Published in final edited form as:
J Opioid Manag. 2019 ; 15(3): 183–191. doi:10.5055/jom.2019.0502.

Primary care physicians' perspectives on Veterans who obtain prescription opioids from multiple healthcare systems

Felicia R. Bixler, MS,
Center of Innovation for Complex Chronic Healthcare, Edward Hines Jr. VA Hospital, Hines, Illinois.

Thomas R. Radomski, MD, MS,
Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; Division of General Internal Medicine, Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Susan L. Zickmund, PhD,
Informatics, Decision-Enhancement and Analytic Sciences Center, VA Salt Lake City Health Care System, Salt Lake City, Utah.

KatieLynn M. Roman, BA,
Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania.

Leslie R. M. Hausmann, PhD,
Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; Division of General Internal Medicine, Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Carolyn T. Thorpe, PhD, MPH
Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; Division of Pharmaceutical Outcomes and Policy, University of North Carolina Eshelman School of Pharmacy, Chapel Hill, North Carolina.

Jennifer A. Hale, BS, **Florentina E. Sileanu, MS**
Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania.

Walid F. Gellad, MD, MPH
Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; Division of General Internal Medicine, Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Abstract

Conflict of interest: None.

Objective: To characterize primary care physicians' (PCPs') perceptions of the reasons patients receive opioid medications from both VA and non-VA healthcare systems.

Design: Qualitative.

Setting: Department of Veterans Affairs (VA).

Participants: Forty-two VA PCPs who prescribed opioids to at least 15 patients and who practiced in Massachusetts, Illinois, or Pennsylvania.

Methods: Thirty-minute, semistructured telephone interviews were conducted in 2016, addressing topics regarding PCPs' experiences and perspectives on patients who use both VA and non-VA healthcare systems to obtain prescription opioids. The analysis focused on two questions: attributes that PCPs believe characterize dual-use patients and reasons that PCPs believe patients obtain opioids from both VA and non-VA sources.

Results: PCPs identified multiple attributes of, and reasons for, patients obtaining opioid medications from both VA and non-VA healthcare systems, including pain issues, opioid misuse, having healthcare managed through multiple healthcare systems, and transferring care between systems. More than half of the PCPs identified addiction and diversion as key attributes and reasons why patients obtain prescription opioids from multiple sources. PCPs also identified several behavioral and psychological factors as attributes of these patients.

Conclusions: PCPs within the VA have varying perceptions of patients obtaining opioid medications from multiple healthcare systems, with pain complaints and opioid misuse as the primary themes. This knowledge about PCPs' perceptions can be incorporated into interventions to better manage pain and prescription opioid use by VA patients.

Keywords

primary care; opioids; pain management; Veterans; dual use

INTRODUCTION

Nearly 20 percent of individuals in the United States (US) received a prescription opioid in 2016.[1] Many of these individuals received prescription opioids chronically, which has been associated with increased rates of suicide,[2] addiction,[3] and drug overdose.[4–6] Primary care physicians (PCPs) face challenges when treating such patients, from addressing common opioid side effects to addressing risks like co-prescriptions of benzodiazepines, high dosage requirements, or addiction. Most PCPs find it stressful or frustrating to treat patients receiving opioids,[7–10] but little research has examined physicians' perceptions toward treating patients who receive opioids from multiple healthcare systems.

Many prescription opioid recipients receive opioids from more than one provider, complicating their treatment.[11,12] This challenge is pronounced in the Department of Veterans Affairs (VA), an integrated insurance and care delivery system for US military Veterans run by the US Government. Veterans can often access care both within the VA and outside of the VA system, because they also have access to health insurance provided by employers and by other government programs that support individuals with disability and

low income (eg, Medicaid, Medicare) or older age (eg, Medicare). Thus, Veterans may receive opioids not only from different providers, but also from different health insurance sources.[13] For example, in 2012, over 13 percent of Veterans dually enrolled in VA and Medicare Part D insurance received opioids from both of these sources.[13] The receipt of opioids across healthcare systems poses increased clinical risks, including receipt of higher opioid dosages and interacting medications like benzodiazepines.[14,15] There is little understanding of why patients obtain opioids from both VA and non-VA sources. Such dual use might happen for a variety of reasons, some of which may be more problematic than others—for example, patients may seek opioids from multiple sources due to addiction, abuse, or diversion, or it could simply be a by product of seeing non-VA providers for different medical reasons.

