePoint site: [Link](#).
- b. **Additional relevant trainings: Motivational Interviewing (MI) (strongly recommended for academic detailers)**
Many motivational interviewing techniques and principles have been incorporated into the VA PBM Academic Detailing Service Basic Skills Trainings and are considered key communication strategies for performing academic detailing. Check local resources to see what options may be available for MI training.
- c. **Other trainings/techniques for consideration: (suggested)**
Sales trainings and/or other resources (e.g. books discussing sales techniques) may also be beneficial for academic detailers.

VII. Continued skill development for detailers

ADS recommends that programs establish standing recurring meetings to discuss difficult cases, barriers encountered, resolution or detailing strategies. One way this could be incorporated is to perform a practice detailing session or role-play of academic detailing scenarios or visits during program meetings. This provides a venue for continued practice among trained detailers who can provide feedback relating to your non-verbal cues and share styles among one another. Additional communication resources may be necessary to allow video sharing during the practice session/role-play:

1. Equipment: Webcam (video) and microphone / headset (audio)
2. Programs: Jabber (recommended) or Lync

Please consult with your local or VISN IT department for the equipment and programs.

Part 4. Setting Goals and Expectations

I. Target number of visits per FTEE

An estimated calculation for the target number of visits per FTEE is **0.25 outreach visits per hour of detailing time** based on workload seen in the later stages of the VISN 21/22 Pilot Program. Other AD time is spent doing non-visit activities to support the AD campaign such as resource development, dashboard reviews, in-services, policy work, and travel.

Example use of this ratio:

1 FTEE = 40 hours per week

→ 0.25 Outreach Visits per 1 hour AD time * 40 hours per week * 12 weeks per QTR

→ 120 Outreach Visits per quarter

It is also important to consider other factors that may affect the target number of visits per FTEE:

1. Program experience or stage of program implementation
 - i. Newer detailers and programs may need more time to establish relationships with their providers
2. Campaign development
 - i. New VISN campaigns often require resource development as there may not be an existing national resource. If more time is spent developing new campaigns, educational resources, and data tools, less time is available for conducting outreach visits.
3. Geographical catchment area
 - i. If a detailer has to travel long distances to meet with providers, the impact of travel time should be accounted for when evaluating workload and expectations

Note: Outreach Visits typically range in duration from 5 to 60 minutes and duration is typically agreed upon by both the detailer and the provider based on availability and the topic being discussed.

II. Campaigns per FTEE per year

The number of campaigns per fiscal year (FY) will vary based on the size of the AD territory and the number of academic detailers present. For a typical CWU model of detailing with the mandated FTEE (3.0–7.0), **implementing one to three academic detailing campaigns per FY is a reasonable goal**. It is important to recognize that attempting to take on too many campaigns during a FY may dilute the impact on any one campaign as your AD efforts

will be spread thin. You want to be sure that your detailers are able to schedule follow-up visits with at least 75% of priority panel providers before finishing a campaign. Meeting with providers more than once has been shown to significantly influence behavior change compared to one visit⁴.

The complexity of the campaign must also be considered and can commonly be grouped into two groups:

- a. Implementation of a new practice
- b. De-implementation of an existing practice

Typically, implementation of a new practice is easier to achieve than de-implementation; however, it is important to note that the range of ease varies by practice. Behaviors that are easier for providers to implement will not take as many visits from an academic detailer as a behavior that is harder for them to implement. For example, getting a provider to order a new medication or a medication they may have forgotten about is often easier than getting a provider to start using a validated measurement based assessment tool like the PHQ-9 for depression. De-implementation can often be more difficult than implementation. Encouraging providers to avoid prescribing antipsychotics for sleep or approaching benzodiazepine tapers in high risk populations may take several visits from an academic detailer as they will likely have questions and need assistance with establishing new protocols or processes for prescribing medications other than antipsychotics or benzodiazepines.

III. Campaign goals

It is important to set campaign goals before initiating academic detailing in any particular area. SMART criteria are often used in program management⁸:

Specific: focus on a specific key message(s) within the campaign

Measurable: use key messages that are tracked in data tools

Achievable: set a realistic goal; aim for an X% improvement compared to your baseline

Relevant: align with leadership interests and local needs

Time-bound: set specific time frames for completion, review and re-evaluation

For example, the OSI campaign's goal to reduce overdose and death associated with opioids can be accomplished in multiple stages:

1. "Urine drug testing should be done at least annually for patients on chronic opioid therapy. When used with a proper level of understanding, they can improve your ability to safely and appropriately manage opioid therapy."
 - a. Increasing annual UDS
 - b. Interpreting UDS results

An increase in annual UDS alone may not reduce overdose and death associated with opioids, but it shifts the frame towards safe and appropriate management of opioid therapy. This provides an opportunity for providers to discuss safety considerations with patients on opioid therapy and consider whether or not to continue the opioid. For example, patients with opioid prescriptions with negative UDS results may be at increased risk of overdose should they self-initiate therapy at previously tolerant levels.

2. “With overwhelming evidence for the misuse, abuse and risk of overdose along with limited efficacy of chronic opioid therapy, it is important to re-examine high-dose opioids (> 120 mg/day MED) and to consider consultation or dose reduction rather than further escalation of the dose.”
 - a. Tapering patients off high dose opioid therapy

Tapering patients to lower, safer doses would not affect a campaign that focused on raw utilization. However, dose reductions with risky medications would impact the overall campaign goal. This provides an opportunity for providers to focus on a subgroup of patients on opioid therapy to address safety concerns.

IV. Target # of visits per provider per campaign

Ideally an academic detailing program would meet with 100% of their identified priority panel providers over the course of a campaign. This however may be an unachievable goal due to staffing limitations, territory size, etc. In order to maximize the opportunity for change in a given campaign, ADS recommends meeting with *at least 75% of priority panel providers* per campaign at least once. Remember, follow-up visits have been shown to be more effective than a single visit, so if you focus on 75% of your priority panel providers, but are able to meet with each of them more than once, you are likely going to be more effective than if you were to have a single visit with each provider.⁵

More specific goals may be identified locally by considering the following factors:

1. Campaign Complexity: For details, please refer to [Part 4.II](#)
2. Number of detailers available
Ideally, the detailer should meet with priority panel providers at least once over the course of one campaign. It is strongly encouraged that you do at least one follow-up visit with those providers in order to maximize your opportunity to influence provider behavior, but that may or may not be feasible with the limited FTEE. It is important to find a balance that fits both the campaign and your staffing model.
3. Number of campaigns the detailer is asked to cover during a FY
This may be quite variable due to the different models of AD in VA (CWU, de-centralized staffing model, or hybrid staffing model)

In the recommended CWU model, the number of campaigns a detailer is asked to cover during a FY is likely equal to the number of campaigns selected for the FY. Each detailer is expected to work on the VISN selected campaigns. The ADS recommends that no

more than three academic detailing campaigns be selected per FY to ensure that at least 75% of priority panel providers are met with at least once.

The ADS currently has no evidence to support recommendations for non-CWU models as this was not tested during the VISN 21/22 Pilot Program.

V. Priority Panels per campaign

Priority panels can be identified in the data by aggregating the actionable patients to providers.

There is no absolute number of priority panels per campaign an academic detailing program should identify; however, consider defining priority panels as the top 20% of panels (aggregated actionable patient panels) in that particular area or key message. This will allow for the most opportunity for improvement.

The top 20% are suggested because of a common observational rule referred to as the 80/20 rule.

