Real-time Design: Educating Clinicians with Compelling Visuals

NaRCAD AD Summit

June 23, 2023, 1:45pm ET

Welcome

We're excited to meet you.

Today's Facilitators

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NaRCAD

CEP Centre for Effective Practice

NaRCAD

Disclosures

- No conflicts of interest
- No financial or non-financial relationships of concern

What's on today's agenda?

- Review the **components of a compelling detailing aid**
- Understand the **process behind developing** detailing tools and materials
- Provide **feedback** on existing detailing materials
- Create a **checklist of considerations** for developing a detailing aid

NaRCAD Resource: Let's Review!

Illustrating the Problem

Include a detailing aid title that focuses on **the impact** the clinician group can have on improving the issue.

Use data and evidence to show that a clinical care gap exists by using **accessible graphic images**.

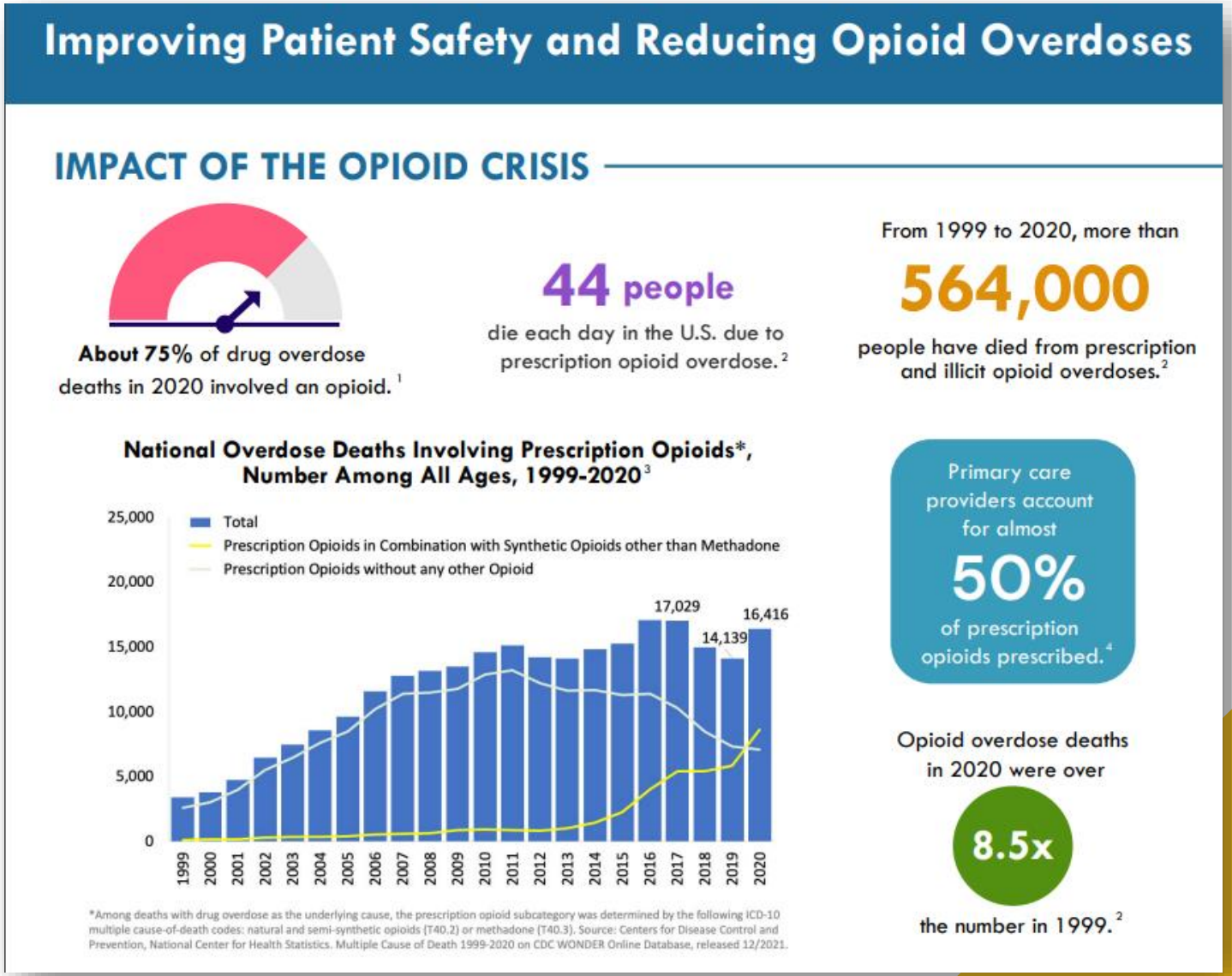
Use **local data** when available.