These varying reasons for receiving opioids from both VA and non-VA sources require different approaches to helping VA providers manage dual system opioid use, but little is known about provider views on such management. Knowing more about how providers perceive dual system opioid use can help the VA create more effective interventions to better coordinate patient care. Interviewing PCPs can tell us what they perceive to be the various circumstances that lead their patients to have dual system opioid use and how they think about such patients. This is especially relevant as the VA offers more non-VA care options, further expanding the proportion of Veterans receiving VA care from dual sources.[14,15]

Thus, our goal was to characterize PCPs' perceptions of the reasons patients receive opioid medications from both VA and non-VA healthcare systems. To do this, we interviewed VA PCPs about the attributes they use to characterize such patients and we asked PCPs for their beliefs about the reasons that patients obtain opioids from both VA and non-VA healthcare systems.

METHODS

Study design, sample, and data collection

We conducted a qualitative study of VA PCPs in 2016 who prescribed opioids to at least 15 patients in the prior fiscal year (October 1, 2014-September 30, 2015). As an aim of the overarching study was to evaluate PCPs' perspectives and experiences regarding patients who receive opioids from more than one healthcare system, we interviewed PCPs who practiced in three states with varying laws and regulations governing state-based prescription drug monitoring program (PDMP) use: Massachusetts (MA), which required PDMP use for initial opioid prescriptions, Illinois (IL), which had a voluntary PDMP, and Pennsylvania (PA), in which PDMPs were unavailable to PCPs during the data collection time period. PDMPs are tools that allow providers to identify their patients' receipt of opioid and other controlled substance prescriptions from other providers, and thus are potentially used by VA prescribers to obtain information about patients' non-VA opioid prescriptions.[16]

Our goal was to interview 15 VA PCPs from each state to achieve thematic saturation, which is when no new themes emerge from new interviews.[17] One-on-one telephone interviews were conducted from the VA, using a pilot-tested interview script, from February to August 2016. Participants were informed about the study prior to the interview that, "the purpose of

this study is to understand how Veterans access opioid and related medications from VA and non-VA sources." Interviewer characteristics were not provided to the participants. An experienced interviewer (F.R.B.) trained in qualitative research methods conducted 30-minute semistructured interviews with each participant, broadly addressing topics regarding PCPs' experiences and perspectives on patients who use both VA and non-VA healthcare systems to obtain opioids (see the interview script in Radomski et al. 2018[18]). In-depth interviews offer a way to gain unique insights from participants, which may not otherwise arise in a more restrictive questionnaire. Prior to the interviews, participants consented to participate and to be audio-recorded. Recordings of each interview were transcribed verbatim (K.M.R.) and verified (F.R.B.) for accuracy. The study protocol was approved by the Veterans Affairs Pittsburgh Healthcare System Institutional Review Board. The study was conducted in accordance with the Consolidated Criteria for Reporting Qualitative Research.[19]

Interview script, codebook development, and analysis

This analysis focused on two questions from the interview: "In your experience, what are three attributes that you believe characterize opioid dual-users in comparison to your patients who receive an opioid from a single provider?"[20] and "What do you believe are the reasons your patients may obtain or have obtained opioids from both VA and non-VA sources?" The first question sought to determine which, if any, attributes PCPs identified as common among these patients, whereas the second question sought to reveal what PCPs perceived as reasons patients utilize multiple healthcare systems to obtain opioid medications. We used a set of specific codes to identify attributes that PCPs used to describe patients who obtain opioids from multiple systems. We specifically asked physicians about the reasons they perceive their patients to have received opioids from VA and non-VA prescribers, but also coded potential reasons for opioid dual use that emerged elsewhere during the interview. Other topics broadly addressed in the interview centered around the dual use of opioids from VA and non-VA prescribers, but emphasized PCPs' PDMP use including overall experiences, barriers to optimal use, and facilitators to improve use.[18]