Part 5. Rolling out an Academic Detailing campaign

Campaign implementation can typically be broken into 4 main phases:

1. Selection/strategic planning
2. Preparation
3. Implementation
4. Evaluation (covered in [Part 7](#) of this document)

1. Selection/strategic planning

- a. Key players:
 - i. VISN Leadership
 1. VISN Pharmacist Executive (VPE)
 2. VISN Director
 - ii. Station Leadership
 1. Chief of Pharmacy
 2. Chief of “x” service
 3. Chief of Staff

The selection/strategic planning process should involve leadership and key personnel throughout the VISN including individuals from above.

b. Select a *potential* campaign

Tailor campaign topics to meet the needs of the AD program’s territory (e.g. facility and VISN). The program’s territorial needs may be based on metric performance, local initiatives, needs of local patients or providers, or other factors. It is important to discuss territory’s needs with leadership in order to determine what should be prioritized. Often times, leadership may have specific priorities which will direct AD efforts.

There are various ways to go about selecting a campaign for an AD program. The following are examples of processes for campaign selection (consider using a combination of processes if possible):

- i. Seek out recommendations from leadership and/or providers on what they believe is a priority or an area of need
- ii. Consider VHA priorities and evaluate whether or not National priorities are being implemented or need to be addressed in the AD territory
- iii. Utilize data tools (e.g. dashboards) and or metric performance to identify an area in need of intervention or behavior change

SMART goals can then be used to strategically plan the campaign (refer to [Part 4.III](#)). For example, the campaign may be designed to focus on Opioid Safety, specifically on high dose opioids defined as patients on greater than or equal to 100 milligram of morphine equivalents daily dose (MEDD) with a goal reduction of 10% from FY15Q1 to FY15Q4.

c. Identify key message(s) for your selected campaign

Key messages are derived from facts and may require multiple iterations to produce a powerful and concise message. Review the evidence surrounding the campaign of interest (Example: OSI) and continue to ask “why”, “how”, and “what can we do.”

- Why are opioids garnering national attention?
- What can we do to reduce the risk of overdose and death with opioid use?
- How can we taper patients on opioids?
- Why are patients not being tapered?

One potential key message for opioid safety: Consider tapering patients on opioids at ≥ 100 MEDD to reduce the risk of overdose.

i. Target number of key messages per campaign

ADS recommends to limit the number of key messages of a campaign to between 4 and 6. Key messages should align with the intended behavior changes. Prior psychological research has demonstrated a paralyzing effect when presented with too many options⁹. “Information overload” may occur and actually become counterproductive.

Although the campaign may include between 4 and 6 key messages, the intention behind academic detailing is not to cover all key messages during one visit but rather to customize delivery of select key messages most relevant for that individual provider. Determining which key messages to focus on can be done by finding out more about the provider’s practice, via discussion with the provider and evaluation of the dashboard.

For example, if you have two key messages, one on the use of combination opioids/benzodiazepines and one on high dose opioids, a provider with patients on high dose opioids but no patients on the combination of opioids/benzodiazepines would be more likely to benefit from discussion regarding high dose opioids than opioids/benzodiazepines.

d. Needs assessment

In order to provide leadership with the necessary information to make a decision on prioritization of campaigns, a needs assessment is recommended.

Step 1 of a Needs Assessment: Gathering the data:

Once you have identified a potential campaign and key message(s), perform a thorough needs assessment to determine if the campaign is worth pursuing.

There are many theories and models of needs assessments or gap analyses but the essence remains the same: it is a systematic process for collecting information that enables justifiable decisions¹⁰.

Data collection can occur in various forms:

- Querying the VA Corporate Data Warehouse
 - Individuals with this skill may include pharmaco-economic pharmacists, data analysts, VISN / Regional / National Data Managers
 - Pros: Rapid, reproducible
 - Cons: Locations may not have staff capable with the necessary skills of collecting data through the Corporate Data Warehouse.
- VISTA Reports
 - Individuals with this skill may include ADPACs, CACs, informatics pharmacists, pharmaco-economic pharmacists, data analysts, VISN / Regional / National Data Managers
 - Pros: Rapid, reproducible
 - Cons: VISTA reports are specific to the instance of VISTA. Access to multiple VISTA systems would be necessary to collect data across a VISN.
- Surveys
 - Surveys can be conducted in various formats (in-person, computerized forms, paper forms, etc.) with variable levels of data integrity (ie. are questions qualitative or quantitative? Are there standardized scales for qualitative responses?)
 - Pros: Generate ideas from specific individuals or groups of individuals.
 - Cons: Time consuming, qualitative.
- Existing national data tools developed by:
 - Academic Detailing Service
 - OMHO (Office of Mental Health Operations)
 - PBM (Pharmacy Benefits Management)
 - VSSC (VHA Support Service Center)

Step 2 of a Needs Assessment: Analyzing the data

Once the data is collected, the data will need to be aggregated and analyzed:

- Data entry: Microsoft Excel is commonly used
- Aggregation: This will depend on the potential key message(s).
 - If the campaign focuses on prescription medications, consider aggregating by prescriber or primary care provider.
 - If the campaign focuses on topics covered during patient care visits, consider aggregating by the provider (specialty or primary care provider) or clinic Stop Code.
- Analysis: Visualization of the data is recommended.
 - Consider using Excel to graph the distribution of actionable patients by the aggregated factor (StopCode Clinics, primary care provider, prescriber, etc.).

Consider reviewing the data and answering the following questions:

- Does the distribution of priority panels align with the 80/20 rule?
- Does academic detailing have sufficient FTEE to meet with the priority panels?
- Does the amount of opportunity for improvement justify deployment of an Academic Detailing campaign?

Consider the underlying, barriers to care that may be affecting performance in this area:

- System: Dated policies; difficult CPRS functions
- Patient: Lack of interest; lack of awareness / knowledge
- Provider: Lack of interest; lack of awareness / knowledge; lack of alternatives; patient push back

Consider the type of activities that are necessary to remove the barrier and whether or not a tailored educational approach will be the most effective and efficient way to address the barrier or problem or if other approaches may be more successful. Some possible approaches by barrier may include:

- System: New policies; workarounds for CPRS (e.g. order sets)
- Patient: Patient educational outreach clinics; Direct-to-consumer (DTC) messaging utilizing cognitive dissonance; sessions utilizing motivational interviewing
- Provider: Academic Detailing Outreach Visits; partnerships with other team based care providers; others

Note: Ultimately, there is no “right” answer to determine if the campaign would meet an objective measure justifying deployment. This is a judgement that should be made by the AD Program Director and leadership. Remember to contact the National ADS office with questions regarding campaign selection or deployment if needed.

2. Preparation to develop a new campaign

a. Resource development

- i. Creating Academic Detailing materials – Core resources: Provider Guide, Quick Reference Guide, Patient Materials

Provider Guide

1. Purpose: This document summarizes and provides updates on medical literature for the topic being addressed; typically includes a combination of text, tables and graphics to illustrate information and provide support for key messages.
2. The first step to creating educational materials is to consider what you are trying to accomplish. What behaviors are you trying to influence? What is the problem with the current state and where are you trying to go? Are you targeting a specific medication class, disease state, or patient population?
3. Next, it is important to consider who your target audience is. Who will be using your materials the most? Who will you be meeting with in order to influence behaviors? Who will find them most helpful when trying to make a change? These are all important things to consider and may influence the information you cover and the way it is presented.
4. Once you have identified your goals of the piece and the target audience, it is important to do a search to see what materials have already been developed in that topic area. Is there something already out there addressing your goals and directed to your target audience? If so can you use it or modify it (with permission) to meet your needs? Is there something innovative out there that would give you ideas on how to design and compile your materials?
5. The next step in material development is to do a thorough literature review. Look for recent guidelines, clinical trials, and recent reviews. Often if you find a recent article addressing your topic, you can look at the reference list to find other articles to include in your piece. Do not just reference guidelines/review articles, go beyond that and pull the references used to make the recommendations and conclusions in the guidelines. For medication information, do not just use tertiary resources like Micromedex and Lexicomp / UpToDate. Go online and find the package insert. It is important that you confirm all information found in tertiary resources to ensure there are not mistakes or errors in the information. Please note that the content and level of evidence of academic detailing materials should be consistent and align with those of the VA including criteria for use, PBM guidance, the VA National Formulary, VA/DoD Clinical Practice Guidelines; and other VA guidance or policies when those resources are available. If VA materials are outdated, or in need of an update, please contact PBM or the ADS to determine the next steps for your materials.

