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Provider Experiences With the Identification, Management, and Treatment of Co-Occurring Chronic Non-cancer Pain and Substance Use in the Safety Net

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Abstract

Background—In the US and internationally, providers have adopted guidelines on the management of prescription opioids for chronic non-cancer pain (CNCP). For “high-risk” patients with co-occurring CNCP and a history of substance use, guidelines advise providers to monitor patients using urine toxicology screening tests, develop opioid management plans, and refer patients to substance use treatment.

Objective—We report primary care provider experiences in the safety net interpreting and implementing guideline recommendations for patients with CNCP and substance use.

Methods—We interviewed primary care providers who work in the safety net (N=23) on their experiences managing CNCP and substance use. We analyzed interviews using a content analysis method.

Results—Providers found management plans and urine toxicology screening tests useful for informing patients about clinic expectations of opioid therapy and substance use. However, they described that guideline-based clinic policies had unintended consequences, such as raising barriers to open, honest dialogue about substance use and treatment. While substance use treatment was recommended for “high-risk” patients, providers described lack of integration with and availability of substance use treatment programs.

Conclusions—Our findings indicate that clinicians in the safety net found guideline-based clinic policies helpful. However, effective implementation was challenged by barriers to open dialogue about substance use and limited linkages with treatment programs. Further research is needed to examine how the context of safety net settings shapes the management and treatment of co-occurring CNCP and substance use.

Keywords

Chronic non-cancer pain; prescription opioids; safety net; primary care; provider-patient interactions; substance use treatment; qualitative research

Introduction

The increase in opioid prescriptions for chronic non-cancer pain (CNCP) and the associated increase in opioid-related overdose deaths (Warner, Chen, & Makuc, 2009) prompted the development of multiple clinical practice guidelines for managing CNCP using prescription opioids (Cheung et al., 2014; Chou et al., 2009; Dowell, Haegerich, & Chou, 2016). Co-occurring CNCP and a history of substance use (SU) is common, with prevalence estimates up to 43% (Morasco et al., 2011). Patients with co-occurring CNCP and SU are more likely to be prescribed opioids (Edlund et al., 2010) and opioid guidelines provide specific recommendations for these patients. For example, guidelines recommend that providers use written agreements called “management plans” that outline behavioral expectations, as well as urine toxicology screening tests (UTS) to monitor opioid misuse and illicit substance use. In addition, guidelines recommend “high-risk” patients with co-occurring SU be referred to SU treatment and/or monitored by a behavioral specialist.

Safety net healthcare settings serve a disproportionate number of poorer patients with co-occurring CNCP and SU (Sullivan et al., 2008; Busch, Meara, Huskamp, & Barry, 2014; Edlund et al., 2010). In the United States, safety net settings are defined as health care settings that care for a substantial share of patients who are uninsured, use Medicaid, or are otherwise vulnerable (Lewin & Altman, 2000). Providers in safety net settings are faced with complex decisions about the initiation and continuation of prescription opioids (Katz, 2016), in part due to limited resources and larger proportions of patients with co-occurring CNCP and SU.

In this brief report, we describe safety net primary care providers’ (providers) experiences interpreting and implementing the American Pain Society and American Academy of Pain Medicine (APS/AAPM) guideline recommendations for prescribing opioids to patients with CNCP and SU history. We focus on 1) the benefits and consequences of guidelines on the provider-patient relationship, and 2) the gap between ideal and feasible SU treatment planning.

Methods

Settings and Participants

We recruited twenty-three providers from six safety net primary care health care settings across four counties in the San Francisco Bay Area. All were primary care providers

(physician, nurse practitioner, or physician assistant) who provided longitudinal primary care to a panel of patients. Consistent with the APS/AAPM guidelines, we defined substance use as any reported personal or family history of alcohol or drug abuse. The Institutional Review Board at [blinded for review] approved this study.

Data Collection and Analysis

Between 2013–2014, we interviewed providers using a semi-structured interview guide that focused on their experiences with the management of co-occurring CNCP and SU history. Interviews were 1–2 hours in duration and audio-recorded. We assigned providers pseudonyms and informed them of the study privacy protocol. The provider pseudonyms used in this manuscript are unique identifiers. Providers received a \$50 gift card to an online retailer for their participation.

All of the audio-recorded material was transcribed verbatim. The coding scheme was developed through an iterative process. First, researchers read each transcript and wrote summary memos. These summary notes were discussed at length in analysis team meetings at which we developed the initial set of inductive codes. We then used this initial set of inductive codes to jointly code a single transcript. Analysts coded the transcript independently, then met to discuss patterns and variations in the data. Discrepancies in the coding process among researchers were discussed until consensus was reached. The initial set of inductive codes was supplemented by emerging thematic concepts from the transcript coding. Remaining transcripts were divided and independently coded by at least two researchers. The analysis team met weekly to discuss the coding process and develop the final code list. All coded transcripts were entered into Atlas.ti. For this analysis, we conducted a content analysis (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005) of Atlas.ti queries for “SU treatment”, “SU”, and “clinic policies”.