The qualitative analysis was guided by the grounded hermeneutic editing approach for research conducted in the health sciences.[21–23] The interviewer (F.R.B.) and another trained qualitative analyst (K.M.R.) used an open and iterative process to produce the codes and code definitions from the interview transcripts. Each analyst independently coded 20 percent of the transcribed interviews using Atlas.ti 7 (Scientific Software, Berlin, Germany). The analysts used an adjudication process to resolve coding discrepancies and intercoder reliability was assessed using Cohen's Kappa[24] statistic (K = 0.70). Subsequently, the main coder (the interviewer) coded the remaining 80 percent of the interview transcripts. We focused our analyses on the main themes that emerged from the interviews regarding PCPs' perceptions about attributes of patients who obtain opioids from both VA and non-VA sources and reasons for dual system opioid use.

RESULTS

Participants

In our efforts to complete 45 interviews, we invited 317 providers (MA: 64, IL: 109, and PA: 144) via email to participate, with follow-up emails sent between 1 and 2 weeks later. Eighty-one PCPs responded; 22 declined, 14 did not respond to subsequent inquiries, 3 were ineligible, and 42 completed the study (MA: 12, IL: 15, and PA: 15) (Table 1). The number of invitations varied among states due to the number of eligible invitees available and differences in the rates at which participants responded. Almost half (48 percent) of participants were female; 62 percent were non-Hispanic white; and 36 percent practiced in VA community-based outpatient clinics (CBOCs) instead of VA medical centers (VAMCs). VAMCs are typically larger than CBOCs and they offer full inpatient and outpatient services, whereas CBOCs are smaller and offer more limited outpatient services. CBOCs are also linked with a VAMC, to which CBOC patients can be referred for services that are not available at the CBOC.

Thematic results

We asked PCPs about (1) the attributes that they believe characterize patients who receive opioids from both VA and non-VA sources in comparison to patients who receive opioids from a single provider and (2) the reasons that they believe explain why patients obtain opioids from both VA and non-VA sources. The attributes and reasons that emerged from these questions overlapped, with the following four themes: pain issues, opioid misuse, dual healthcare system managed patients, and transferring care. A fifth theme of behavioral and psychological factors emerged solely from the attributes question. We describe each of the themes below, integrating quotations from both questions together, although details of each of the two questions are provided separately in Tables 2 and 3. There were no substantive differences in themes across states.

Pain issues.—Pain issues were the top attribute assigned to patients by PCPs (Table 2) and the second most frequently mentioned reason for opioid dual healthcare system use (Table 3). PCPs noted that patients who obtain opioids from within and outside the VA have acute pain, chronic pain, and/or uncontrolled pain issues. For acute pain issues, PCPs noted urgent or emergent care, surgical procedures and post-surgical recovery prescriptions, dental pain or procedures, extending a non-VA acute opioid prescription at a VA, and vehicular accidents as examples leading to dual VA and non-VA system use of prescription opioids. PCPs noted that patients who have chronic pain or who are on opioids long term may seek prescriptions in both systems due to uncontrolled chronic pain or acute on chronic exacerbation of pain. Pertaining to patients with chronic uncontrolled pain, one PCP stated, “many of them have chronic-use narcotics for the pain and then their dose keeps escalating because they develop tolerance, so they reach a point where the pain is not controlled; therefore, they go to different providers to get the medications.” Other pain-related examples given by PCPs included bone fractures and breaks, kidney stones, and appendicitis.

Opioid misuse.—PCPs frequently assigned attributes (Table 2) and reasons (Table 3) indicating some form of opioid misuse to patients with dual-use, including addiction,

diversion, and/or unintentional misuse. One PCP stated, “Well, most of the [patients who obtain opioids from multiple systems] that I track down have addiction issues.” PCPs described patients as having drug-seeking behavior, pseudo-addiction, substance abuse, “fired from another provider for problems with adherence,” and/or as being abusers of opioids and other substances: “They probably also use other substances like marijuana or sometimes cocaine …” Diversion often referred to selling and sometimes referred to sharing opioids with somebody who needs it. One PCP noted that patients who are diverting opioids are, “in their mind, they’re entrepreneurs.” When PCPs discussed unintentional misuse, they referred to confusion around the opioid contract agreement (that patients are to get opioids from only one provider), patients having an “unawareness of the complications of the dual-use,” patients “just not understanding that [getting opioids from multiple systems] is something we don’t want them to do,” or patients not realizing that acute prescriptions apply to the opioid agreement.