6. Once you have done your literature review, the next step is deciding what resources to use. Typically we use around 50-90 resources for each provider guide. It is important to consider the quality of evidence when doing a literature review and deciding which articles or resources to include. Is it a randomized placebo-controlled trial or a case study? Where was it published and how was it funded? Is the patient population extremely different than yours, and if so, is the information still applicable? Is there conflicting evidence out there? It is important to keep in mind that when developing educational materials, establishing credibility requires the use of balanced sources of information. In addition, we do not recommend presenting only one side of the data. We recommend presenting both sides of controversial issues and discussing those issues with providers. Keep in mind, if the data is that mixed, or controversial, you may need to reconsider the goals of the campaign and whether or not this really is a viable academic detailing campaign.
7. When putting it all together, it is important to develop a comprehensive guide and go beyond “just say no”. If you look at your outline and you notice that the content is mainly “no, no, no”, “don’t do this, avoid this” and so forth, that is cause for concern. Providers may know what not to do, however they may not know what they should do. Discussing with them what they cannot do without discussing what they should do instead, will cause provider frustration. Take a step back and consider what alternatives you could review or present in the materials in order to help them understand what should be done instead. It is more likely that your piece will be considered useful if you provide information on what they should do, instead of focusing only on what they should not do.
8. Selecting a title and creating a strong introduction are important parts of the provider guide. The title should describe the topic yet be catchy or creative. An example title: Leading the Charge in the Treatment of Alcohol Use Disorders (AUD). The introduction should grab your audience. Why is this topic important? How does it affect Veterans? Provide information on why it is important and make it Veteran specific if possible. In your introduction, try to use a graphic to illustrate the information instead of text to describe it.
9. The body of the provider guide should provide referenced information to identify the issues and recommend key messages and goals of the campaign. It is important to remember that the provider guide is not meant to be all inclusive, it is meant to be a discussion guide academic detailers use during outreach visits with providers. This means you do not want the material to be text heavy. Try to use graphics and visuals when possible to illustrate data and key information. You do not need to give the provider every statistic or every detail of each study. What is the point of the study? What would you want to know as a clinician about the study and/or the findings? Make the document less text heavy by summarizing information. Consider things like, can you change the paragraph into one strong bullet point that summarizes the information?

10. It is important to use strong references to support your “key messages” and to keep your key messages brief and action oriented. (See [Part 5.1.c](#)). Please see below for examples of a recommended vs not recommended key message:
 - b. Not recommended: Using antipsychotics for sleep has been shown to lead to side effects and has not been shown to be very effective.
 - c. Recommended: Avoid using antipsychotics for sleep due to the risk of side effects and lack of evidence to support their use.
11. Remember that the document should flow in a logical order. For example, you do not want to skip from assessment to follow-up then to treatment. Present the information in an order that would make sense for someone trying to apply that information in the real world: assessment, treatment, monitoring, follow-up.
12. Take a step back and consider whether or not your document is visually appealing. To make it more visually appealing, avoid copying and pasting information into the guide; recreate graphics whenever possible (be sure to follow copyright laws). To keep the document visually pleasing, also consider how you’re using the white space, is there enough? Does the information looked crammed onto the page? Is the text size large enough? ADS typically uses a 14 font size for provider guide text and 16-18 size font for key messages. Sometimes a smaller font, size 12, is used for text that appears under graphs and tables. In addition, try to keep the total length of the document somewhat short, you do not want to create a guideline type of resource that is 50+ pages. That will overwhelm the provider and be very challenging to use during an academic detailing outreach visit. Aim to keep the total length of the provider guide to no more than 25 pages.

Quick Reference Guide

1. Purpose: The quick reference guide is intended to assist providers as they attempt to act on the “key messages” identified in the provider guide. With this in mind, consider what information you would need to know in order to act on the key messages. What would you need to know to prescribe and monitor the recommended medications? Are there particular lab monitoring issues they should be aware of (example: false positives/negatives)? What side effects would you want to know about? Are there any contraindications or warnings you would want to know about? Are there rating scales they could use to assess effectiveness or side effects? Are there any non-medication interventions they should consider or offer to the Veteran? Will they know how to do these non-medication interventions or understand what they are in order to agree to refer their patient to receive it? The more of these applicable questions you can answer in the quick reference guide, the more useful the resource will be for your providers.

2. The primary content of the quick reference guide is typically displayed via tables and algorithms. Like the provider guide, you want to avoid text heavy documents and attempt to summarize information. Remember to make sure the information is presented in an organized, visually appealing way.
3. Like the provider guide, you want to keep the quick reference guide brief, or “quick” if you will. Typically we try to keep our quick reference guides 25 pages or less. Please note: the pages are not formatted like the provider guide. The page layout settings for the quick reference guide are as follows: Landscape, custom size (8” x 4.25”), all margins at 0.25”. These settings allow the quick reference guide information to be printed as smaller “pocket cards” and not as a typical handout.

Patient materials

1. It is important to consider Veteran needs during the material development process. Veterans need to be informed of the risks, alternative options and know what they can do if they have concerns or questions about their current care. Patient pieces can be used to facilitate shared decision making, engage a patient in a particular topic and encourage them to talk to their provider, or to advertise a particular treatment option or assessment tool.
2. Try to create at least one patient piece for each module. If there are already good patient education or direct-to-consumer pieces available from other organizations or programs, consider whether or not you can use those materials instead of developing something new. In some cases ADS uses a combination approach where something new is created but materials developed by other programs are also hosted and recommended. It is important attempt to anticipate the needs of the field and the Veterans they serve. If possible, garner feedback from providers and/or patients (if possible) on what they think would be most helpful for them.
3. There are different ways to design your patient materials. Examples may include a tri-fold format intended to be available to patients in a clinic waiting room or a direct-to-consumer handout intended to be mailed to the Veteran.
4. Keep in mind that if you develop your own patient materials, you will likely need to have the materials reviewed and approved. Local policy regarding patient materials may vary so it is important to check with local patient education committees to determine requirements and existing policy for patient materials.

Other resources

1. During some campaigns you may find a need for “other resources”. Some examples may be fact sheets, algorithm tools or discussion guides for providers to use with patients during a clinic appointment. These resources are supplemental resources to the 3 standard academic detailing materials (provider guide, quick reference guide, and patient materials). You may identify a need for supplemental materials during a campaign as you start to meet with providers. If there is a need and you are still focusing your efforts on that topic, it is not too late to create something to meet the need. Other resources should undergo a similar review and approval process used for the standard academic detailing materials (see below).

ii. Review process for new materials

Please note: It is important to follow the applicable policies and procedures when developing educational materials (example: VISNs policies/procedures if developing VISN-level materials).

