NaRCAD

2020 WEBINAR SERIES

AD for Opioid Safety: An Overview for New OD2A Programs

Wednesday, July 29th, 2020, 2:00 P.M. – 3:15 P.M. EST

National Resource Center for Academic Detailing
Division of Pharmacoepidemiology and Pharmacoeconomics [**DoPE**]
Brigham and Women's Hospital | Harvard Medical School


Welcome!

Stick around to take our 60-second survey!


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Zoom Webinar Chat
Take a minute to change your chatbox settings.
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To:
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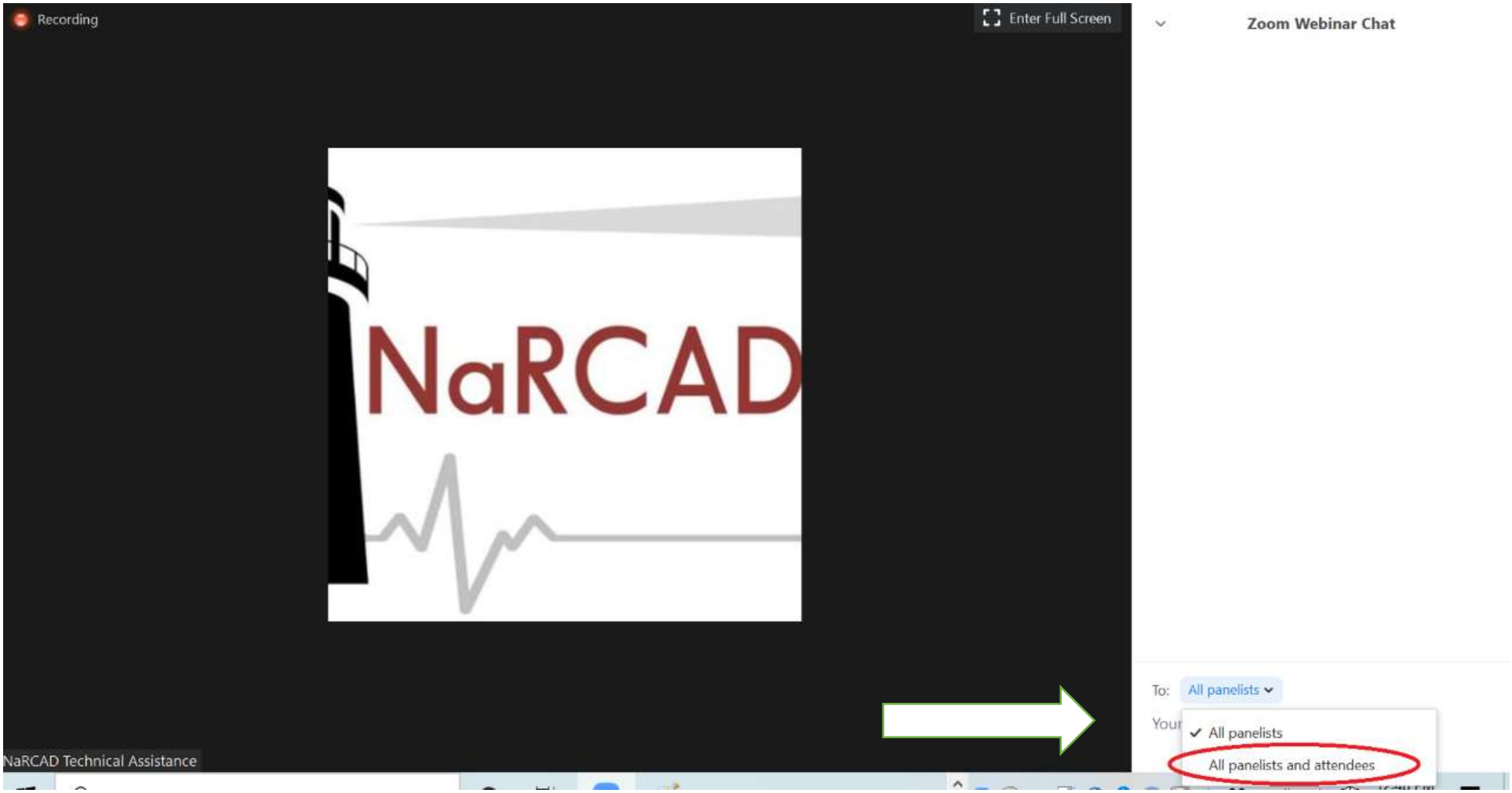
All panelists
All panelists and attendees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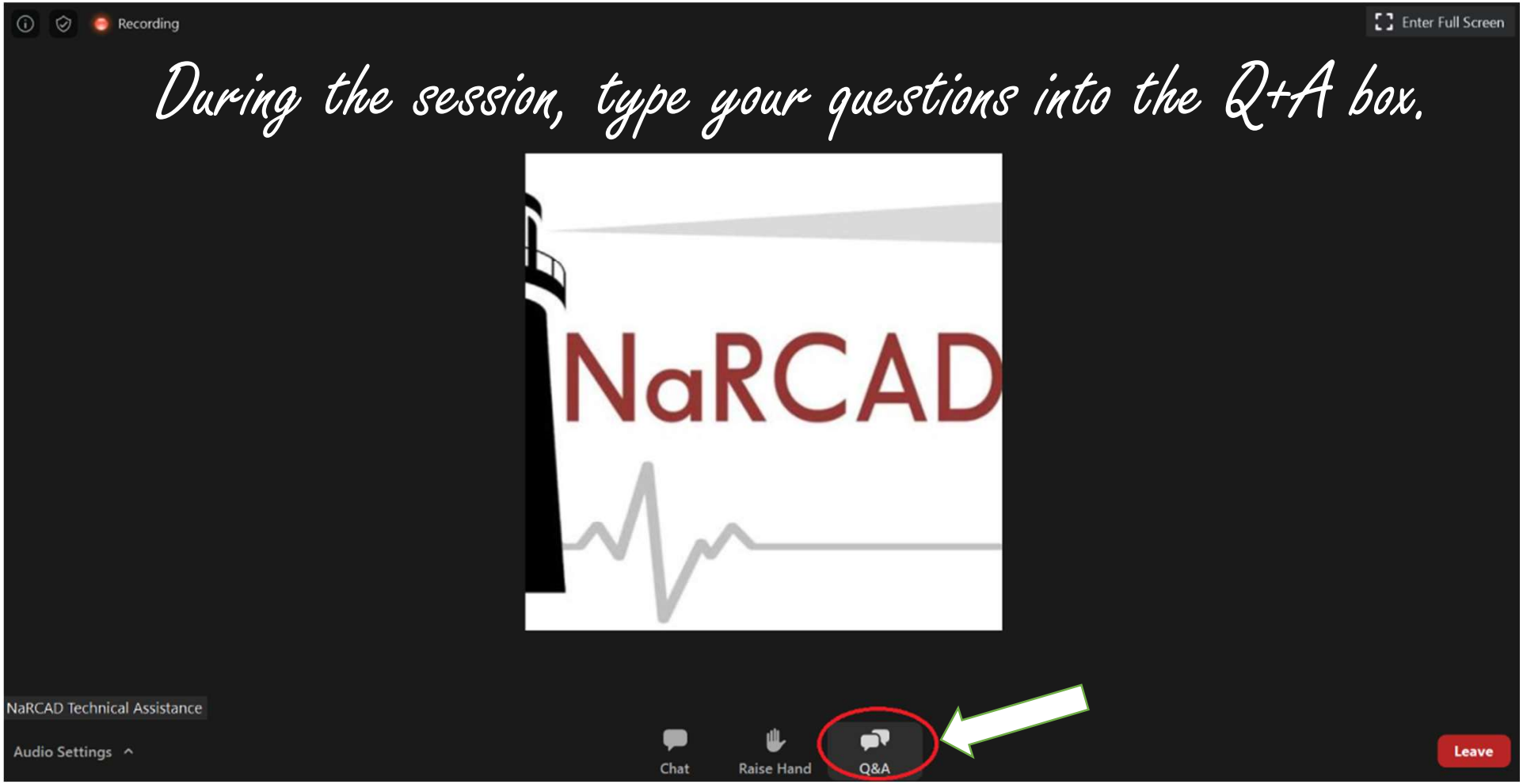
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Webinar Goals:

