Campaign Materials & Messaging: Creating Tools for Impact

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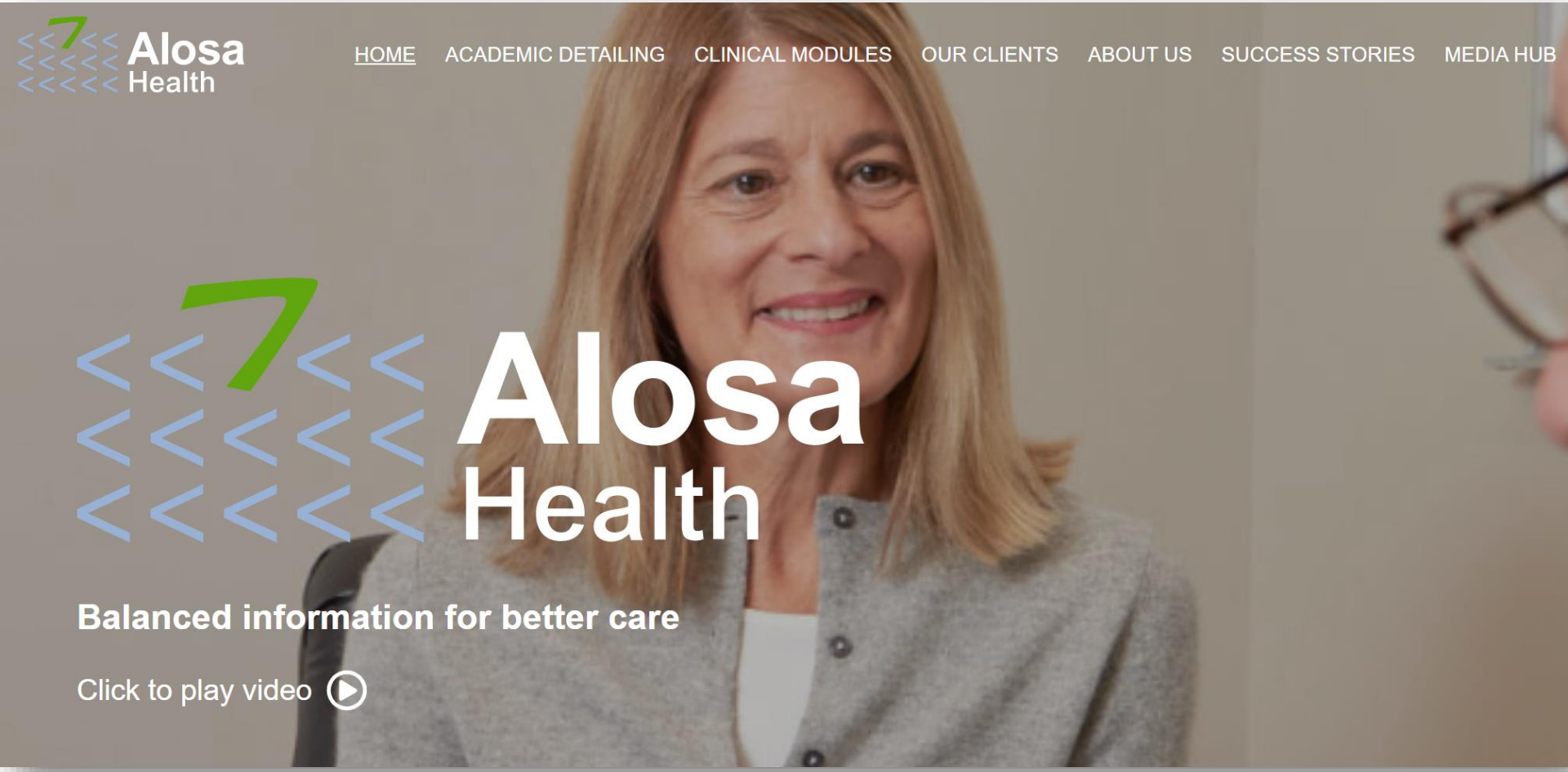
www.alosahealth.org



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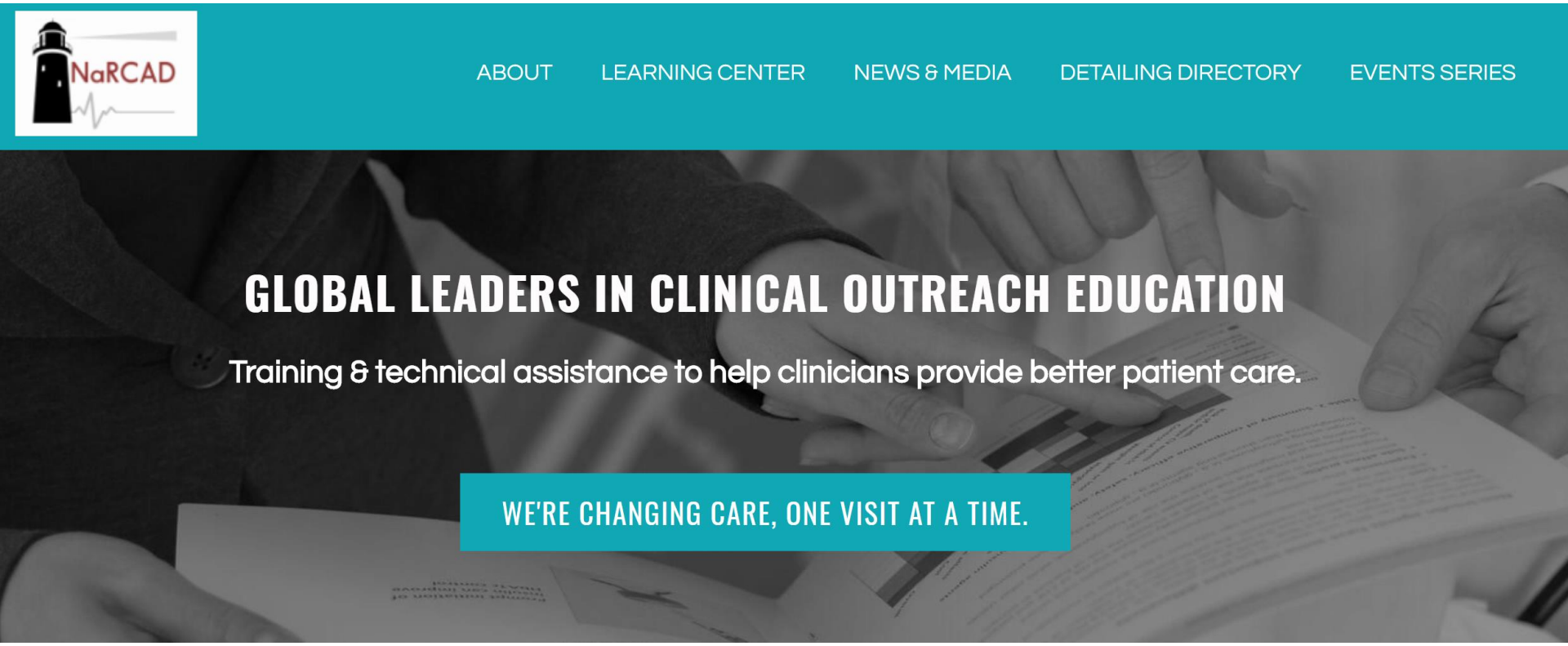

Front line healthcare providers have their hands full.

Using the strategy of "academic detailing", personalized visits from a trained outreach educator can arm busy clinicians with the critical support, tools, and evidence to provide the very best care to their patients.

MORE ABOUT THE STRATEGY

REVIEW AD LITERATURE

EXPLORE SUCCESS STORIES

JOIN A TRAINING CLASS

Our Goals Today:

- ✓To demystify the materials creation process
- ✓To help you begin planning how you'll create your campaign materials
- ✓To share impactful materials that promote engagement & behavior change for providers
- ✓To provide free or low-cost tools to get started or enhance your materials

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Who's Here & How Can We Help?

- **Partner Share: 2 Minutes (1 each):**

❑ ***What's your role? How long have you been doing it?***

- Detailer
- Program Manager
- Stakeholder
- Other

❑ ***Who develops materials for your program?***

- Me!
- Someone else.
- Not sure yet!