1. Internal review: The review process for academic detailing materials should always start with internal review, amongst either fellow academic detailers or other pharmacists (if you do not work with other academic detailers). Things to consider during an internal review of materials:
 - a. Review for spelling and grammatical errors.
 - b. Will the flow of the documents be understandable for providers and patients?
 - c. Are the documents fair and balanced?
 - d. Is there too much or too little information?
 - e. Are the key messages actionable, appropriate, and clear?
 - f. Is the information presented in the provider handout appropriate for the provider handout, or would it fit better in the quick reference guide (and vice versa)
 - g. Does the quick reference guide provide guidance or information on anticipated questions or frequently asked questions?
 - h. Is the information provided in the materials useful and accurate?
2. Subject matter expert review (SME): The review process should also include review by SMEs. ADS recommends having 3 or more SME reviewers for each piece developed (can use the same 3 for all materials). Determining which disciplines and specialties should be represented and how many SMEs are needed is variable and depends on the topic being addressed. More complex topics/materials (like Pain Management or Opioid Use Disorder) may need more

reviewers than simpler topics/materials (such as a piece that focuses only on the risk of suicide in patients with pain or a fact sheet on cognitive behavioral therapy for depression). If your topic crosses multiple disciplines, we strongly recommend using at least one SME from each discipline affected (example: 2 physicians, 2 pharmacists, 2 psychologists).

Please note: some SME reviewers will spend more time reviewing the piece(s) and providing feedback than others. The primary author of the document should decide if and when additional reviewers are needed based on the quality and quantity of feedback received. Oftentimes a certain number of SMEs is predicted to be sufficient, but it is determined that additional reviewers are needed based on the quality of reviews received.

Other considerations for academic detailing materials

1. How will your materials be available to the field? Will you stock them in the clinics, will you have them available online only? Will the provider be able to order copies of the material he/she feels is most useful?
2. When will the documents be updated or revised? The evidence is constantly evolving, new medications are being approved, will you consider revising or updating your materials? Will you update them every time new evidence comes out? Or will you update them at pre-determined intervals? Will you do a combination of both depending on the topic and the evidence? These are important considerations as you begin to develop educational materials.

iii. Data tools

Data tools allow for identification of priority panels that would provide the most return on investment for an Academic Detailing program. Data tool development requires a specialized skillset of understanding Structured Query Language (SQL), the Corporate Data Warehouse (CDW) environment, report development in SQL Server Reporting Services (SSRS) or SQL Server Report Builder (SSRB) or Visual Studios Data Tools (VSDT), and system administrator access to SQL Server Management Studios (SSMS) or SQL Server Integrations Services (SSIS) on your local data warehouse production environment. Development is further conducted in partnership with subject matter experts (SMEs). The technical details required to develop a clinical dashboard goes beyond the scope of this document. Please contact the Academic Detailing Services if additional support is needed.

Development of local data tools may proceed under less stringent conditions than national data tools. For example, the tool's speed, user-interface, and validity of a data tool are dependent upon the needs of the end-users. Local tool development, having a smaller audience, may be willing to compromise on the need of a tool versus the perfection of a tool.

The following section will outline recommended key concepts for local development of data tools:

Development Workgroups: Workgroups are often established to gain insight from multiple players, generate shared ownership, and shared interest in the campaign topic:

Key Players:

- Developer
- SMEs
- General end-users (Academic Detailers, pharmacists, physicians, etc.).

Meeting Frequency: Once or twice monthly for the duration of the development

Development Timeframe: Variable; national, validated data tools take approximately four to six months.

Data products often developed for academic detailing campaigns:

1. Dashboards
 - a. Developed to provide an overview of the campaign and its key messages. Information provided at this level is typically aggregated for understanding how the population is managed.
2. Patient Reports
 - a. Developed to provide the necessary details (clinical indicators) required to determine if action is warranted. In other words, a dashboard alone will not enable change to occur as it merely identifies a potential problem without understanding the clinical context.
3. Priority Panel Reports
 - a. Developed to identify the largest panels of actionable patients and their associated providers.
4. Trend Reports
 - a. With any new intervention taking place, evaluation is highly warranted. A trend report can help identify the changes that occur over time due to a new academic detailing campaign.
 - b. This report does not provide causation. It simply aids monitoring of progress over time.

Phases of Data Validation:

These phases do not have fixed, objective timeframes. Data validation is an iterative process that progresses towards later phases depending on the general accuracy and validity of the tool.

- Alpha-testing:
 - Tests usability, functions, and basic data validation
 - Number of testers: small
 - Example: What are the descriptive statistics (average, maximum, and minimum) associated with the serum creatinine labs?
- Beta-Testing:
 - Tests user interface, usability, functionality, and data validation
 - Number of testers: variable depending on the interest
 - Example: Does flag A really correspond to A in CPRS?

Additional details can be found in the [Academic Detailing Dashboard Development and Product Standardization document](#)

b. Content Training

Assuming all detailers deploying the campaign have already received AD basic skills training, it is important to also ensure that detailers are trained on the content to be discussed, whether this is a new campaign developed by your program, or a National AD campaign you will be deploying using National materials. This is particularly important if using detailers from various specialties who may or may not have substantial knowledge or experience in that particular area. Training does not have to be formal and can be done independently if resources are limited. Examples of content training exercises or activities to consider for detailers when preparing to deploy a new campaign:

1. Self-study – read the studies presented in the provider guide, review drug information for recommended medications, etc
2. Journal clubs – review of evidence included in educational materials; journal clubs can be helpful tools to go back to months after the initial training if the detailer needs to brush up on the material quickly.
3. Subject matter experts – arrange for experts in the area to provide lectures or didactic training for the detailers (could be virtual or face-to-face; MDs, Nurses, Psychologists, Pharmacists, etc depending on the area of content)

4. Brainstorming – it is important to brainstorm potential barriers, objections and issues that may come up with your key messages and content so that you will be more prepared when the campaign is implemented
5. Practice – practicing with either a provider willing to help with the training or amongst fellow team members or colleagues is important. Practice discussing the educational materials and content with another person will help to increase confidence, help iron out kinks in messaging, and prepare you for questions or comments that may come up during a real academic detailing interaction. If there are other detailers or others who have completed the academic detailing basic skills training available to observe the practice outreach visit, they may be able to provide valuable feedback and constructive criticism or to pick up on “best practices” they hear other detailers voice.
6. Consider making your first detailing visits with champion or supportive providers to garner their opinion on the new campaign and key messages. This allows you to develop confidence in the materials and identify key objections you may not have previously discovered. This also garners additional support and advice on how to navigate the identified topic area.

3. Implementation of a campaign

Step 1. Socialization of a campaign

Now that the campaign has been developed and approved by leadership, it is essential to begin socializing the campaign (“aka getting the message out”). During the development process, you likely identified and worked with subject matter experts and/or leadership to help champion your campaign. You may have their awareness but that is only the tip of the iceberg!