Include the **population** it affects and how (what's the ripple effect?)

Illustrate **the gap** between best evidence and patient care clearly on the cover page.

Chat Waterfall

What makes this cover page compelling?



Key Messages

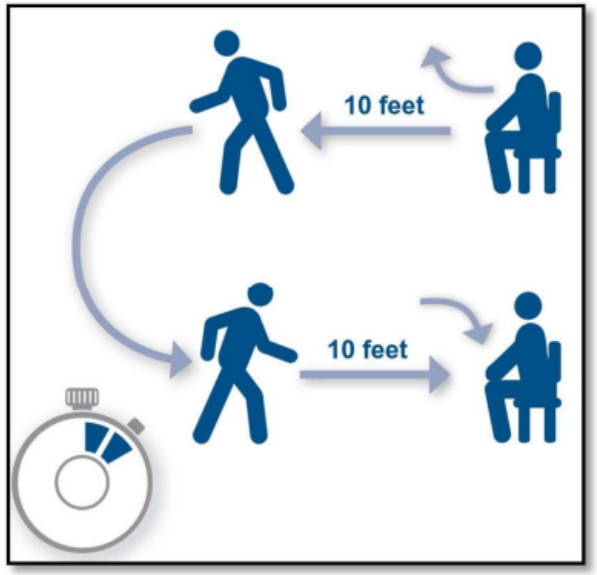
- Each key message should include an **action verb**
- The key messages need to be **easy to identify** with either a unique call out color or icon
- The messages should be numbered in order, especially if each message is part of an **overall process**
- The detailing aid should include any **relevant steps** involved for the clinician to **implement the key message**

KEY MESSAGE 1

Use the TUG test to determine which patients are at high risk of falling due to impaired gait, mobility, or balance.

Timed Up and Go (TUG) Test

A systematic approach to assessing fall risk.[3]



Time your patient while they complete these steps:[3]

1. Stand up from a chair
2. Walk forward 10 feet at a normal pace
3. Turn
4. Walk back to the chair
5. Sit down

If the time is above 12 seconds, your patient is at high risk for falling.

Addressing Concerns & Barriers

Clinicians may not immediately accept all the key messages presented and will have concerns during a detailing visit.

The detailing aid should include specific content to help address the most common concerns and/or barriers clinicians may face.

