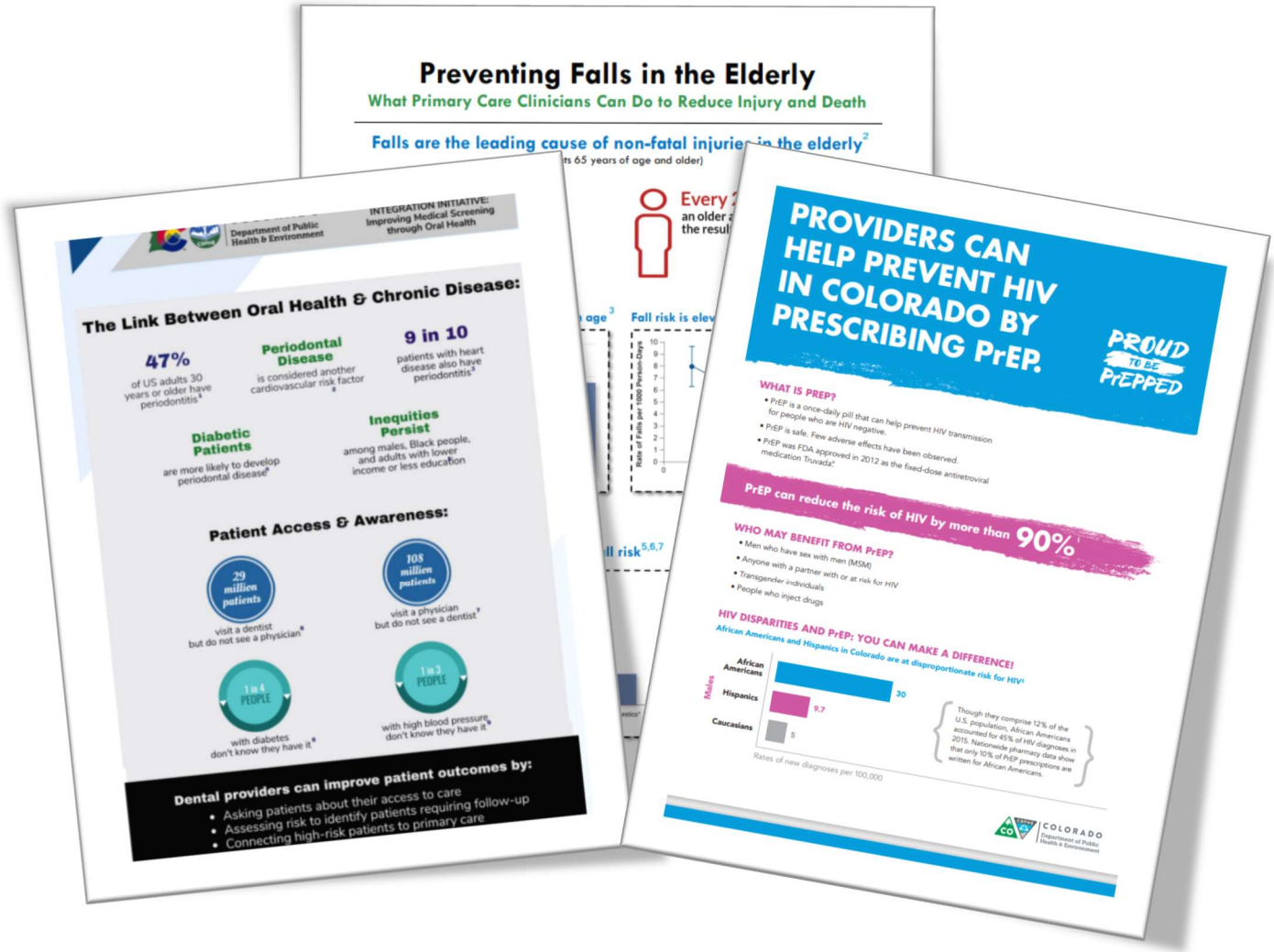
BUILDING AN IMPACTFUL DETAILING AID:

NaRCAD's How-to Guide



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Purpose of This Guide

This guide serves to provide structure to the task of building an engaging educational brochure, or "Detailing Aid", to support detailers' 1:1 visits with clinicians. During these visits, detailers engage with clinicians using a custom-tailored approach, asking needs assessment questions and eliciting storytelling to encourage the clinician to share beliefs, knowledge, and attitudes related to a specific clinical intervention.

These encounters are exponentially more impactful when a corresponding detailing aid successfully highlights relevant data, guidelines, and recommended key messages, all used in tandem to encourage adoption of behavior change to improve patient outcomes.

An impactful detailing aid will:

- ✓ Support, but not be the only focus of the conversation
- ✓ Encourage a robust dialogue between detailer and clinician
- ✓ Streamline complex evidence into easily digestible graphics
- ✓ Allow for various learning styles to be engaged and maximize interactivity
- ✓ Serve as a shared focal point to promote a solutions-oriented partnership
- ✓ Correspond directly with specific behavior change commitments
- ✓ Support the building of a relationship that includes a service-oriented approach
- ✓ Offer options for continued contact for the clinician to ask follow-up questions
- ✓ Provide a tangible resource for clinicians to refer back to and support any new approaches to care

This guide provides a step-by-step process to utilize best practices in building a detailing aid that will support the adoption of evidence-based approaches to care.

The example detailing aids included within this guide show a spectrum of approaches, with an emphasis on finding the balance between illustrating the unique goals of your campaign intervention while following best practices in creating a graphically engaging, accurate, and easy to follow resource.

This guide was authored primarily by Anna Morgan, with support from Winnie Ho, Bevin Shagoury, and Michael Fischer.
Morgan A, Ho W, Shagoury B, Fischer MA. Building an Impactful Detailing Aid: NaRCAD's How-to Guide. National Resource Center for Academic Detailing, Brigham Health, Boston, MA; December 2020

Table of Contents

I. Start by Illustrating the Problem: This is where you frame the issue and begin to make the case for action *(typically on a 'cover page'; see the Falls Prevention detailing aid 'cover page', the Opioid Safety detailing aid 'cover page', the Dental Health detailing aid 'cover page', and the PrEP detailing aid 'cover page' in the attached appendix).*

A. Include a title that focuses on the impact the clinician group can have on improving the issue.

Figure 1a. *Title from Falls Prevention detailing aid includes focus on ability to reduce adverse patient outcomes.*

Figure 1b. *Title from the Opioid Safety detailing aid includes focus on patient safety.*

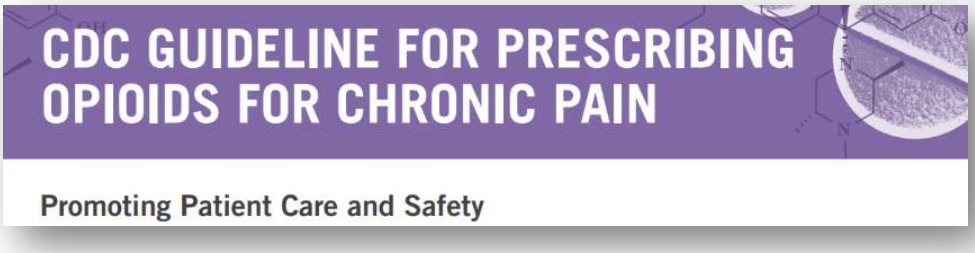
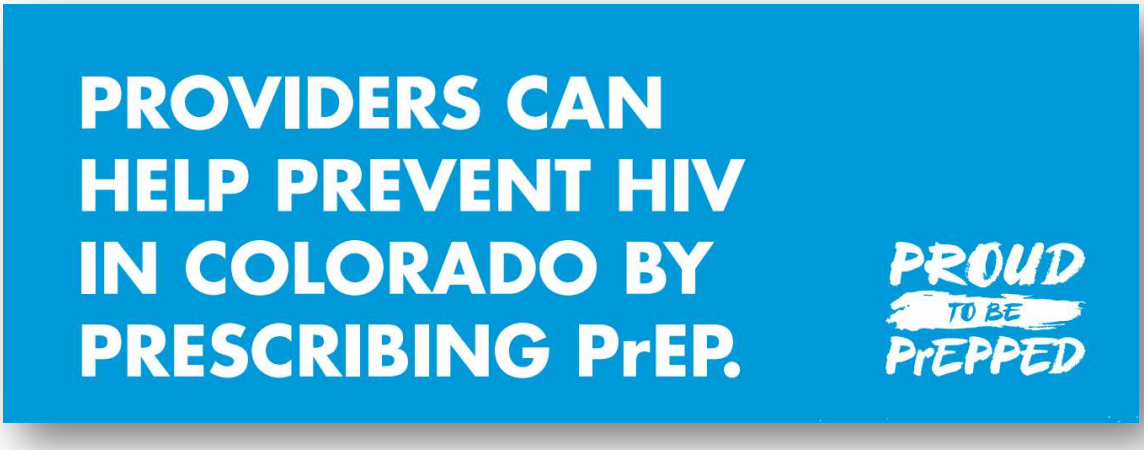