Dual healthcare system managed patients.—PCPs mentioned aspects such as distance that patients live from the VA, having non-VA providers, and having non-VA insurance as attributes of (Table 2) and reasons that (Table 3) patients obtain opioids from both VA and non-VA healthcare systems. One PCP noted, “they have very chaotic medical management using extensive numbers of outside providers.” PCPs used the term “dual-managed” to describe patients who receive care from both VA and non-VA sources. For example, patients under the care of a VA PCP are also seen by a non-VA pain clinic doctor, are under the supervision of a non-VA neurosurgeon, seek a second opinion on their pain management plan, or “they’re receiving [opioids] from a provider in the community that they have an ongoing relationship with. Sometimes that’s a pain specialist that they see; sometimes it’s a family doctor or primary care doctor they’ve known for a long time.”

PCPs noted additional reasons that patients obtain opioids from both VA and non-VA healthcare systems including opioid prescription cost, filling prescriptions outside the VA that are not on the VA formulary, and seeing non-VA providers due to access issues such as the amount of time it takes to get a VA appointment.

Transferring care.—PCPs noted transferring care as an attribute of (Table 2) and a reason for (Table 3) patients obtaining opioids from both VA and non-VA sources, meaning that patients transferred their medical care, including opioid pain management, to the VA from a non-VA provider or vice-versa. PCPs often noted that non-VA and VA opioid prescriptions did not overlap in these instances, but instead the VA prescription began when the non-VA prescription ended. One PCP stated, “Oftentimes it’s a transition from one practice to the other. Again, because the other practice is closing or there are some other issues like insurance that may come into play …”

Behavioral and psychological factors.—This was the only theme that came up in the attributes question (Table 2) but not in the reasons question. PCPs identified patients who obtain opioids from both VA and non-VA healthcare systems as having mental health issues. This attribute was described by including psychiatric disorders such as anxiety, depression, and post-traumatic stress disorder (PTSD). One PCP stated having had “the sense that they’re more likely to be socially disorganized, whether it’s a disorganized home, unstable

housing, unstable relationships, unstable mental health issues – just not be very well put together …" Frequently, PCPs noted mental health and chronic pain together. For example, one PCP stated, "I mean chronic pain. I don't know if that's really an attribute of their character, but people who are dealing with chronic pain and who probably may have some mental health disease."

PCPs also stated that patients could be "manipulative" and "demanding." It was noted by one PCP that, "sometimes the spouses speak on behalf of the patient about why they need the opioids. They tend to be a little bit more pushy than the patient themselves. It's as if the patient needs somebody to kind of back up their claim – how much pain they are in …" Phrases used to describe manipulative patients included dishonest, deceitful, and believing that the rules do not apply to them.

DISCUSSION

In this qualitative analysis of 42 VA PCPs from three states, we found that the most common PCP-identified attributes of and reasons for patients obtaining opioid medications from both VA and non-VA healthcare systems were pain issues, opioid misuse, having healthcare managed through multiple healthcare systems, and transferring care between healthcare systems. PCPs also identified specific behavioral and psychological factors as attributes of these patients. There were no substantive differences across PCPs from the three states. These insights can shed light on how PCPs approach the care of patients who obtain opioid prescriptions from multiple healthcare systems, and how that care can be improved.

While solutions to address the opioid epidemic have been studied and refined, knowledge about providers' perceptions on treating patients receiving opioids is minimal. Kennedy-Hendricks et al. found that providers have negative attitudes toward people with prescription opioid use disorders (OUD).[25] Other studies reviewing physicians' attitudes toward prescribing opioids found that physicians are concerned about treating patients who are taking prescription opioids. These studies primarily used surveys and did not identify the level of detail that we gathered here.[26–28] Our study extends the prior research by specifically addressing PCPs' perceptions of their own patients who receive opioid medications across healthcare systems, and by using semistructured interviews that allowed us to gain a greater understanding of PCPs' beliefs. Finally, rather than limiting to PCP attitudes about patients with an OUD diagnosis or in a single metropolitan area, we looked at any PCP across three states who prescribed opioid medications to at least 15 patients over the year.

