RUTGERS

Center for State Health Policy

A Unit of the Institute for Health, Health Care Policy and Aging Research

Prescriber Perspectives on Opioid Prescribing in New Jersey and Impact of 2017 State Legislation

Jennifer Farnham, M.S.
Stephen Crystal, Ph.D.

January 2020

Table of Contents

Acknowledgments

This report was created for and is funded through a grant from The Horizon Foundation for New Jersey. Stephen Crystal's time was additionally supported by NIH grants 1R01 DA047347 and UL1TR003017. The authors would also like to acknowledge the valuable input from our 22 confidential interviewees, along with input and assistance from our colleagues Joel Cantor, Margaret Koller, Manisha Agrawal, Sheree Neese-Todd, Mary Kate Marasco, Leslie Zuniga, Miriam Ladao, and Peter Treitler. The authors are responsible for claims made in the report, as well as any errors.

Prescriber Perspectives on Opioid Prescribing in New Jersey and Impact of 2017 State Legislation

Jennifer Farnham, M.S. and Stephen Crystal, Ph.D.

Executive Summary

New Jersey's 2017 legislation restricting initial prescriptions for acute pain to 5 days, requiring monitoring of longer-term prescriptions, and reducing limitations on coverage of substance abuse treatment is one of many actions taken by state and national leaders to address the opioid epidemic. In late 2018, we spoke with a diverse group of 22 prescribers in New Jersey regarding their thoughts on the 2017 law and opioid prescribing (including medication-assisted treatment). Though diverse, the group is not likely to be representative of all New Jersey prescribers—our interviewees were probably more likely than the average prescriber to prescribe opioids, and particularly interested in doing so in a thoughtful way (we offered a $125 gift card for interviewees, which is not a large amount to most clinicians relative to their salary or service/procedure reimbursement).

Many interviewees agreed that some restriction on prescribing was warranted, though opinions differed as to the ideal restrictions. Many were happy to have the regulations as backup for their discussions with patients, as they wanted to restrict their prescribing due to their concerns for addiction, diversion, or lack of efficacy of opioids. Most clinicians prescribing long-term for chronic pain had already implemented the measures required by the legislation (though a few found them burdensome). Comments were very positive regarding the New Jersey Prescription Monitoring Program, which allows prescribers to see what prescriptions for controlled substances have been filled by the patient.

Unless they were already providing it, most prescribers we spoke with were not interested in providing medication assisted treatment (MAT) for opioid use disorder, seeing this as beyond their scope of expertise, impossible given the structure of their practice (e.g., solo and small-group practitioners without needed support staff), or undesirable given the patient population seeking this treatment. These responses are important in the light of current initiatives to increase engagement of primary care providers in offering MAT, highlighting the complexities of recruiting additional providers, particularly in solo and small-group practice. Prior authorization restrictions were a significant barrier to those providing MAT to Medicaid beneficiaries; the

removal of these restrictions in April 2019 (after the conclusion of our interviews) may have improved access to treatment. In July 2019, the governor signed into law legislation requiring that MAT be provided without prior authorization in Medicaid.[1]

Some interviewees were hopeful that prescribing restrictions could reduce opioid exposure and addiction, but several noted, as found by Cicero and Ellis (2017), that the availability of illicit opioids and the lack of available treatment for mental health issues facilitate addiction.

There was some concern among interviewees that prescribing had gotten too strict in some cases, and that people with a legitimate need for opioid medications were not getting them. This could be due to any or all of several potential reasons: overzealous interpretations of the cautions raised in the New Jersey law or other guidelines; avoidance of opioid prescribing due to increased regulatory oversight and the burdens of documentation; and stigmatization of patients seeking treatment of pain. In 2019, the FDA and US Department of Health & Human Services released statements discouraging prescribers from abruptly tapering patients from opioid therapy (FDA 2019; Throckmorton 2019; U.S. Department of Health and Human Services 2019), and the authors of the CDC guidelines noted that practitioners were going beyond what the guidelines recommended in ways that could harm patients (Dowell et al. 2019).