❑ ***What clinical topic are you currently focusing on?***

❑ ***What's the #1 thing you want to get out of this session?***

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Share with the whole group:

- ***What's your role? How long have you been doing it?***
- ***Who develops materials for your program?***
- ***What clinical topic are you currently focusing on?***
- ***What's the #1 thing you want to get out of this session?***

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Before Materials: Planning Ahead

- **Complete background research on the clinical topic**
  - Identify critical studies
- **Know your audience**
  - Materials will have a different focus depending on whether they are targeted to:
    - ***Prescribers***
    - ***Support staff***
    - ***Patients***
    - ***Administrators/others***
- **Agree on key messages with your team**
  - What behavior change(s) are you looking for?
  - Choose between 3-5 (on average) action-based key messages

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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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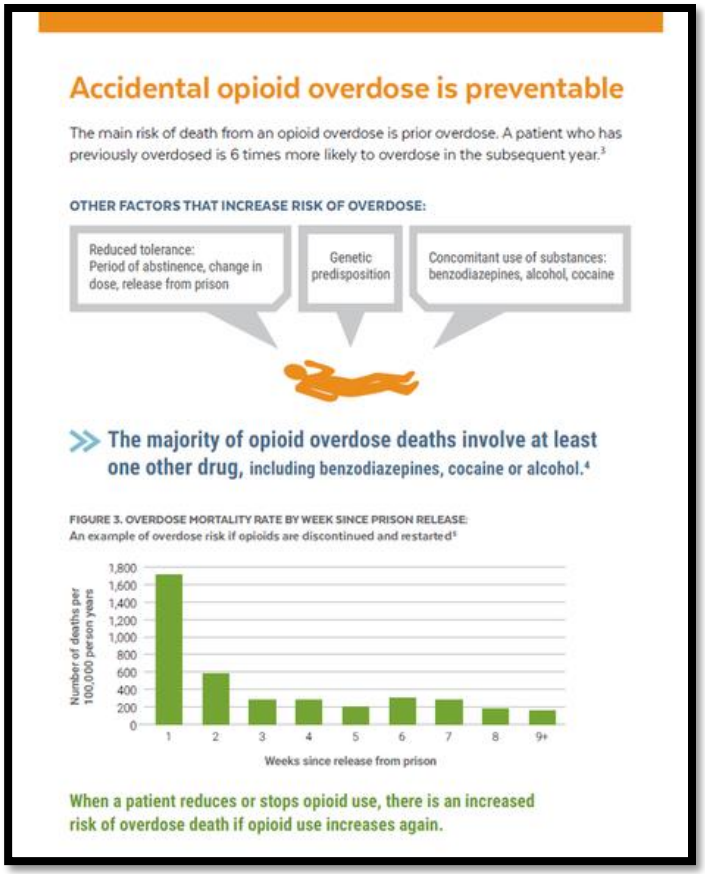
Educational Materials are:

Visual aids that support a tailored, interactive conversation.

- ✓ **Brochures or Detailing Aids**
- ✓ **Reference cards or “pocket cards”**
- ✓ **Risk calculators**
- ✓ **Checklists or other office tools**
- ✓ **Any patient-facing tools that clinicians can use**



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Strong materials & proper use should:

- **Clarify** complex information
- **Customize** a visit to meet the needs of a clinician
- **Support**, but not replace, the conversation!

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What Support Materials are NOT:

- Copies of every scientific paper used to prepare your module or presentation topic
- PowerPoint lecture slides (never!)
- Individual-level data that will be used punitively
- A typed Word Doc

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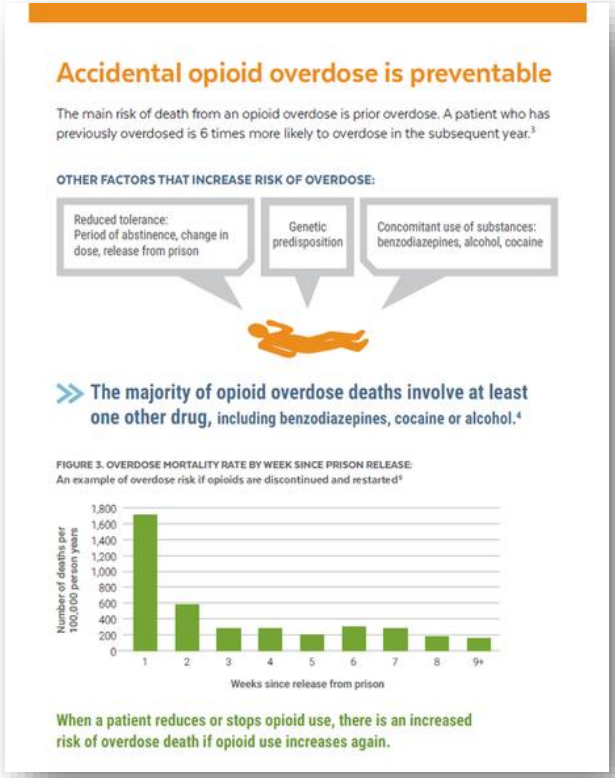
ABOUT LEARNING CENTER NEWS & MEDIA DETAILING DIRECTORY EVENTS SERIES

MATERIALS LIBRARY

Learn how to make evidence engaging, accessible, and relevant to frontline care.



Accidental opioid overdose is preventable

The main risk of death from an opioid overdose is prior overdose. A patient who has previously overdosed is 6 times more likely to overdose in the subsequent year.[3]

OTHER FACTORS THAT INCREASE RISK OF OVERDOSE:

- Reduced tolerance: Period of abstinence, change in dose, release from prison
- Genetic predisposition
- Concomitant use of substances: benzodiazepines, alcohol, cocaine

The majority of opioid overdose deaths involve at least one other drug, including benzodiazepines, cocaine or alcohol.[4]

FIGURE 3. OVERDOSE MORTALITY RATE BY WEEK SINCE PRISON RELEASE:
An example of overdose risk if opioids are discontinued and restarted[5]

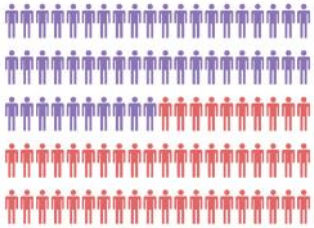
When a patient reduces or stops opioid use, there is an increased risk of overdose death if opioid use increases again.

Polypharmacy

noun | poly-phar-ma-cy

The concurrent use of five or more prescribed medications.

At the age of 75



50% of older adults' remaining life expectancy will be spent taking 5 or more medications

Academic Detailing Outreach Summary
Fiscal Year 2015-2016

December 2016

The Idaho Diabetes, Heart Disease and Stroke Programs had subgrants with the seven Local Public Health Districts (LPHD) during the 2015-2016 fiscal year to implement academic detailing with healthcare providers in their communities. Academic detailing is an innovative one-on-one outreach education technique designed to help clinicians provide evidence-based care to their patients with hypertension, prediabetes and diabetes.

During the fiscal year, the LPHD Coordinators:

- ✔ Promoted **14** evidence-based resources and tools.
- ✔ Visited **106** clinics.
- ✔ Shared **5** to **6** resources per visit on average.

Half or more clinics were interested in learning about 4 resources.

"[The office manager] was not aware of the local DSME programs or how they differed from education provided from a Certified Diabetes Educator. We discussed the benefits of those programs and she agreed to add that resource to the clinic's referrals once I provided her with the information."

~ LPHD Coordinator

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 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

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

	MYTH	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.

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

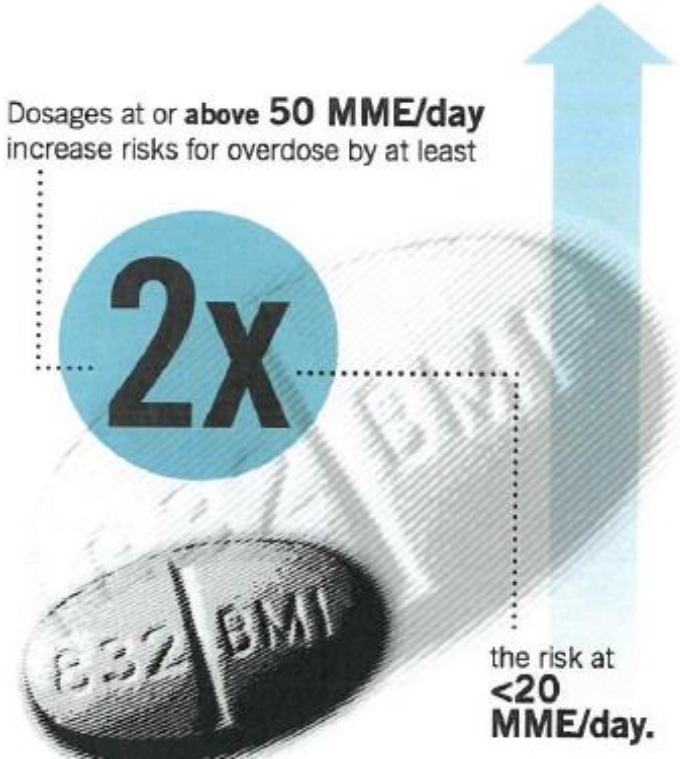
Offer or arrange evidence-based treatment (e.g. medication-assisted treatment and behavioral therapies) for patients with opioid use disorder *(Recommendation #12)*

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.

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.