Figure 1c. *Title from the PrEP detailing aid includes focus on preventing HIV.*



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

Figure 2a. *Falls Prevention detailing aid displays data in a graph.*

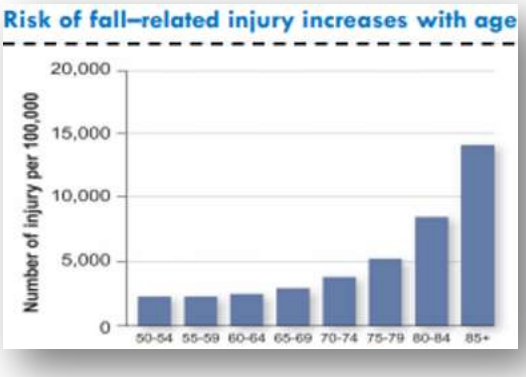


Figure 2b. *Opioid Safety detailing aid displays data with an image.*

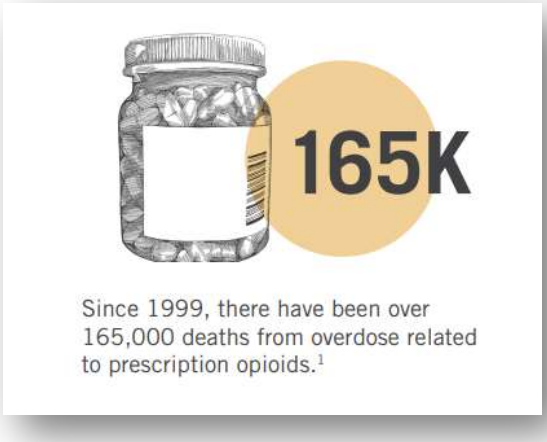
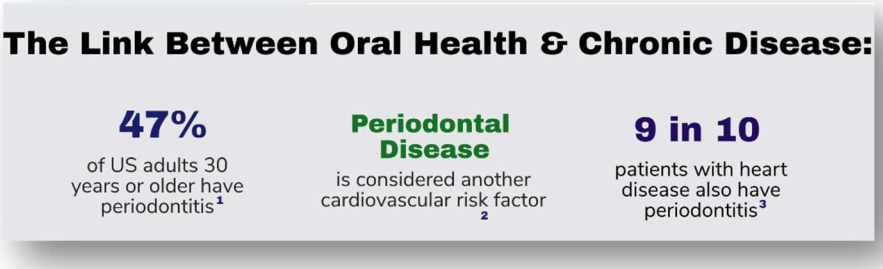


Figure 2c. *Dental Health detailing aid displays data in an accessible way.*



C. Use local data when available.

Figure 3a. *Cover page from Ware County, Georgia uses local data related to the opioid crisis.*

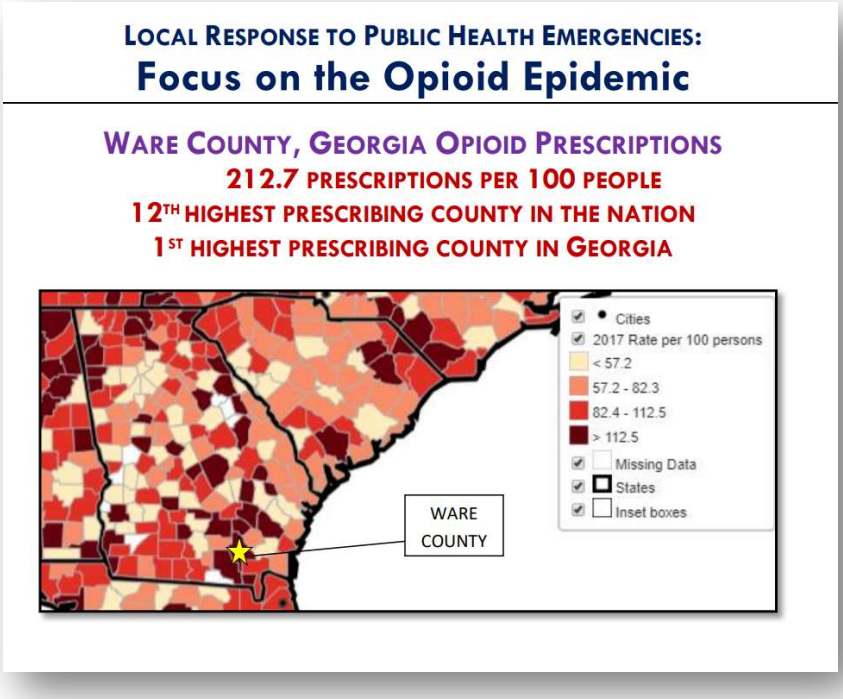
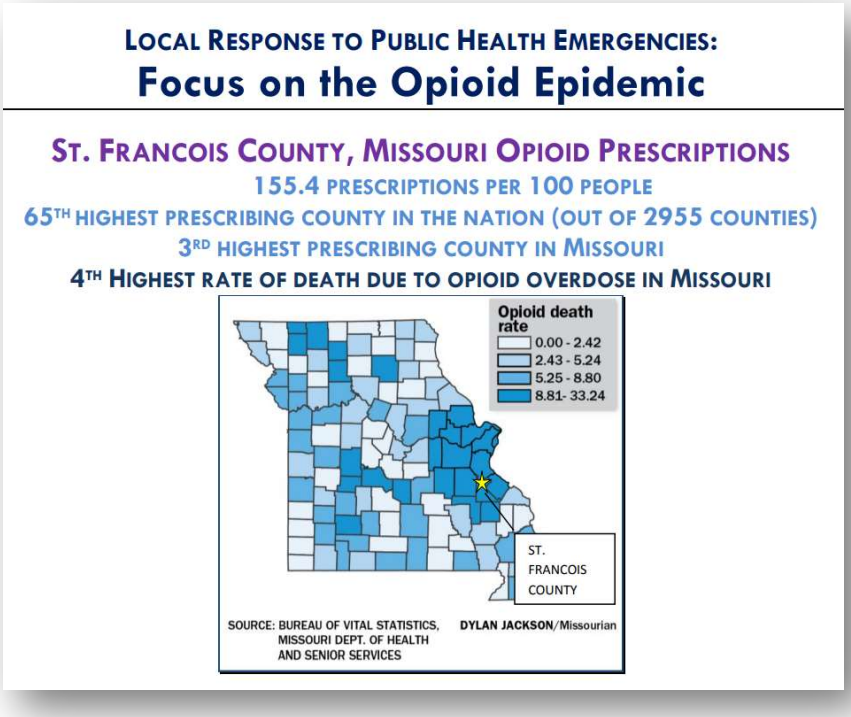


Figure 3b. *Cover page from St. Francois County, Missouri uses local data related to the opioid crisis.*



D. Include the population it affects and how *(what's the ripple effect? what are the negative outcomes? why is this important to the clinician?)*.

Figure 4a. *The Falls Prevention detailing aid shows why this issue is important to the clinician.*

Figure 4b. *The Opioid Safety detailing aid shows the ripple effect of prescriptions written for opioid pain medication.*

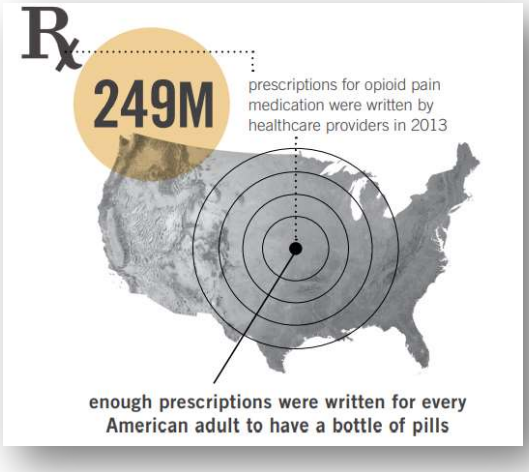
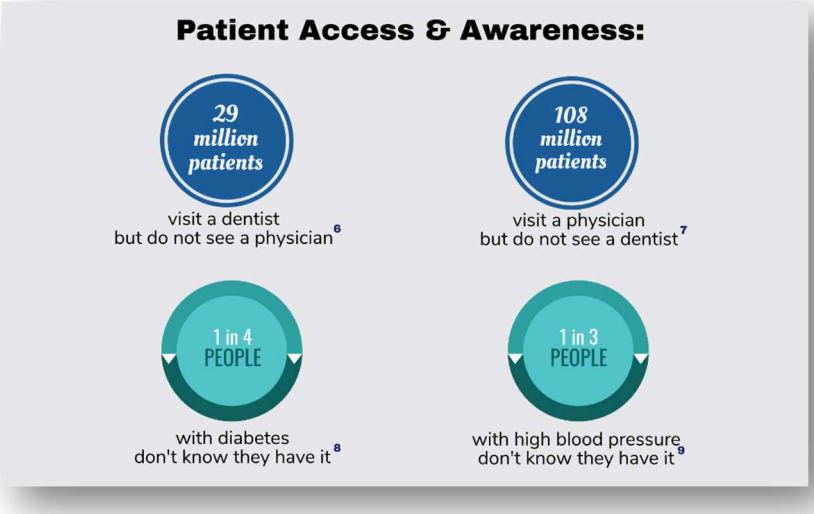


Figure 4c. *The Dental Health detailing aid shows the negative outcomes of limited access to care.*



E. A cover page should clearly illustrate the gap between best evidence and patient care. It's even more impactful when the cover page clearly shows the potential for clinician impact to better the situation.

Figure 5a. *The Falls Prevention detailing aid clearly shows the potential for clinician impact to better the situation.*

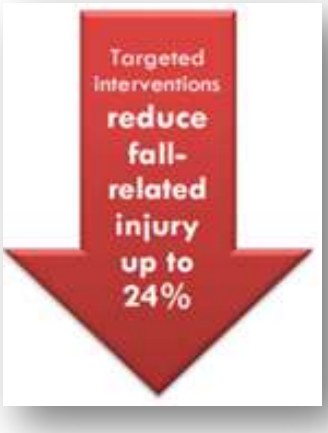


Figure 5b. *The PrEP detailing aid illustrates the gap between best evidence and patient care.*

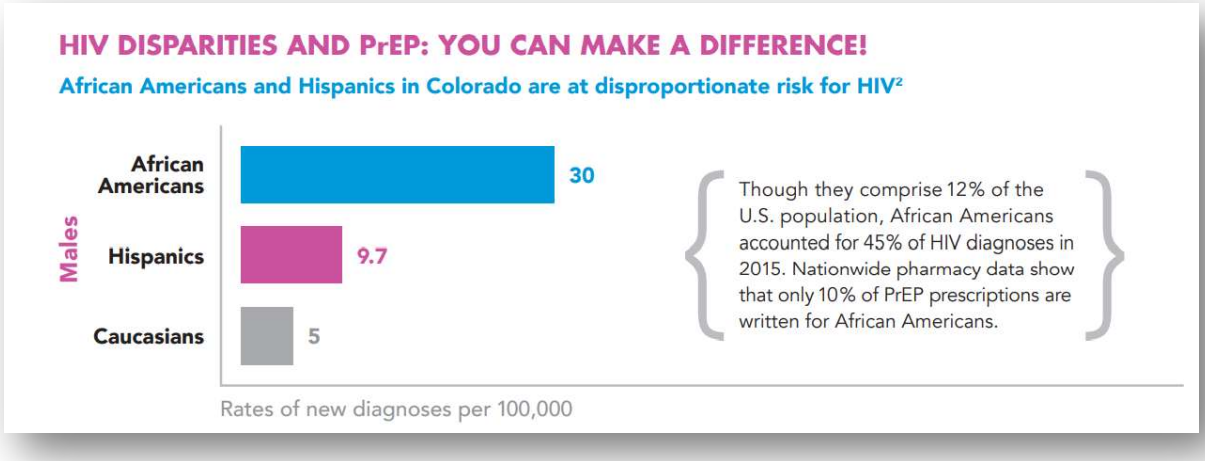


Figure 5c. *The Dental Health detailing aid clearly shows the potential for clinician impact to better the situation.*

