Educational Support Materials & Clinical Content Overview

Making Visits Successful with Engaging Visual Aids

The National Resource Center for Academic Detailing

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Why use support materials?

- To accommodate various learning styles
- To guide conversations and stay "on track"
- To **reinforce key messages**
- To read, share, or be referred to after you leave

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Key Points:

Good materials & proper use should:

- Helps clarify complex information
- Helps customize a visit to meet the needs of a participant
- **Support, but not replace, the conversation!**

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Dangers of Support Materials

- Poor familiarity with materials undermining credibility
- Allowing the materials to turn a tailored, interactive conversation into a didactic presentation
- Over-reliance on materials
- Losing 'control' of the materials (and control of conversation)

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Support Materials are:

Paper or electronic visual aids that support a tailored, interactive conversation

- Brochures or "Un Ads"
- Clinical papers or evidence documents
- Reference cards
- Risk calculators
- Checklists or office tools
- Patient-facing tools that clinicians can use

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Support Materials <u>are NOT</u>:

- Copies of every scientific paper used to prepare your module or presentation topic
- PowerPoint lecture slides
- Individual-level data that will be used punitively

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Managing Materials: Planning Ahead

- **Practice using materials**
  - Avoid shuffling papers during a conversation
  - Have the materials ready to use, without delay
- **Be selective**
  - Don't overwhelm the clinician with too much material
  - Adjust based on the conversation (e.g. not every provider will want a copy of a study, but some will)

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Thinking About Environment

- **Where will the visit take place?**
  - In an office?
  - In a conference room?
  - Standing in a hallway?
- **Who will be at the visit?**
  - One detailer to one provider
  - Small group
  - Mix of providers and staff
- **Some materials are better in one situation vs. another**
- **Make sure you have enough!**

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During a Visit: Body Position

Coordinate your body position and the position of the material so it is:

- Close enough to be read easily
- Angled so that your participant can comfortably see it

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Material Control

- Manage the "control" of material
- Have back-up materials available, just in case
- Plan ahead for how you'll handle the situation so that you're prepared if you lose control of the materials
  - Options:
    - Point out a specific graphic or stat you'd like to share to regain control
    - Don't worry & go where the provider wants to go

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Closing a Visit: Sharing Materials

- Leaving materials behind:
  - Materials are costly resources; make sure those resources are put to good use.
  - Will it be read/referred to?
  - Will it be shared?

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Detailing Aid Review

CDC Provider Materials: 4-Pager

Cover Page:

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Promoting Patient Care and Safety

THE US OPIOID OVERDOSE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn't changed. This epidemic is devastating American lives, families, and communities.

More than 40 people die every day from overdoses involving prescription opioids.[1]

Since 1999, there have been over 165,000 deaths from overdose related to prescription opioids.[1]

4.3 million Americans engaged in non-medical use of prescription opioids in the last month.[2]

PRESCRIPTION OPIOIDS HAVE BENEFITS AND RISKS

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.

enough prescriptions were written for every American adult to have a bottle of pills

[1] Includes overdose deaths related to methadone but does not include overdose deaths related to other synthetic

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WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

Primary care providers account for approximately

50%

of prescription opioids dispensed

Nearly

2 million

Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chronic pain
- Primary care providers are concerned about patient addiction and report insufficient training in prescribing opioids

MYTH	VS	TRUTH
1 Opioids are effective long-term treatments for chronic pain		While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.
2 There is no unsafe dose of opioids as long as opioids are titrated slowly		Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer.
3 The risk of addiction is minimal		Up to one quarter of patients receiving prescription opioids long term in a primary care setting struggles with addiction. Certain risk factors increase susceptibility to opioid-associated harms: history of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.

WHAT CAN PROVIDERS DO?

First, **do no harm**. Long-term opioid use has uncertain benefits but known, serious risks. CDC's ***Guideline for Prescribing Opioids for Chronic Pain*** will support informed clinical decision making, improved communication between patients and providers, and appropriate prescribing.