A key finding of our study was that PCPs often identified pain issues as attributes of and reasons for patients being treated with opioid prescriptions across healthcare systems. Within this theme, the PCPs did indicate some contextual factors that play into why patients get opioids from multiple sources, such as the presence of acute pain and requirement to travel to a closer facility, or transitions in care in which opioids are started outside the VA and continued within the VA. In some cases, however, the concerns about pain overlapped with issues of addiction. The VA has worked to better address patients' pain by expanding access to non-opioid medications and complementary and integrative medicine treatments,

implementing a policy directive for stepped pain treatment, and expanding programs to increase PCPs' capabilities to manage pain.[29] Despite these advances, PCPs still have negative attributions about patients who get opioids from multiple systems, and recognize gaps in the system that may lead to patients getting opioids from more than one source. The improved treatment of pain—and better understanding of the challenge that dual healthcare system utilization places on managing this pain—remains a key clinical need for these patients given the risks associated with receiving opioids, and related medications, across healthcare systems.[13]

Some of the pain issues identified overlapped with care coordination problems perceived by PCPs to be the cause of, or associated with, dual receipt of opioid care. There is difficulty with coordinating care when patients must switch practices, or when they already receive some care outside the VA on a regular basis. There may be a need to develop infrastructure or provide additional personnel to help VA PCPs manage these care coordination challenges, especially if they are leading patients to receiving opioids in multiple healthcare systems. Addressing these gaps in care coordination will allow PCPs to better manage pain, and opioids, among this population of patients.

Opioid misuse was also identified as an attribute of and reason for dual healthcare system use of opioids. More than half of the PCPs identified addiction and diversion as key attributes and reasons for why patients obtain prescription opioids from multiple sources. Coupled with multiple mentions of mental health concerns and manipulative or demanding behavior, these findings illustrate the challenges felt by PCPs while trying to manage opioid medications in individuals who receive care across healthcare systems. These findings could indicate stigmatization of patients using chronic prescription opioids, while they also represent the real experiences of PCPs and should be incorporated into educational or care coordination programs to improve the care of patients receiving care across systems. Since this study was conducted, use of PDMPs is now mandated across VA providers, and the VA has completed the process of sharing its own prescription information with state PDMPs, allowing non-VA providers to see patients' VA prescriptions. While these tools may help identify patients at risk for misuse, there remains the potential for stigma and barriers to access for these patients if PCPs perceive patients receiving opioids across systems as likely to be abusing or misusing opioid medications.

This study has several limitations. First, the study was restricted to VA PCPs in three states within the United States. Providers in other states or outside of the VA treating non-Veteran patients may have different perspectives. Second, the data are from 2016 and may not reflect current environments; however, they are more recent than related studies and fill a key gap in knowledge by using in-depth interviews. A third possible limitation is that PCPs had a difficult time distinguishing between patient "attributes" and "reasons" why patients may obtain opioids from multiple systems, often giving the same response across the two items. This may be a limitation of the interview script and/or it may signal PCPs' reluctance to label patients without providing more rationale for their labels (eg, rather than say someone is addicted, they may want to explain the reasons why they are likely addicted, or how they came to be that way).

In summary, our qualitative analysis of VA PCPs across three states in the United States shows that the PCP-perceived reasons for patients obtaining opioid medications from dual healthcare systems are multifactorial, although opioid misuse and pain issues were among the main reasons. Our findings highlight that PCPs understand that pain issues often overlap with misuse and addiction, and that patients may get opioids from multiple systems due to difficulty navigating care across healthcare systems. While PCPs may assume that dual-use represents intentional nefarious behavior or addiction, they also readily acknowledge that there are other system-related factors—or even inadequate pain control—that may lead patients to have opioids from multiple systems. This new knowledge about the perceptions of practicing clinicians can be incorporated into the design of interventions to better manage pain and opioid use by Veterans within the VA.