Interviewees seemed to agree that opioids were not the first choice for chronic non-cancer pain treatment, and in many cases were not effective or even harmful (with risk of dependence and hyperalgesia) but many noted that in some cases opioids were the best choice available, and that some patients achieved a better quality of life with opioid treatment.

Several gaps in existing pain treatment were identified. Interviewees noted a procedural focus by many pain management practices that neglected patients for whom procedures were ineffective or undesired, particularly given what appeared to be an increasing tendency of primary care doctors to refer patients with pain to pain management rather than treating them directly. Additionally, significant insurance coverage barriers were noted with respect to many medications or treatments serving as opioid alternatives, such as Lyrica®, diclofenac patches or gel, lidocaine patches, and massage therapy. Finally, some interviewees noted a lack of good treatments for many types of chronic pain, which affects a significant portion of the population. Though most of our interviewees were not involved in prescribing it, medical marijuana was raised by several as a topic of interest among prescribers and patients. One had reviewed existing literature and thought it held a lot of promise, one had positive reports from patients, one felt that their patients who used it were overcharged and did not benefit, and several were skeptical

[1] P.L. 2019, c.163, approved July 15, 2019 (from A4744/S3314).

given the lack of clinical research. Several thought it was cost-prohibitive for Medicaid patients.

Significant barriers to all types of treatment were noted for Medicaid patients. This includes access to clinicians (including those treating pain such as pain management specialists, physical therapists, chiropractors and acupuncturists), many of whom do not accept Medicaid.

Prescriber Perspectives on Opioid Prescribing in New Jersey and Impact of 2017 State Legislation

Jennifer Farnham, M.S. and Stephen Crystal, Ph.D.

Overview

This report describes high-level findings from our 22 interviews with New Jersey opioid prescribers, with selected quotes. Our extended report, available as a separate document,[2] contains extensive quotations from the interviews as well as references to relevant literature. Other components of this project included investigations of Medicaid-reimbursed prescriptions for both opioid medications (Agrawal et al. 2019b) and medication assisted treatment (MAT) for opioid use disorder (Agrawal et al. 2019a), and a survey of New Jersey substance use treatment providers to ascertain the availability of pharmacotherapy for opioid use disorder (Clemans-Cope, Epstein & Winiski 2019).

Background

New Jersey, along with other states, has seen an increase in drug-related deaths and overdoses, with opioids constituting the bulk of the increase. Many states have undertaken policy efforts to restrict the supply of prescription opioids that could easily be misused. In 2017, the New Jersey legislature passed, and the governor signed, legislation that restricted initial opioid prescriptions for acute pain to a 5 day supply, required pain management contracts and monitoring for longer-term usage (some patients are exempt), and eliminated prior authorization requirements to access substance use treatment for state-regulated plans (this excludes Medicaid and self-insured plans). The measure passed in February 2017 and went into effect in May 2017.[3] Implementing regulations specified requirements not spelled out in the statute, such as random urine screens at least every 12 months.[4] Exempted are patients who are in "active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long-

[2] Farnham J, and S Crystal. 2020. *Prescriber Perspectives on Opioid Prescribing in New Jersey and Impact of 2017 State Legislation (Extended Report)*. New Brunswick, NJ: Rutgers Center for State Health Policy.

[3] P.L. 2017, c. 28. See https://www.njconsumeraffairs.gov/prescribing-for-pain/Pages/default.aspx for a copy of the law, regulations, FAQs, and other reference materials for prescribers and patients.

[4] See, e.g., NJAC 13:35-7.6 for physicians and NJAC 13:37-7.9A for nurses (available at https://www.njconsumeraffairs.gov/prescribing-for-pain/Pages/default.aspx).

term care facility, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence."

Our qualitative inquiry involved reaching out to a variety of prescribers for in-depth telephone interviews to assess how this new legislation had affected prescribers' practices and patients.