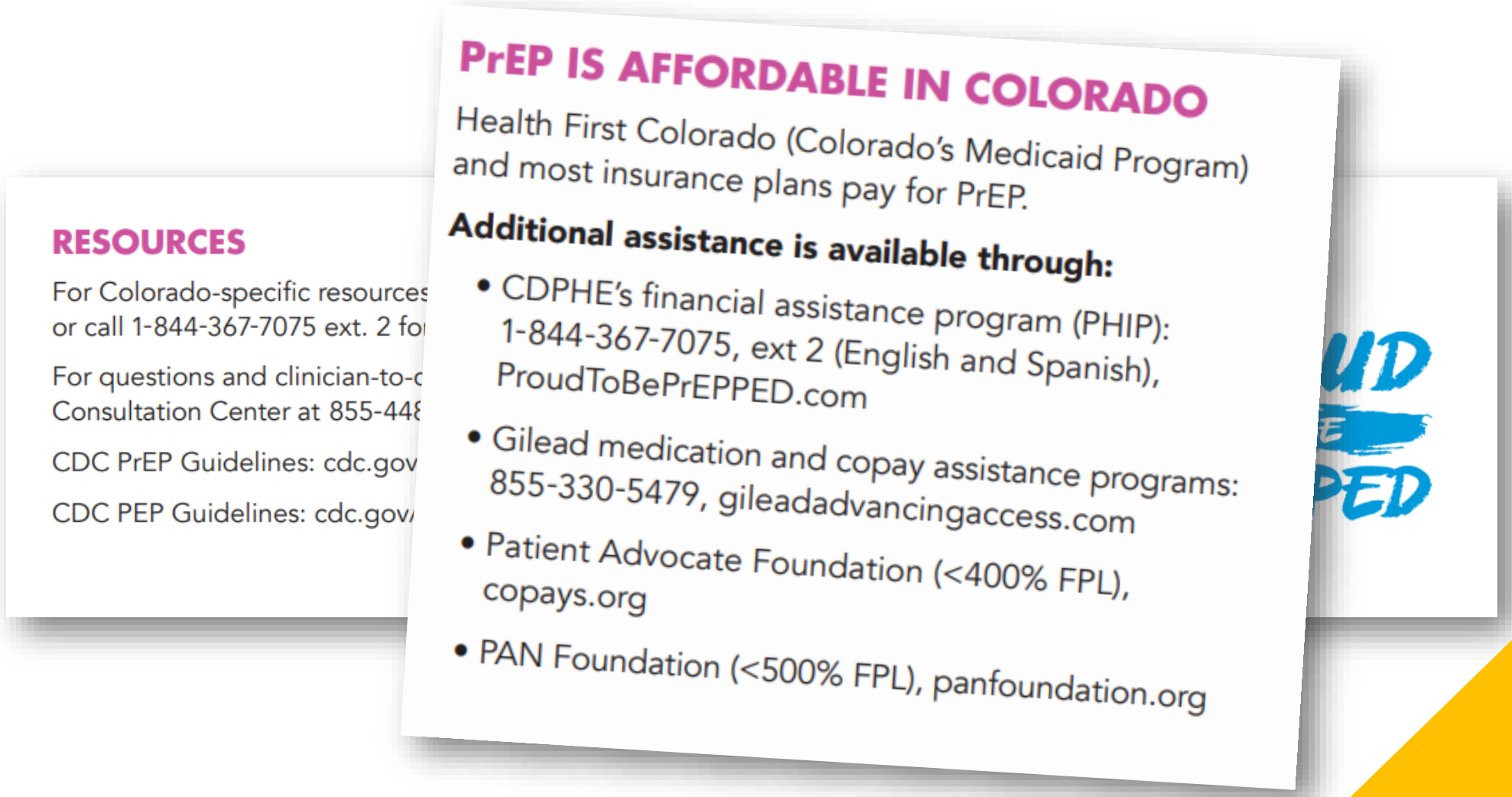
Nonopioid pharmacologic treatment examples	Nonpharmacologic intervention examples
• Topical nonsteroidal anti-inflammatory drugs (NSAIDs) • Oral NSAIDs • Tricyclic and tetracyclic antidepressants • Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressants • Anticonvulsants such as pregabalin/gabapentin • Acetaminophen	• Ice • Heat • Elevation • Rest • Immobilization • Exercise therapy

Centers for Disease Control and Prevention

National & Local Resources

Include relevant resources, especially those that are community-based to support both the clinician and the clinician's patients.

Resources may include options for payment, patient advocacy, referral to treatment, etc.



Colorado's PROUD TO BE PREPPED Campaign

Reference List

- Include a **reference list** at the end of the detailing aid that clinicians can **refer to for more information**

REFERENCES

(1) CDC The Drug Overdose Epidemic: Behind the Numbers: https://www.cdc.gov/opioids/data/index.html
(2) Opioid Data Analysis and Resources: https://www.cdc.gov/opioids/data/analysis-resources.html
(3) NIH National Institute on Drug Abuse – Overdose Death Rates: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
(4) CDC Why Guidelines for Primary Care Providers: https://www.cdc.gov/drugoverdose/pdf/Guideline_Infographic-a.pdf
(5) CDC Guideline for Prescribing Opioids for Chronic Pain (2016): https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm
(6) CDC Guideline for Prescribing Opioids for Chronic Pain at a Glance: https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf
(7) Center for Innovation in Academic Detailing on Opioids (CIAO) Opioids and Chronic Pain: A Guideline for Primary Care Providers: https://www.csuhsf.org/_files/ugd/91710f_62300d00ca9e43d48eabf0f41a97a0cd.pdf
(8) CDC Prescription Drug Monitoring Programs (PDMPs): https://www.cdc.gov/drugoverdose/pdmp/index.html
(9) NIH National Institute on Drug Abuse: Naloxone DrugFacts: https://nida.nih.gov/publications/drugfacts/naloxone
(10) Massachusetts Department of Public Health: https://www.mass.gov/service-details/naloxone-facts-and-formulations
(11) CDC When to Offer Naloxone to Patients Fact Sheet: https://www.cdc.gov/opioids/naloxone/factsheets/pdf/Naloxone_FactSheet_Clinicians.pdf
(12) SAMHSA Medication-Assisted Treatment (MAT): https://www.samhsa.gov/medication-assisted-treatment
(13) NIH MOUD Infographic: https://nida.nih.gov/sites/default/files/images/NIDA_MOUD-Infographic_1.jpg.