Results

Most of the providers were physicians (78%), four were nurse practitioners, and one was a physician assistant. Sixty-five percent of the providers were women.

Finding 1: Benefits and Consequences of Guidelines on the Clinician-Patient Relationship

The providers identified patient SU through 1) the use of a SU or opioid risk screening tool, 2) use of UTS, and/or 3) patient disclosure. Management plans - referred to by the providers as “pain agreements”, “pain contracts”, or “informed consent” – were used to give patients with CNCP an overview of the risks and expectations of opioid therapy. While the language in these management plans differed across clinical settings, they routinely included the following conditions: 1) patients would not use illicit drugs or alcohol while on opioids; 2) patients would only receive opioids from a single provider and single pharmacy; and 3) patients would take opioids as prescribed. Typically, patients were asked to sign the management plan as a condition of initiating or continuing opioid therapy. Patients were informed that any SU would be monitored using UTS.

Providers described management plans and UTS as useful tools for working with CNCP patients because they aided communication about the expectations of opioid therapy. They

helped providers systematically inform CNCP patients about the risks of opioid use, as well as the requirement to abstain from illicit substances (Table 1, Provider A and B1).

However, management plans also created tension in the clinical interaction. Several providers expressed concern that these tools might hinder conversations with patients about SU and treatment. Management plans often prohibited drug and alcohol use while on opioid therapy, and as such providers worried this prohibition could impede an honest dialogue about a patient's drug or alcohol use (Table 1, Clinician C and D). As the "gatekeeper" of prescription opioids, providers were not surprised when patients downplayed or denied SU, even when UTS indicated active use. The lack of open dialogue and trust could harm the provider-patient relationship. Providers expressed concern that patients may leave care due to stressful clinical interactions related to substance use (Table 1, Provider B.2 and E.1).

Finding 2: The Gap Between Ideal and Feasible Substance Use Treatment Planning

The APS/AAPM guideline recommendations state that, "Patients who meet criteria for a SU disorder should be referred for treatment of this serious comorbidity" (Chou et al., 2009). Although there was a high prevalence of patients with co-occurring CNCP and SU, almost all of the providers described a lack of integration with and availability of SU treatment programs (Table 2, Provider F). When linkages existed between primary care settings and SU treatment programs, providers described these linkages as fragmented and difficult to keep up to date (Table 2, Provider G and H). Providers identified regulatory barriers such as the Health Insurance Portability and Accountability Act (HIPAA) that prevented stronger communication between primary care settings and SU treatment settings (Table 2, Provider E.2).

Discussion

We describe providers' experiences addressing opioid use and co-occurring CNCP and SU in safety net healthcare settings. In summary, providers reported that management plans and UTS were useful for setting expectations around SU for patients prescribed or seeking opioids for CNCP. However, providers also identified potential unintended consequences resulting from guideline adherence, including increased patient secrecy about SU in provider-patient interactions, and patients choosing to discontinue primary care. While SU treatment is recommended in the APS/AAPM guidelines, providers described the lack of availability of treatment options for their patients with SU issues.

This study has three implications. Providers, such as those interviewed in this study, need prescribing guidelines that are tailored to patients in the safety net. In the context of increased opioid-related overdose deaths, providers need a stronger evidence-base on the specific types and patterns of SU that are problematic for patients on prescription opioids. They need clearer guidelines for questions such as: Is all SU a marker for "high-risk"? Are there specific SU types or patterns that warrant discontinuation or tapering of prescription opioids? What pain management alternatives are available for patients who must be discontinued or tapered from opioids due to SU? What options should apply in cases when SU treatment options are not available? Moreover, information on the social environmental

circumstances associated with opioid overdose would help providers better assess patients for overdose risk and aid in treatment decision-making.

Second, findings from this study suggest that the use of management plans and UTS in patients with co-occurring CNCP and SU could be barriers in the provider-patient relationship. In all clinical settings, the advantages of management plans and UTS should be balanced with the potential risks to clinical interactions, particularly since they have only modest effects on patient opioid misuse (Starrels et al., 2010). Consistent with other studies (Matthias, Krebs, Bergman, Coffing, & Bair, 2014; Krebs et al., 2014; Nicolaidis, 2011, Baldacchino, Gilchrist, Fleming, & Bannister, 2010), the providers in our study reported that the recommended guidelines could create a dynamic of policing and judgment that is harmful to the provider-patient relationship. These interactional barriers occurred because clinic policies conveyed the expectation that any illicit SU was not permitted. An abstinence-only policy may be an unrealistic expectation in health care settings where many patients use opioids for CNCP, and use drugs and/or alcohol as well. Education about how to use management plans and UTS to facilitate and initiate open conversations about SU and addiction, in addition to using them for monitoring, may improve the care of patients.