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Naloxone
for opioid safety

A provider's guide to prescribing naloxone to patients who use opioids

Accidental opioid overdose is preventable

The main risk of death from an opioid overdose is prior overdose. A patient who has previously overdosed is 6 times more likely to overdose in the subsequent year.[3]

OTHER FACTORS THAT INCREASE RISK OF OVERDOSE:

Reduced tolerance: Period of abstinence, change in dose, release from prison

Genetic predisposition

Concomitant use of substances: benzodiazepines, alcohol, cocaine

» The majority of opioid overdose deaths involve at least one other drug, including benzodiazepines, cocaine or alcohol.[4]

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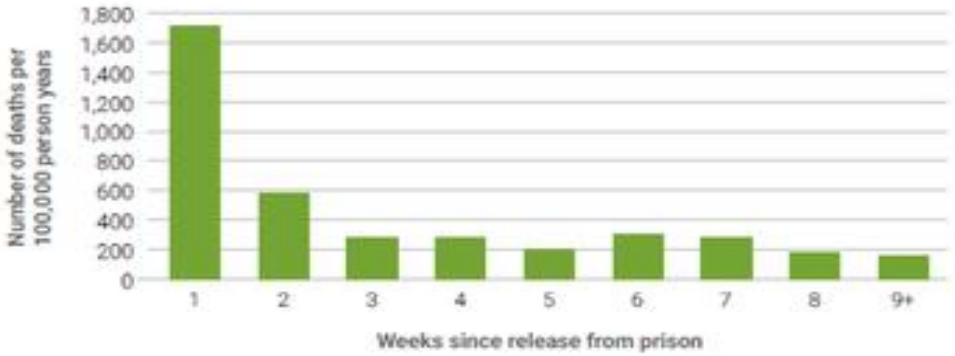
An example of overdose risk if opioids are discontinued and restarted[5]



When a patient reduces or stops opioid use, there is an increased risk of overdose death if opioid use increases again.

4-page summary brochure

Managing type 2 diabetes

- Select an HbA1c target; ≤7% is typical for most patients.[1]
- Start treatment with diet and exercise; add metformin if needed.[2-4]

DIET
- Reduce calories to achieve weight loss
- Favor complex carbohydrates over simple carbs

EXERCISE
- Set a goal of about 20 min
- A combination of aerobic
lowering HbA1c

METFORMIN
- Reduces risk of major c
- Safe side effect profile
- Low cost

- Address related conditions.[1]
  - **Blood pressure:**
    - Goal: <140/90 mm Hg for most patients;
    - Start medications for patients not at goa
    - patients with albuminuria. Two agents m
  - **Cholesterol: For all patients with diabet**
    - Without ASCVD, use a moderate interv
    - With ASCVD, use a high intensity stati
  - **Smoking cessation:**
    - Encourage patients to stop smoking;
    - Support available at 1-800-QUITNOW
  - **Ophthalmology:** Refer to ophthalmolo
  - **Diet:** Consider referral to GNBCHC nu

Greater New Bedford Community Health Center, Inc.

Benefits and risks vary by class and by drug

Most glucose-lowering agents reduce HbA1c by about one percentage point.[5-6]

TABLE 1. Cardiovascular outcomes and adverse effects of glucose-lowering medicines[7-9]

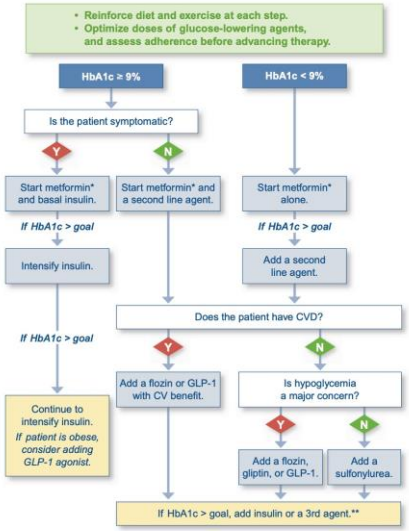
Class	CV outcomes	Weight change	Hypoglycemia	Precautions
biguanide metformin (Glucophage)	32% reduction	loss	low risk	avoid in severe renal impairment
sulfonylureas chlorpropamide (Diabinese) glyburide (DiaBeta, Glynase)	16% reduction	gain	high risk	hypoglycemia
glipizide (Glucotrol)	*			
glitazones (TZD) rosiglitazone (Avandia)	64% increase	gain	low risk	heart failure, fracture
pioglitazone (Actos)	18% reduction			
gliptins (DPP-4 inhibitors) alogliptin (Nesina) saxagliptin (Onglyza) sitagliptin (Januvia)	neutral	*	*	? pancreatitis
linagliptin (Tradjenta)	*			
GLP-1 receptor agonists liraglutide (Victoza)†	13% reduction	loss	*	? pancreatitis
semaglutide (Ozempic)†	26% reduction			
albiglutide (Tanzeum) dulaglutide (Trulicity) exenatide (Byetta, Bydureon) lixisenatide (Adlyxin)	*			
flozins (SGLT-2 inhibitors) empagliflozin (Jardiance)†	24% reduction	loss	low risk	UTI, ketoacidosis, genital infections, hypotension, amputation
canagliflozin (Invokana)†	14% reduction			
dapagliflozin (Farxiga) ertugliflozin (Steglatro)	*			

* No data available.
† New CV data is for patients with established CVD only.

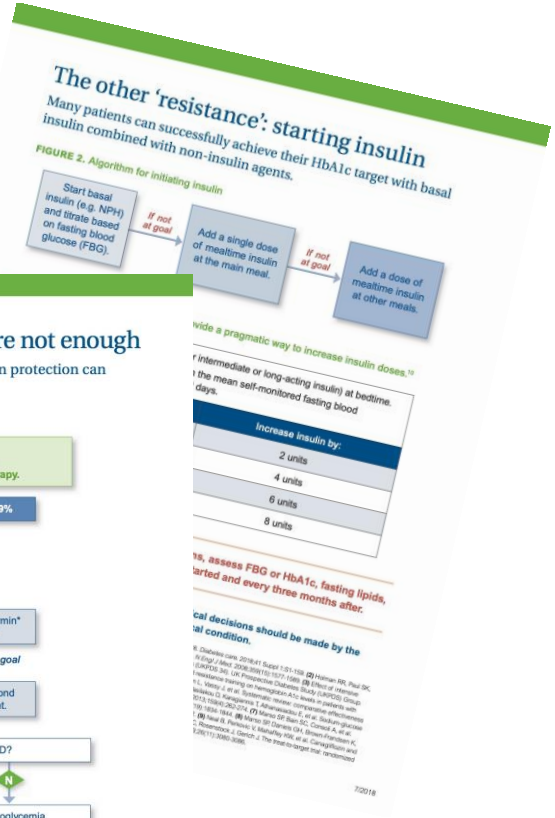
When lifestyle and metformin are not enough

The patient's clinical situation and data on end-organ protection can help determine which drug to add to the regimen.

FIGURE 1. Algorithm for selecting treatment



* If contraindicated or not tolerated, go to the next step.
** A gliptin can be added if a GLP-1 is not selected as the second agent.



The other 'resistance': starting insulin

Many patients can successfully achieve their HbA1c target with basal insulin combined with non-insulin agents.

FIGURE 2. Algorithm for initiating insulin

wide a pragmatic way to increase insulin doses.[10]

r intermediate or long-acting insulin) at bedtime.
the mean self-monitored fasting blood
days.

Increase insulin by:
2 units
4 units
6 units
8 units

ts, assess FBG or HbA1c, fasting lipids, arted and every three months after.

cal decisions should be made by the al condition.

7/2018

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Managing type 2 diabetes

Select an HbA1c target; ≤7% is typical for most patients.[1]

Start treatment with diet and exercise; add metformin if needed.[2-4]

DIET

- Reduce calories to achieve weight loss
- Favor complex carbohydrates over simple carbs

EXERCISE

- Set a goal of about 20 minutes of physical exercise each day
- A combination of aerobic and resistance training is best at lowering HbA1c

METFORMIN

- Reduces risk of major cardiovascular outcomes and HbA1c
- Safe side effect profile
- Low cost

Address related conditions.[1]

- **Blood pressure:**
  - Goal: <140/90 mm Hg for most patients; <=130/80 mm Hg if high risk of CVD.
  - Start medications for patients not at goal. ACE inhibitors and ARBs are preferred in patients with albuminuria. Two agents may be needed if >20 mm Hg above goal.
- **Cholesterol: For all patients with diabetes >40 years of age, prescribe a statin:**
  - Without ASCVD, use a moderate intensity statin (atorvastatin 20 mg, simvastatin 40 mg);
  - With ASCVD, use a high intensity statin (atorvastatin 80 mg, rosuvastatin 10 mg).
- **Smoking cessation:**
  - Encourage patients to stop smoking; use drug therapy or nicotine replacement as needed.
  - Support available at 1-800-QUITNOW.
- **Ophthalmology:** Refer to ophthalmology yearly to assess for diabetic retinopathy.
- **Diet:** Consider referral to GNBCHC nutritionist or diabetic nurse for education on diabetic diet.