Clear Contact Information

- Including contact information for your program will allow clinicians to:
  - **Easily schedule** follow-up visits with detailers
  - **Ask** additional questions
  - **Recruit** new clinicians to be detailed

- Share detailer-specific **contact information** via a **business card or email**

SUPPORT

Contact NYC Well 24 hours a day/7 days a week to find naloxone or for support with substance use or mental health.

Call 888-NYC-WELL (888-692-9355).

Text "WELL" to 65173.

Chat online at nyc.gov/nycwell.

You can also visit the **OASAS HOPEline** at 877-8-HOPENY (877-846-7369), text HOPENY to 467369 or visit **oasas.ny.gov/treatment**.

What is Naloxone? New York City Department of Health and Mental Hygiene

Established in **2004**, the **Centre for Effective Practice (CEP)** is one of the largest independent, **not-for-profit** knowledge translation organizations for **primary care** in Canada.

Research & evaluation

WE REVIEW LITERATURE AND USE EVIDENCE TO IDENTIFY SOLUTIONS FOR SPECIFIC CONTEXTS IN HEALTH CARE.

Clinical tools and digitization

WE DEVELOP PRACTICAL TOOLS FOR PRIMARY CARE AND OTHER PROVIDERS TO ADDRESS KEY HEALTHCARE TOPICS.

Education programs

WE BRING EVIDENCE TO PROVIDERS THROUGH SUITABLE EDUCATIONAL OUTREACH METHODS.

Engagement & communication

WE ENGAGE CLINICAL EXPERTS IN EVERY PHASE OF OUR WORK AND PARTNER WITH KEY ORGANIZATIONS TO ENSURE WE REACH THE INTENDED AUDIENCE.

Diversity

Accessibility

Equity

Inclusion

Respect

CEP Centre for Effective Practice

A Partner of Choice

100+ stakeholder organizations engaged

1000+ primary care practitioners engaged with academic detailing

>141,000 downloads from COVID Resource Centre

Ontario College of Family Physicians
Leaders for a healthy Ontario

NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

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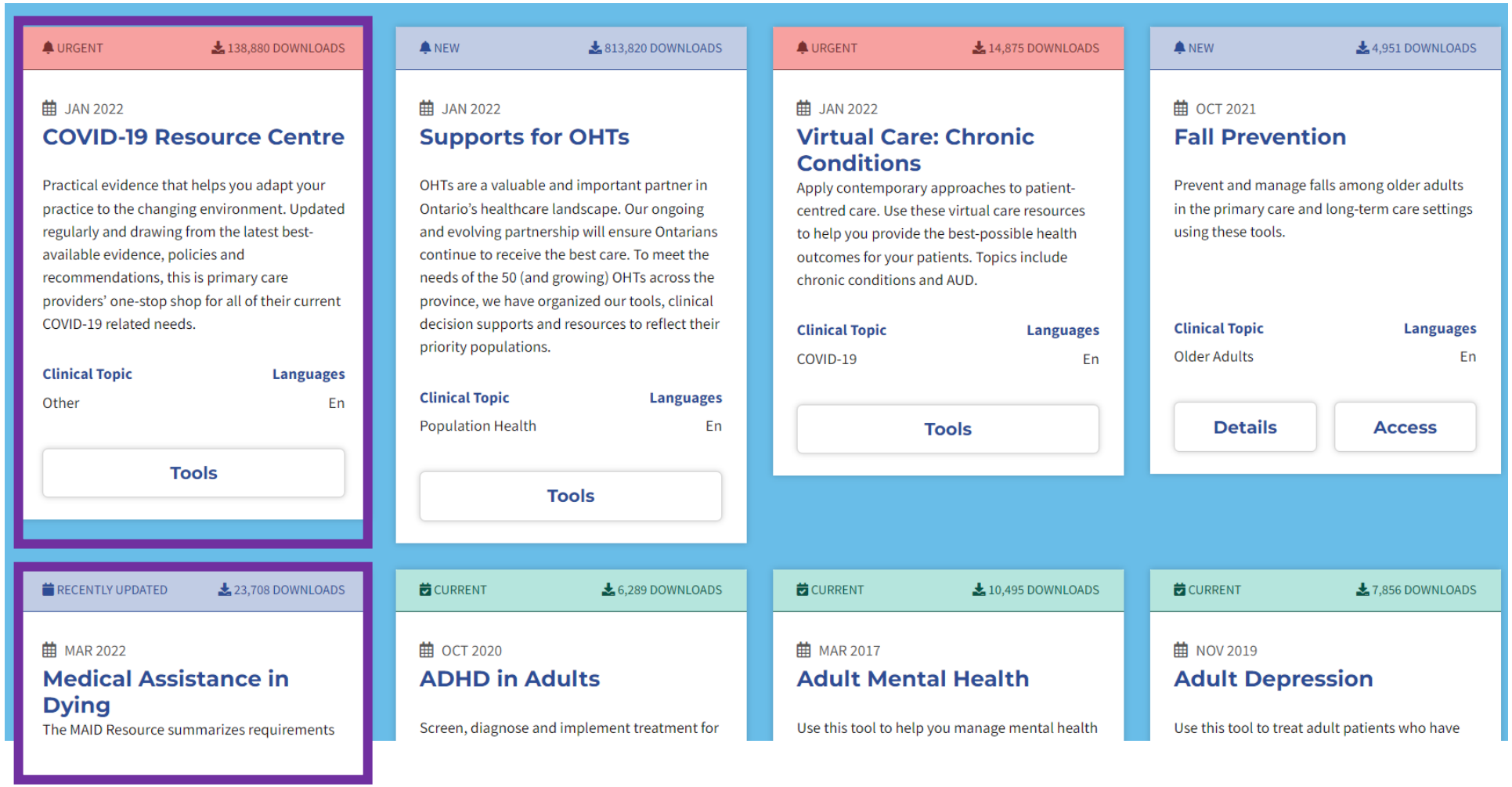
CEP Tools
www.cep.health/tools