1. Leadership – start from the top down
 - a. Each campaign may have a different set of leadership to meet with.
 - E.g. CBT-I → Chief of Mental Health, Lead Psychologist, etc.
 - E.g. AUD pharmacotherapy → Lead Addiction Psychiatrist, Chief of MH / Pharmacy / Primary Care, etc.
 - b. Discuss the plans of the program and what detailers will be doing with leadership to make sure they are in agreement with your messaging and your campaign goals.
 - c. Allow them the opportunity to recommend points of contact or champions
 - d. Request permission to begin contacting providers to request appointments

- e. Identify reporting preferences
 - i. Would leadership like updates on campaign progress?
 - ii. How frequently would they like to be updated?
 - iii. Would they like representatives from the Academic Detailing program to attend leadership meetings?
- 2. Local champion(s)
 - a. It is important to meet with any local champions before deploying your campaign. You do not want to leave a local champion out of the initial stage of implementation as that may offend them or lead to them not supporting your campaign and/or your messages. Champion(s) are likely to vary based on the campaign and key messages being promoted but may be: leadership, physicians, pharmacists, nurses, etc.
 - b. Local champions may:
 - i. Assist in the appointment making process or introductions to other practitioners
 - ii. Agree to serve as speakers or provide presentations
 - iii. Identify current system limitations or suggest barriers that may be encountered
 - iv. Provide general input on how to best implement the campaign
 - v. Be subject matter experts with useful perspectives to consider while tailoring your campaign's implementation
- 3. Local pharmacists (including clinical pharmacy specialists)
 - a. It is important to meet with local pharmacists who may be affected by your campaign and or messaging so that they are aware of the campaign goals, are provided an opportunity to ask questions, and are included in the implementation process. A sudden, unfamiliar change in prescribing practices or unfamiliar faces providing education to members of their team may generate push back from pharmacists or may lead to them providing different information than what is being messaged on by the detailers. Remember, it is important that academic detailers partner with pharmacists at the local facilities, not work against them.
 - i. E.g. Detailer messaging on use of high dose prazosin for PTSD related nightmares. If pharmacists processing orders for prazosin are not informed of the messaging in the PTSD campaign, he or she may be taken off guard by a bedtime prazosin dose of 10mg. Ensuring that pharmacists who may be affected or impacted by the campaign are allowed the opportunity to ask questions and are included in the implementation process will reduce chances of the providers receiving mixed messages from various pharmacists.

4. Clinical staff

- a. Often introducing yourself and your program at a staff meeting can increase the likelihood that people will recognize your name or respond to your appointment request. They may also be more likely to assist you with acquiring an appointment with a priority panel provider if he or she knows who you are and what your purpose is. Leadership or a local champion support may assist with gathering information on when and where various staff meetings are or providing contact information for the meeting coordinator.

Caution: Some providers will use staff meetings as a reason to decline one-on-one appointments believing they are more effective. They are not. Both types of meetings have their purpose and it is important to recognize this as a potential barrier for your one-on-one appointments.

Step 2. Request an appointment with priority panel providers

1. Use their preferred mode of communication (e.g. email, Lync/IM, phone call, or drop in); if you do not know their preferred mode, ask someone who works with them or try one mode and if you don't get a response, try a different mode.
2. Offer to meet with them at their practice or office location, the place most convenient for them.
3. Consider if your appointment can be made during the provider's administrative time (if applicable) so that it is more convenient for the provider
4. Consider meeting with the provider either before or after their clinic hours, if that is more convenient for the provider
5. If you are requesting an appointment with a provider near your location, offer to meet with the provider when and if he or she has a no show.
6. Last resort option may be to consider if you can request an appointment during a patient visit slot if that would be more convenient for provider

- a. Taking a patient visit slot may require leadership support; access is very important and be careful not to obstruct access to care for Veterans. The Veteran comes first!

Note: It sometimes takes several appointment requests using different modes of communication to obtain an appointment with some providers

7. If the clinician is unwilling to meet one-on-one, or is not responding to your various requests for an appointment:
 - a. Consider offering small group appointments with his or her team
 - b. Consider focusing your efforts on another priority panel provider and perhaps asking that provider to introduce you to the non-responsive provider

- c. Consider asking someone working with that priority panel provider how he or she typically prefers to be contacted (e.g. speak to a nurse, pharmacist, administrative assistant, etc.) and use that route
- d. Consider revisiting the provider at a later date. Academic Detailing is not a mandatory service for providers; persistently resistant providers may eventually become more open when the culture shifts
- e. Consider involving leadership to endorse the programming and allow you to cc them on appointment request emails or reach out to their employees.
 - i. *Caution:* Avoid involving leadership from the perspective of enforcing punitive actions or forcing individuals to meet with Academic Detailing. This may damage any developing relationship with the provider

As an academic detailer, the majority of your outreach visit time should be dedicated to acquiring and meeting with priority panel providers, however it is important not to forget about the support staff and other staff who may also work with the provider. Nursing, pharmacy, psychology, social work, and/or administrative support staff may have a strong influence on the Veteran and or the topic area being discussed. It is important to keep these staff members in mind and consider whether or not you should meet with them as well. Sometimes a provider may suggest you meet with his or her staff, if this is the case than by all means, do so.

Other non-priority providers to consider meeting with may be “best practice” providers. These providers may be able to share what they do and how they do it so that you are able to spread that information to other providers. In addition, you may also be asked by leadership or perhaps another provider, to meet with certain providers or certain staff. If that is the case, by all means attempt to set up a meeting with him or her. It is important to not assume you know all the information about various providers and their practices. You may be surprised what you find out!

Step 3. Academic Detailing visits

1. Group vs one-on-one visits, which is better?
 - a. One-on-one visits have been shown to be up to 3 times more effective than group visits^{11,12}. Keep in mind that an outreach visit should involve a back and forth interaction, where you are engaging the clinician in a discussion, asking them open ended questions in order to learn about their current practices, their beliefs regarding management of certain disorders or diseases, the objections they have with evidence-based recommendations regarding one or more “key messages” you are there to discuss with them. This is more easily accomplished in a one-on-one setting where you can focus on the specific needs of one provider and tailor the interaction to meet his or her needs.
 - b. If you do perform group visits, we typically suggest to keep the group ≤ 5 because it is more likely you will be able to accomplish the necessary components of what should be included in an outreach visit. It is sometimes possible to have groups slightly larger than this and still be able to accomplish the necessary components of an outreach visit; however, it can be more and more difficult as the group size climbs above 5.

- c. If there is not a back and forth interaction between the detailer and participants that includes all of the components of an outreach visit (see above for specific components), then this visit would be considered an in-service, not an outreach visit. Keep in mind that an in-service can be done with any number of participants, even 4 or less, depending on the way the information is presented. Although in-services are not expected to strongly influence behavior, they are commonly used as a method to socialize, share information, and raise awareness.
2. Which mode of communication (face-to-face, IM, telephone, or video conference) should I use?
 - a. The logistics of academic detailing may require use of alternative communication methods. It may not be feasible for an academic detailer to conduct all communications directly in person especially when the covered territory encompasses several hundred square miles. Whenever possible, face-to-face visits should be utilized for introductory visits and the initial outreach visit. Face-to-face is thought to be more likely to help the detailer gain a better understanding of the provider's work environment and assist with relationship building (e.g. putting a face with a name).

General tips for meeting with providers:

- Do not be late for your appointment. Be on time or early for the appointment so that you aren't keeping the provider waiting. If for some reason you are running late, send a message to the provider that informs him or her of your delay and apologizes for the inconvenience. If you are going to be extremely late (use your discretion), consider whether or not you will still have enough time to discuss the topic with the provider and whether or not you should offer to reschedule the appointment for their convenience. Remember you are providing a service to them.
- Be sure to bring any applicable academic detailing materials or resources with you so that you are prepared to discuss the topic and refer to materials if and when necessary. Keeping the materials in your possession until the conclusion of the visit is generally recommended. Giving the materials to the provider, or allowing them to take control of the material, may serve as a distraction and may derail the visit. If a provider does end up taking the material from you, do your best to politely and respectfully regain control of the material without making it uncomfortable or being disrespectful to the provider. An example strategy to regain control of your material may be to indicate that you would like to show them a specific graphic in the document and politely reach over and regain control of the document while showing them the particular graphic.