Page 2, Bottom: Key Messages

PRACTICES AND ACTIONS

USE NONOPIOID TREATMENT

Opioids are not first-line or routine therapy for chronic pain *(Recommendation #1)*

In a systematic review, opioids did not differ from nonopioid medication in pain reduction, and nonopioid medications were better tolerated, with greater improvements in physical function.

START LOW AND GO SLOW

When opioids are started, prescribe them at the lowest effective dose *(Recommendation #5)*

Studies show that high dosages (≥100 MME/day) are associated with 2 to 9 times the risk of overdose compared to <20 MME/day.

REVIEW PDMP

Check prescription drug monitoring program data for high dosages and prescriptions from other providers *(Recommendation #9)*

A study showed patients with one or more risk factors (4 or more prescribers, 4 or more pharmacies, or dosage >100 MME/day) accounted for 55% of all overdose deaths.

AVOID CONCURRENT PRESCRIBING

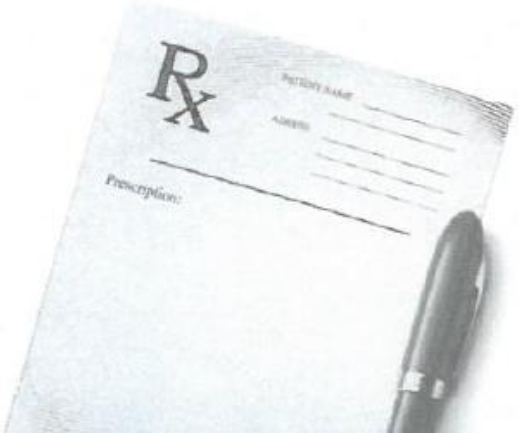
Avoid prescribing opioids and benzodiazepines concurrently whenever possible *(Recommendation #11)*

One study found concurrent prescribing to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone.

OFFER TREATMENT FOR OPIOID USE DISORDER

Offer or arrange evidence-based treatment (e.g. medication-assisted treatment and behavioral therapies) for patients with opioid use disorder *(Recommendation #12)*

A study showed patients prescribed high dosages of opioids long-term (>90 days) had 122 times the risk of opioid use disorder compared to patients not prescribed opioids.



RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First-line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First-line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

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Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).

WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

Reference Articles

Used to Support Your Key Messages & Detailing Aid Visuals

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Please Note:

The following studies are available online on our website's Opioid Toolkit.

Study: SPACE Trial

March 6, 2018

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain

The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH[1,2]; Amy Gravely, MA[1]; Sean Nugent, BA[1]; et al

» Author Affiliations

JAMA. 2018;319(9):872-882. doi:10.1001/jama.2018.0899

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SPACE Trial

Talking Points:

- VA patients with 6+ months of back, hip, knee pain
- Randomized to opioid or non-opioid treatment strategy, doses could be adjusted based on patient response
- Outcomes were pain-related function, pain score, & self-reported side effects:
    - **No difference in function**
    - **Pain relief slightly better in non-opioid group**
    - **Side effects reported as slightly higher in opioid group**

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SPACE Trial

The Bottom Line:

For patients with chronic musculoskeletal pain, opioids are no better than non-opioid treatments and can increase risk of side effects

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ER Acute Pain Study:

November 7, 2017

Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department

A Randomized Clinical Trial

Andrew K. Chang, MD, MS[1]; Polly E. Bijur, PhD[2]; David Esses, MD[2]; et al

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JAMA. 2017;318(17):1661-1667. doi:10.1001/jama.2017.16190

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ER Acute Pain Study

Talking Points:

- Patients seen in ER with acute extremity pain bad enough to require imaging
- Randomized to 4 groups for initial pain med, acetaminophen plus:
  Ibuprofen **Oxycodone** **Hydrocodone** **Codeine**
- Outcome was change in pain score at 2 hours
- All experienced moderate relief; **NO differences in pain relief between groups**
- Patients with more severe initial pain scores or fractures also had no difference in pain relief

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ER Acute Pain Study

The Bottom Line:

For acute pain, non-opioid options provide equal pain relief to opioids.

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Questions & Discussion

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