Methods

Twenty-two opioid prescribers practicing in New Jersey were interviewed (21 by phone, one by email) between September and December 2018 regarding their thoughts on the impact of New Jersey legislation that took effect in May of 2017, as well as other influences on opioid prescribing (Centers for Disease Control (CDC) or insurer guidelines, public knowledge of increased deaths from opioid overdoses, etc.). See Table A1 in Appendix for more detail on the sample.

Prescribers were identified via Medicare Part D public data for 2016. Our initial goal was to obtain several higher than average prescribers, in higher than average opioid-prescribing specialties, in each of 3 regions of the state[5] to ensure that we were speaking with prescribers who were affected by the new legislation. However, because so few specialists accept Medicaid (of 14,637 prescribers who served dual eligible participants in the 2016 Medicare data, only 3,703 (25%) had actually billed Medicaid, according to the Center for State Health Policy's Medicaid claims database), we adjusted our strategy to recruit more primary care doctors. And, while all interviewees prescribed opioid medications to some degree, not all were higher than average. At least 266 prescribers or organizations were contacted, and all who expressed interest were interviewed.

There were 13 men and 9 women interviewed. Twenty were physicians, while two were advanced practice nurses (APN's). Interviewees were about equally split among physician-owned practices, academic medical settings, federally qualified health centers (FQHCs), and hospital systems or settings. With regard to specialty, interviewees were not always exclusive to one specialty. Specialty areas included internal medicine (11 practitioners), pain management (three anesthesiologists and one physical medicine and rehabilitation), addiction medicine (three), two each from palliative care/hospice and HIV, and one each from emergency medicine, geriatrics, neurology, oncology, oral surgery, psychiatry, and rheumatology. Years of experience ranged from one to more than 30, with 17 having more than 10 years of practice. Interviewees were about evenly distributed among the North, Central, and Southern regions, with 41% from the South. Though we achieved some diversity among our interviewees, they may not be

[5] 1) North: Bergen, Essex, Hudson, Morris, Passaic, Sussex, Union, Warren; 2) Central: Hunterdon, Mercer, Middlesex, Monmouth, Somerset; and 3) South: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean, Salem.

representative of New Jersey prescribers overall in part because they were willing to talk for an hour or more about prescribing and patient care with only a $125 gift card incentive, and because they self-selected from such a large pool of prescribers who were approached. We understand that there is a selection bias.

Interview questions were developed in advance, and follow-up questions were created as interviews proceeded to assess interviewee reactions to emerging themes.

Interview Findings: Assessment of 2017 Legislation

5 Day Limitation on New Prescriptions for Acute Pain

For most of our interviewees, some limitation on prescribing seemed reasonable and the potential burdens of the rule were diminished by the perceived public health benefit. Many interviewees were already limiting their prescribing enough that the law did not particularly affect their practice. A few would prefer a longer period to allow for patients to check in after the initial prescription, because it was hard to circle back with patients within five days. One noted some negative health effects from patients taking too many NSAIDs when they were not able to get back to the prescriber within five days (see also Foglia 2019 as an example). However, many noted a standard past practice of a 30 day prescription, which most seemed to think was excessive. Many reported a positive effect of the law on their interactions with patients because it gave them support in limiting prescribing. One prescriber described the effect in the following way: *"I think like all the things with the opiate law, it's meant to complicate things enough that you think twice about prescribing something. ... one of the ... organizing principles of this law seems to be just make it a little bit more annoying … And I don't know if that's a bad thing. … It's probably decreased my prescriptions for incidental opiates. Has it changed things dramatically? I don't think so. It's not burdensome enough to make it not worth doing." (9)*

Prescription Monitoring Program (PMP)