- The outreach visit is the time to rely on and use your Academic Detailing Basic Skills training. Using your academic detailing skills will help guide you through the visit and ensure that you incorporate the techniques and skills of academic detailing in order to have a successful visit. Please see the [AD training manual](#) for more information on AD basic skills techniques and components of an academic detailing visit. *Remember: do not force information or resources onto the provider. You must gain their buy-in before discussing and offering resources. Use open ended questions and simple motivational interviewing techniques to ensure that you are tailoring the interaction to meet the needs of the provider.*
- Upon finishing your summary and close, take note of any action items you have. Some examples may be: did the provider request something or additional information during the visit? Did the provider ask you to follow-up with someone or meet with one of his/her staff? Following-up on action items is very important for establishing and maintaining a working relationship and well as building trust and credibility with that provider.

Step 4. Follow-up visits

Based on experience from the VISN 21/22 Academic Detailing Pilot as well as published evidence from Dr. Jerry Avorn's work, a follow-up reinforcement visit was a strong independent predictor of prescribing change ($p < 0.05$). Increasing from one visit to two visits was associated with an approximate doubling of the size of the program effect⁴. Remember, your goal is not to come in, tell the provider what to do, then move on to the next provider. Your goal as an academic detailer is to engage the provider in a discussion, tailor the interaction to meet their specific needs, and partner with them to improve the care of Veterans. A partnership is a trusted and valued relationship that must be built and maintained over time.

Part 6. Workload Documentation

The [Academic Detailing Documenting Workload Standard Operating Procedure](#) covers how to gain access to the platform, Salesforce, ADS provides for documenting workload.

1. Why document workload?

The implementation of Academic Detailing nationally has occurred without additional funding for recruiting and hiring new staff. This places VISNs into a difficult position to fiscally justify the benefits of hiring new academic detailers. Many of the activities performed by an Academic Detailer are not directly associated with Direct Patient Care Activities (see [Part 3.V.](#)); therefore a majority of the academic detailing workload goes uncredited detailers because it cannot be recorded in CPRS. Using the workload tracking platform, Salesforce, allows detailers and academic detailing programs to input their workload data which can be then utilized for evaluative purposes (see [Part 7](#)) to provide justification for AD positions or programs and to demonstrate value and impact of the outreach visits and other work performed by detailers.

In addition, campaign materials and resources are extremely important for the success of an academic detailing initiative. If national materials are not used, the development of VISN or local campaign materials requires time and effort by the detailers or the program staff. The time dedicated towards material development can significantly impact time available to perform outreach visits, which is the key component for influencing a change in behavior. Development of materials should be taken into account when determining workload expectations (e.g. when using the recommended estimated ratio of 0.25 outreach visits per 1 hour of AD time; see [Part 4.I](#)).

The need for workload documentation extends all the way up through VA Central Office. The IUSH memorandum mandating Academic Detailing nationally, included a requirement for the quarterly reporting of Academic Detailing related activities, thus making it extremely important that we are able to track and report these activities².

2. How to document workload?

ADS recommends documentation of all AD associated work in Salesforce. Salesforce is a contracted platform that the VA ADS has acquired and rolled out nationally. Recorded trainings and PowerPoint slides are provided on the ADS SharePoint Workload page ([link](#)) to assist with learning how to use this new workload tracking tool. If you have specific questions on Salesforce licenses, please contact the [ADS Data Team](#).

3. What type of workload recording is required versus optional?

Outreach Visits are the predominant activity associated with Academic Detailing behavior change and must be documented in Salesforce ([see glossary for definition of an outreach visit](#)).

The other two types of documentable workload in Salesforce are Visit Requests and Non-Visit Activities. Recording these two types of workload is not required, but is available and optional for programs to use if needed (please see below for examples of when this information might be useful to record). ADS recommends standardizing documentation efforts across the VISN regarding which non-visit activities to record (if any) and whether or not to record visit requests. Maintaining consistency amongst the various detailers in any one program will provide more meaningful data

that can be more easily evaluated and compared. Recording outreach visit data is required for all AD programs, and should be consistent regardless of the location or the detailer doing the recording. If there are questions regarding documentation of certain activities, please do not hesitate to contact the [National ADS Program Office](#).

Potential reasons for recording visit requests and non-visit activities:

- Visit Requests
 - This may be particularly useful for new AD Programs with new detailers
 - Consider using visit request data to set a simple, achievable goal for how many attempts to strive for and what to do if they reach that number of attempts but are not successful at acquiring an appointment.
 - Recording this information may also help your program realize that one method of communication is more successful or more efficient than another.
 - Recording visit requests may also be particularly helpful when implementing new campaigns. This will allow you to see which key staff have been contacted, and how many times, independent of whether or not you an outreach visit was performed. If the detailer is sending out multiple requests and not scheduling many visits, that may indicate a need for additional training or support.
 - Priority panel providers
 - Key leadership individuals
 - Campaign champions
- Non-Visit Activities
 - Based on the experience from the VISN 21/22 AD Pilot program, recording the following top three non-visit activities in order of priority or importance is suggested:
 1. In-service (campaign socialization)
 2. Implementing an order set, prior authorization, or policy/procedure
 3. Designing an educational piece or information to help support the campaign
 - Times when recording non-visit activities may be useful:
 - An academic detailer assigned to multiple sites that are several hundred miles away from one another. Your VISN may wish to document travel time to reflect how much time is spent traveling versus doing outreach visits. You may decide to do this temporarily, maybe 1 quarter, in order to give you an idea of workload and travel demands to expect. You may consider things like using this documentation to provide evidence that an additional academic detailer at a particular location is needed in order to minimize travel time and maximize outreach visit time.

Part 7. Evaluations

Why are evaluations of academic detailing important?

Evaluation is a process that critically and systematically assesses a program, activity, and/or individual. Not only can an evaluation help determine program or detailer effectiveness, but they can also be used to identify opportunities for improvement within the AD program or with a particular detailer^{13,14}.

It may be necessary to provide unbiased empirical evidence supporting the effectiveness of Academic Detailing. Some potential outcomes that can occur due to the results from program evaluations:

- Justifying the need for a Program Director to manage the Academic Detailing Program
- Justifying the need to hire more Academic Detailers
- Incorporating Academic Detailing activities into the existing roles and responsibilities of local pharmacists
- Expanding the program into new clinical topic areas (e.g. Hepatitis C, tobacco use disorder)

Within the scope of Academic Detailing, there are three types of evaluations recommended by ADS:

1. Impact evaluations: Long-term impact

Impact evaluations require a long time horizon before adequate changes to patient care can be measured (e.g. mortality). These evaluations may be complicated, especially with campaigns garnering national interest due to the number of confounding variables, and will require the assistance of a health services researcher or someone familiar with program and implementation evaluations.

- a. Opportunity to demonstrate long-term changes to patient care
- b. Timing: At least six months after completion of a campaign
- c. Complexity: Difficult; recommend statistician involvement. Please contact ADS for assistance if needed.
- d. Example: What impact did the VISN's Academic Detailing program have on overdose and mortality during FY16?

2. Outcome evaluations: Short and medium-term outcomes

Outcome evaluations are the near-term, measurable outcomes associated with a campaign. For example, OSI metrics will be directly affected when providers change their prescribing practices towards lower utilization of opioid therapy. This short-term outcome may or may not actually impact clinical outcomes (e.g., mortality) depending on the implementation of this change. These evaluations will typically be less complicated but may still require the assistance of a trained statistician.

- a. Opportunity to measure immediate changes due to a campaign
- b. Timing: Quarterly after campaign initiation with trend reports
 - i. Goal is to only view general trends in the interim metrics and not determine if AD was the cause of the change.
- c. Complexity: Variable; statistician involvement preferred. Please contact ADS for assistance if needed.
- d. Example: What percent change did the VISN's Academic Detailing program have on patients on high dose opioids?