II. List Action-Based Key Messages

A. The detailing aid should include action verbs within each key message.

Figure 6a. *The key message from the Falls Prevention detailing aid uses the action verb "conduct"*

Figure 6b. *The key message from the Opioid Safety detailing aid uses the action verb "use"*

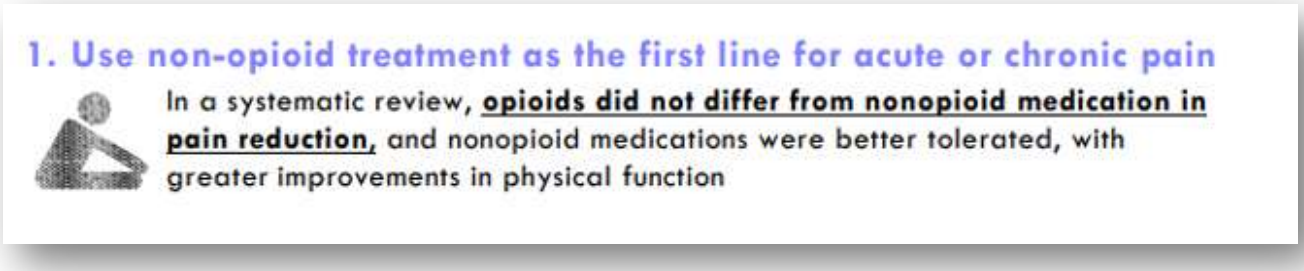
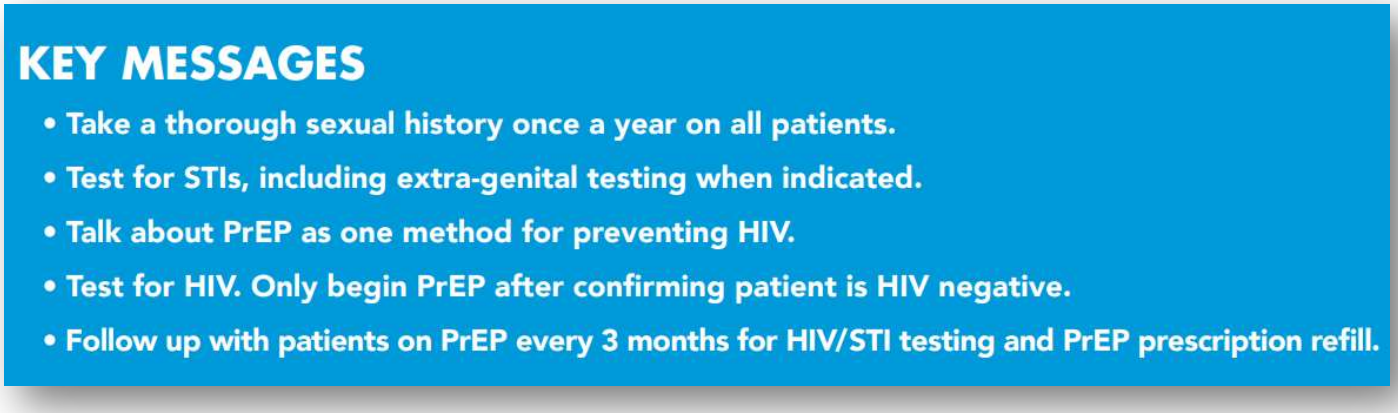


Figure 6c. *The key messages from the PrEP detailing aid use the action verbs "take", "test", and "talk"*



B. The key messages should be easy to identify with either a unique call out color or icon.

Figure 7a. *The green arrow in the Falls Prevention detailing aid allow the key message to be easily identified.*

Figure 7b. *The bright blue checklist in the Opioid Safety detailing aid allow the key message to be easily identified.*

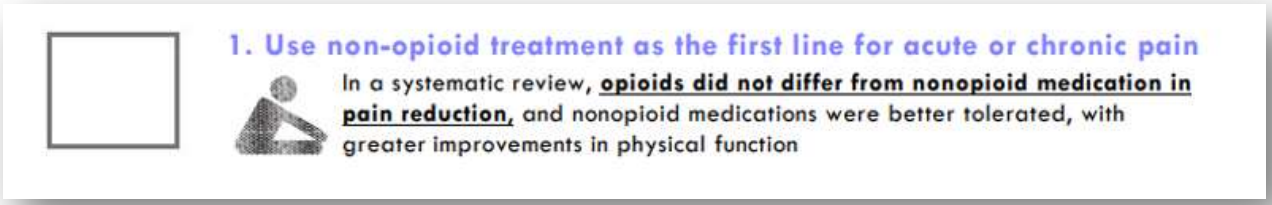
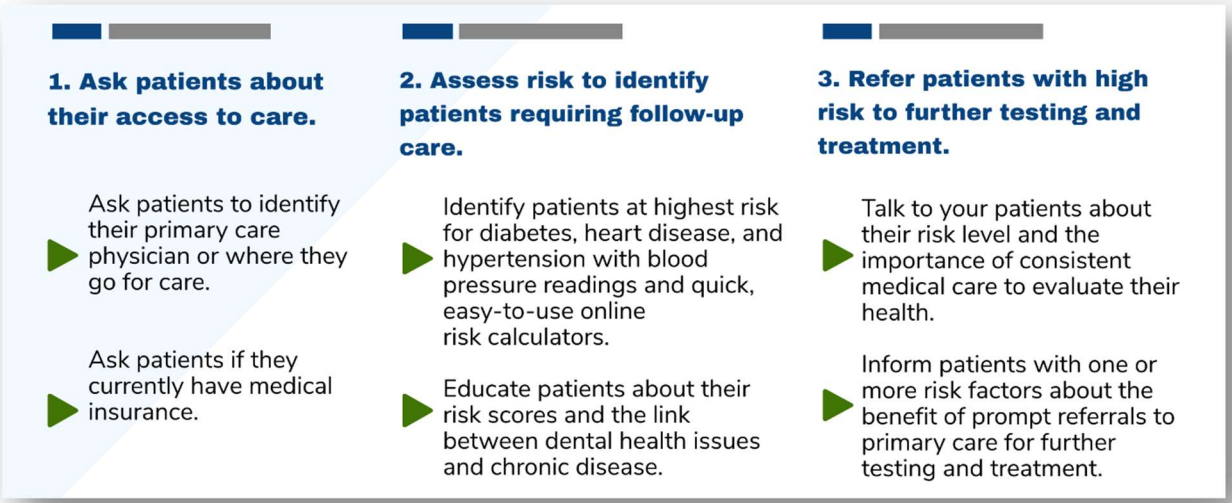


Figure 7c. *The dark blue font in the Dental Health detailing aid allow the key messages to be easily identified.*



C. The key messages can even be labeled as "key messages" as well as numbered in the order they should appear, especially if each message is part of an overall process.

Figure 8a. *The key messages in the Opioid Safety detailing aid are numbered in the order they should appear.*