Funding/Support:

VA Health Services Research & Development (HSR&D) I01 HX001765-01.

REFERENCES

1. Centers for Disease Control and Prevention: Annual Surveillance Report of Drug-Related Risks and Outcomes—United States, 2017 Washington, DC: Centers for Disease Control and Prevention, US Department of Health and Human Services, 2017 Surveillance Special Report 1. Available at https://www.cdc.gov/drugoverdose/pdf/pubs/2017pdf. Accessed February 5, 2018.
2. Madadi P, Persaud N: Suicide by means of opioid overdose in patients with chronic pain. Curr Pain Headache Rep. 2014; 18: 460. [PubMed: 25249422]
3. Mendelson J, Flower K, Pletcher MJ, et al.: Addiction to prescription opioids: Characteristics of the emerging epidemic and treatment with buprenorphine. Exp Clin Psychopharmacol. 2008; 16: 435–441. [PubMed: 18837640]
4. Bohnert AS, Valenstein M, Bair MJ, et al.: Association between opioid prescribing patterns and opioid overdose-related deaths. JAMA. 2011; 305: 1315–1321. [PubMed: 21467284]
5. Okie S: A flood of opioids, a rising tide of deaths. N Engl J Med. 2010; 363: 1981–1985. [PubMed: 21083382]
6. Paulozzi LJ, Budnitz DS, Xi Y: Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiol Drug Saf. 2006; 15: 618–627. [PubMed: 16862602]
7. Dobscha SK, Corson K, Flores JA, et al.: Veterans affairs primary care clinicians' attitudes toward chronic pain and correlates of opioid prescribing rates. Pain Med. 2008; 9: 564–571. [PubMed: 18777608]
8. Jamison RN, Sheehan KA, Scanlan E, et al.: Beliefs and attitudes about opioid prescribing and chronic pain management: Survey of primary care providers. J Opioid Manag. 2014; 10: 375–382. [PubMed: 25531955]
9. Upshur CC, Luckmann RS, Savageau JA: Primary care provider concerns about management of chronic pain in community clinic populations. J Gen Intern Med. 2006; 21: 652–655. [PubMed: 16808752]
10. Wolfert MZ, Gilson AM, Dahl JL, et al.: Opioid analgesics for pain control: Wisconsin physicians' knowledge, beliefs, attitudes, and prescribing practices. Pain Med. 2010; 11: 425–434. [PubMed: 20002590]
11. Jena AB, Goldman D, Weaver L, et al.: Opioid prescribing by multiple providers in Medicare: Retrospective observational study of insurance claims. BMJ. 2014; 348: g1393. [PubMed: 24553363]
12. Wilsey BL, Fishman SM, Gilson AM, et al.: Profiling multiple provider prescribing of opioids, benzodiazepines, stimulants, and anorectics. Drug Alcohol Depend. 2010; 112: 99–106. [PubMed: 20566252]