- ✓ Consider what challenges clinicians are up against every day
- ✓ Think about the ideal learning environment: What does it look like? How is it applied?
- ✓ Explore AD as a flexible strategy to improve patient care, and learn how to build your own program
- ✓ See examples of successful opioid safety AD campaigns
- ✓ Discussion/Q+A Session

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Level Setting: First Impressions

Type in the chatbox:

- When you see/hear the following words, type the first word(s) or a phrase that comes to mind:

1. Clinicians
2. The Opioid Crisis
3. Quality Improvement Initiatives

Level Setting:
What We Know So Far

Type in the chatbox:

Rate your knowledge of Academic Detailing on a scale of 1-10:

1 = I don't know much at all yet.

5 = I'm conversational, but not an expert.

10 = I am an AD ninja.

NaRCAD Technical Assistance

- **Program Building**
  - In-person trainings, webinars, and ongoing virtual support, including training videos, resources, & more.

- **Phone Support**
  - Follow-up to help you trouble shoot your visits and deal with challenges along the way.

- **E-mail Support**
  - Unlimited guidance, resource requests, & troubleshooting.

What's "AD"?

It's educational outreach

- 1:1 visits in the frontline clinician's own office
- Emphasizing an individualized needs assessment
- Using compelling educational "Detailing Aids"
- Facilitating interaction with best available evidence

Information is provided interactively to:

- Understand the clinician's knowledge, attitudes, behavior
- Keep the practitioner engaged while continuing to assess needs
- Encourage behavior change via action-based key messages

✓**The visit ends with an agreed upon commitment to specific practice changes**

✓**Over time, the relationship is strengthened, based on trust and usefulness**

Why "AD"?

Clinicians want the best outcomes for their patients.

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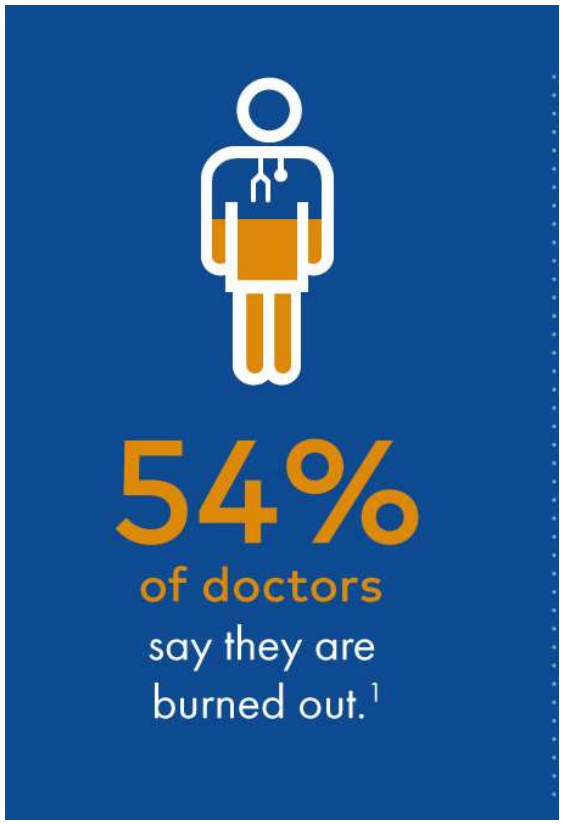
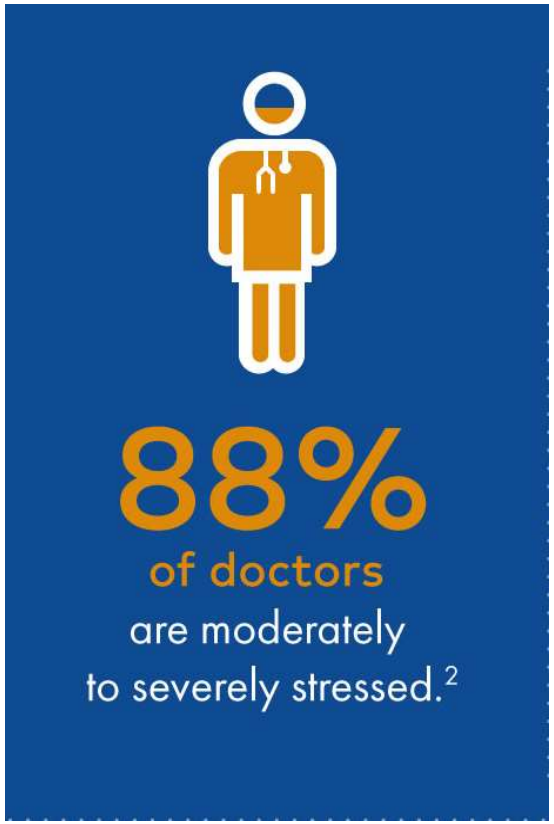
Primary Care Burnout: Stats