- ADHD
- Alcohol use disorder
- Antipsychotics & dementia
- Anxiety & depression
- Benzodiazepine use
- Childhood obesity
- Chronic insomnia
- Chronic non-cancer pain
- Concussion
- CORE back tool
- COVID-19
- Diabetes
- Early Lyme disease
- Falls prevention
- Low back pain
- Manual therapy for MSK pain
- Medical assistance in dying
- Mental health (adults & youth)
- Neck pain and headache
- Non-medical cannabis
- Opioid manager
- Opioid tapering
- Opioid use disorder
- Osteoarthritis
- Poverty
- Preconception
- PPI use
- Supports for OHTs
- Type 2 diabetes
- Urinary incontinence
- Women-centred HIV care

CEP Tools: Mobile "Cards"



CEP Centre for Effective Practice

CEP Tool Development Process

Diversity, accessibility, equity, inclusion, and respect (DAEIR) at CEP

- Top 5 **priority** for 2023
- **Organization-wide changes** in leadership, hiring, training and tool development
- **DAEIR training** for staff
- Building **relationships** with, and providing support to, **equity-deserving groups**
- Adding the **voice of equity-deserving patients and groups** to tool development

https://tools.cep.health/tool/type-2-diabetes-insulin-therapy/

Ecological Impact

Consider the environmental impact of insulin

Click for details

COVID-19: Clinical Guidance for Primary Care Providers

Developed by: CEP Centre for Effective Practice | In collaboration with: McMaster University Family Medicine, Ontario College of Family Physicians, NPAO Nurse Practitioners' Association of Ontario | With support from: SGFP General & Family Practice

What's new!

Primary Care Operations in the COVID-19 Context

Preparing for fall in primary care

Click on the sections below to get started:

Expand All

- Testing and isolation requirements
- Outpatient management of patients with COVID-19
- New guidance for the prescription of nirmatrelvir / ritonavir (Paxlovid™)
- COVID-19 Clinical Assessment Centres (CACs): Information for Primary Care Providers
- Long-term symptoms / Post-acute sequelae of COVID-19 (PASC)
- Emerging evidence: COVID-19 variants, transmission, paediatric symptoms, and Rx research
- Palliative care and COVID-19
- Acknowledgement and legal

Anxiety and Depression

Last Updated: April 4, 2023

Search Content

Sign up for academic detailing (one-on-one education) with a pharmacist on this topic

This clinical tool helps family physicians and primary care nurse practitioners identify and manage anxiety and depression in adult patients. The tool was developed to help guide conversations with patients and families over a series of visits, as needed.