13. Gellad WF, Thorpe JM, Zhao X, et al.: Impact of dual use of Department of Veterans Affairs and Medicare Part D drug benefits on potentially unsafe opioid use. Am J Public Health. 2018; 108: 248–255. [PubMed: 29267065]
14. Col SE, Caykoylu A, Karakas Ugurlu G, et al.: Factors affecting treatment compliance in patients with bipolar I disorder during prophylaxis: A study from Turkey. Gen Hosp Psychiatry. 2014; 36: 208–213. [PubMed: 24359677]
15. Gellad WF, Cunningham FE, Good CB, et al.: Pharmacy use in the first year of the Veterans choice program: A mixed-methods evaluation. Med Care. 2017; 55(suppl 7 suppl 1): S26–S32. [PubMed: 28221274]
16. Reisman RM, Shenoy PJ, Atherly AJ, et al.: Prescription opioid usage and abuse relationships: An evaluation of state prescription drug monitoring program efficacy. Subst Abuse. 2009; 3: 41–51. [PubMed: 24357929]
17. Guest G, Bunce A, Johnson L: How many interviews are enough?: An experiment with data saturation and variability. Field Methods. 2006; 18: 59–82.
18. Radomski TR, Bixler FR, Zickmund SL, et al.: Physicians' perspectives regarding prescription drug monitoring program use within the Department of Veterans Affairs: A multi-state qualitative study. J Gen Intern Med. 2018; 33: 1253–1259. [PubMed: 29520747]
19. Tong A, Sainsbury P, Craig J: Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007; 19: 349–357. [PubMed: 17872937]
20. Madon S: What do people believe about gay males? A study of stereotype content and strength. Sex Roles. 1997; 37: 663–685.
21. Crabtree BF, Miller WL (eds.): Doing Qualitative Research. 2nd ed. Thousand Oaks, CA: Sage Publications, Inc., 1999.
22. Barnett JM: Review Jacqueline M. Barnett: "Doing qualitative research" (Crabtree & Miller 1999). Forum Qual Soc Res. 2002; 3: Article 3.
23. Silverman D: Doing Qualitative Research: A Practical Handbook. London: Sage Publications, 2005.
24. McHugh ML: Interrater reliability: The kappa statistic. Biochem Med (Zagreb). 2012; 22: 276–282. [PubMed: 23092060]
25. Kennedy-Hendricks A, Busch SH, McGinty EE, et al.: Primary care physicians' perspectives on the prescription opioid epidemic. Drug Alcohol Depend. 2016; 165: 61–70. [PubMed: 27261154]
26. Ebbert JO, Philpot LM, Clements CM, et al.: Attitudes, beliefs, practices, and concerns among clinicians prescribing opioids in a large academic institution. Pain Med. 2018; 19: 1790–1798. [PubMed: 29177439]
27. Lin DH, Lucas E, Murimi IB, et al.: Physician attitudes and experiences with Maryland's prescription drug monitoring program (PDMP). Addiction. 2017; 112: 311–319. [PubMed: 27658522]
28. Wenghofer EF, Wilson L, Kahan M, et al.: Survey of Ontario primary care physicians' experiences with opioid prescribing. Can Fam Physician. 2011; 57: 324–332. [PubMed: 21402971]
29. Gellad WF, Good CB, Shulkin DJ: Addressing the opioid epidemic in the United States: Lessons from the Department of Veterans Affairs. JAMA Intern Med. 2017; 177: 611–612. [PubMed: 28288245]

Table 1.

Characteristics of Veterans Affairs (VA) primary care physicians interviewed in 2016

Characteristic	Overall participants (N = 42)
Gender, n (percent female)	20 (48)
Race, n (percent)	
Non-Hispanic white	26 (62)
Non-Hispanic black	3 (7)
Hispanic	3 (7)
Asian	10 (24)
Years in practice, median (Q1-Q3)	17.5 (10–24)
Years practicing in VA, median (Q1-Q3)	8 (3–13.5)
Clinical half days, median (Q1-Q3)	7 (4–9)
Practice setting, n (percent)	
VA medical center	28 (67)
VA community-based outpatient clinic	15 (36)
Also practice outside VA, n (percent)	4 (10)
Medical school faculty appointment, n (percent)	20 (48)
Pharmacy and Therapeutics Committee member, n (percent)	7 (17)

Q1, first quartile; Q3, third quartile.

Table 2.

Attributes of patients who obtain opioids from both within and outside Veterans Affairs (VA) identified from interviews of 42 primary care physicians in 2016