MedScape Mayo Clinic, VITAL Worklife2015





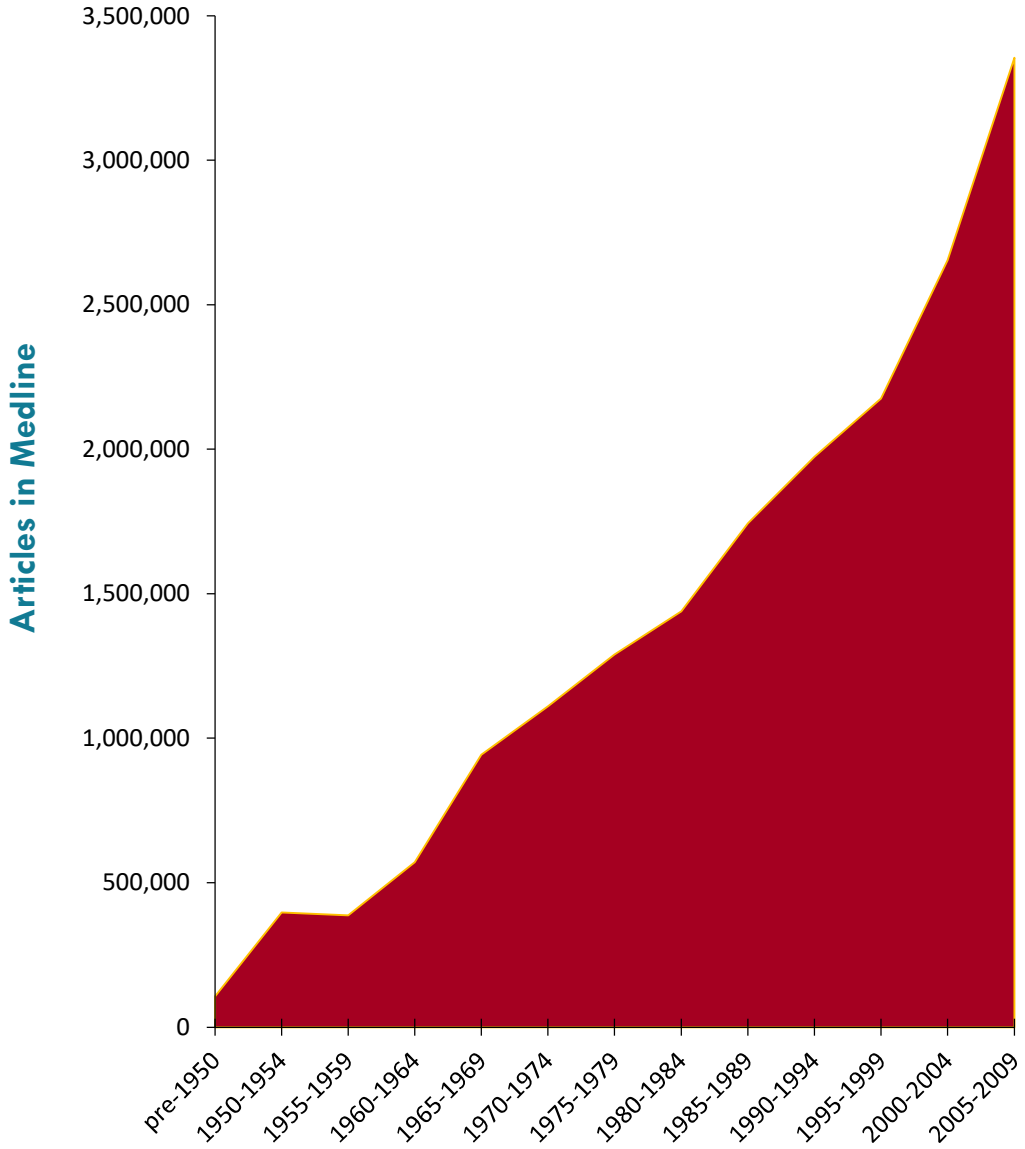
10% of physicians

identified their burnout as "so severe I'm thinking of leaving medicine."

Why? *Type in the chatbox* →

The Volume of "Evidence" is Overwhelming

- In 1992, internists needed to read an estimated 17 articles every day of the year in order to "keep up" with the literature
- The volume of published articles since then has increased exponentially
- Not all evidence is of equal quality
- Creates a virtually impossible problem for practicing physicians



***SOURCES**: Davidoff et al BMJ 1995; 310: 1085; http://www.nlm.nih.gov/bsd/medline_lang_distr.html*

Sources: Yearbook of Medical Informatics 2000; Implementation Science 2010

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Bringing Best Evidence to Clinicians

Clinicians need high quality data that is:

- ✓Relevant to real-world decisions
- ✓Customized to their clinical setting
- ✓Practical and usable

Academic Detailing can offer:

- ✓Continuous engagement
- ✓A sense of purpose
- ✓Ability to reinvigorate primary care

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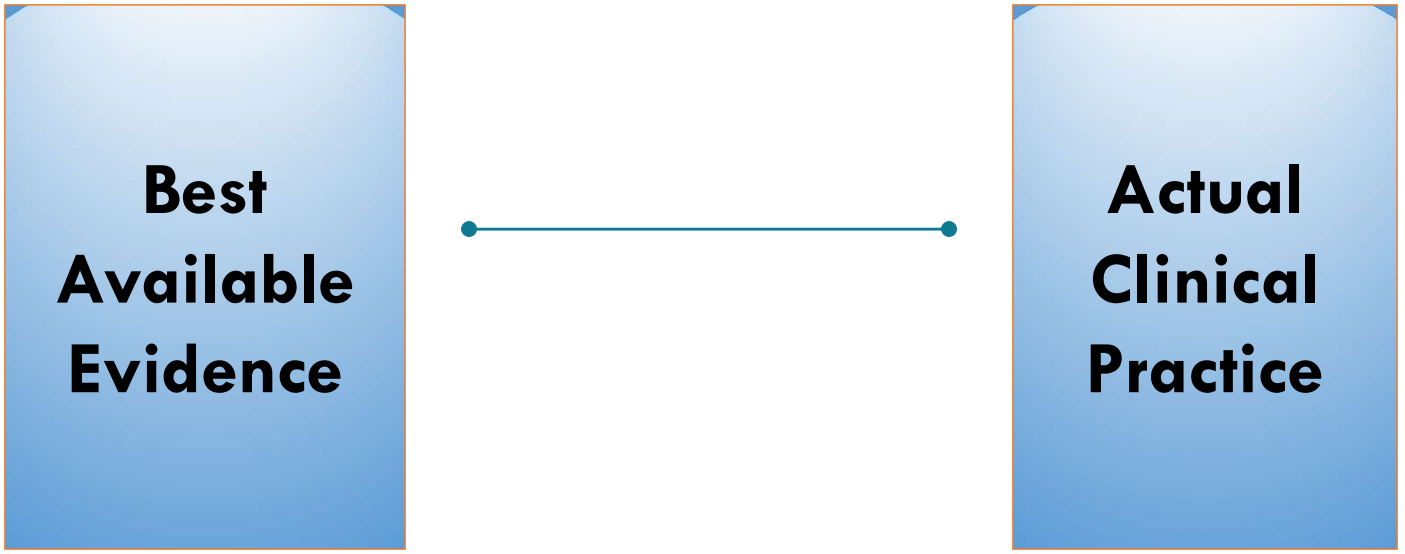
The Goal of Academic Detailing

Closing the gap between:



Level Setting: Our Experiences

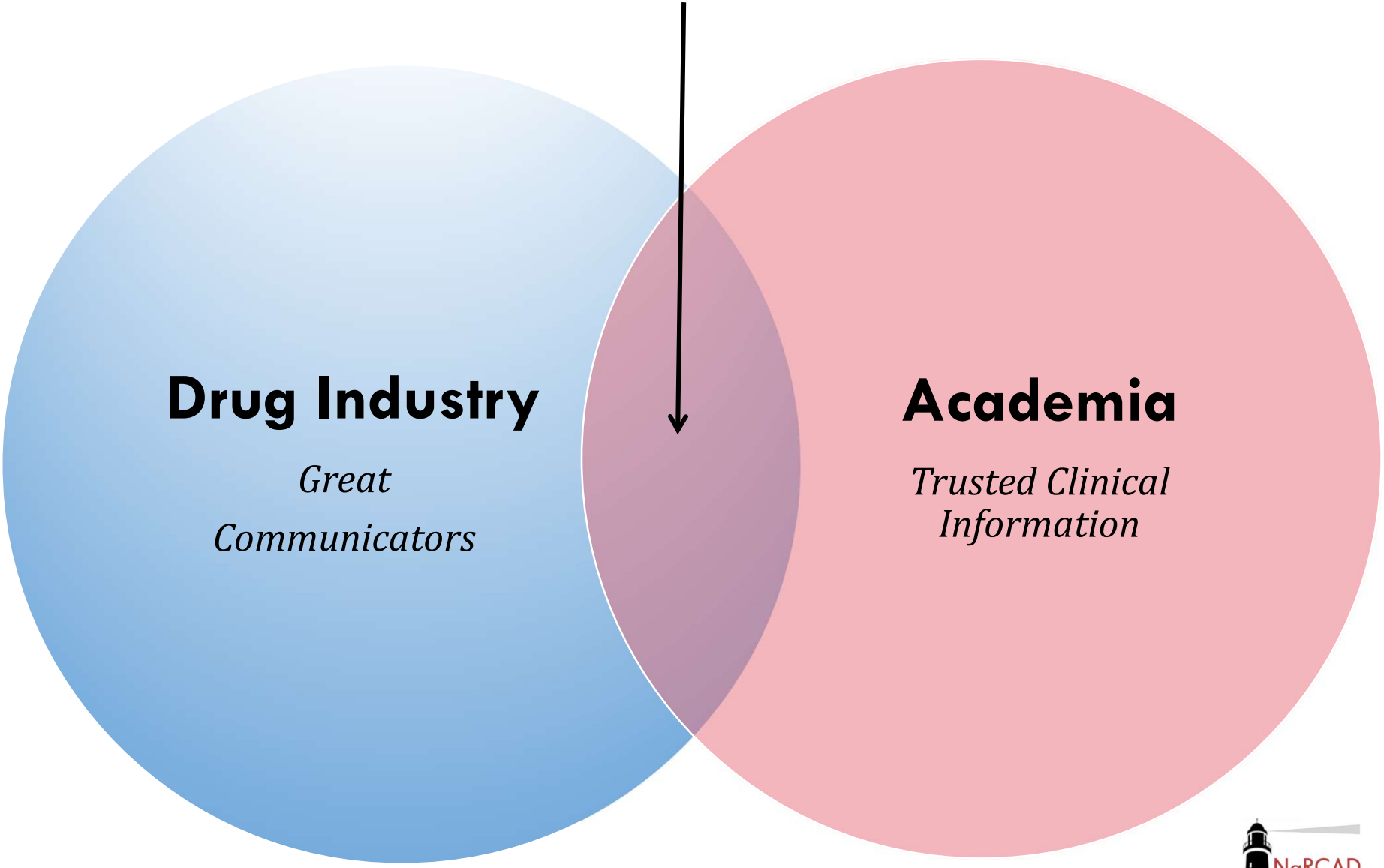
Type in the chatbox:

- **When you hear the following words,**

type the first word(s) or a phrase that comes to mind:

1. **Pharmaceutical Sales Representatives**
2. **Researchers & Academic Faculty**

Academic Detailing



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What Typical Learning Looks Like:

Type in the chatbox:

- **When you hear the following word**

type the first word(s) or a phrase that comes to mind:

CME (Continuing Medical Education) Sessions

What Academic Detailing is Not:

- **Lectures** delivered in the doctor's office
- **Memos or brochures** (*"the truth"*) sent through **mail/e-mail**
- About **formulary compliance,** or **cost reduction,** primarily
- Merely an attempt to **"un-do" industry marketing** (*AD is not "counter-detailing"*)

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Your Expertise:

Type in the chatbox:

- **What should an ideal learning environment look like?**

The Structure of a 1:1 Visit

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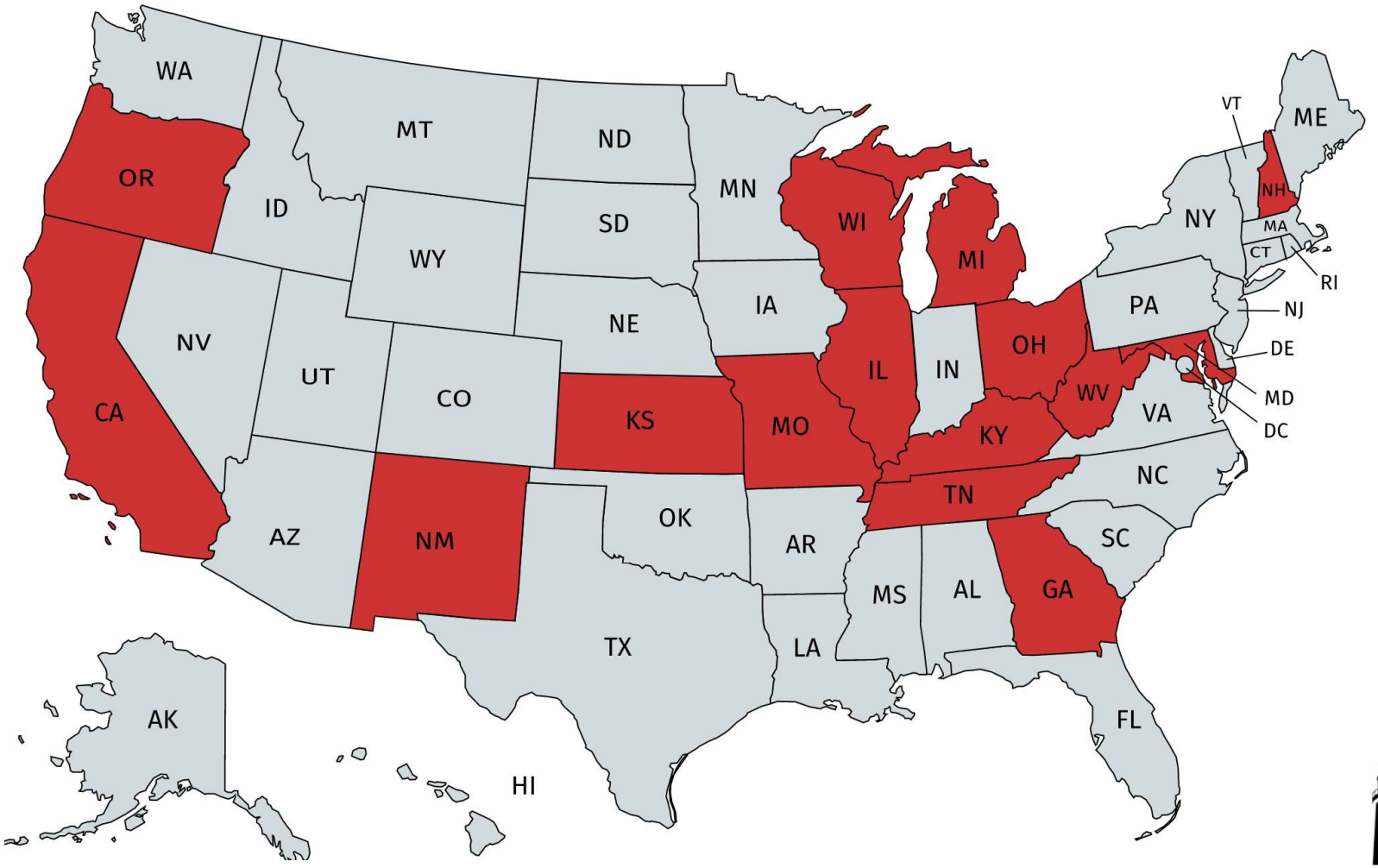
Building Your Program:
State-Level Opioid Safety AD Initiatives