Expand All

Screening and assessment

Management

Follow-up/monitoring

CEP Centre for Effective Practice

https://tools.cep.health/tool/anxiety-and-depression/

Selective Serotonin Reuptake Inhibitors (SSRI)

Scroll (left-right) for details

Selective Serotonin Reuptake Inhibitors (SSRI)

Citalopram (Celexa®)

10 mg, 20 mg, 40 mg tablet

First-line for

- Major depressive disorder
- Panic disorder (+/- agoraphobia)

Coverage

- ODB ✓
- NIHB ✓

Cost for usual dose ($/100 days)

- $24-60

Overall tolerability*

- Well-tolerated

Activating or sedating

- Activating/sedating

Interaction risk

- + (CYP)
- Caution: combined QT-prolongation risk

Features**

- A preferred pharmacological options in pregnancy

View dosing, side effects, warning and contraindications

Selective Serotonin Reuptake Inhibitors (SSRI)

Escitalopram (Cipralex®)

10 mg, 20 mg tablet

First-line for

- Major depressive disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Panic disorder (+/- agoraphobia)

Coverage

- ODB ✓
- NIHB ✓

Cost for usual dose ($/100 days)

- $26-45

Overall tolerability*

- Very well-tolerated

Activating or sedating

- Activating/sedating

Interaction risk

- + (CYP)
- Caution: combined QT-prolongation risk

Features**

- A preferred pharmacological option in pregnancy

View dosing, side effects, warning and contraindications

Selective Serotonin Reuptake Inhibitors (SSRI)

Fluoxetine (Prozac®)

10 mg, 20 mg, 40 mg, 60 mg tablet
4 mg/mL oral solution

First-line for

- Major depressive disorder
- Panic disorder (+/- agoraphobia)

Coverage

- ODB ✓ (excludes 10mg tablet)
- NIHB ✓

Cost for usual dose ($/100 days)

- $45-152

Overall tolerability*

- Well-tolerated

Activating or sedating

- Activating

Interaction risk

- +++

Features**

- Easy to discontinue (self-taper)

View dosing, side effects, warning and contraindications

Selective Serotonin Reuptake Inhibitors (SSRI)

Side effects of all SSRIs:

CNS: headache, sleep disturbance, drowsiness, nervousness, dizziness, somnolence, fatigue
GI: nausea, vomiting, diarrhea
Anticholinergic: dry mouth, constipation, blurred vision, hyperhidrosis
CV: orthostatic hypotension, tachycardia
Urogenital: sexual dysfunction

Warnings for all SSRIs:

Anxiety/agitation may worsen initially (first 1-2 weeks)
GI bleeding (consider gastroprotective agent if high risk)
Hyponatremia (especially in elderly)
Fractures (especially in first 6 weeks)
Suicidal thinking & self-harm (patients 30 years and under)

Medication	First-line for				Features (Consider in addition to other patient and medication factors)	Side effects, warnings and contraindication (In addition to those listed above)	Overall tolerability*	Activating or sedating?	Interaction risk	Dosing**	Coverage and cost for usual dose ($/100 days)
	MDD	GAD	SAD	Panic							
Citalopram (Celexa®)[G] 10 mg, 20 mg, 40 mg tablet	X			X	A preferred pharmacological option in pregnancy	QTc prolongation risk Contraindicated in patients with known QT prolongation or congenital long QT syndrome		Activating/ sedating	+ (CYP) Caution: combined QT-prolongation risk	**Initial**: 10-20 mg daily (am/pm) **Usual**: 20–40 mg daily **Max**: 40 mg daily (20 mg in older adults, liver disease, concurrent CYP 2C19 inhibitor)	ODB: ✓ NIHB: ✓ $24 - 60
Escitalopram (Cipralex®)[G] 10 mg, 20 mg tablet	X	X	X	X	A preferred pharmacological option in pregnancy	QTc prolongation risk Contraindicated in patients with known QT prolongation or congenital long QT syndrome		Activating/ sedating	+ (CYP) Caution: combined QT-prolongation risk	**Initial**: 5-10 mg daily (am/pm) **Usual**: 10-20 mg daily **Max**: 20 mg daily (10 mg in older adults, liver disease, concurrent CYP 2C19 inhibitor)	ODB: ✓ NIHB: ✓ $26 - 45
Fluoxetine (Prozac®)[G] 10 mg, 20 mg, 40 mg, 60 mg capsule 4 mg/mL oral solution	X			X	Easy to discontinue (self-taper)	**Side effects**: insomnia, agitation, anorexia Higher rates of confusion QTc prolongation risk		Activating	+++	**Initial**: 10-20 mg daily (am) **Usual**: 20 mg daily **Max**: 80 mg daily (lower dose recommended for older adults)	ODB: ✓ (excludes 10mg tab) NIHB: ✓ $45 - 152
Fluvoxamine (Luvox®)[G] 50 mg, 100 mg tablet	X		X	X		**Side effects**: severe GI upset, anorexia, anticholinergic potential Caution when using in older adults		Sedating	+++	**Initial**: 25-50 mg daily (hs) **Usual**: 100–200 mg daily **Max**: 300 mg daily Divide doses above 150 mg (max 150 mg at bedtime) Hepatic/renal disease: increase dose slowly & monitor carefully	ODB: ✓ NIHB: ✓ $55 - 132