Interviewees spoke very highly of the New Jersey PMP as a tool for responsible prescribing. One example: *"it's wonderful and transformative. It's probably the best website that I use in my life. It is amazing and it's super fast. It reflects everything. It really transformed care when it came in." (9).* Most had begun using it well before the new law. A few felt that it took up significant time to use (about 5 minutes of a 15 minute visit) or otherwise had mixed feelings. Two wished it were possible to default to all states rather than having to select additional states (including more states increases the time for searches to complete). One mentioned that an autocomplete that would fill in the names of patients searched previously would be helpful. One collaborates with social workers and would like them to be able to check, one desired to have other drugs that affect the central nervous system listed (such as serotonin-norepinephrine reuptake inhibitors

(SNRIs), selective serotonin reuptake inhibitors (SSRIs) and tricyclics), and one noted that mail order pharmacies do not appear to report.

Monitoring Longer-Term Usage

Pain Contracts. Most interviewees who prescribed opioids long-term were already using pain contracts before the law passed. Those who were using them prior to the law's passage generally found them to be a good practice that helped them monitor patients' progress and inform patients about the risks of opioids or other controlled substances. Those who started because of the law seemed more likely to find them burdensome—more about protecting prescribers from liability than building a good patient relationship. One prescriber noted some disagreement in his practice with regard to whether cancer patients should be required to have agreements. Palliative care patients are exempt from the NJ law, but some prescribers still find it best practice to do agreements with them.

- A prescriber that had successfully integrated pain contracts said *"We just try to put all those things* [health/safety for them and others] *out in the very beginning … in a consultative way so that we can talk to them about the regular clinic practices so that they never feel like they're being targeted and that all of the things that we might ask them to do at any time in their treatment are laid out right in the beginning." (18)*
- A prescriber who thought contracts were just to protect the doctor said, "*I've never seen the benefit of pain management agreements. The main benefit of them is to the physicians, that if they find somebody breaking some rule, they can say, "You agreed to abide by this rule, and now I'm done with you." But I don't know that they really do anything to educate the patients or do a better job of getting satisfactory patient compliance as opposed to just building a proper therapeutic relationship or therapeutic alliance with the patient." (1)*
- A third prescriber noted that patients may not initially understand the contract, but still believed they were helpful in managing opioid use: "*I think sometimes people are in such distress that I don't think the totality of what they're agreeing to is sinking in. They may just be saying, "Okay, I'm signing this because this is what I need in order to get treated for my pain," and what is being expected is not totally reflected on at the time they're executing the agreement. But I've found it very helpful to go back and say, "Look, this is what we agreed to, and you're stepping outside of that, so here's what we need to do."" (7)*

Urine Screening. Urine or other types of screening presented some logistical issues for practices that had not incorporated it prior to the law. One said, *"it wasn't clear to me how to go about getting it. Somebody had to clarify how to obtain that." (1)*. Another noted *"when I see patients I'm all by myself." (15).* A few interviewees expressed some hesitance about the interpretation

of the results of screening analyses, and one who had expertise in the area talked about how complicated it could be due to substances being changed as they are metabolized, and the necessity of knowing how long certain substances stay in the body: "*If you don't have any Oxymorphone dose* [in the urine sample], *that's telling me you're not taking it regularly. You haven't taken it probably for a week, or two, but … some prescribers who really don't know the intricacies of it will just say, "Oh, they have a lot of Oxycodone, they're taking it." I think education is key." (19)*

Dealing with Nonadherence. Possible screening results that would trigger some kind of action included finding additional substances (raising questions of a concern for the patient's health due to substance abuse) or not finding evidence of the substance (raising questions of diversion). Interviewees differed in their responses to these findings. Comprehensive practices offering substance abuse treatment could continue relationships with patients under these circumstances by increasing monitoring, but other practices would often begin a tapering plan (if additional substances were found) or dismissal (if prescribed substances were not found).