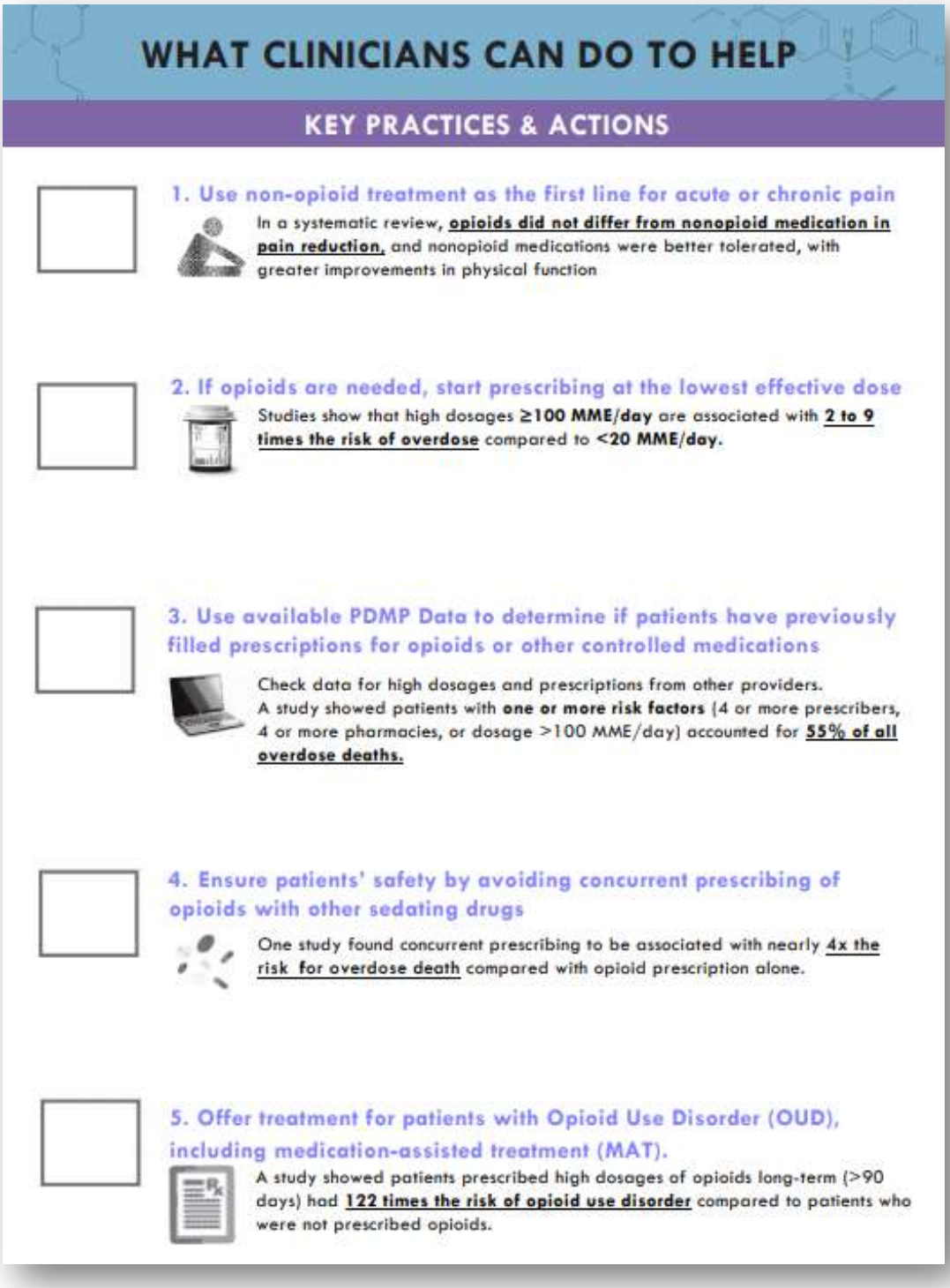
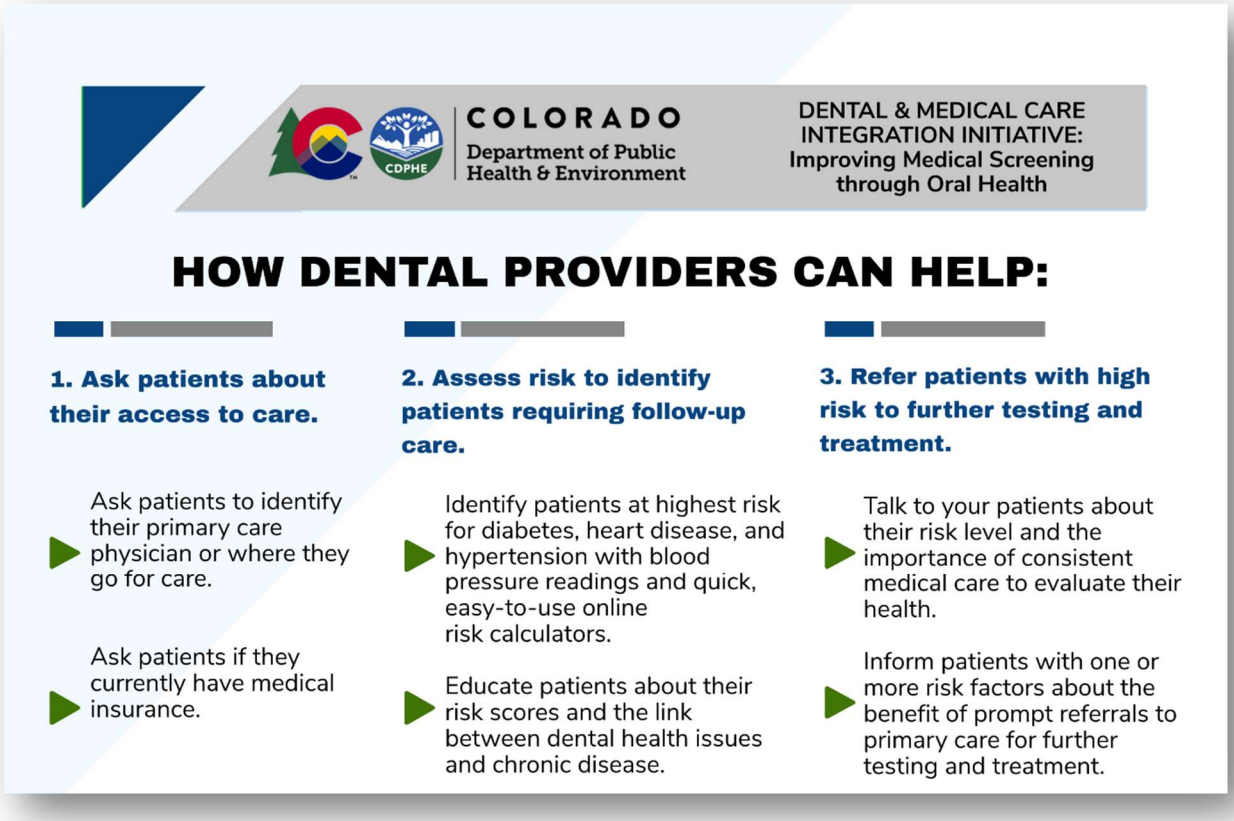


Figure 8b. *The key messages in the Dental Health detailing aid are numbered in the order they should appear.*



D. The detailing aid should include any relevant steps involved for the clinician to implement the key message.

Figure 9a. *The Falls Prevention detailing aid includes steps involved for the clinician to use the TUG Test.*

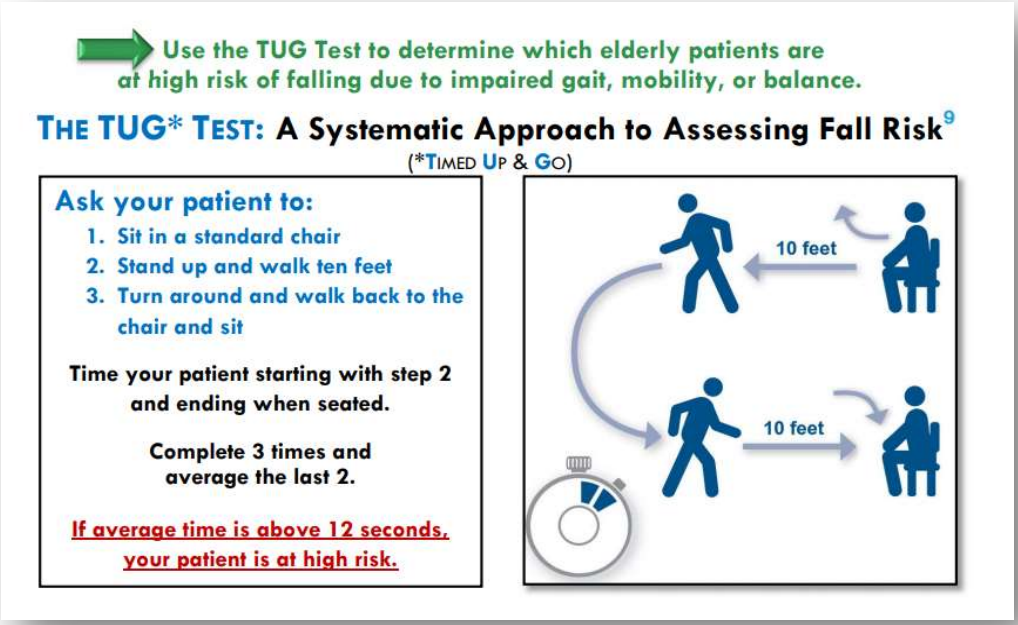
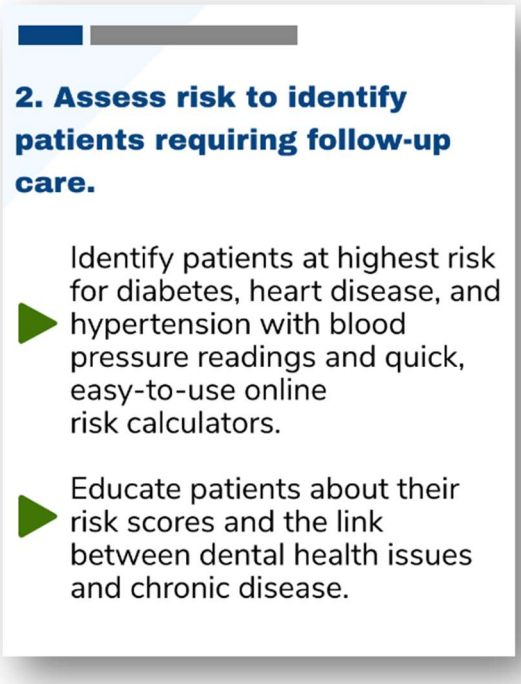


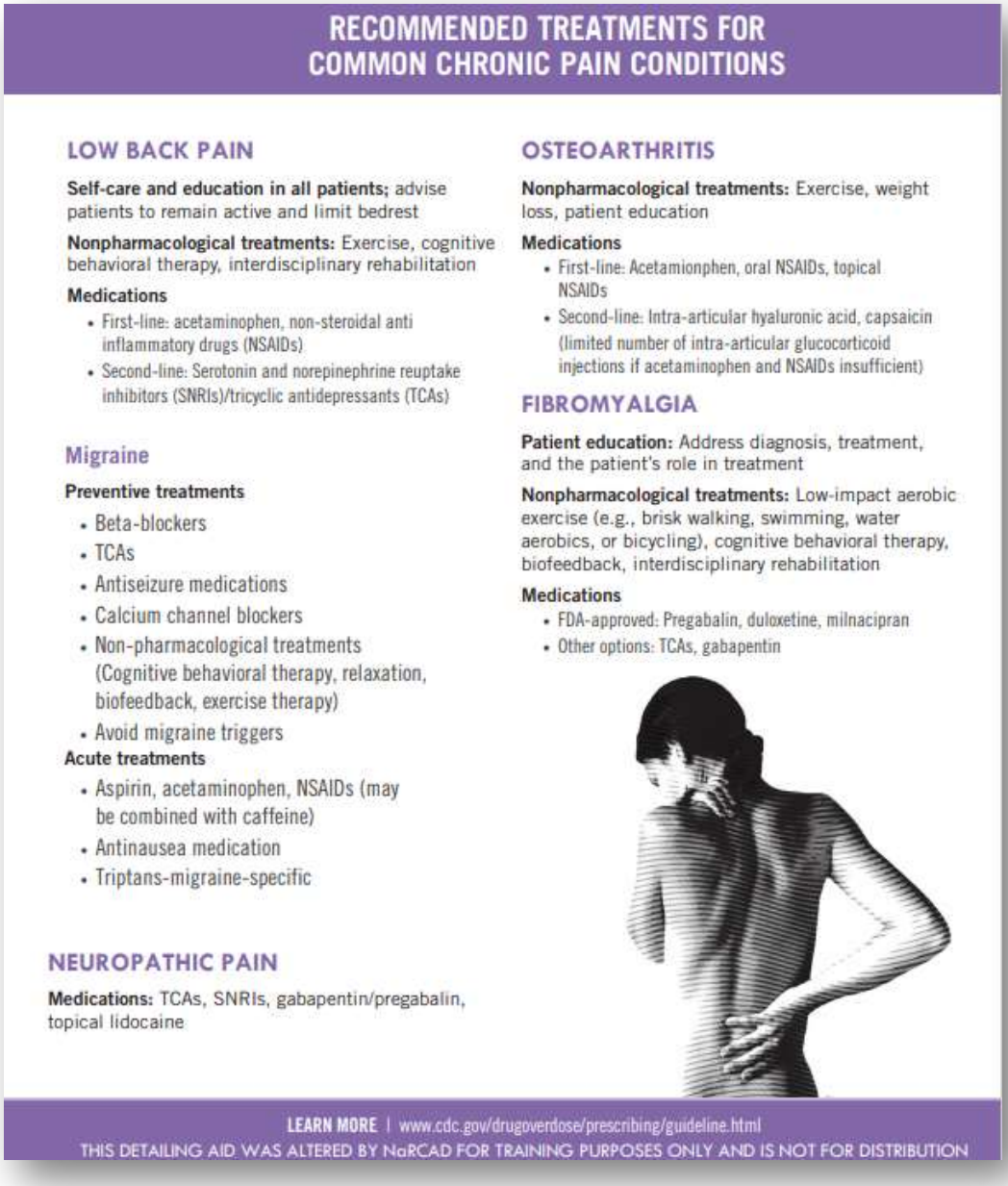
Figure 9b. *The Dental Health detailing aid includes steps involved for the clinician to assess patient risk.*