Clinical PrEP Essentials

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Efficacy key messages:

- PrEP is highly effective for preventing HIV infection when taken daily;
- Full protection after 7 daily doses for rectal sex and after 20 daily doses for vaginal sex;
- PrEP does not prevent GC/CT/syphilis/genital warts/HSV/HCV.

Side Effects:

- 1 in 10 may have GI side effects (N/V/abd pain); usually resolves by 1 month,
- 1 in 200 may have renal dysfunction (typically reversible if d/c PrEP),
- 1% average loss of bone mineral density; reversible if d/c PrEP; no increased risk of fx.

Recommended Lab Screening & Visits:

Initial Labs: HIV Ag/Ab (4th gen); HIV RNA (If possible); HBsAg (if non-immune); HCV Ab; ALT; Cr; 3 site GC/CT; RPR; **Consider:** Upreg, HAV, HBV, & HPV vaccines.
Week 1: Call, check if prescription was filled, adherence, and insurance copay.
Month 1: If no HIV RNA test at screening, check HIV Ag/Ab (4th gen), Adherence check.
Q 3 Months: HIV Ag/Ab, Cr, GC/CT (3 sites), RPR; check adherence & PrEP indications.
Documentation: ICD-10 Z20.6: HIV Exposure.

Need Help? U.S. PrEPline, 855-448-7737

Created by: Lauren Wolchok & Robert Grant

Clinical PrEP Essentials

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Indications (by history in the past 6 months):

Asking for PrEP, OR any sex partner with untreated HIV or HIV risk factors, OR injection drug use and sharing needles, OR used PEP > 1x in the past year, OR a man or trans woman reporting an STI or condomless anal sex with men.

Caution:

1. HBV infection and ALT >2 X ULN (continue HBV treatment if PrEP is stopped),
2. At risk for kidney disease, i.e. DM or uncontrolled HTN (consider monthly Cr),
3. Acute viral syndrome (send HIV RNA, consider FTC/TDF/INSTI or delay PrEP),
4. Osteoporosis or h/o non-traumatic fracture (consider Vit D, DXA, referral),
5. Pregnancy or breastfeeding (discuss risks/benefits).

Contraindications:

1. eGFR < 60, **2.** HIV+, **3.** HIV exposure < 72hrs (PEP, then consider PrEP)

Rx: Emtricitabine/tenofovir 200mg/300mg (Truvada®) dispense 30 tabs plus 2 refills.

Counseling: Link dosing to a daily habit; develop plans for STI prevention and contraception or safer conception; notify if PrEP is stopped more than 7 days.

(last modified 11/15/2015)

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Identify elder abuse with a six-question screen for older adults[1]

1. Are you afraid of anyone in your family?
2. Has anyone close to you tried to hurt or harm you recently?
3. Has anyone close to you called you names or put you down or made you feel bad recently?
4. Does someone in your family make you stay in bed or tell you you're sick when you know you aren't?
5. Has anyone forced you to do things you didn't want to do?
6. Has anyone taken things that belong to you without your OK?

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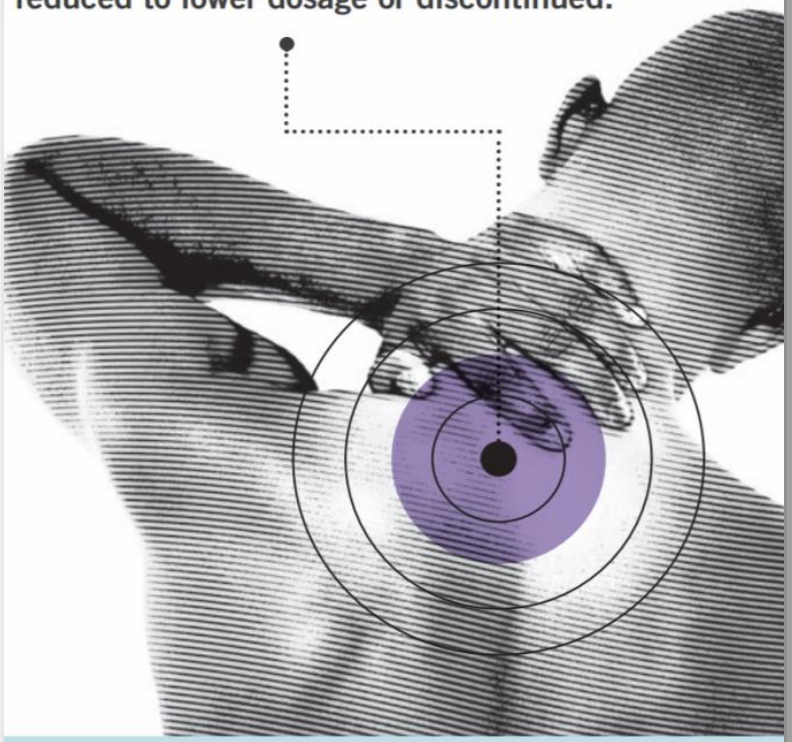
POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN*

Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued.

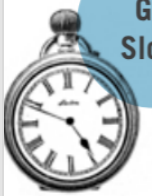


CDC

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

HOW TO TAPER

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications. In general:



Go Slow

A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.

Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.

Consult

Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.

Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

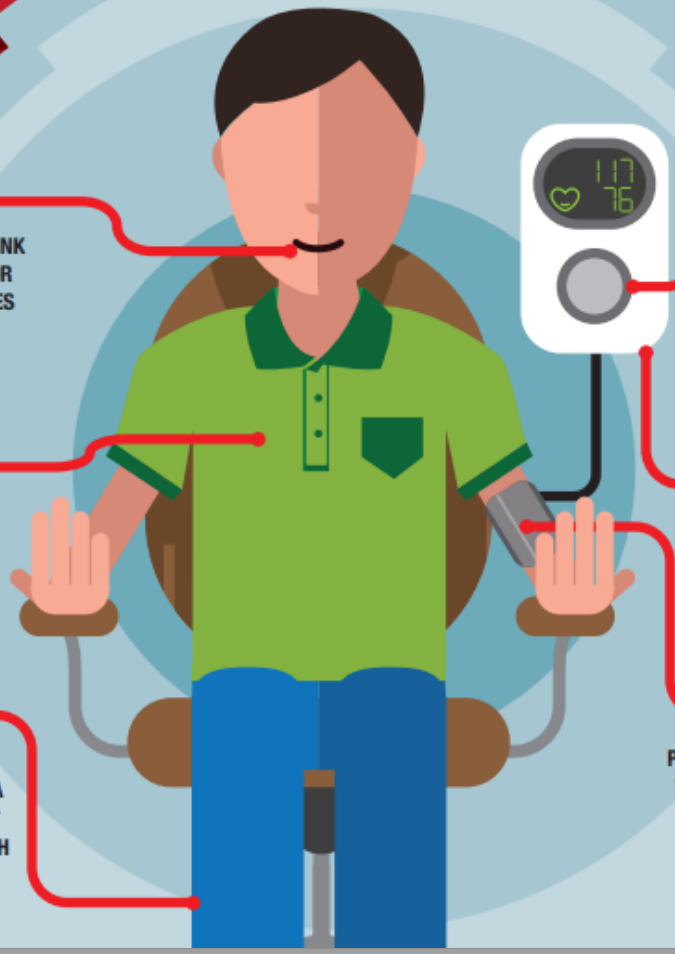
Support

Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.

Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

BLOOD PRESSURE MEASUREMENT INSTRUCTIONS

American Heart Association | American Stroke Association
life is why



DON'T SMOKE, EXERCISE, DRINK CAFFEINATED BEVERAGES OR ALCOHOL WITHIN 30 MINUTES OF MEASUREMENT.

REST IN A CHAIR FOR AT LEAST 5 MINUTES WITH YOUR LEFT ARM RESTING COMFORTABLY ON A FLAT SURFACE AT HEART LEVEL. SIT CALMLY AND DON'T TALK.

MAKE SURE YOU'RE RELAXED. SIT STILL IN A CHAIR WITH YOUR FEET FLAT ON THE FLOOR WITH YOUR BACK STRAIGHT AND SUPPORTED.

TAKE AT LEAST TWO READINGS 1 MIN. APART IN MORNING BEFORE TAKING MEDICATIONS, AND IN EVENING BEFORE DINNER. RECORD ALL RESULTS.

USE PROPERLY CALIBRATED AND VALIDATED INSTRUMENT. CHECK THE CUFF SIZE AND FIT.

PLACE THE BOTTOM OF THE CUFF ABOVE THE BEND OF THE ELBOW.