- An example of a comprehensive practice: *"If it's not going well, meaning if somebody's not taking their medicine as prescribed … we ask them to come in even more frequently. We'll see them twice a week, three times a week, and then up to five days a week. So they'll come in Monday through Friday and check-in with our front desk, our outreach health worker, our nurse. Then we can even go up to the point of having people doing observed medication in the office where they bring in their medication and take it in the office up to five days a week. And we do that for patients who really want to stay on buprenorphine because they feel like it's helping and yet they're still struggling with using or struggling with not taking it every day or having lost their prescription, things like that. And we've found that that helps patients when they have a severe use disorder or chaotic social lives, that we can offer them that support. So basically, we say if you're not doing well, we want to see you more, not less. We don't kick you out if you're not doing well; we bring you in closer. And then if we've tried all those things … we'll say, hey, we've got other medicines. We have other things we can do. We can help you get into inpatient. We can help you get into methadone. We can get you into a detox and then transition you to Vivitrol®. So that's how we work." (18)*
- One prescriber described the complex decisionmaking necessary when patients were nonadherent, including allowing for genuine mistakes, trying to get them to see other practitioners, taking people back because they couldn't find another practitioner, and knowledge that patient buy illicit substances: *"if they violate it basically I take them off, and they know that. I mean I wean them off. But they're told upfront. And if it's somebody who did it kind of like not on purpose, I don't know, maybe they're in the hospital, and the hospital sent them home with something, then I'll just kind of reschool them that they*

have to only get it from me. But the people that are running out early and begging for more, and that kind of stuff, I don't allow that. I mean we don't kick them out … I just won't order opioids for them. I think that I'll tell them they have to go to pain management, and get whatever other modality they can get, or they can try and see an orthopedic, that kind of thing. I mean we've had people that I've kicked off and put back on again because they just couldn't find any other place to go, and I think I do have a patient who continually overtakes at times, but he knows now that if he overtakes he can't ask me for more. They seem to be able to buy it off the street around our area, so if they run out they buy... which is not something we encourage." (13)

Availability of Treatment for Substance Use

Interviewees generally reported no change in the availability of treatment for substance use due to changes in the law, though one who treated patients with SUD who had private insurance appreciated the removal of prior authorizations for their clients. Several saw some movement toward greater availability of MAT (medication assisted treatment), though they did not attribute this to the law. Several raised the issue of affordability in SUD treatment and one mentioned barriers in terms of the structure of existing treatment with respect to requiring intensive treatment that people weren't willing to attend, showing up instead in the emergency room. Many had the sense that people who wanted treatment could get it, but they generally did not follow up with people who they referred to treatment to check on the results from the referral.

- On the movement (or lack thereof) toward MAT: "*a lot of the inpatient rehab, a lot of the detox places, a lot of AA and NA meetings, that's still very much in the 12 step culture. And so that whole idea that you're substituting one addiction for another. There's been so much education the last couple years, so I feel like the needle is moving on that. But we do have a lot of inpatient facilities that we work with, and it's very hard to refer our patients there, because they wanna detox them off everything and send them out on nothing. And it's a huge problem still. And I think the state and the federal government needs to step in and stop accrediting people if they don't provide MAT and whatnot. I think we need to have some licensing requirements that are changed*." *(21)*
- On MAT for Medicaid patients: *"MAT, it hardly exists for Medicaid patients. … I imagine that the majority of patients who are in need of intensive services for substance abuse are on Medicaid or would qualify for Medicaid." (9)*

Because the law did not change the prior authorization requirement in Medicaid (this was removed later, in April 2019), access to substance use treatment for this population was still difficult at the time of our interviews, as was access to other services for Medicaid patients, such as specialty care and physical therapy. Providers also reported trouble gaining approval for

extended release buprenorphine injections for patients who had trouble taking medication in a timely way or for whom there were diversion concerns.