III. Include Content to Address Typical Concerns/Barriers

A. Clinicians may not immediately accept all the key messages. It's highly likely that they 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. For example, if a detailing aid is promoting non-opioid treatment for chronic pain, clinicians will need information about non-pharmacological treatment options.

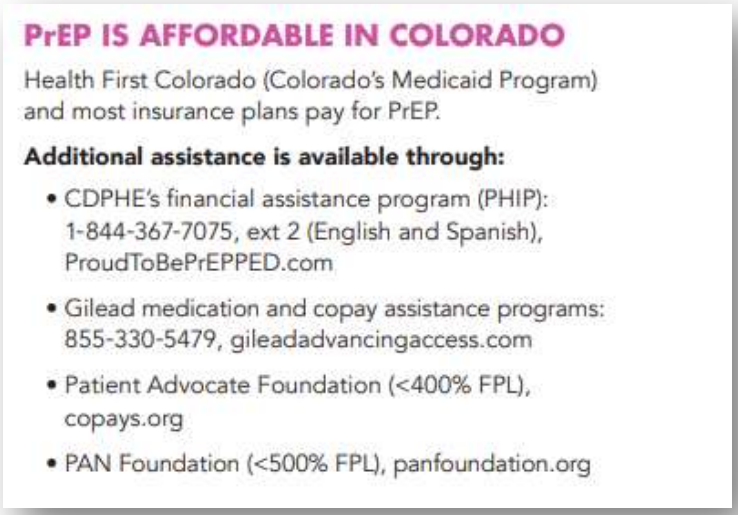
Figure 10. *The Opioid Safety detailing aid provides clinicians with information about recommended treatments for common chronic pain conditions.*



IV. List National and Local Resources

A. 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.

Figure 11a. *The PrEP detailing aid includes options for payment.*



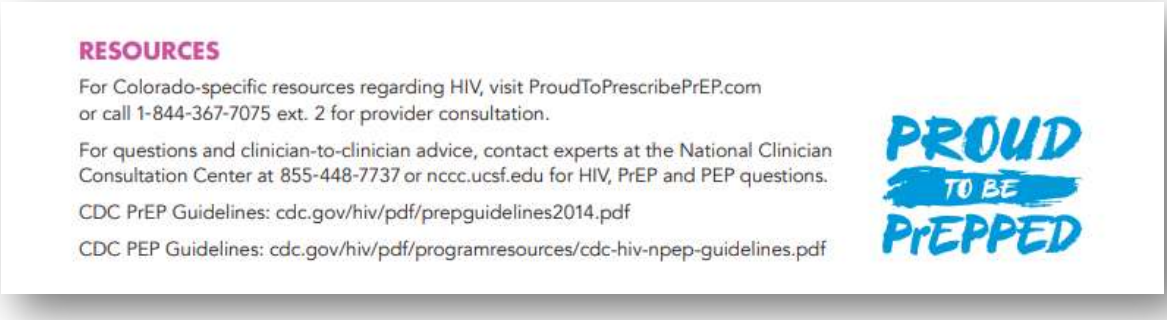
PrEP IS AFFORDABLE IN COLORADO

Health First Colorado (Colorado's Medicaid Program) and most insurance plans pay for PrEP.

Additional assistance is available through:

- CDPHE's financial assistance program (PHIP): 1-844-367-7075, ext 2 (English and Spanish), ProudToBePrEPPED.com
- Gilead medication and copay assistance programs: 855-330-5479, gileadadvancingaccess.com
- Patient Advocate Foundation (<400% FPL), copays.org
- PAN Foundation (<500% FPL), panfoundation.org

Figure 11b. *The PrEP detailing aid includes clinician resources.*



RESOURCES

For Colorado-specific resources regarding HIV, visit ProudToPrescribePrEP.com or call 1-844-367-7075 ext. 2 for provider consultation.

For questions and clinician-to-clinician advice, contact experts at the National Clinician Consultation Center at 855-448-7737 or nccc.ucsf.edu for HIV, PrEP and PEP questions.

CDC PrEP Guidelines: cdc.gov/hiv/pdf/prepguidelines2014.pdf

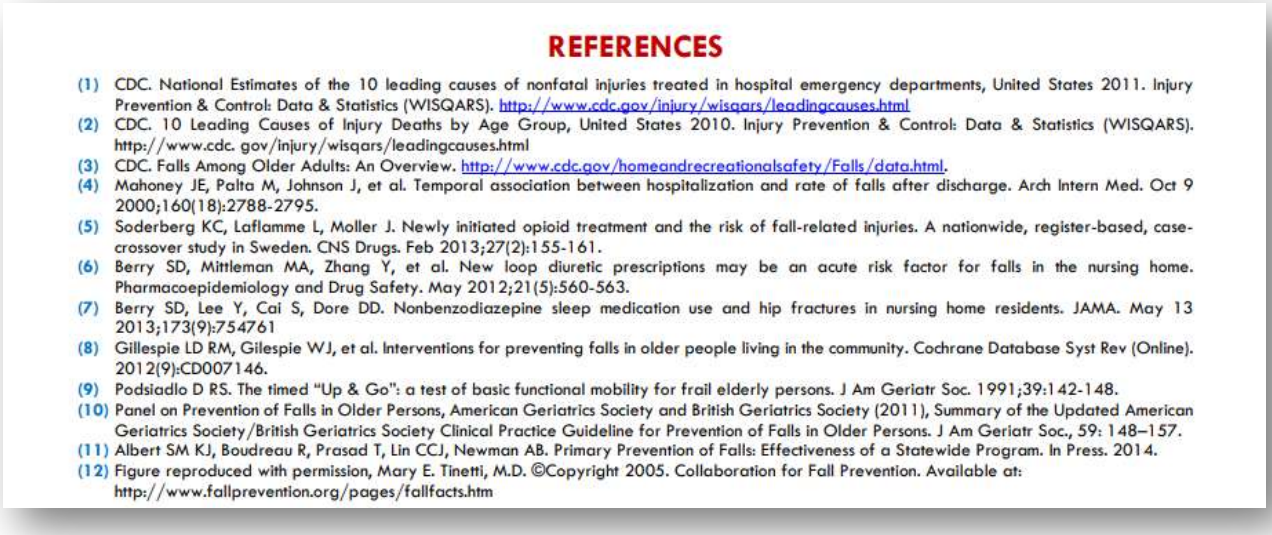
CDC PEP Guidelines: cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

PROUD TO BE PrEPPED

V. Include a Complete Reference List

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

Figure 12a. *The Falls Prevention detailing aid includes a reference list.*



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(2) CDC. 10 Leading Causes of Injury Deaths by Age Group, United States 2010. Injury Prevention & Control: Data & Statistics (WISQARS). http://www.cdc. gov/injury/wisqars/leadingcauses.html
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(4) Mahoney JE, Palta M, Johnson J, et al. Temporal association between hospitalization and rate of falls after discharge. Arch Intern Med. Oct 9 2000;160(18):2788-2795.
(5) Soderberg KC, Laflamme L, Moller J. Newly initiated opioid treatment and the risk of fall-related injuries. A nationwide, register-based, case-crossover study in Sweden. CNS Drugs. Feb 2013;27(2):155-161.
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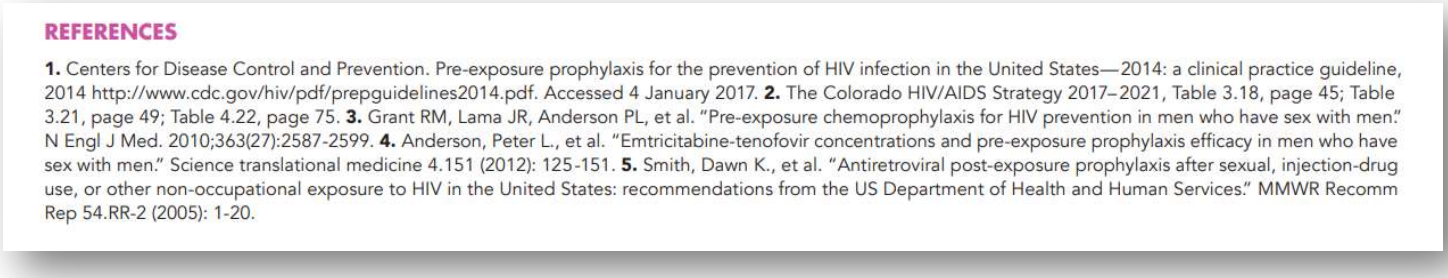
(7) Berry SD, Lee Y, Cai S, Dore DD. Nonbenzodiazepine sleep medication use and hip fractures in nursing home residents. JAMA. May 13 2013;173(9):754761
(8) Gillespie LD RM, Gilespie WJ, et al. Interventions for preventing falls in older people living in the community. Cochrane Database Syst Rev (Online). 2012(9):CD007146.
(9) Podsiadlo D RS. The timed "Up & Go": a test of basic functional mobility for frail elderly persons. J Am Geriatr Soc. 1991;39:142-148.
(10) Panel on Prevention of Falls in Older Persons, American Geriatrics Society and British Geriatrics Society (2011), Summary of the Updated American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons. J Am Geriatr Soc., 59: 148–157.
(11) Albert SM KJ, Boudreau R, Prasad T, Lin CCJ, Newman AB. Primary Prevention of Falls: Effectiveness of a Statewide Program. In Press. 2014.
(12) Figure reproduced with permission, Mary E. Tinetti, M.D. ©Copyright 2005. Collaboration for Fall Prevention. Available at: http://www.fallprevention.org/pages/fallfacts.htm