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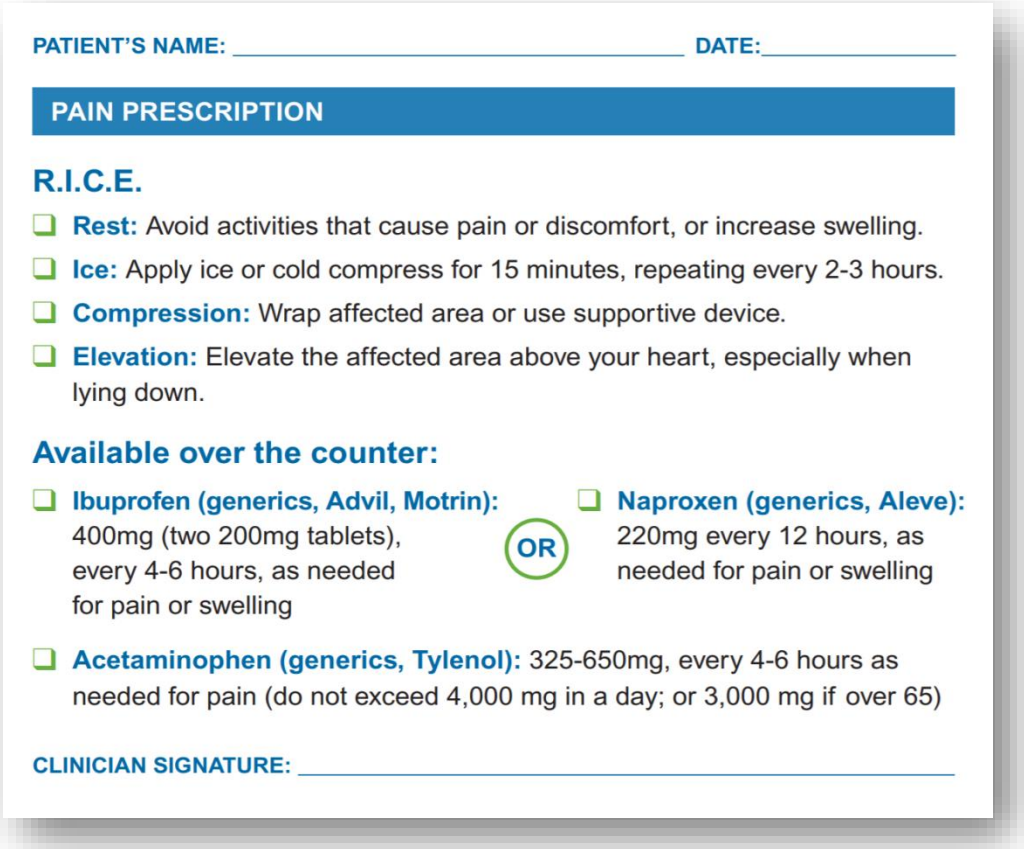
Patient-Facing Tools

Example of a "non-prescription"



PATIENT'S NAME: _____ DATE: _____

PAIN PRESCRIPTION

R.I.C.E.

- ❑ **Rest:** Avoid activities that cause pain or discomfort, or increase swelling.
- ❑ **Ice:** Apply ice or cold compress for 15 minutes, repeating every 2-3 hours.
- ❑ **Compression:** Wrap affected area or use supportive device.
- ❑ **Elevation:** Elevate the affected area above your heart, especially when lying down.

Available over the counter:

- ❑ **Ibuprofen (generics, Advil, Motrin):** 400mg (two 200mg tablets), every 4-6 hours, as needed for pain or swelling

OR

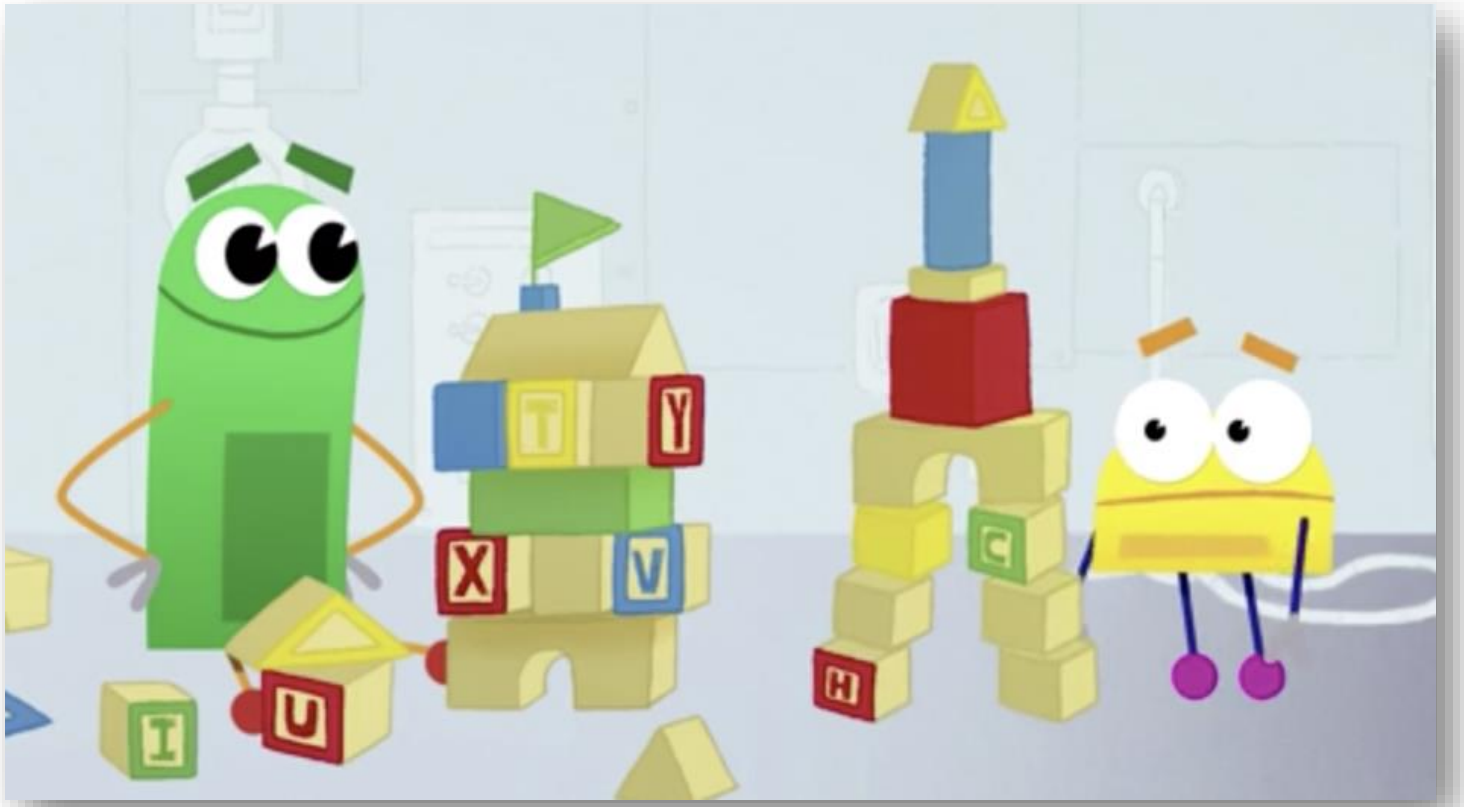
- ❑ **Naproxen (generics, Aleve):** 220mg every 12 hours, as needed for pain or swelling

- ❑ **Acetaminophen (generics, Tylenol):** 325-650mg, every 4-6 hours as needed for pain (do not exceed 4,000 mg in a day; or 3,000 mg if over 65)

CLINICIAN SIGNATURE: _____

Now What?

How to build impactful materials



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Staying on Budget

- Graphic Designers? Who's in your area?
- Student designers! Will often work for free or low cost.
  - Check out local colleges and schools or art/design
- Free programs online: teach yourself!

