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Barriers to Guideline-Concordant Opioid Management in Primary Care—A Qualitative Study

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Abstract: Prior studies have demonstrated poor physician adherence to opioid management guidelines in primary care. The objectives of this qualitative study were to understand physicians' and patients' perspectives on recommended opioid management practices and to identify potential barriers to and facilitators of guideline-concordant opioid management in primary care. Individual semistructured interviews were conducted with 14 primary care physicians and 26 of their patients receiving long-term opioid therapy. Data were analyzed using a qualitative immersion/crystallization approach. We identified 3 major barriers to and 1 facilitator of use of recommended opioid management practices. Major barriers were inadequate time and resources available; relying on general impressions of risk for opioid misuse; and viewing opioid monitoring as a "law enforcement" activity. The third barrier was most apparent for physicians in the context of drug testing and for patients in the context of opioid agreements. Beliefs about the need to protect patients from opioid-related harm emerged as a major facilitator, especially among patients. We hypothesize that future interventions to improve opioid management in primary care will be more effective if they address identified barriers and use a patient-centered framework, in which prevention of opioid-related harm to patients is emphasized as the primary goal.

***Perspective:** This article describes primary care perspectives on guideline-recommended opioid management practices. Barriers identified in this study may contribute to underuse of recommended opioid management practices. Consideration of barriers and facilitators to guideline-concordant care could improve effectiveness of future interventions aimed at improving opioid management in primary care.*

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Over the past 2 decades, opioid analgesic prescribing for acute and chronic pain has increased exponentially in the United States. This trend has been accompanied by an epidemic of prescription opioid abuse and overdose, raising concerns about misuse and diversion of opioid analgesics prescribed by physicians.[23] Although the proper place of opioid therapy in chronic pain management is controversial, broad consensus exists on recommended opioid management practices when long-term opioid therapy is undertaken. Guidelines for opioid prescribing in chronic pain are consistent in their recommendations for both careful patient selection at the outset and ongoing monitoring

of opioid benefits, harms, and adherence for the duration of therapy.[1,10,33] Specific recommended practices include frequent face-to-face visits, routine urine drug testing, and opioid treatment agreements.

Studies suggest that recommended opioid management practices have not been widely implemented in primary care, where most long-term opioids are prescribed.[12,14,17,20,27] For example, a retrospective cohort study conducted in 8 university-affiliated primary care clinics found that fewer than half of patients on long-term opioids received regular office visits and only 8% received a urine drug test.[27] Studies conducted in Veterans Affairs (VA) settings have similarly found infrequent use of recommended practices, even among patients with recently diagnosed substance use disorders.[12,17,20]

Reasons for limited use of recommended opioid management practices are not well understood. The objective of this qualitative study was to better understand primary care physicians' and patients' perspectives on recommended opioid management practices and to identify potential barriers and facilitators of guideline-concordant opioid management in primary care.

Methods

This was a qualitative study using an individual semi-structured interview approach. We conducted in-depth interviews with 14 primary care physicians and 26 of their patients who were receiving long-term opioid therapy in primary care. Procedures were reviewed and approved by the local institutional review board, and informed consent was obtained from all participants.

Setting and Participants

Primary care physicians were recruited from 5 primary care clinics associated with 1 VA Medical Center, using a purposeful sampling approach.[18] This approach included consideration of diversity in terms of clinic location, patient age, sex, and race/ethnicity, as well as snowball sampling to maximize variation in perspectives. At the end of each interview, the interviewer asked each participating physician to name 1 or more colleagues "who may think differently about this topic than you do." Physicians were invited by email from the first author (E.E.K.) to be interviewed individually and in-person by a nonclinician member of the research team. Recruitment continued until theoretical saturation was reached, meaning that additional interviews yielded no substantial new information about themes.[29] Physicians (N = 14) were 50% female and self-identified race/ethnicity as Asian (n = 6, 42.9%), black/African American (n = 2, 14.3%), and white (n = 6, 42.9%). Physician age range was 32 to 57 years and VA employment duration was 1 to 24 years.

Participating physicians were asked for authorization to approach their patients for the study; 13 of the physicians agreed. Patients of participating physicians were eligible if they received long-term opioid therapy in primary care, defined as having filled at least 6 opioid prescriptions from the outpatient pharmacy in the prior 12 months. Ninety days is often used as the cutoff between short- and long-term opioid therapy.[7,32] We used 6 months as our operational definition of long-term prescribing because of our focus on experiences of patients who were receiving well-established long-term opioid therapy. Patients receiving opioids for a shorter duration may be less likely to have experience with the opioid management practices of interest. The study coordinator sent invitation letters to patients randomly selected from lists of eligible patients. For each physician, 1 to 3 patients were recruited to participate in an individual face-to-face interview. Patients (N = 26) were 92% male and self-reported race/ethnicity as white (n = 20, 76.9%), black/African American (n = 4, 15.4%), American Indian/Alaska Native (n = 1, 3.8%), and Native Hawaiian/Pacific Islander (n = 1, 3.8%).

Data Collection

Interview guides were designed and refined after pilot testing to elicit experiences with opioid management and barriers/facilitators to recommended practices. Questions were open-ended and designed to stimulate reflections about personal experiences with prescribing (for physicians) or receiving (for patients) opioid analgesics and communication about opioids and pain medication decisions. In addition, the interview was designed to elicit perceptions of specific commonly recommended opioid management practices, consistent with those recommended in 2010 VA opioid management guidelines[33] that were released more than a year before the start of study interviews. Rather than describing these practices in an abstract manner, which could potentially bias responses, we provided high-quality representative examples of these practices to serve as common reference points for all participants. This approach allowed us to gauge responses to optimized examples of recommended practices, even among participants with variable or no direct prior experience with those practices. In addition to asking for reactions to the examples, we asked participants to describe any similar experiences they had. All participants, including patients and physicians, were shown the same 3 examples: 1) a 30-second video clip of a physician describing "ground rules" for prescribing to a patient; 2) a 40-second video clip of a physician taking a substance use history from a patient; and 3) an opioid agreement sample document excerpted from 2010 VA clinical practice guidelines.[33] The opioid agreement document was used to elicit reactions both to the practice of obtaining a signed opioid agreement and to the practice of urine drug testing, which was specifically described in the sample document. Both video clips were excerpts from an opioid-prescribing educational course and used with permission of the author.[30,31] Table 1 shows examples of questions included in the interview guide. Interviews were conducted by trained interviewers (A.A.B., J.M.C., S.R.C.) using the interview guides. To minimize potential biases or preconceptions that might shape the nature of the interviewer-participant interaction or follow-up probes, the primary interviewers were nonclinicians