Figure 12b. *The PrEP detailing aid includes a reference list.*



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1. Centers for Disease Control and Prevention. Pre-exposure prophylaxis for the prevention of HIV infection in the United States—2014: a clinical practice guideline, 2014 http://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf. Accessed 4 January 2017. **2.** The Colorado HIV/AIDS Strategy 2017–2021, Table 3.18, page 45; Table 3.21, page 49; Table 4.22, page 75. **3.** Grant RM, Lama JR, Anderson PL, et al. "Pre-exposure chemoprophylaxis for HIV prevention in men who have sex with men." N Engl J Med. 2010;363(27):2587-2599. **4.** Anderson, Peter L., et al. "Emtricitabine-tenofovir concentrations and pre-exposure prophylaxis efficacy in men who have sex with men." Science translational medicine 4.151 (2012): 125-151. **5.** Smith, Dawn K., et al. "Antiretroviral post-exposure prophylaxis after sexual, injection-drug use, or other non-occupational exposure to HIV in the United States: recommendations from the US Department of Health and Human Services." MMWR Recomm Rep 54.RR-2 (2005): 1-20.

VI. Ensure that Your Program's Contact Information is Clear

A. Including contact information for your program will allow clinicians to easily schedule follow-up visits with detailers, ask additional questions, and/or recruit new clinicians to be detailed. Share detailer-specific contact information via business card or email.

Figure 13. *Business card example.*

VII. Appendix

A. Additional Resources

a. **Clinical Modules & Corresponding Detail Aids | *Alosa Health***
(https://alosahealth.org/clinical-modules/)

b. **Smoking Cessation in Primary Care | *NaRCAD & Healthy Hearts for Oklahoma***
(https://www.narcad.org/uploads/5/7/9/5/57955981/smoking_detail_aid.pdf)

c. **Taking a Comprehensive Sexual Health History: The 5 P's Pocket Card | *Access Matters***
(http://www.narcad.org/uploads/5/7/9/5/57955981/csi-prep-pep-sex-history.pdf)

d. **Adapting Educational Materials for e-Detailing Webinar | *NaRCAD***
(https://us02web.zoom.us/rec/play/LdtZ9BRbsYv6tjbjlj2KWOsZmGLhXY7WNOQlKLV1QOzcFUJBESNS8YUJpZZD7zlaXAfU3Y1pR-d3YtWr.o_jZvgkEGTewJxgT?continueMode=true)

e. **Materials Toolkit | *NaRCAD***
(https://www.narcad.org/examples-of-program-materials.html)

B. See below for the complete detailing aid examples included within the guide (Falls Prevention detailing aid, Opioid Safety detailing aid, Dental Health detailing aid, and PrEP detailing aid)

Preventing Falls in the Elderly

What Primary Care Clinicians Can Do to Reduce Injury and Death

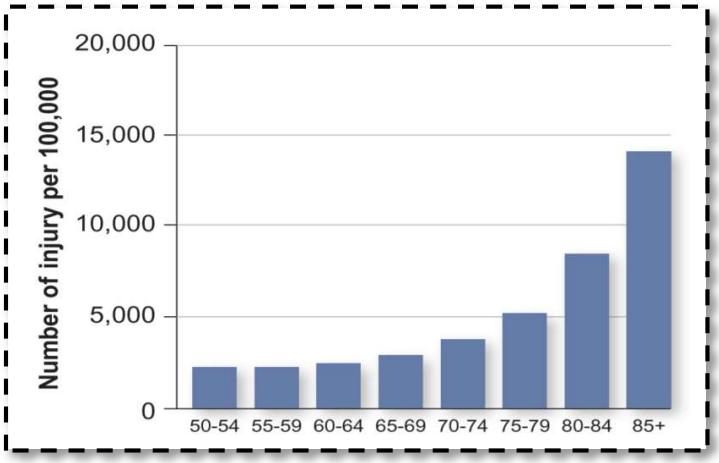
Falls are the leading cause of non-fatal injuries in the elderly[2]

(patients 65 years of age and older)

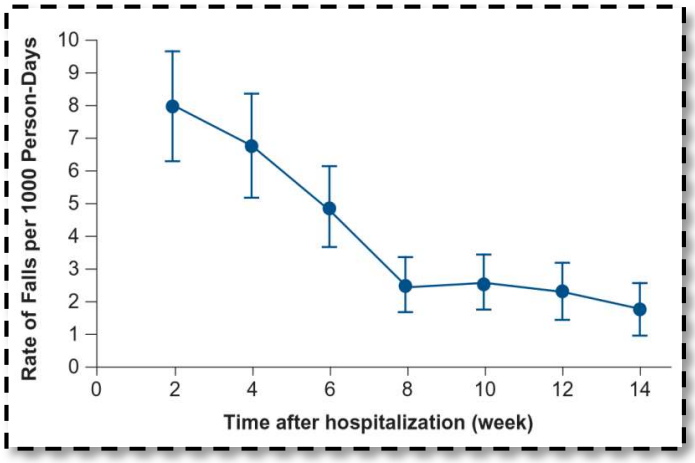
Every 13 seconds
an older adult is taken to the ER because of a fall-related injury.[1]

Every 24 minutes
an older adult dies as the result of a fall.[2]

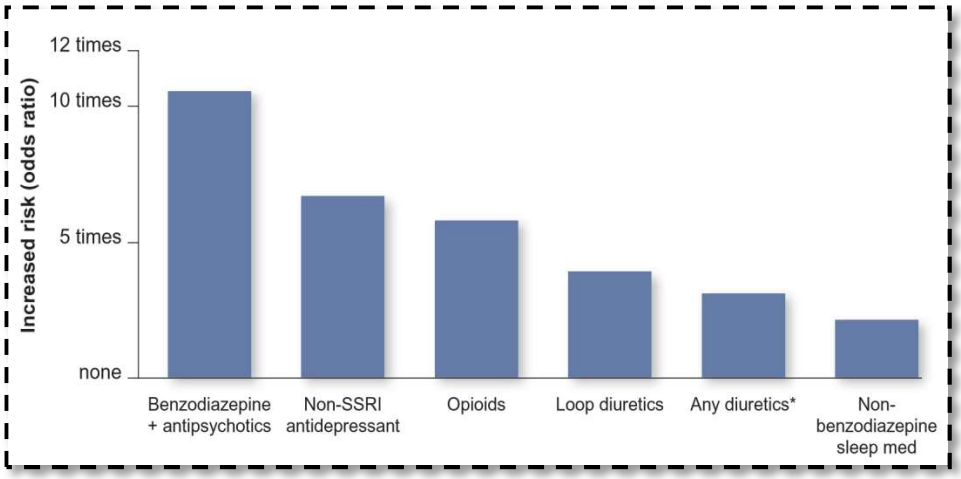
Risk of fall–related injury increases with age[3]



Fall risk is elevated after hospitalization[4]



Medication starts or dose changes can significantly increase a patient's fall risk[5,6,7]



Targeted interventions **reduce fall-related injury up to 24%**[8]

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

THE TUG* TEST: A Systematic Approach to Assessing Fall Risk[9]

(*TIMED UP & GO)

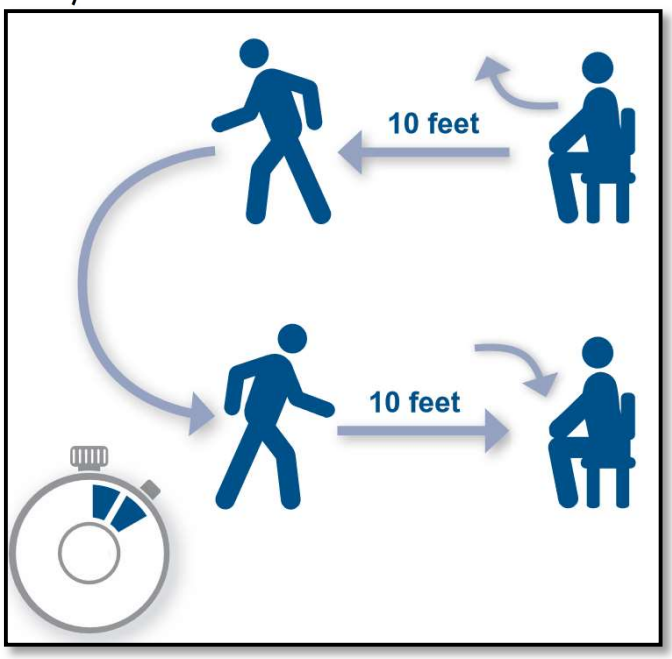
Ask your patient to:

1. Sit in a standard chair
2. Stand up and walk ten feet
3. Turn around and walk back to the chair and sit

Time your patient starting with step 2 and ending when seated.

Complete 3 times and average the last 2.

If average time is above 12 seconds, your patient is at high risk.



Conduct a multi-factorial assessment to determine which additional risk factors may contribute to a potential fall.