3. Process evaluations: Measure effort and direct outputs of the program

Process evaluations will focus on the minutia of the program. These process evaluations can be easily conducted with descriptive statistics. Many of these components are built into the Salesforce VISN Dashboards which provide immediate data. ADS has also created an [Outreach Visit Assessment Tool](#) to assist programs with evaluating the skills of academic detailers and/or academic detailing trainees to ensure that the necessary techniques and skills required for an effective academic detailing session are being utilized. You may also consider using a provider satisfaction survey to assess provider response to the program and your detailers. The ADS has a [provider satisfaction survey](#) located on the National ADS SharePoint and is available to all VISNs for use.

- a. Opportunity for continuous process improvement
- b. Timing: Immediately after program establishment
- c. Complexity: Low
- d. Examples:
 - i. How many Outreach Visits are conducted monthly? → Salesforce
 - ii. What percentage of priority panel providers was detailed within a fiscal year? → Salesforce
 - iii. How often are my academic detailers avoiding the righting reflex during their Outreach Visits? → [Outreach Visit Assessment Tool](#)
 - iv. How do detailed providers feel about their interactions with academic detailers? → [Provider Satisfaction Survey](#)

The National Academic Detailing Service is available for consultations regarding local program evaluations and will be performing National level evaluations which will be shared with leadership and AD programs. Please contact the National ADS with questions regarding evaluations.

If you decide to create your own assessment tools outside of Salesforce and the available resources from the National ADS, please consider these general survey tips:

- Use Likert Scales (1 = Strongly Agree, 2 = Agree, 3 = Neutral, etc.) to help aggregate and analyze survey results
- Limit surveys to providers no more than once annually to minimize provider fatigue and frustration
- Integrate detailer assessments into routine activities for continuous self-improvement

Part 8. Conclusion

This guidance document has extensively covered the topic of Academic Detailing in VHA from what it is to implementing an AD program (hiring and staffing models) to developing and implementing new AD campaigns (leadership buy-in, literature reviews, product layout, and more) to evaluating AD campaigns (long-term outcomes and short term continual process improvement suggestions). The provided information is largely based upon the experience of the Academic Detailing Service and is intended to guide implementation of Academic Detailing in the field.

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Glossary

Academic Detailer (or detailer)

A clinician who has received academic detailing training. This training should include an in-person basic skills training endorsed by the Academic Detailing Service.

Academic Detailing (AD)

An educational service for clinicians, by clinicians, that provides individualized, face-to-face outreach, to encourage evidence-based decision making to improve Veteran health.

Academic Detailing Basic Skills Training

Teaches detailers the skill of academic detailing via didactics and interactive role-play.

Academic Detailing Program Director

Manages an academic detailing program; provides guidance, support and oversight to AD program and staff, facilitates leadership involvement, evaluates program and staff performance.

Academic Detailing Service (ADS)

Refers to the national program designed to support VISN academic detailing programs.

Actionable Patient

A patient who may benefit from an evaluation or intervention in relation to an identified topic.

Alpha-testing

Internal review process covering usability, functions, and validation of data included in data tools.

Beta-testing

End-user testing focused on the user interface, usability, functionality, and validation of data included in data tools.

Campaign

Overarching topic or initiative; usually comprised of 4-6 key messages and cover a specific clinical area or medication class.

Clinical pharmacy specialist (CPS)

Pharmacist with a scope of practice.

Consolidated Work Unit (CWU)

Staffing model that incorporates management of academic detailers at the VISN level.

Corporate Data Warehouse (CDW)

This national data set is managed by the Business Intelligence Service Line (BISL) section of the Office of Information and Technology (OI&T). The data originates from source systems (mostly Vista) without “scrubbing”, filtering, and without business logic applied. Therefore, this data set is representative of the VA electronic health records and is the primary data source for ADS-developed reports and dashboards.

Dashboard

This is a unique type of data tool that displays an overview of data regarding a particular topic and associated key messages using aggregated data.

Data Validation

Large scale testing intended to include chart reviews of typically between 5-20% of identified actionable patients to ensure accurate data is returned.

De-centralized Staffing Model¹⁵

Pharmacists integrate Academic Detailing activities within their existing Clinical Pharmacy Specialist duties; many variations of this model with the core component being that Academic Detailers are ultimately hired by the facility rather than the VISN.

Educational Outreach Visit

An interaction between an academic detailer and another party in an effort to influence behavior and promote evidence-based care in an academic detailing campaign. This may be with one or multiple parties and may be face-to-face (preferred) or virtual*.

An outreach visit **must**:

- Have an exchange of information related to an AD campaign
- Convey at least one key message
- Contain open-ended questions as a needs assessment or provide educational resources or implementation strategies to support provider needs

*Virtual interactions may include the following:

- Video/webinar interface (e.g. Lync)
- Instant Messaging
- Telephone

Hybrid Staffing Model

This Academic Detailing program staffing model includes a mixture of FTEE allocation. Some individuals are full time Academic Detailers belonging to the VISN Pharmacy Executive / VISN Academic Detailing Program Director and others are local facility-level clinical pharmacy specialists who have some academic detailing responsibilities.

Impact Evaluation

These evaluations provide insight into the effect or “impact” of the intervention incorporating primary clinical outcomes of interest (e.g. mortality). Robust statistical analyses are required to appropriately account for the many potential confounders that arise over extended timeframes.

Key Message

Derived from factual evidence; a strong, simple message with a call to action.

Motivational Interviewing (MI)¹⁶

Client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Opioid Safety Initiative (OSI)

Initiative in VA focused on improving pain management in Veterans.

Outcome evaluations

These evaluations are utilized for measuring intermediary changes in the short/medium-term and provide insight into the direct effect of the intervention (e.g. decreasing MEDD) rather than the true intended effect (e.g. decreasing the prevalence of overdose and death; providing appropriate pain management).

Patient Reports

Data resources that provide the necessary clinical details required to determine if an intervention is warranted; provides clinical indicators (upcoming appointments, demographic information, and more) to assist with decision making.

Pharmacy Benefits Management (PBM)

Service in VHA responsible for pharmacy related activities in VA.

Priority Panel

A group of actionable patients belonging to a provider based on an indicator defined in the academic detailing campaign. For example, the providers with the largest actionable patients (typically the top 20%) can be classified as priority panels.

Provider Guide

Document summarizing and providing updates on literature and guidelines for the topic being addressed; typically includes a combination of text, tables and graphics to illustrate information and provide support for key messages.

Process evaluations

Measure effort and direct outputs of the program; useful for continuous process improvement efforts

Quick Reference Guide (aka “pocket cards”)

Document containing detailed information needed to carry out key messages identified in the provider guide (see above for definition of provider guide)

Salesforce

A contracted, commercial, customer relationship management platform utilized by the Academic Detailing Service to assist with workload tracking

Subject Matter Expert (SME)

Clinician with considerable experience and knowledge in the topic area being discussed

Trend Report

Data resource that illustrates change in metric performance over time

Veterans Integrated Service Network (VISN)