In addition to the prior authorization barriers, providers wanting to offer substance use treatment together with primary care encountered problems with licensing and reimbursement—two providers mentioned a long wait for a license, delaying treatment; one provider was going ahead without the license; and one reported having to let in-house psychiatric staff go because of the lack of licensure and felt it created a gap in their services: "*because we're not licensed as a mental health facility we actually can't have in-house psychiatric care, and so since we lost our in-house psychiatric care, it's been a big problem, huge problem. It's one of our biggest issues to not have mental health treatment because the other clinics are just overwhelmed and there's a really long wait to get anybody to see a psychiatrist on Medicaid. If they do go to see the psychiatrist, and they miss even one appointment they'll like not see them anymore, so it's very unforgiving, which makes no sense to me because some of these people are mentally ill. They're all mentally ill, and so they can't get themselves up out of bed, or they can't remember their appointment, that's because of their illness. They shouldn't be penalized." (13)*. Other than several FQHCs or prescribers who were already providing addiction treatment, prescribers we interviewed were not interested in taking on medication assisted treatment in their practices (discussed in more detail in the next section).

One provider at an FQHC awaiting certification described the situation: *"I have a waiver to prescribe buprenorphine … We do some Vivitrol®, that's about it … The issue has been that the state government… has required FQHCs to have a substance abuse treatment license in order to provide MAT, and there have been some rule changes that I think are in draft right now that it should allow us to do it as long as we have MOUs set up with some treatment programs, but for a while, even though there's this massive need ... there's nobody who does Suboxone® for Medicaid patients. … government regulations here have made it very challenging for FQHCs to go forward." (9)*. For now, this provider's patients have to switch their assigned PCP to their Suboxone® provider, but that person does not treat their other health issues: *"I have [several] patients that I can think of right now who are stable on Suboxone®, just stable. These are probably the patients that I will merge back into my practice because one of them pays cash to somebody, $150 a month to get, she's got Medicaid, $150 just to get a Suboxone® prescription, and she's able to make it work, and then [number] of them go to [city 20 miles away], and they have to be PCPs there, but they're not really doing primary care. These are people who have massively complicated other medical issues going on, but the only way for them to access Suboxone® is to have their PCP, that doctor, because that's the only person who does Suboxone® for Medicaid, and that person is sort of ... I think, doing Suboxone® every month, and having them come, but really not addressing broader health issues with these patients, and it's a big challenge." (9)*

Unintended Consequences

Many, though not all, of our interviewees thought that there was an increase in untreated pain due to increasing restrictions on opioid prescribing, including the New Jersey law as well as changing norms about opioid usage influenced by other factors including the release of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain, communications from insurers or other health care organizations, and attention by the media and community institutions about the opioid crisis. In addition to prescriber reluctance, several interviewees mentioned patient reluctance to take opioids (or pressure from family members to avoid), even when the prescriber was concerned about patients' pain.

Interviewees noted health problems that could arise with long-term use of non-opioid pain relievers, such as organ damage from non-steroidal anti-inflammatory medications or acetaminophen. They also discussed insurance approval barriers to opioid alternatives such as Lyrica® and diclofenac patches or gel, lidocaine patches, and treatments such as physical therapy, acupuncture, and massage.

There was concern among some interviewees that the New Jersey law as well as other attention to the opioid crisis was leading to prescriber or patient avoidance of opioid medications even when they were clearly indicated, as in cases of cancer pain, recent surgery, or sickle cell crisis. Authors of the CDC guidelines have noted that some practices have gone beyond their recommendations (Dowell et al. 2019), and the US Department of Health and Human Services published a new "Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics," (U.S. Department of Health and Human Services 2019) which reminds clinicians that dependence occurs after more than a few days of use and notes potential harm in reducing dosages abruptly. One interviewee noted: "*I think it's really important that as we're cutting down or even tapering or trying to limit opioid prescriptions that we have a way out for patients, that we have a treatment plan, that we're not just cutting people off because we've had many, many patients flood our emergency rooms and other local emergency rooms being cut off of opioid medications. … we've seen patients who were slowly cut off, tapered off, any number of things and then ended up switching to heroin. … the key is that we have to be really mindful about training physicians how to do this well and how to take care of people if their chronic opioid prescription isn't the right thing anymore. … help them find a safer and better treatment alternative." (18)*