[10]

	RISK FACTOR CHECKLIST
	☐ History of falls ○ Location & frequency ○ Injuries ○ Symptoms ☐ Environmental hazards ☐ High-risk medication use ☐ Orthostatic hypotension ☐ Visual impairments (e.g. cataracts) ☐ Heart rate & rhythm issues ☐ Feet and footwear problems

Fall Risk Factors are Additive:[12]

Number of risk factors*	Chance of falling in one year
0	 1 person in 10 will fall
1	 2 people in 10 will fall
2	 3 people in 10 will fall
3	 6 people in 10 will fall
4 or more	 8 people in 10 will fall

* Common risk factors (weighted equally) that were assessed in this study include: limited mobility; use of alcohol; 4 or more medications; foot problems; unsafe footwear; orthostatic hypotension; impaired vision; tripping hazards in home

Create a tailored intervention based on the identified risk factor(s).

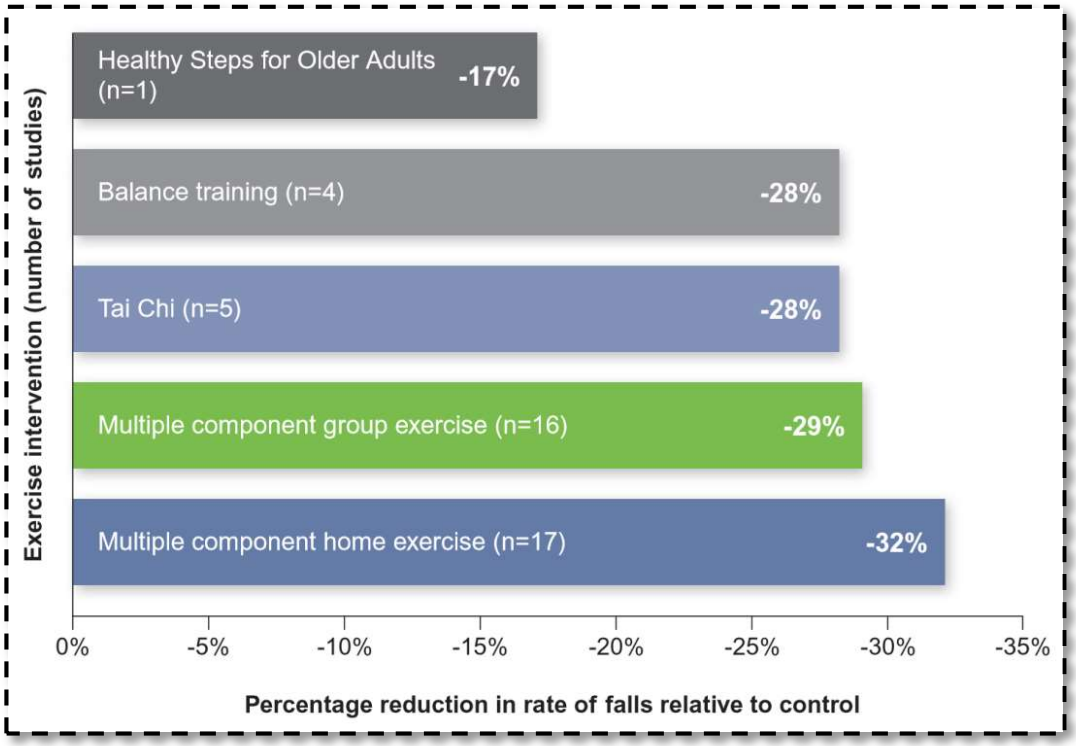
Always include the following in your intervention:

- **Exercise program**[10]
- **Home hazards evaluation**

Target additional intervention components based on identified risk factors:[10]

☐ High risk medication use	→ Minimize psychoactive medications
☐ Orthostatic hypotension	→ Minimize postural BP change
☐ Visual impairments	→ Eye examination and treatment
☐ Heart rate & rhythm issues	→ Manage any heart rate problems
☐ Feet and footwear problems	→ Podiatry examination and treatment

Individualize an exercise program to improve strength, gait, and balance.



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NaRCAD: National Resource Center for Academic Detailing

DIVISION OF PHARMACOEPIDEMIOLOGY & PHARMACOECONOMICS

DEPARTMENT OF MEDICINE
BRIGHAM AND WOMEN'S HOSPITAL
HARVARD MEDICAL SCHOOL

This detailing aid was adapted by NaRCAD from original content created by **Alosa Health** (alosahealth.org) and is intended for education & training purposes only.

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Promoting Patient Care and Safety

THE US OPIOID OVERDOSE EPIDEMIC

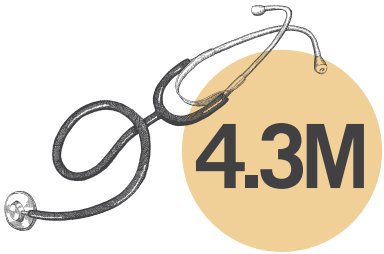
The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn't changed. This epidemic is devastating American lives, families, and communities.

40

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

165K

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



4.3M

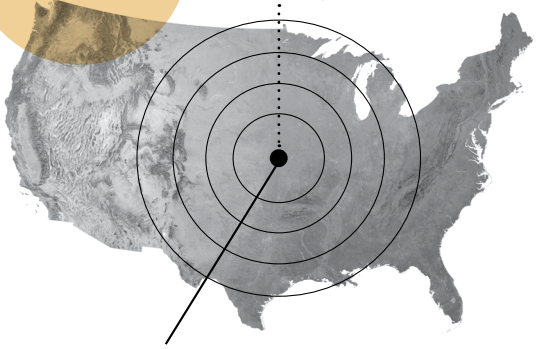
4.3 million Americans engaged in non-medical use of prescription opioids in the last month.[2]

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.

249M

prescriptions for opioid pain medication were written by healthcare providers in 2013



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 prescription opioids such as fentanyl.

[2] National Survey on Drug Use and Health (NSDUH), 2014

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

WHAT CLINICIANS CAN DO TO HELP

KEY PRACTICES & ACTIONS

1. Use non-opioid treatment as the first line for acute or chronic pain

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

2. If opioids are needed, start prescribing at the lowest effective dose

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

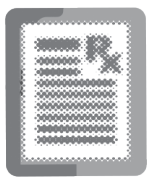
3. Use available PDMP Data to determine if patients have previously filled prescriptions for opioids or other controlled medications

Check data for high dosages and prescriptions from other providers.
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.**

4. Ensure patients' safety by avoiding concurrent prescribing of opioids with other sedating drugs

One study found concurrent prescribing to be associated with nearly **4x the risk for overdose death** compared with opioid prescription alone.

5. Offer treatment for patients with Opioid Use Disorder (OUD), including medication-assisted treatment (MAT).



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 who were not prescribed opioids.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

NEUROPATHIC PAIN

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

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)

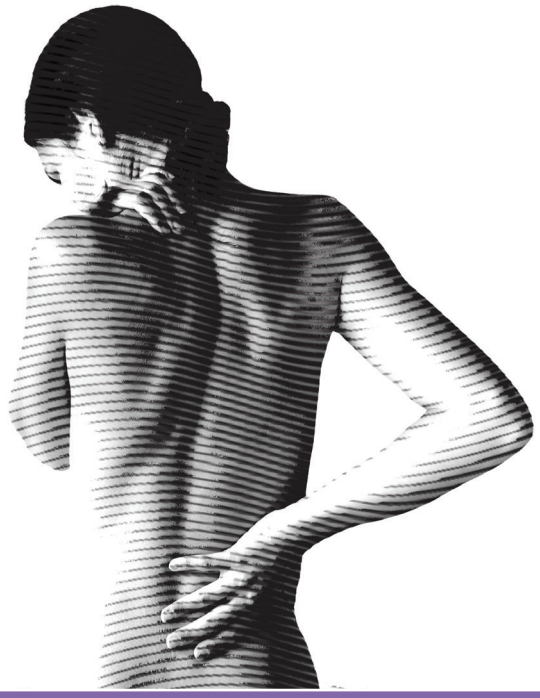
FIBROMYALGIA

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

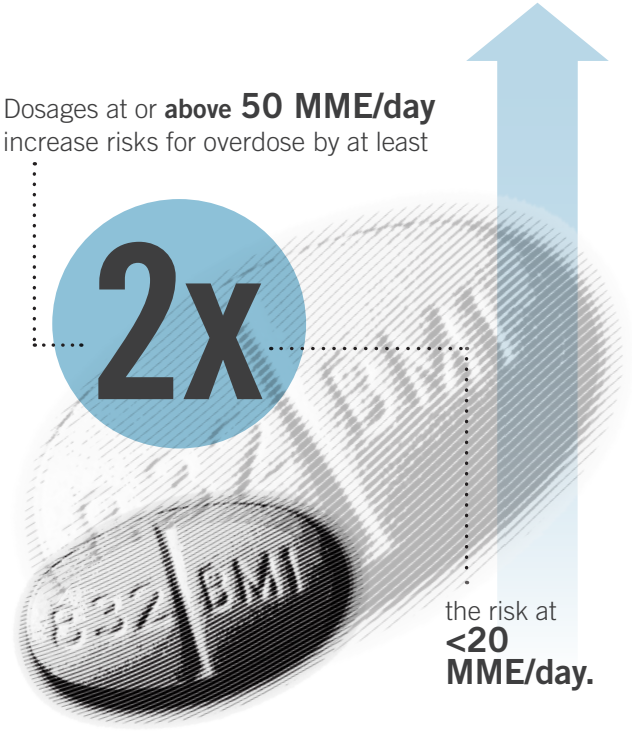


LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

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.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

COLORADO
Department of Public Health & Environment

DENTAL & MEDICAL CARE INTEGRATION INITIATIVE: Improving Medical Screening through Oral Health

The Link Between Oral Health & Chronic Disease:

47%
of US adults 30 years or older have periodontitis[1]

Periodontal Disease
is considered another cardiovascular risk factor[2]

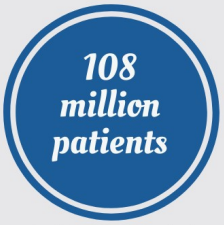
9 in 10
patients with heart disease also have periodontitis[3]

Diabetic Patients
are more likely to develop periodontal disease[4]

Inequities Persist
among males, Black people, and adults with lower income or less education[5]

Patient Access & Awareness:

visit a dentist but do not see a physician[6]



visit a physician but do not see a dentist[7]

with diabetes don't know they have it[8]

with high blood pressure don't know they have it[9]

Dental providers can improve patient outcomes by:

- Asking patients about their access to care
- Assessing risk to identify patients requiring follow-up
- Connecting high-risk patients to primary care
- Increasing patient awareness & self-advocacy

HOW DENTAL PROVIDERS CAN HELP:

1. Ask patients about their access to care.

- Ask patients to identify their primary care physician or where they go for care.
- Ask patients if they currently have medical insurance.