NaRCAD Trainings to Date:



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Elements of a Successful AD Program

- ❑ Identifying gaps in care
- ❑ Defining intervention goals:
  - ➢ What's the change you want clinicians to make?
- ❑ Recruiting & training detailers
- ❑ Delivering 1:1 clinician visits
- ❑ Building capacity & sustainability
- ❑ Evaluation & assessment

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Applying AD to the Opioid Crisis

Natural fit for AD framework:

- Knowledge deficits for many clinicians
- Identifiable behavior changes desired
- Educational messages nuanced

With some challenges:

- Evidence base limited in some areas
- Upending of prior pain management principles
- Scope of problem

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Strengthening AD for Opioid Safety

- Overuse of prescription opioids a continued problem and still a priority

- Shift to synthetic/illicit opioids creates new focus for clinicians:

  - **Responding to Opioid Use Disorder (OUD)**
  - **Managing clinician stigma**
  - **Engaging in new topic area**
  - **Clinician/patient conversations about treatment and support**

What We've Learned: Predictors of Intervention Success Level

Key Characteristic	Successes	Challenges
Strong leadership within the local health department	**Building stronger teams via excellent recruitment and consistent involvement**	**Less effective recruiting decisions + less connected teams**

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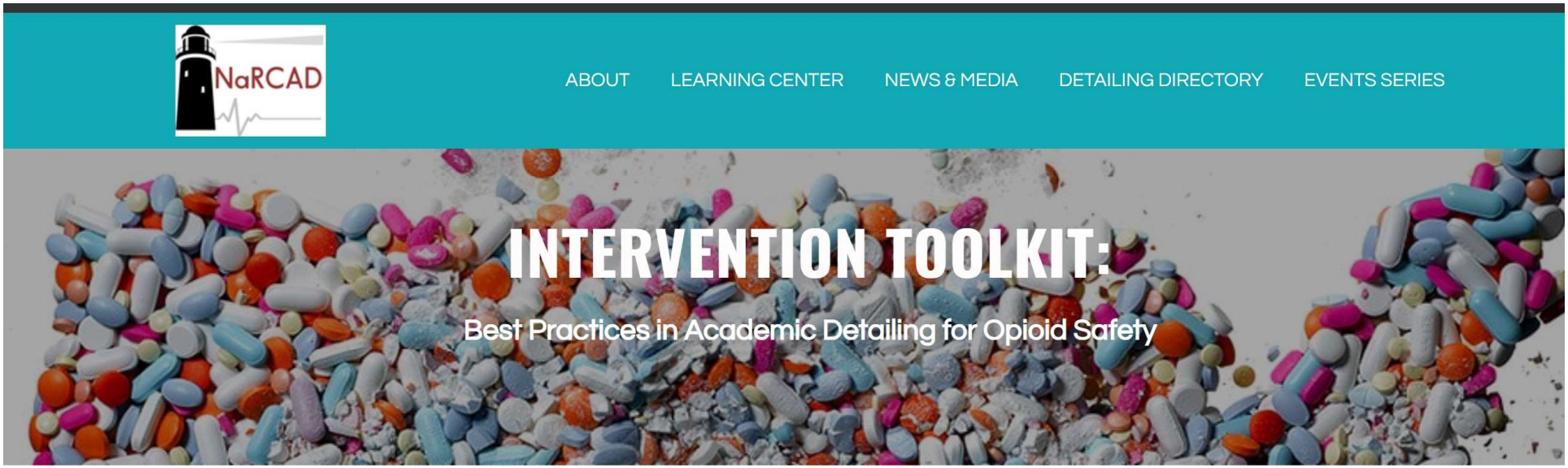
Ongoing Learning Opportunities via peer-to-peer networking & clinical content refreshers	Chances to share successes and request assistance with challenges; increased knowledge of clinical info	Less connection to strategies and support; limited knowledge on clinical content updates

EXAMPLE CAMPAIGN:

Opioid Safety Intervention for Primary Care Clinicians



Shareable resources to build your Academic Detailing program.

Educational Tools & Materials

- CDC: GUIDELINES & TOOLS
- THE VA ACADEMIC DETAILING SERVICE: PAIN & OPIOID SAFETY INITIATIVE
- PUBLIC HEALTH AD PROGRAMS: OPIOID SAFETY CAMPAIGN MATERIALS
- MEDICATION ASSISTED TREATMENT (MAT) RESOURCES

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

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WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

Primary care providers account for approximately

50%

of prescription opioids dispensed

Nearly

2 million

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

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

MYTH VS TRUTH

	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.

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Strong Key Messages:

- ✓ **Answer: What do you want providers to do differently?**
- ✓ **With language that is: Action-oriented and specific.**

1. **Start Low and Go Slow: Prescribe at the Lowest Effective Dose**
2. **Use Non-Opioid Treatment as First-line Therapy**
3. **Review the Prescription Drug Monitoring Program [PDMP]**
4. **Avoid Concurrent Prescribing with Benzodiazepines**
5. **Offer Treatment for Opioid Use Disorder**