"Attributes" themes	Total participants, n (percent) (N = 42)	Sample quote
Pain issues *	**25 (60)**	
Acute	14 (33)	"Some of my patients will have a good reason for getting an opioid from post-surgery that happened to be at a non-VA facility and, six or twelve months later, getting an opioid for a post-surgical procedure through the VA."
Chronic	12 (29)	"patients who have been dealing with chronic pain for a long time"
Uncontrolled	9 (21)	"patients who have uncontrolled pain or perceived pain and are doing what they think is fair because they don't feel any single provider is adequately addressing their needs."
Opioid misuse *	**24 (57)**	
Addiction	22 (52)	"a lot of these patients come to us years later after they've been on the medication. So, the fact that no one really addressed this five years ago – now it's ten years later and they can't do without the medication. So, I still say there's kind of a component of addiction in some of these patients and that also makes them seek dual care."
Diversion	9 (21)	"There's a bit of a con involved, and that may involve them directly using the medications themselves or them passing them on to somebody else."
Unintentional	4 (10)	"patients who seem to … not fully understand the extent of what the chronic opioid therapy physician-patient agreement says. I think those patients … have a tendency not to ask as many questions about their therapy. And for whatever reason, whether it be they're shy to ask, if they don't understand something, or they think it's just very simple and they don't foresee any issues even if they are receiving non-VA care … maybe they're just not as inquisitive about their care and how it's managed."
Behavioral and psychological factors *	**15 (36)**	
Mental health	10 (24)	"the people who I've seen who typically have dual-use are people who … have other mental health issues; you know, anxiety, depression, PTSD"
Manipulative	6 (14)	"And it's the same patient who … every visit will still try to ask me … if I will prescribe something for the pain."
Demanding	2 (5)	"some are demanding when they show up to the clinic."
Dual healthcare system managed patients *	**11 (26)**	
Distance	6 (14)	"Sometimes they might not live close by the VA so they might have to see a provider that's closer to their home for any acute issue."
Non-VA provider	5 (12)	"they usually have a provider that they've been seeing in the private sector that's also a primary care doctor, so sometimes that doctor might prescribe medications."
Non-VA insurance	5 (12)	"Generally, they're insured. They don't have only VA coverage."
Transferring care	**7 (17)**	"the patients that are most common are the ones who have been prescribed opioids by outside providers in the past and they come to me now and I end up prescribing them."

* Counts and percentages of codes in each theme may not total 100 percent of the theme totals because use of codes can overlap.

Table 3.

Reasons that patients obtain opioids from both within and outside Veterans Affairs (VA) identified from interviews of 42 primary care physicians in 2016

"Reasons" themes	Total participants, n (percent) (N = 42)	Sample quote
Opioid misuse *	**32 (76)**	
Addiction	25 (60)	"I believe there's types who are substance abusers, and the more they get, the more they have; their drug of choice or they can sell that drug for their drug of choice."
Diversion	16 (38)	"Sometimes people do it because their intent is to sell medications, and they might use the medications from one source and sell the medication from another source."
Unintentional	8 (19)	"I think also people don't fully understand the [opioid] agreement again that when something changes and they have acute pain that's different from their chronic pain, I think they think the agreement no longer applies … I find that I have to explain this multiple times"
Pain issues *	**29 (69)**	
Acute	22 (52)	"occasionally patients that I'm prescribing opioids for, for chronic pain, will get a prescription for opioids from a non-VA provider for an acute indication, like they presented with an injury to an outside ED or got a dental procedure and was given a prescription by the dentist or something like that."
Uncontrolled	11 (26)	"And then patients find – unfortunately, one of the problems with opioids is … tolerance develops and a dosage that might have been pretty effective no longer is effective"
Chronic	7 (17)	"I'm willing to say that about 10 percent are gonna be chronic pain management people"
Transferring care	**24 (57)**	"They start elsewhere; providers, pain specialists have maybe discontinued their practice and now the Veteran is seeking another place to continue their pain management"
Dual healthcare system managed patients *	**17 (40)**	
Non-VA provider	10 (24)	"they get part of their care from the VA and part of their care outside the VA. And depending on the setting where they happen to be at the time and what condition's being treated, it can be appropriate for them to get [opioids] from the VA one time and from a non-VA source at another time."
Cost	9 (21)	"Our copays are cheaper and it's just less expensive, for the most part."
Access (time and/or distance)	3 (7)	"we do have a lot of dual-managed patients, meaning patients who wanna access the VA for whatever reason, but still wanna have a non-VA physician, oftentimes somebody who is much close to where they live."
Non-formulary	2 (5)	"I find that sometimes it's because a community pain specialist or pain clinic will start prescribing medications we don't have through the VA like the newer long-acting Opana or the longer acting morphine or opiate type medications that just aren't carried in the VA system"

*Counts and percentages of codes in each theme may not total 100 percent of the theme totals because use of codes can overlap.