2. Assess risk to identify patients requiring follow-up care.

- Identify patients at highest risk for diabetes, heart disease, and hypertension with blood pressure readings and quick, easy-to-use online risk calculators.
- Educate patients about their risk scores and the link between dental health issues and chronic disease.

3. Refer patients with high risk to further testing and treatment.

- Talk to your patients about their risk level and the importance of consistent medical care to evaluate their health.
- Inform patients with one or more risk factors about the benefit of prompt referrals to primary care for further testing and treatment.

American Diabetes Association.

[American Diabetes Association - Free 60-Second Type 2 Diabetes Risk Test](#)[10]

Blood Pressure Categories[6]

American Heart Association | American Stroke Association.

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120 – 129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130 – 139	or	80 – 89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

heart.org/bplevels

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PROVIDERS CAN HELP PREVENT HIV IN COLORADO BY PRESCRIBING PrEP.

PROUD TO BE PrEPPED

WHAT IS PREP?

- PrEP is a once-daily pill that can help prevent HIV transmission for people who are HIV negative.
- PrEP is safe. Few adverse effects have been observed.
- PrEP was FDA approved in 2012 as the fixed-dose antiretroviral medication Truvada®.

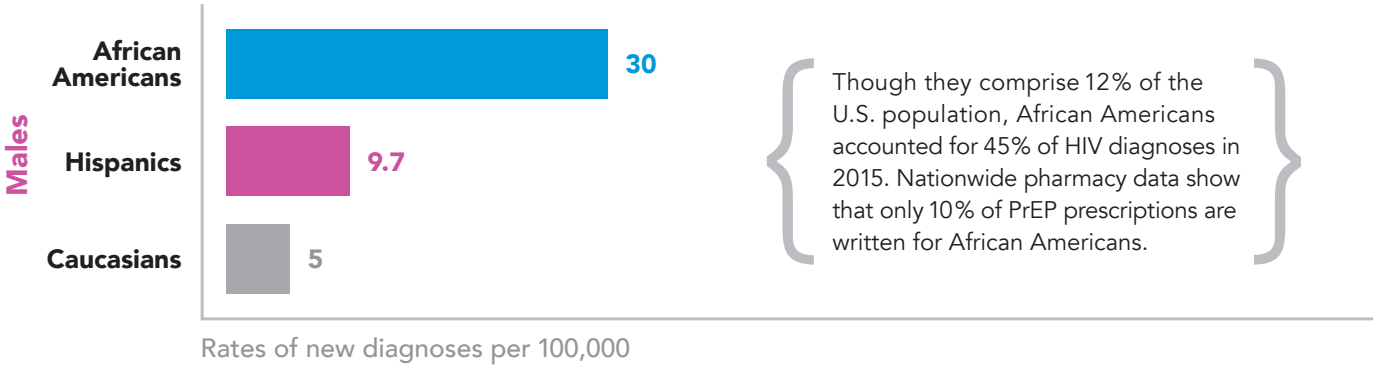
PrEP can reduce the risk of HIV by more than 90%[1]

WHO MAY BENEFIT FROM PrEP?

- Men who have sex with men (MSM)
- Anyone with a partner with or at risk for HIV
- Transgender individuals
- People who inject drugs

HIV DISPARITIES AND PrEP: YOU CAN MAKE A DIFFERENCE!

African Americans and Hispanics in Colorado are at disproportionate risk for HIV[2]



Though they comprise 12% of the U.S. population, African Americans accounted for 45% of HIV diagnoses in 2015. Nationwide pharmacy data show that only 10% of PrEP prescriptions are written for African Americans.

CDPHE CO COLORADO Department of Public Health & Environment

KEY MESSAGES

- **Take a thorough sexual history once a year on all patients.**
- **Test for STIs, including extra-genital testing when indicated.**
- **Talk about PrEP as one method for preventing HIV.**
- **Test for HIV. Only begin PrEP after confirming patient is HIV negative.**
- **Follow up with patients on PrEP every 3 months for HIV/STI testing and PrEP prescription refill.**

SEXUAL HISTORY

- Partners: Do you have sex with men, women or both?
- Practices: In the past year, what type(s) of sex have you had: vaginal, oral, anal receptive, anal insertive?
- Protection from STIs: What methods do you use to prevent STIs (STDs)? If you use condoms, how often?
- Past history of STIs: Have you ever had an STI?
- Pregnancy: Are you trying to conceive or father a child? Are you trying to avoid pregnancy?
- PrEP: Do you think a daily pill for HIV prevention would improve your sexual health?

BASELINE ASSESSMENT

(PrEP PRESCRIBED WITHIN 7 DAYS OF DOCUMENTED NEGATIVE HIV TEST)

- ☐ Screen for symptoms of acute HIV (fever, fatigue, myalgia/arthralgia, rash, headache, pharyngitis, cervical adenopathy, night sweats, diarrhea)
- ☐ HIV test: 4th generation Ag/Ab preferred; 3rd generation if 4th not available (plus HIV viral load if concern for acute HIV)
- ☐ STI screening: gonorrhea & Chlamydia NAAT (urine or vagina, rectum, pharynx), syphilis screen. Rectal swabs can be self-collected.
- ☐ Serum creatinine (contraindicated if CrCl<60 ml/min)
- ☐ Pregnancy test*
- ☐ Hepatitis B Surface Antigen (HBsAg)*
- ☐ Hepatitis C Antibody*

*Not a contraindication, but follow-up indicated if positive

FOLLOW-UP ASSESSMENT EVERY 3 MONTHS

- ☐ HIV test
- ☐ Screen for symptoms of acute HIV
- ☐ STI screening

OTHER

- ☐ Serum creatinine, every 6 months
- ☐ Hepatitis C Antibody, every 12 months
- ☐ Pregnancy test, as appropriate

TESTING FOR HIV AND PRESCRIBING PrEP

HIV TEST:

4th generation Ag/Ab preferred; 3rd generation if 4th not available

AND IF

Potential exposure < 72 hours: → **Consider PEP***

Potential exposure within last 2 weeks: → **Consider HIV viral load**

*See back for prescribing procedure.

HIV TEST POSITIVE (+) → **Do not start PrEP; begin or refer for 3 ARV drug regimen**

HIV TEST NEGATIVE (–) → **Start PrEP**

PRESCRIBING PrEP

Truvada® 200/300mg

(emtricitabine 200mg/tenofovir disoproxil fumarate 300mg)

1 tablet PO daily, 30-day supply with 2 refills (after negative HIV test)

ICD-10: Z20.6 Contact with and (suspected) exposure to human immunodeficiency virus

PATIENT COUNSELING

- **Daily dosing** is recommended, though imperfect, yet regular, adherence can still provide significant protection for men who have sex with men. Intermittent dosing is not currently recommended.[4]
- PrEP reaches maximum protection **in blood** after approximately 20 days of daily oral dosing, **in rectal tissue** at approximately 7 days and **in cervicovaginal tissues** at approximately 20 days.
- **Combining prevention strategies**, such as condoms plus PrEP, provides the greatest protection from HIV and other STIs. Reinforce the need for HIV and STI testing **every 3 months** for optimal sexual health.
- Identify and address barriers to **medication adherence**.

SIDE EFFECTS AND POTENTIAL RISKS[3]

- PrEP is generally well-tolerated. About 10% of patients experience **nausea and fatigue** in the 1st month of treatment. This typically resolves after 3–4 weeks.
- Decline in **renal function**: consider more frequent monitoring in patients with risk factors for kidney disease.
- Decrease in **bone mineral density**: caution in those with osteoporosis or history of pathologic fracture. Consider baseline DXA for patients with history of or at risk for osteoporosis.

WHAT IF MY PATIENT HAS A POSITIVE HIV TEST ON PrEP?

- Discontinue PrEP immediately to avoid potential development of HIV drug resistance.
- Determine the last time PrEP was taken and recent pattern of taking PrEP.
- Ensure establishment with HIV primary care for prompt initiation of a fully active ARV treatment regimen and counseling/support services.
- Report new HIV diagnosis to Colorado Department of Public Health & Environment: 303-692-2694.

PrEP IS AFFORDABLE IN COLORADO

Health First Colorado (Colorado's Medicaid Program) and most insurance plans pay for PrEP.

Additional assistance is available through:

- CDPHE's financial assistance program (PHIP): 1-844-367-7075, ext 2 (English and Spanish), ProudToBePrEPPED.com
- Gilead medication and copay assistance programs: 855-330-5479, gileadadvancingaccess.com
- Patient Advocate Foundation (<400% FPL), copays.org
- PAN Foundation (<500% FPL), panfoundation.org

PRESCRIBING POST-EXPOSURE PROPHYLAXIS (PEP)[5]

Three antiretroviral drugs are recommended for PEP regimen:

Tenofovir DF (300mg)/Emtricitabine (200mg) daily + Raltegravir 400mg BID

OR

Tenofovir DF (300mg)/Emtricitabine (200mg) daily + Dolutegravir 50mg daily

- Potential HIV exposure within past 72 hours and patient has not taken PrEP for past 7 days
- Provide 28-day supply of PEP, and then transition to only PrEP

RESOURCES

For Colorado-specific resources regarding HIV, visit ProudToPrescribePrEP.com or call 1-844-367-7075 ext. 2 for provider consultation.

For questions and clinician-to-clinician advice, contact experts at the National Clinician Consultation Center at 855-448-7737 or nccc.ucsf.edu for HIV, PrEP and PEP questions.

CDC PrEP Guidelines: cdc.gov/hiv/pdf/prepguidelines2014.pdf

CDC PEP Guidelines: cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

PROUD TO BE PrEPPED

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