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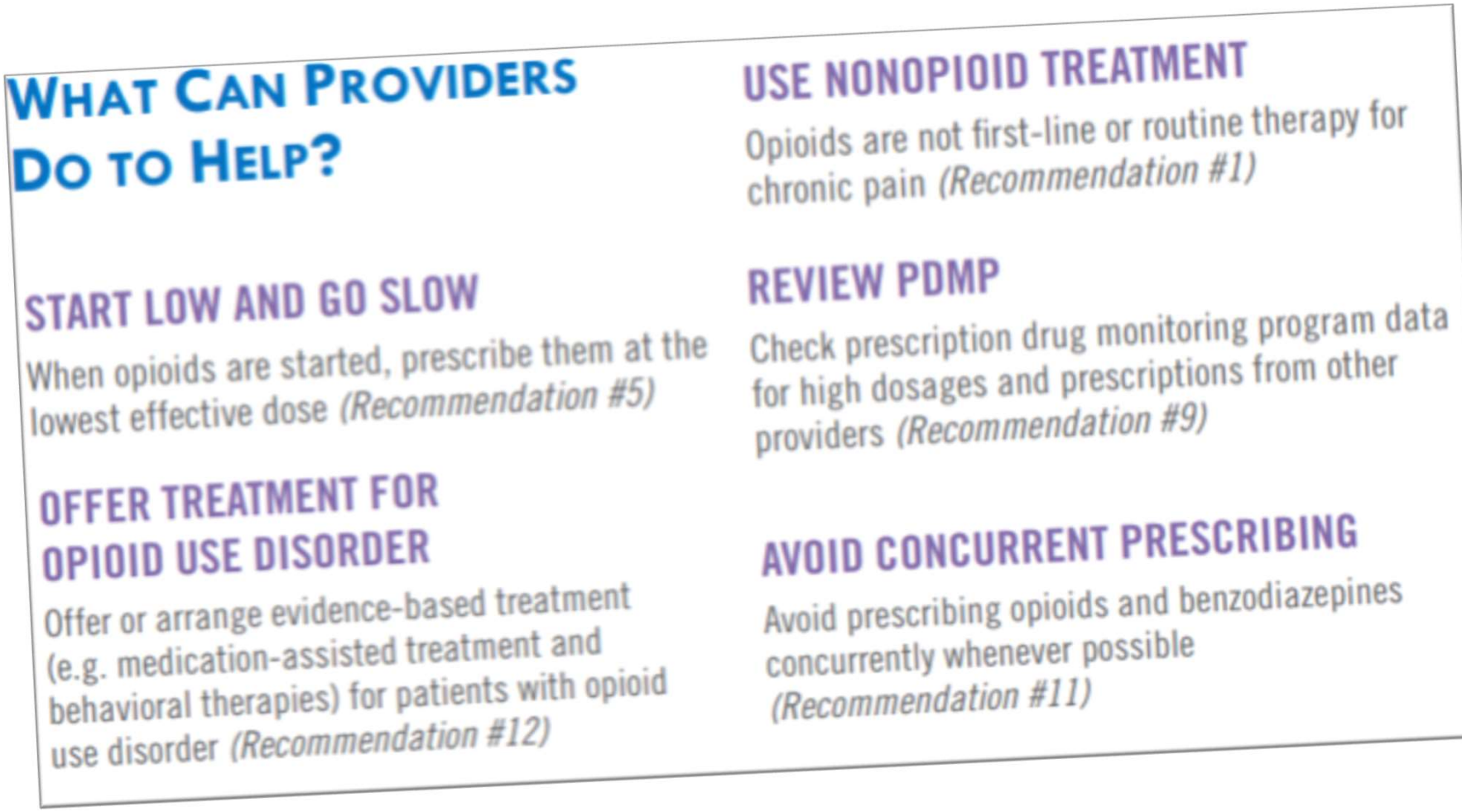
POCKET CARDS:
Easier Access & Implementation



What Can Providers Do to Help?

START LOW AND GO SLOW

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

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)*

USE NONOPIOID TREATMENT

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

REVIEW PDMP

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

AVOID CONCURRENT PRESCRIBING

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

RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

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

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

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

Migraine

Preventive treatments

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

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

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

Fibromyalgia

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

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

Medications

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

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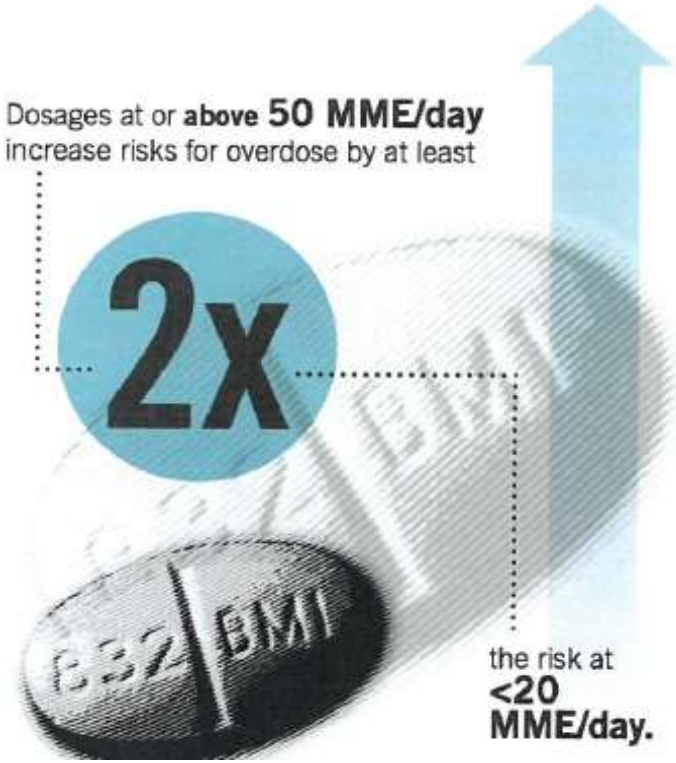
CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

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).



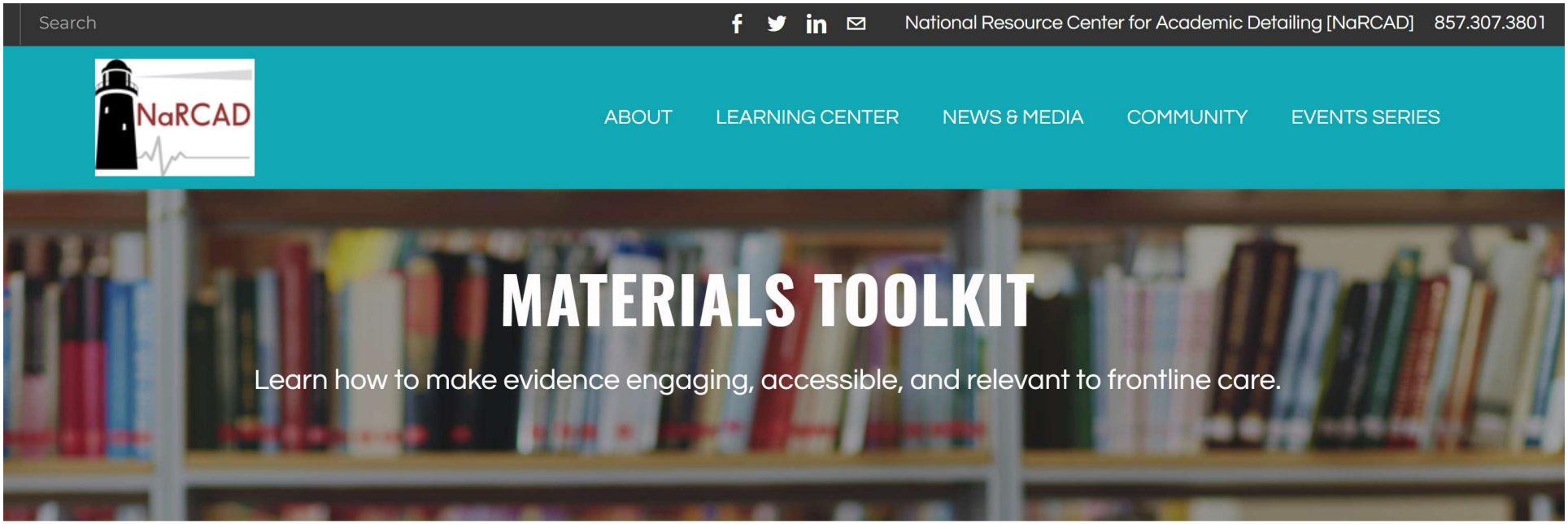
WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

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.

Explore More Campaign Materials



To search by clinical topic, please visit The Detailing Directory.