Represents a group of VA facilities all under the same network leadership

Appendix A: Elements of a VA Academic Detailing Program

Element	Options
I. Model (Staffing structure)	<ol style="list-style-type: none"> 1. Consolidated Work Unit (CWU) – Recommended 2. De-centralized Staffing Model 3. Hybrid (CWU + De-centralized) <p>For details, please refer to Part 3.I</p>
II. FTEE	3.0 – 7.0+ FTEE per VISN
III. Disciplines / Specialties	<p>Clinical Pharmacy Specialists – Recommended in VA</p> <p>Other (physicians, NPs, PAs, etc.)</p> <p>For rationale, please refer to Part 3.II</p> <p>Specialization is not a prerequisite for academic detailing. Detailers are likely to cover distinct clinical campaigns over time and are expected to learn topics that may be less familiar.</p>
IV. Roles & GS Rating	<p>Academic Detailer (GS–13 or 14)</p> <p>AD Program Director (GS–14) – Having an AD Program Director is Recommended</p> <p>For specifics, please refer to Part 3.IV</p>
V. Labor Mapping	<p>AD activities typically mapped as Education and Administrative FTEE. Academic detailers may also have clinical responsibilities, which would be mapped as direct patient care if present.</p> <p>An Academic Detailer labor mapping example:</p> <ul style="list-style-type: none"> • 0.2 FTEE for Direct Patient Care (one clinic day weekly) • 0.5 FTEE for Education (preparation and travel) • 0.3 FTEE for Administrative (outreach visits and other activities) <p>For specifics, please refer to Part 3.V</p>
VI. Training	<ol style="list-style-type: none"> 1. AD Basic Skills Training – Required 2. Relevant trainings: Motivational Interviewing 3. Other trainings: Sales <p>For details, please refer to Part 3.VI</p>
VII. Continued Development	Consider role-play or practicing academic detailing amongst AD team members

Appendix B: Setting Goals and Expectations

Component	Goals and Expectations
<p>I. Target number of visits per FTEE</p> <p>Note: This suggested target was established based on the VISN 21/22 Pilot during the later years with experienced detailers. This recommendation may need to be adjusted for newer detailers and AD programs.</p>	<p>0.25 Outreach Visits per hour</p> <p>1 FTEE = 40 hours / week</p> <p>Example:</p> <p>1 FTEE = 40 hrs /week * 0.25 Outreach Visits / hr * 12 weeks / quarter → 120 Visits per Quarter</p> <p>For details, please refer to Part 4.I</p>
<p>II. Campaigns per FTEE per year</p>	<p>1-3 campaigns</p> <p>For details, please refer to Part 4.II</p>
<p>III. Campaign goals</p>	<p>Use the SMART criteria</p> <ul style="list-style-type: none"> ● Specific ● Measurable ● Achievable ● Relevant ● Time-Bound <p>For details, please refer to Part 4.III</p>
<p>IV. Target # of visits per provider per campaign</p> <p>Note: Ideally a detailing program would meet with all priority panel providers, however due to limited time, travel funds, and other logistical challenges this may not be a reasonable expectation.</p>	<p>Meet with ≥ 75% of <i>priority panel providers</i> at least once per detailing campaign</p> <p>For details, please refer to Part 4.IV</p>
<p>V. Priority panels per campaign</p> <p>Note: Priority panels can be flagged in Salesforce; please contact the ADS program for more information.</p>	<p>ADS typically defines priority panels the largest 20% of actionable patient panels; this may vary based on variables such as size of territory, campaign being addressed, number of detailers, etc.</p>

Appendix C: Checklist for Developing New Campaigns

- Query leadership for priorities, suggestions, and key thought leaders
- Determine if the campaign and tools already exist elsewhere (other offices, other organizations, etc.)
- Create SMART campaign goals (Specific, Measureable, Achievable, Relevant, Time-Bound)
- Create key messages aligning with campaign goals (**Rec:** limit key messages to ≤ 6)
- Perform needs assessment
 - Collect data (Recommend using existing tools or querying CDW)
 - Analyze data
 - Consider underlying barriers
 - Consider necessary actions for barrier resolution
 - Consider distribution of actionable patients
- Gain leadership approval to proceed with campaign development
- Identify campaign champions
- Develop Education Materials
 - Provider Guide
 - Quick Reference Guide
 - Patient Materials
- Develop Data Tools
 - Dashboard
 - Patient Report
 - Priority Panel Report
 - Trend Report
- Train detailers on the campaign content (or promote independent learning of content)

Appendix D: Checklist for Developing New Academic Detailing Materials

- Provider Guide: Summarize and provide relevant information from literature and guidelines.
 - Identify goals for the material and the target audience
 - Evaluate existing materials on the campaign topics created by other offices or organizations and adapt (if available)
 - Perform a literature search to identify and determine what content to include in your material
 - Number of references (typical range: 50-90):
 - Number of Key Messages (typical range: 4-6):
 - Writing style
 - Incorporate alternatives for providers; don't just say "don't do this" or "avoid"; what should they do instead?
 - Incorporate balanced arguments if the literature is mixed; do not present one side of the story only.
 - Refine key messages until it results in a concise action statement
 - Be sure to follow the clinical flow (assess → treat → monitor → follow up) when developing content
 - Total Length (typically: ≤ 25 pages)
 - Dimensions (typically: 8.5" x 11")
- Quick Reference Guide: To provide detailed information on how providers can act on the key messages identified in the provider guide
 - Style: predominantly flowcharts & tables
 - Total Length (typically: ≤ 25 pages):
 - Dimensions (typically: 8" x 4.25", margins: 0.25")
- Patient Materials (e.g. posters / infographics, brochures, mailers, factsheets, etc.)
 - Review local policies (e.g. Reviewing and approving bodies; reading level, etc.)
- All developed materials align with National CFU, RFU, and formulary status; if outdated information is identified in existing VA resources, contact your PBM representative to discuss what approaches should be taken.

Checklist for Educational Material Review and Approval

- Review Process – Dynamic and iterative; be patient. A thorough review process will ensure that your materials are both accurate and useful.
 - Internal Review
 - Spelling, grammar, balance, design, flow
 - Are key messages appropriate and clear?
 - Is the information relevant? Can it be shortened?
 - Is it easy to read? Appropriate use of white space, diagrams, tables, bullets...
 - Subject Matter Expert Review
 - Number of reviewers: ≥ 3 (Consider multiple SMEs from multiple disciplines when the campaign crosses disciplines)
- Approval
 - Follow local/VISN procedures
- Logistics
 - How will these materials be available?
 - Hardcopy
 - Who will print?
 - Where will it be stored?
 - How can it be requested?
 - Electronic version
 - Where will it be hosted?
 - How will it be marketed?
 - Is it 508 Compliant?
 - Revisions
 - When should the product be revised? How frequently? When will it be retired?

Appendix E: Checklist for Campaign Implementation

- Campaign Socialization
 - Permission from leadership to proceed (start with leadership)
 - Local champion(s)
 - Pharmacist(s)
 - Clinical Staff
 - Request meeting with Priority Panel Providers
- Outreach Visits
 - Aim for on one-on-one visits (especially for the initial visit)
 - Aim for face-to-face visits (especially for the initial visit)
 - Aim to conduct at least one follow up visit per priority panel provider per campaign
 - Tips
 - Be punctual!
 - Be prepared with your educational materials and resources
 - Use core components of Academic Detailing as appropriate
 - 3Fs (Feel, Felt, Found)
 - OARS (Open-ended Questions, Affirmations, Reflective Listening, Summarizing)
 - EPE (Elicit – Provide – Elicit)
 - Follow up with discussed actions and schedule follow-up appointment
 - Consider doing a post-visit, self-reflection (What did I do well? Which core components were effective? How was my body language?)
- Document relevant workload activities into Salesforce

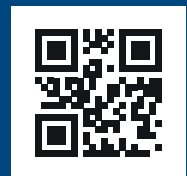


VA Academic Detailing Service

*Real Provider Resources
Real Patient Results*

VA PBM Academic Detailing Service Email Group
PharmacyAcademicDetailingProgram@va.gov

VA PBM SharePoint Site
<https://vaww.portal2.va.gov/sites/ad>



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