  - **Free stock images** on google.com
  - **Creative Commons** (creativecommons.org)
  - **Public Health Dept. Clearing Houses**
  - **Public-Facing National Orgs** (SAMHSA, CDC, VA, etc.)
  - **Piktochart!** (piktochart.com)

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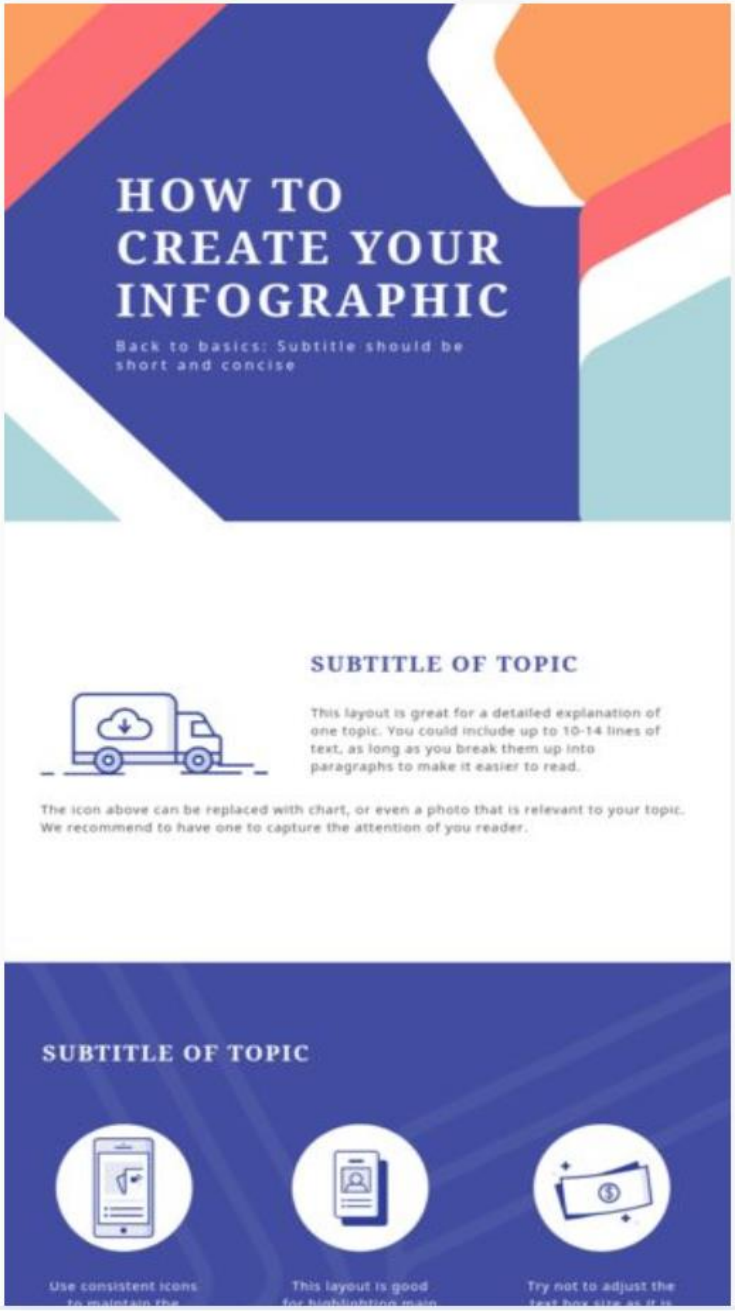
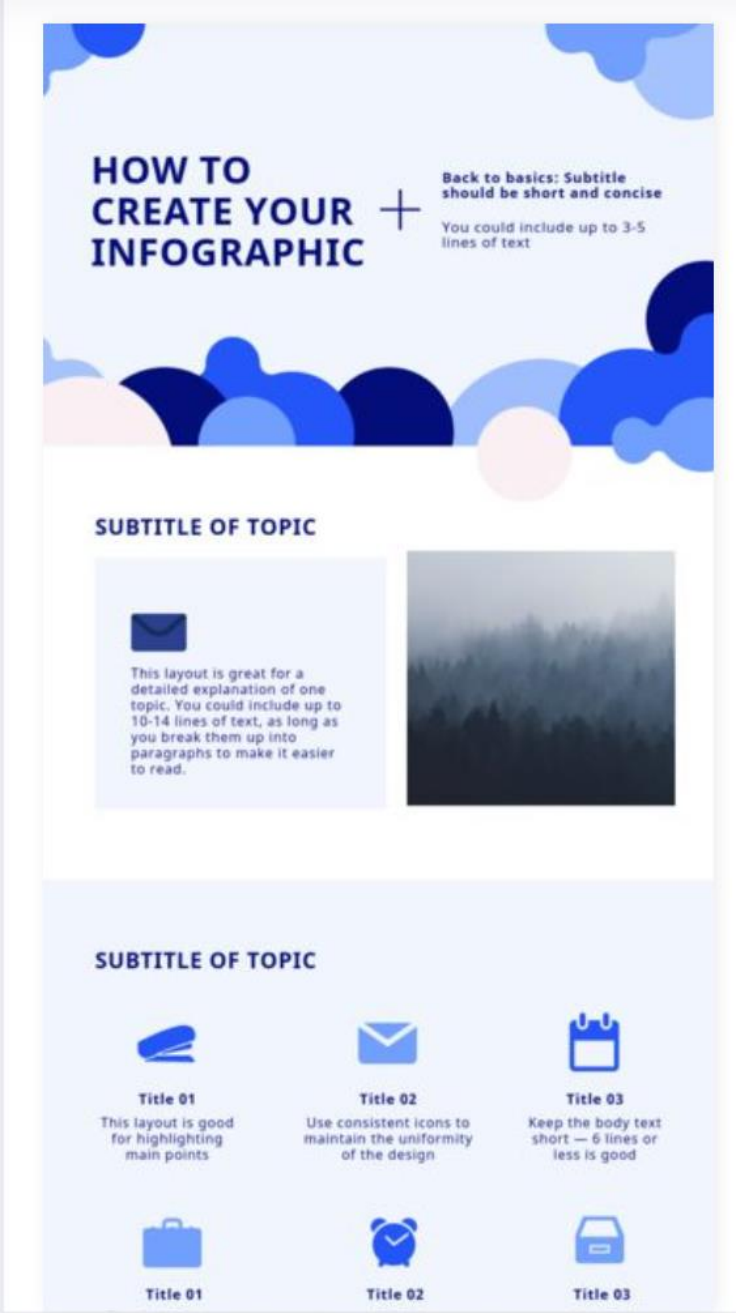
piktochart.com



piktochart.com



Outlining content

- What information is new vs. a review?
- What is the ‘hook’?
- What’s the story, and how is the story told best?
- What visual tools do the detailers need to convey the key messages for the campaign?

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Layout

- Make the key point or message of the page the focal point.
- Don’t make space too cluttered: leave some white “breathing” space.
- Keep information bite sized/easy to digest.

Keep in mind what draws the eye.

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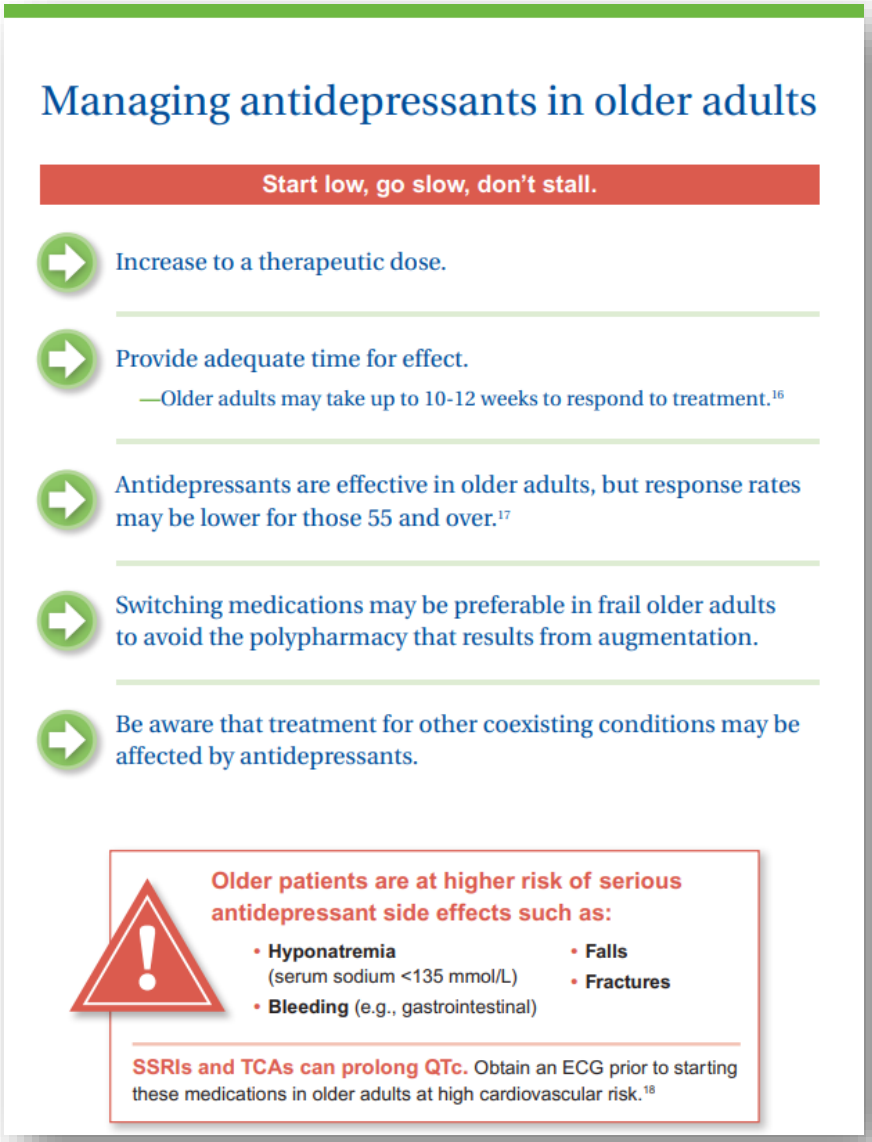
Make Text Easier to Digest



Managing antidepressants in older adults

Start low, go slow, don't stall.