Tracking & Evaluating Your Visits

Program Planning & Evaluation - Materials & Examples:

- Planning An Evaluation of an Academic Detailing Intervention: Guide | NaRCAD
- **Form: Planning & Tracking Your Visits:** Form for Logging Practice Visits and Follow-Up
- **Form: Tracking Data:** Overall Tracking List Sheet & Detailing Visit Targets
- **Form: Provider Evaluation of A Visit:** Post-Detailing Session Evaluation Form
- Evaluation Summary Report | *Idaho Department of Health and Welfare's "AD Outreach Summary"*
- Special Blog on Prioritizing Evaluation: *The National Academic Detailing Service's Opioid Overdose Education & Naloxone Distribution (OEND) Program*
- Presentation: Pragmatic Program Evaluation | *NaRCAD Workshop Presentation Deck by Niteesh Choudhry, MD, PhD & Melissa Christopher, PharmD*

Outreach Summary"

- Special Blog on Prioritizing Evaluation: *The National Academic Detailing Service's Opioid Overdose Education & Naloxone Distribution (OEND) Program*
- Presentation: Pragmatic Program Evaluation | *NaRCAD Workshop Presentation Deck by Niteesh Choudhry, MD, PhD & Melissa Christopher, PharmD*

- Provider HIV Prevention Pre-Survey & Post-Survey | Colorado Department of Public Health & Environment
- CDC Overdose Prevention Evaluation Profile for Academic Detailing |

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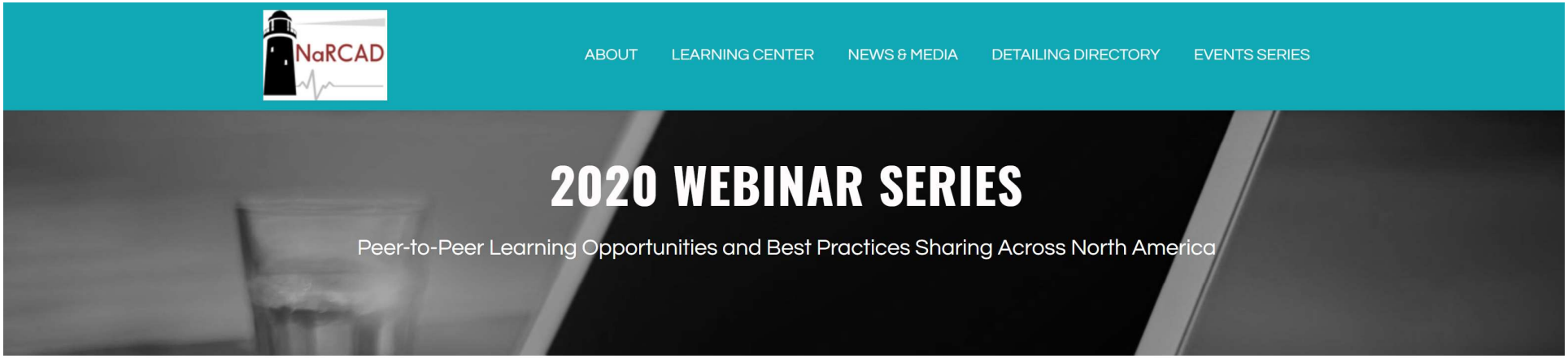
Individual Visits: Detailing Session Notes Form

Key Messages List:
1. Start Low and Go Slow (*includes calculating doses*)
2. Use Non-Opioid Treatment
3. Review the PDMP
4. Avoid Concurrent Prescribing
5. Offer Treatment or Referral for OUD (*Opioid Use Disorder*)

Other Topics:
6. Naloxone
7. Harm Reduction
8. Titration
9. Inherited Patients
10. Other (*describe in notes*)

		Notes:
Clinician Name:	Ann Jones, RN	Also knows Suzanne Montgomery from SafeNet, will follow up with introductory e-mail
Clinic:	East Safety Net Clinic, Downtown	Part of Safety Net Health System
Visit Occurred:	10/30/2018	Rescheduled twice; realize that Practice Manager Greg Smith is best point of contact, not reception
Length of Visit:	20 minutes	Originally scheduled for half hour, Ann was running behind
General Reception:	Positive/receptive	Was trained in 90's, taught that long-acting opiates had no risk of being addictive; wants to find ways to help her patient population especially veterans who she's received as legacy patients. Challenging to engage at first; asked more needs assessment questions to ask about specific patients who were a challenge to treat.
Key Messages Covered:	1, 3, 4	Really wants to start using PDMP more effectively; challenges with introducing into clinic workflow; understaffed team. Suggested assigning delegate via medical assistant, Lars. She will follow up with Lars.
Other topics covered	6, 8, 9, 10 (veteran population)	Has concerns about whether PDMP really has most up-to-date data, but realizes better to check, especially for vets on Benzodiazepines for anxiety/PTSD
Commitment and Time Period	Will start on November 1st having Lars pull PDMP info each morning for two weeks and see how it goes.	Seems receptive to follow-up and said she'll keep notes on progress
Follow-up visit plans	Will reach out to Greg in two weeks to set something up for end of November; will also e-mail Lars to check in.	N/A
Resources Offered	4-pager Detailing Aid on CDC Primary Care prescribing guidelines; pocket card	Really liked pocketcard and asked for a few others when I next visit
Resources to send	PDMP "how to" state tutorial link and CDC 2016 Guidelines	Will send both via e-mail by EOD
Other Notes	Said she would introduce me to other nurses during a staff meeting on 12/2/2018	Will prepare small presentation for other nurses and plan to speak with Greg about 1:1 visits with each nurse thereafter



NaRCAD 2020 WEBINAR SERIES

Webinars will be hosted monthly from January-September

All webinars will be recorded and available to view after each broadcast. The 2020 monthly webinar series will cover a broad range of topics that will support program implementation. We invite academic detailing program staff from diverse clinical interventions to join us.

Monthly series, with wide range of topics, including:

Clinician Stigma

Pivoting to e-Detailing

Acute & Chronic Pain Management

Strategic Data Collection for Program Sustainability

Strengthening the Detailer-to-Clinician Relationship

Recruiting Detailers to Build a Strong Field Team

E-DETAILING TOOLKIT

Curated tools to facilitate effective virtual visits

NaRCAD e-detailing Community of Practice

TAKE OUR 1-MINUTE SURVEY

Tell us what your needs are around e-Detailing and inform our new Community of Practice.

- Getting Started with e-Detailing
- Resources for Implementation
- Relevant Research Articles
- Free or Low-Cost Virtual Learning Platforms

Please type your questions into the Zoom Q + A box.

We'll try to get to all of your questions, and we will post those we can't get to on our Discussion Forum.