Third, providers needed substance use treatment options for patients with co-occurring CNCP and SU, but found access to these services limited and fragmented. In the United States, this finding is particularly relevant since the Affordable Care Act has called for SU issues to be considered “at parity” with other health conditions, and the role and integration of SU treatment in primary care is gaining attention (Wen, Cummings, Hockenberry, Gaydos, & Druss, 2013; Buck, 2011). Consistent with other studies that found suboptimal linkages between primary care and SU treatment (Lewis et al., 2014; Samet, Friedmann, & Saitz, 2001), we found that providers lacked formal linkages and referral pathways for their patients to enter into treatment. Sustainable, formal, and long-term alliances between primary care settings and SU treatment programs are needed to provide the widest range of treatment options for patients. To overcome linkage barriers, institutional and regulatory policies related to the ability to share protected patient data information would need to be examined.

This study has several limitations. The sample size is relatively small, but adequate for qualitative research. We did not provide detailed demographic information about the providers who enrolled in this study to protect their anonymity, which limited our ability to describe the individual context of quotes. While we report on the experiences of primary care providers working with patients with co-occurring CNCP and SU, these findings may not apply to all health care specialties. Additional research is warranted on the more effective use of guideline recommendations for patients with co-occurring CNCP and SU, particularly those cared for in safety net settings.

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Table 1

Provider quotes: Benefits and consequences of guidelines on the clinician-patient relationship.

Provider A	"It has been helpful to have more people [signing the management plan] once a year. Going over stuff with the patients, like, 'We're going to review your [pain registry] report, we're going to review your UTS.'"
Provider B.1	"Providers have the patient initial [the management plan] at least four key pieces - drug test would be done, you don't have other substances, that we may stop the medications, and that these medications are addicting. Those are the things we should go over with a patient."
Provider C	"I'm like, 'We have resources to help connect you with [SU] treatment when you're ready to address that. There's no judgment.' But I'm a gatekeeper for [patients' opioids] so it is a loaded thing. They're incentivized to say that they're not using [drugs/alcohol], or to act surprised when their UTS comes back positive.... It's a very fraught interaction."
Provider D	"One of the downsides to [management plans] ... the conversation [about substance use] goes down, it makes it more secretive ... In some ways we can't talk about, 'Are you actively using [illicit drugs or alcohol]?' as much because [patients] know it's a violation of pain management agreements. So that does limit the way we can talk about it [SU]."
Provider B.2	"There were many times where patients would walk out on me and wouldn't sign the [pain] contract. One patient was very upset ... she was in the emergency room a couple months later and was meth positive ... It was really hard for me to not give her pain meds knowing that she was in pain. The [clinic policies] made it feel less targeted, but that doesn't mean that every patient took it exactly the same."
Provider E.1	"[After I discontinued opioids and my patient left primary care] I never asked [the patient], 'How did you get through those last three months?' I didn't want to know, frankly. I didn't want to hear the diversion story. I didn't want to hear that he robbed someone ... He works with his hands and needs the medications to be able to do his job. [He]'s got pain and I'm sure he's got addiction. I'm trying to get him semi-stable in some component of his life."

Table 2

Provider quotes: The gap between ideal and feasible substance use treatment planning.

Provider F	"I feel completely unsupported by the substance abuse treatment community. It just doesn't exist. There's nothing. When someone has a cocaine positive [UTS], I'm supposed to refer them to substance abuse treatment program? Give me a break ... It has not been developed in such a way to become more accessible, to be less stigmatized, to be effective. So the primary care doc is left out in the lurch."
Provider G	"There are not a whole lot [of substance use treatment options]. Alcoholics Anonymous and [local detox clinic], which is not that great. [A nearby hospital] had a program for inpatient. In my career I've got maybe two people into there. I don't even know if [the program] is still alive. The last [referral] was years ago."
Provider H	"Probably most of our [patients with CNCP and SU] get referred to a [local community-based treatment program]. We had a partnership, which I don't know if it exists anymore."
Provider E.2	"There's a scarcity of resources and well-established processes ... At the interface of primary care and substance use treatment and psychiatric treatment, there are very rigid firewalls between those domains ... There is need to protect this [privacy] barrier, but there's got to be better information sharing between these three entities."