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
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!
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)
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
Support Materials are NOT:

- Copies of every scientific paper used to prepare your module or presentation topic
- PowerPoint lecture slides
- Individual-level data that will be used punitively
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)
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!
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
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
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?
Pilot Project & Materials Review
*all materials at narcad.org/opioid-toolkit
Pilot Study to Improve Opioid Safety

4 Sites Chosen based on High Burden
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.

Rx

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 opioids.

² Includes updated September 2013 numbers.
**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. **MYTH**
   - Opioids are effective long-term treatments for chronic pain.

   **TRUTH**
   - 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. **MYTH**
   - There is no unsafe dose of opioids as long as opioids are titrated slowly.

   **TRUTH**
   - Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer.

3. **MYTH**
   - The risk of addiction is minimal.

   **TRUTH**
   - 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.
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.

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.

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.

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.

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.
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)

Osteoarthritis

**Nonpharmacological treatments:** Exercise, weight loss, patient education

**Medications**
- First-line: Acetaminophen, 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

Migraine

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

**Dosages at or above 50 MME/day increase risks for overdose by at least 2x.**

**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.
PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

Checking the PDMP: An Important Step to Improving Opioid Prescribing Practices

WHAT IS A PDMP?

A PDMP is a statewide electronic database that tracks all controlled substance prescriptions. Authorized users can access prescription data such as medications dispensed and doses.

PDMPs improve patient safety by allowing clinicians to:

- Identify patients who are obtaining opioids from multiple providers.
- Calculate the total amount of opioids prescribed per day (in MME/day).
- Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

249M

prescriptions for opioids were written by healthcare providers in 2013

enough prescriptions for every American adult to have a bottle of pills
WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?

**High Dosage**
Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.

**Multiple Providers**
Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.

**Drug Interactions**
Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.
WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?

Patients should not be dismissed from care based on PDMP information. Use the opportunity to provide potentially life-saving information and interventions.

1. **Confirm that the information in the PDMP is correct.**
   Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.

2. **Assess for possible misuse or abuse.**
   Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.

3. **Discuss any areas of concern with your patient and emphasize your interest in their safety.**
HOW CAN I REGISTER AND USE THE PDMP IN MY STATE?

Processes for registering and using PDMPs vary from state to state.

For information on your state’s requirements, check The National Alliance for Model State Drug Laws online:

www.namsdl.org/prescription-monitoring-programs.cfm

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

Used to Support Your Key Messages & Detailing Aid Visuals

[Image of JAMA journal cover]
Please Note:

The following studies are in full print on your online toolkit, as well as the following slides with talking points for your reference.
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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, MPH¹,²; Amy Gravely, MA¹; Sean Nugent, BA¹; et al

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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:
  
  o No difference in function
  o Pain relief slightly better in non-opioid group
  o Side effects reported as slightly higher in opioid group
The Bottom Line:

For patients with chronic musculoskeletal pain, opioids are no better than non-opioid treatments and can increase risk of side effects.
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, MS¹; Polly E. Bijur, PhD²; David Esses, MD²; et al

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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
ER Acute Pain Study

The Bottom Line:

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