- Increase to a therapeutic dose.
- Provide adequate time for effect.
  —Older adults may take up to 10-12 weeks to respond to treatment.[16]
- Antidepressants are effective in older adults, but response rates may be lower for those 55 and over.[17]
- Switching medications may be preferable in frail older adults to avoid the polypharmacy that results from augmentation.
- Be aware that treatment for other coexisting conditions may be affected by antidepressants.

Older patients are at higher risk of serious antidepressant side effects such as:

- **Hyponatremia** (serum sodium <135 mmol/L)
- **Bleeding** (e.g., gastrointestinal)
- **Falls**
- **Fractures**

SSRIs and TCAs can prolong QTc. Obtain an ECG prior to starting these medications in older adults at high cardiovascular risk.[18]

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Thinking About Branding & Consistency

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FontS: What look do you want to convey?

- Font matters. Can you read it?
- **Each font conveys a tone without saying a word.**
- How do you want your materials to feel to the reader?
- Select no more than 3 fonts for your entire project.
- THE FONT SHOULD NOT BE THE STAR OF YOUR MATERIALS!
- (But unique fonts can draw attention to key points!)
- *Never sacrifice legibility for aesthetic design.*

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Headlines should have the **largest** font

- (Decreasing sizes of font suggest less emphasis.)
- **A darker, heavier weight increases the importance of a statement.**
  - **A lighter color doesn't draw the same attention**

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COLOR

- **Colors convey a mood! Figure out what you're trying to say in advance.**
- **If you pick a color related to your brand, select colors that flow/are complementary.**
- **Don't overdo it on color. A branding scheme typically has one lead/main color and two supporting colors.**

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Color can highlight differences

FIGURE 1. Annual hospital admissions for common Medicare diagnoses[1]

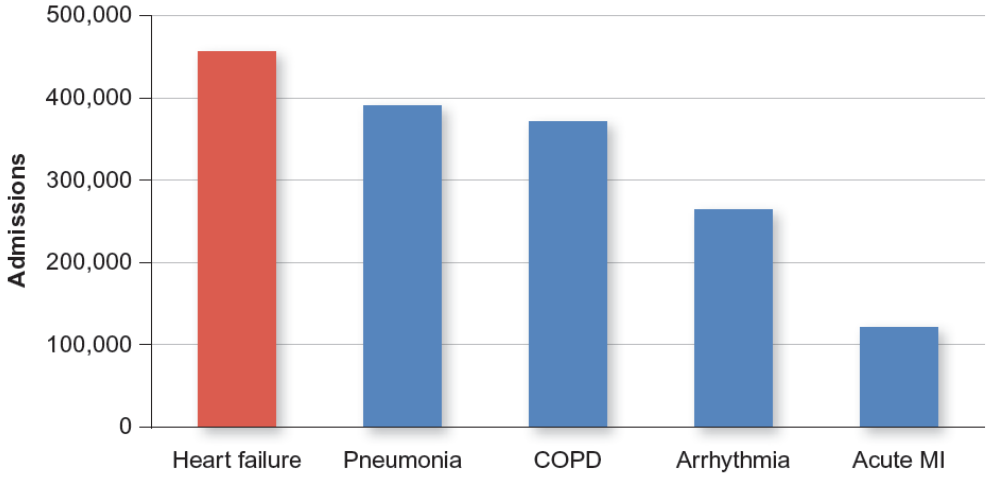
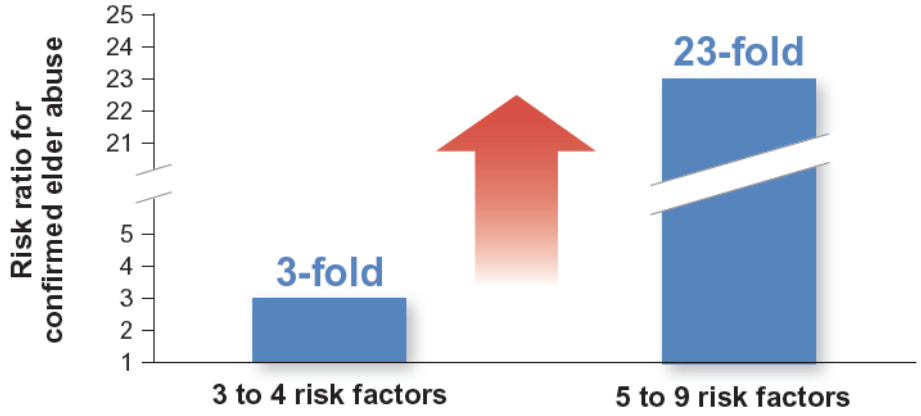


FIGURE 3. Compared to elders with 0 to 2 indicators, the prevalence of elder abuse is dramatically higher in patients with multiple risk factors.[10]



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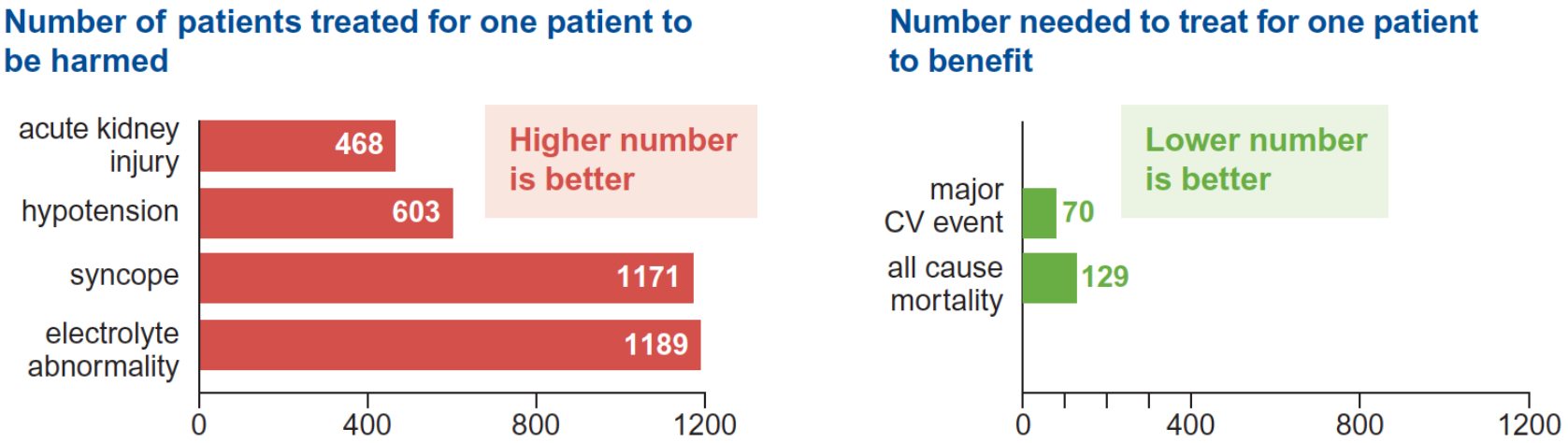
Use of color to symbolize benefit or risk

The benefit of achieving lower BP outweighs the risk of harm.

FIGURE 3. In a population of patients treated to an SBP goal of <130, far more will benefit from prevented CV events or death than will have side effects.[5]