Before starting a treatment, discuss the following with the patient, and if desired, their family or caregiver(s):[1-5,9]

Medication option(s)

Expected benefit(s) of the particular medication

Overall plan to "start low and go slow" to the "target" dose

Onset of action

- Depression: 2-4 weeks[1]
- Anxiety: 2-8 weeks[7]

Full effect(s)

- Depression: 4-8 weeks[4,5]
- Anxiety: 6-12 weeks or more[3,7]
- Older adults may take longer to respond[9]

Cost/coverage of the treatment

- Understand your patient's access to private health insurance
- Reach out to drug companies to inquire about their compassionate use programs
- Connect your patient with Ontario Works and Ontario Disability Support Program for financial assistance with drug coverage

Side effects/risks of treatment and how to manage

Use your clinical judgement to move patients through the stepped-care approach. For the psychological and pharmacological management of anxiety and depression. Individualize therapy based on a patient's symptom severity, concerns and preferences. This may involve skipping steps to achieve appropriate treatment for an individual patient. Routinely follow-up and monitor changes in the patient's symptoms and quality of life. Empower patients to make decisions with you about their treatment plan.[2]

Talking tips

Click to view

Guiding principles for the management of anxiety and depression:

- Understand the patient's context and life circumstances, such as:[6]
  - Coverage options (e.g., access to extended health coverage, Non-insured health benefits program mental health counselling benefit, and Employee Assistance Plans)
  - Potential barriers to treatment (e.g., disability, language or communication)
- Cost considerations
  - Reach out to drug companies to inquire about their compassionate use programs
  - Connect patients with Ontario Works and the Ontario Disability Support Program for financial assistance with drug coverage
- Account for how coexisting conditions may impact treatment options.

I felt like a person again

RITA'S STORY

RITA IS A RESIDENT OF SASKATCHEWAN.

I started having pain issues when I was 17, off and on. Then when I was 19, the pain got severe, and I needed something all the time. I took Tylenol 1's, then Tylenol 3's, then OxyContin, and finally morphine. All through this, the dose kept increasing, because the pain was never controlled. At first a dose increase would feel better - but only for a while.

I was on opioids for 10 years, and things were not getting better. My doctor didn't want to go any higher with the dose. She kept encouraging me to reduce. And eventually I realized - the morphine was making me sicker, not better.

Back when I was on morphine, for a long time I thought I was doing OK. But I wasn't functioning normally at all. I was blind to it, I couldn't see it. Once my dose got low enough - I can only describe it as an awakening of the body and mind. I felt like a person again. I could feel pleasure again - I hadn't realized that the opioid was doing that to me.

I think now that my pain was getting worse because I continued to use opioids. My neighbour was on opioids, and she watched me go off, and then she used my tips to help her get off. Now she's a completely different person.

Tapering was really hard. It was like having a severe flu. It took me 2 years to taper - I felt horrible, but I felt like I was doing something that was going to help me. My doctor told me I didn't have to go all the way, that I could stop the taper - but I wanted to get off. She prescribed some medications that really helped with the withdrawal.

It's been over 2 years now since I was on opioids. The taper was 100% worth it. People don't know how much better things can be. The more people who try, the more people who will see that it's possible. That you don't have to be stuck. **I FELT LIKE A PERSON AGAIN.**

Note: Rita worked with her family physician and pharmacist to implement a successful tapering plan. Her name has been changed to protect her privacy.

RITA'S TIPS FOR TAPERING

- You'll need to have help - there's no way to do it by yourself.
- If you have a plan and schedule in place, it can keep you focused.
- Medications can help with withdrawal. In my case, clonidine and melatonin were especially useful.
- To help with hot and cold sweats in withdrawal, I would get into an empty bathtub and fill it with hot water - once the tub got full my temperature would reset.
- It's OK to slow the taper down if you need to, if the withdrawal gets too uncomfortable.
- The days right after you reduce a dose are going to be hard - be ready, and remember the increase in pain is only for a few days.
- Stay determined. It's hard, but it's worth it.