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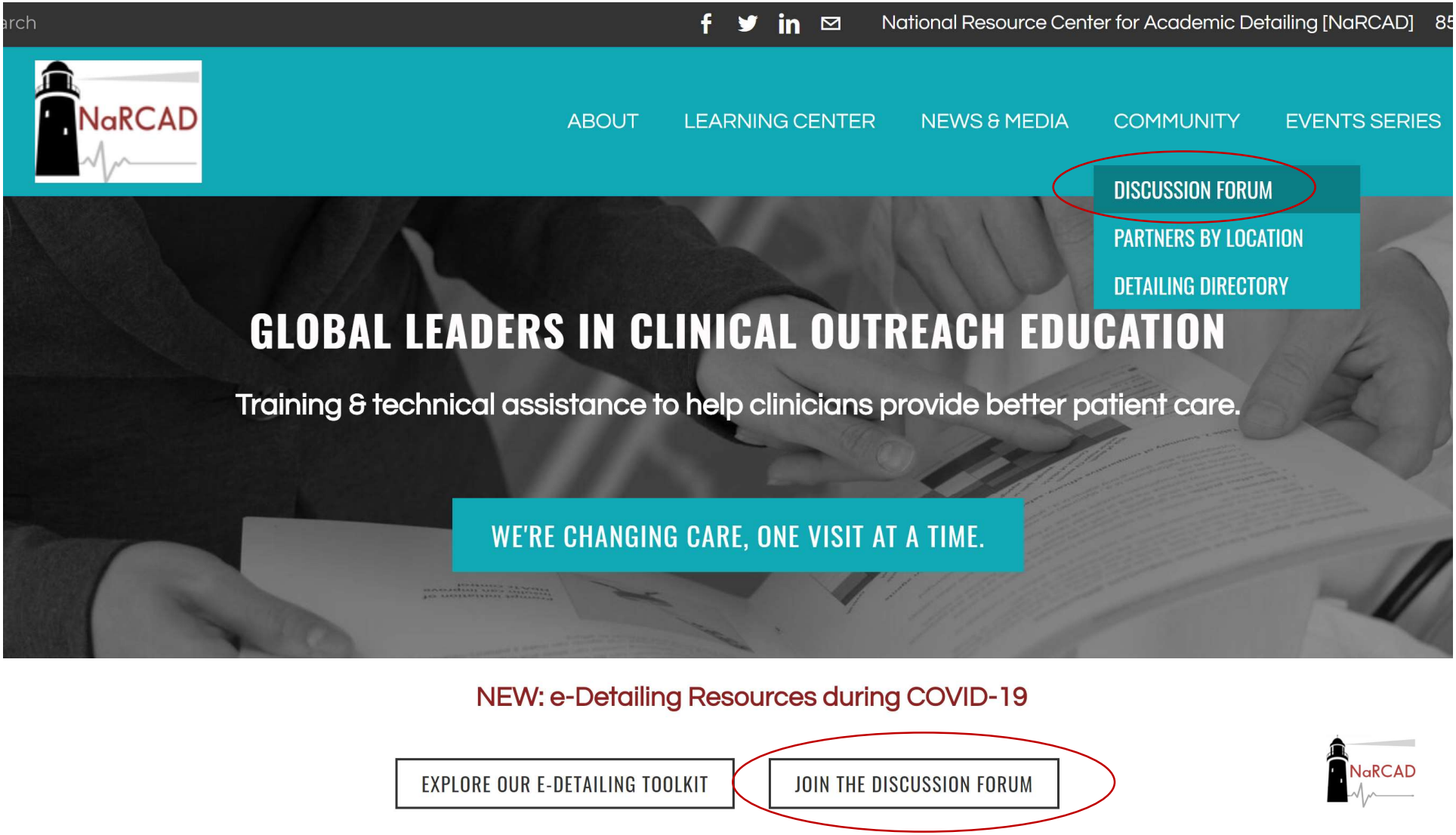

NEW: e-Detailing Resources during COVID-19

EXPLORE OUR E-DETAILING TOOLKIT

JOIN THE DISCUSSION FORUM

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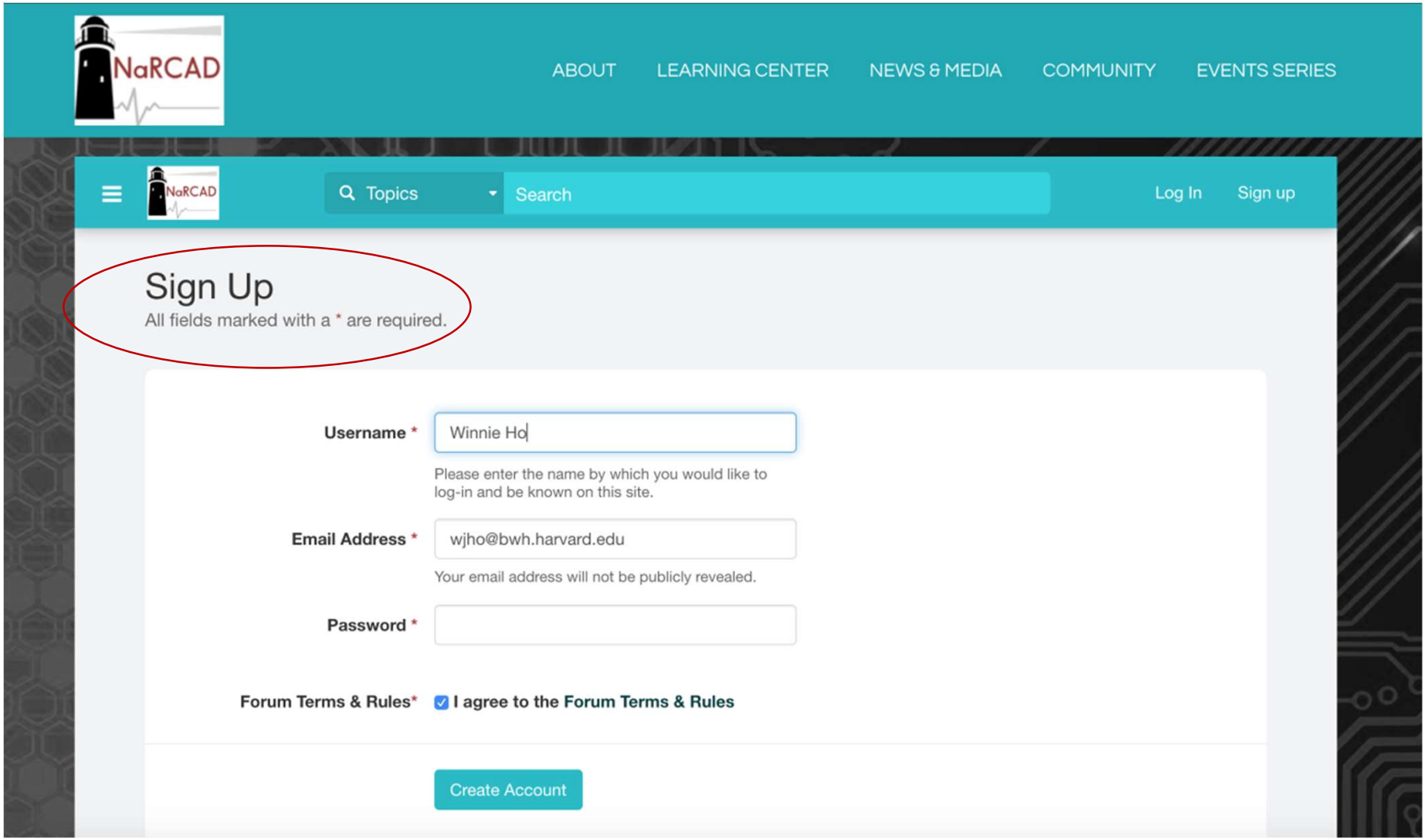
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Stick around to take our 60-second survey!

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