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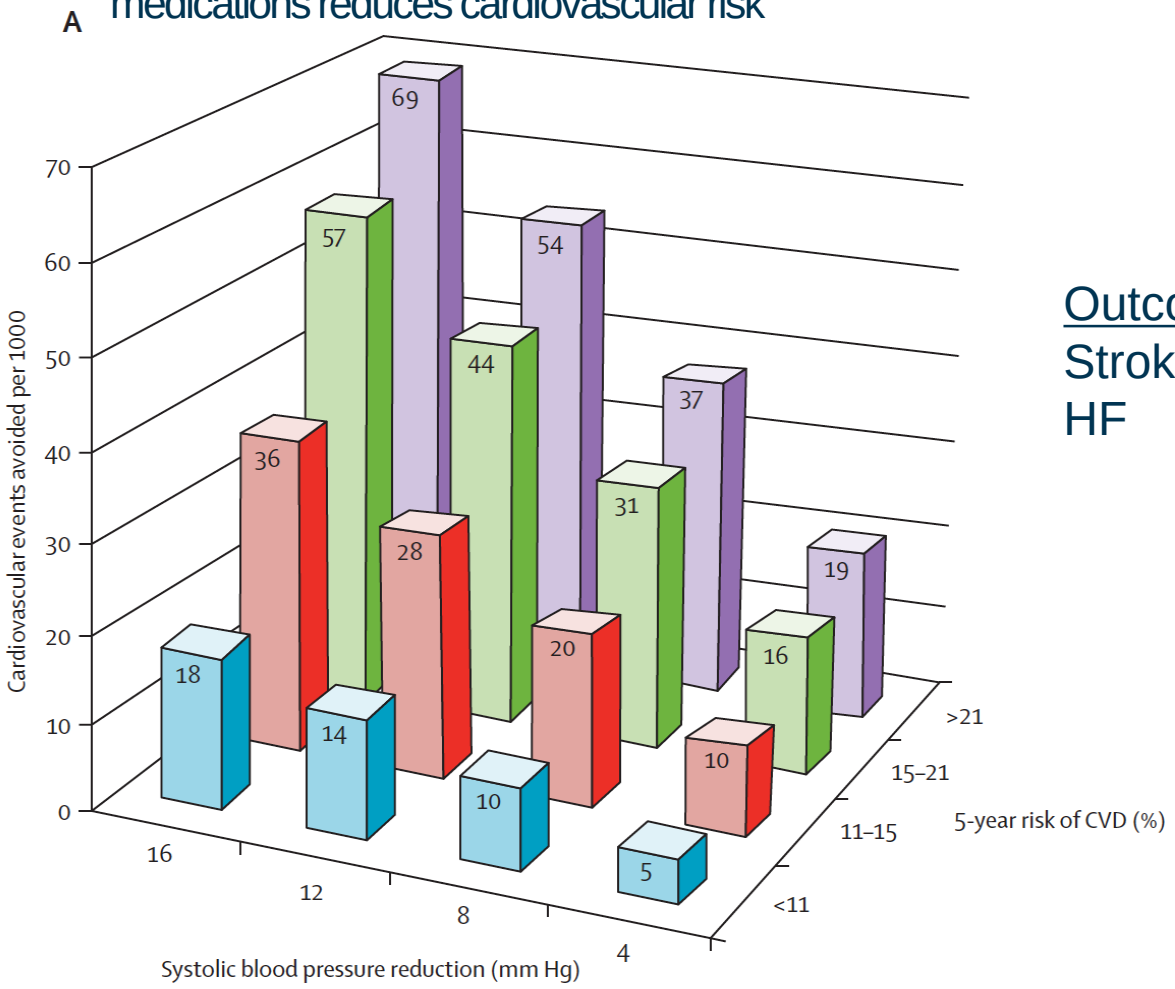
Graphs should simplify complex information

Treating high blood pressure with medications reduces cardiovascular risk



Outcomes avoided:

Stroke MI

HF CVD Death

The Blood Pressure Lowering Treatment Trialists' Collaboration. *Lancet*. 2014;384:591-8.

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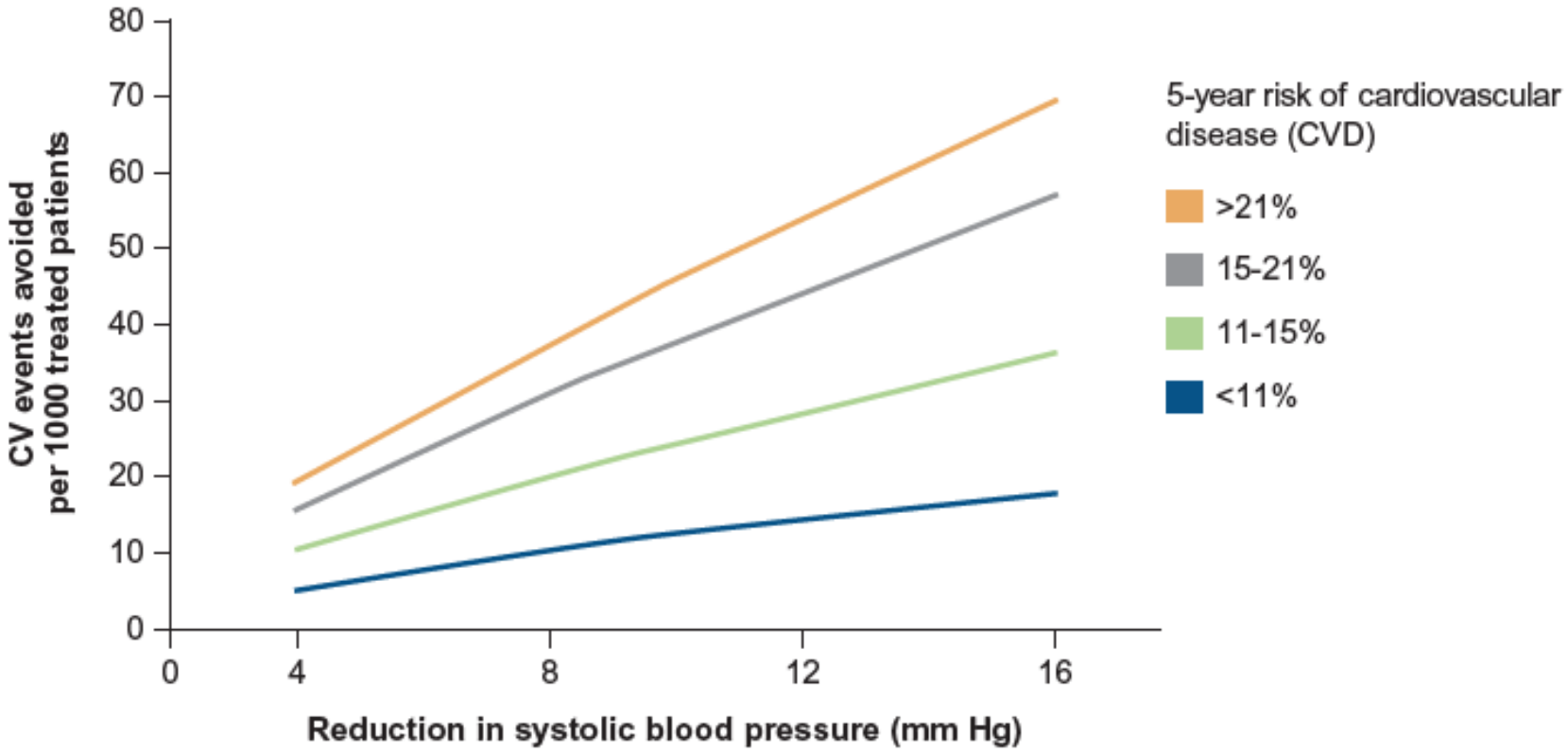
A more intuitive adaptation

FIGURE 1. Treating hypertension prevents stroke, coronary heart disease, heart failure, and cardiovascular (CV) death across all risk groups. Benefit is greatest in those at highest risk.[1]



Testing Along the Way

- Materials should go through several rounds of testing.
- Ask clinicians you trust to review content.
- Test it on a few trusted clinicians in a ‘faux’ detailing session
- Hold a focus group for 90 minutes where you provide dinner and a small stipend to 4-6 providers who represent your target audience:
  - **Ask for their honest feedback**
  - **Review wording, graphic choices, key messages**
  - **Pulse point: Would this work? Would you change your clinical practice?** (If not, make changes to content or messaging.)
- Ask non-clinicians to review for clarity and fresh perspective
- Take a break: Look at other clinical topics for new ideas

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Remember: Rome wasn't built in a day

The "Get Up And Go" test is a good way to assess several aspects of mobility.[7]

The Get Up and Go Test
Ask the patient to:
• Stand from a sitting position without using arms for support
• Walk several paces (10 feet)
• Turn
• Return to the chair
• Sit down again without using arms for support

Patients who answer "yes" to any of the questions, or have difficulty/deficits in gait, mobility or balance when performing the test require further assessment. Think **HIP**:

- **H**istory
- **I**nspection (physical examination)
- **P**rescription

3

2008

Fall risk factors are additive

The more risk factors a patient has, the greater the vulnerability to falling when exposed to a stress.

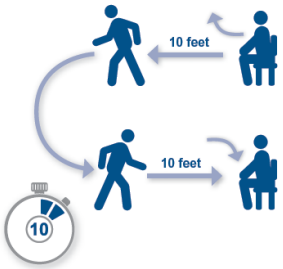
FIGURE 6. Risk factors and falls in patients 65 years and older[8]

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

Evaluate gait and mobility with the Timed Up-and-Go (TUG) test

FIGURE 7. Timed Up-and-Go test[9]



Instructions

- Ask the patient to sit in a standard chair.
- Tape a line on the floor 10 feet away.
- Tell the patient to *"Stand up from the chair, walk at your normal pace to the line on the floor, turn, walk back to the chair, and sit down again."*
- Repeat 3 times and average trials 2 and 3.
- Average time > 12 seconds suggests high risk.

In addition, the TUG test may reveal several characteristic gait patterns.

4 **Preventing falls in the elderly**

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Activity: Barriers to Materials Design

- Turn to partner and discuss:
  - Top 3 major barriers to creating materials for your program
  - 1 possible solution to each barrier

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Group Share: Barriers & Solutions

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