Patient Voices

Used with permission from RxFiles: https://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Patient-Booklet-Taper-RxFiles.pdf

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Breakouts: Round 1

1. **Introduce** yourself and your program
2. **Walk through and review** the assigned detailing aid as a group:
    - Discuss **3 things you like** about this tool
    - Discuss **3 things you would improve**
    - Give **1-2 examples of how** you would make those improvements

Groups 1 and 2: *Review the NaRCAD detailing aid*
Groups 3 and 4: *Review the CEP detailing aid*

Small Group Logistics

- The discussion goals will be available to view in your chatbox
- You can request help from the host if you need assistance from the NaRCAD team

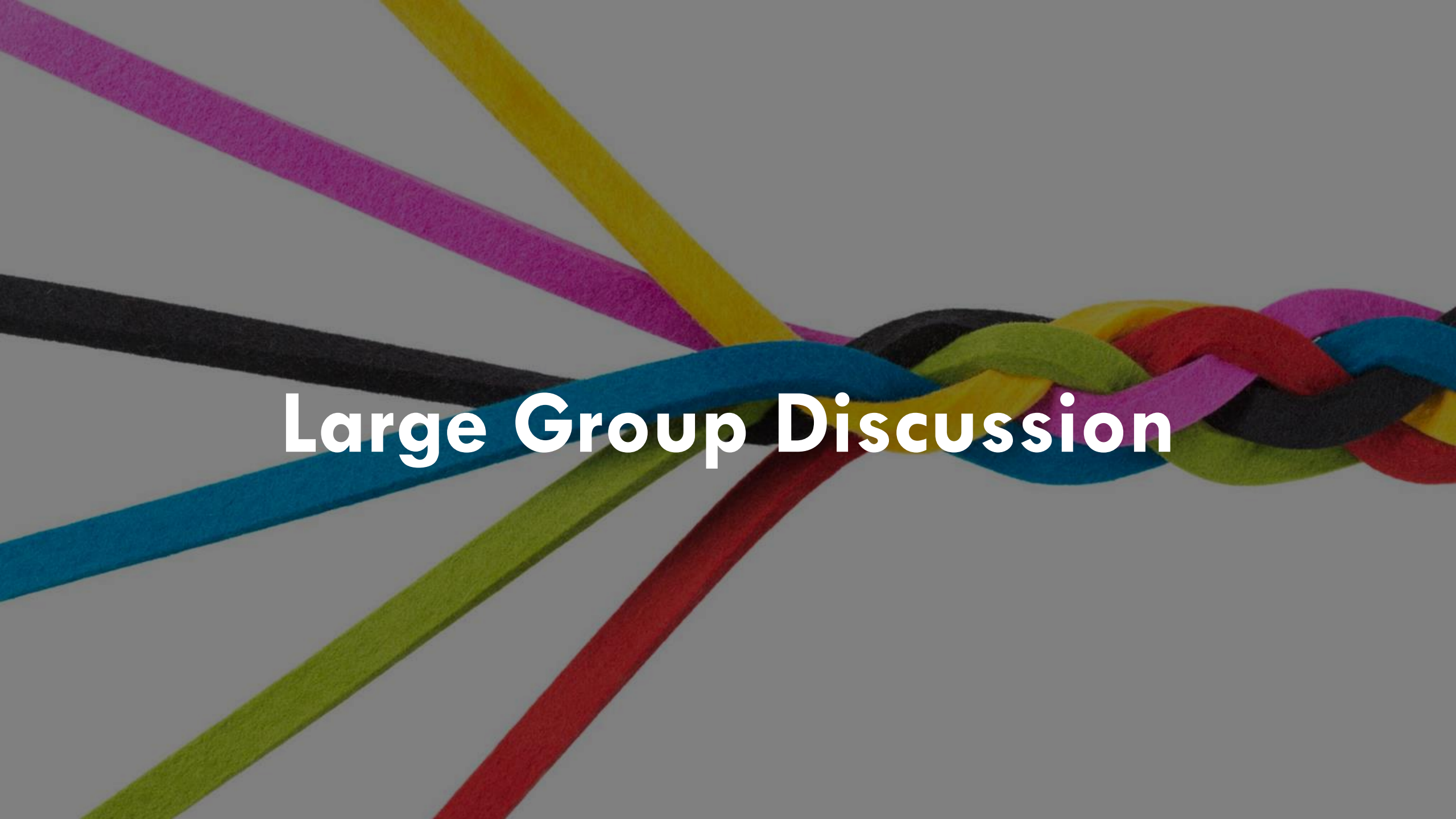
Large Group Discussion

Breakouts: Round 2

Make a **checklist of considerations** for developing the perfect detailing aid *(think about evidence, content, and design)*

Small Group Logistics

- The discussion goals will be available to view in your chatbox
- You can request help from the host if you need assistance from the NaRCAD team


Large Group Discussion

THANK YOU!

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