Thoughts on Whether the Law Would Reduce Risk of Overdose Deaths

Most interviewees didn't offer a direct opinion on this. Two were hopeful that prescribing restrictions could prevent addictions that might otherwise have occurred. However, several noted that most overdose deaths are from illicit rather than prescribed opiates, so that the

effects would be indirect. Several interviewees felt that access to adequate substance use treatment and mental health treatment would be key in reducing overdose deaths. A comment from one suggests that both substance use treatment and better pain management would be helpful: *"all of our patients who overdose, I am pretty sure they all overdosed on what we think is probably heroin and fentanyl. But some of them came to us as straight heroin users and some of them came to us as chronic pain patients." (8)*

Interview Findings: Other Themes

Past Pressure—Pain as Vital Sign

Several interviewees with more years of experience discussed past pressures to treat pain as the 5th vital sign, coupled with beliefs that opioids were not harmful, as driving high levels of opioid prescribing. One noted, "*you would be reprimanded in residency rounds if you didn't ask the patient how bad his pain was and what you could do to get his pain better. Isn't it amazing how it's 180 degrees. It's the complete opposite nowadays." (14)*. Another brought up fear of complaints, "*If we don't control pain, people are going to complain, people aren't going to come our hospital, our Press Ganey scores are going to be terrible because we didn't treat the patient's pain well. … it's unreasonable … there was this expectation people were going to be pain-free." (17)*

Stigma of Long-Term Use

One noted longstanding stigma toward longer-term opioid use that had co-existed with the focus on aggressively treating acute pain (i.e., negative attributions of drug seeking among chronic pain patients): *"when I used to speak throughout the state [about a painful condition, 10-15 years earlier]… The impression I had is that every family doctor that I spoke to feels that if his patient is asking for a narcotic, he must be an addict. I first didn't believe it, but the more I spoke, the more I realized that these family doctors actually believe that everybody they're seeing is looking for drugs and is a drug addict. In my experience, it's been just the opposite. … most people don't want to be on narcotics, but pain can destroy their lives. Sometimes, putting them on a narcotic can turn their life around for the good. … I really think the family doctors are missing the essence of pain when they think all these patients who are looking for pain meds are addicts." (14)*

Stigma of Addiction Treatment

One prescriber brought up the history of narcotics regulation, where, in the early 1900s "*doctors felt persecuted for treating patients with addiction … And unfortunately I think the psychological ramifications of that are still here today, where we have an entirely different treatment system for addiction … And I think a lot of that goes back to stigma and fear." (21).* Another prescriber noted that this stigma seemed to keep colleagues from wanting to treat addiction, even when

their system encouraged it: *"I can think of at least three or four instances in recent weeks, in which we've been informed that buprenorphine is now stocked … we're allowed to initiate it, that the healthcare system … is in favor of us doing so. But whenever I have raised the question of starting someone on it … I've been informed that [supervising] physicians have asked me to not do so. … And so I think that there's like this larger stigma and reticence to treat opioid addition with medications. … I remember at least two [supervising] physicians saying that, "It's not like opioid withdrawals have killed anyone. I wouldn't bother."" (6)*

False Dichotomy between Appropriate/Inappropriate Use

One prescriber who treated both pain and addiction drew a distinction between the way they saw prescribing and the way they had been taught: *"everything we were trained was there's the appropriate pain medicine patient and then there's the one who is abusing or misusing, diverting, etc. … starting to recognize that they're all in some degree one and the same, and that it's really a disservice to a patient to almost kind of pretend that here's this way where we're going to make the pain go away. It's going to be great and there's never going to be problems. It's much better to, from the very beginning, just say this is an extraordinarily powerful, yet dangerous tool, and we want to be really straightforward about the ins and outs. We want to always have an exit strategy. Then the same is true when we see patients for MAT, we always say to them, so you're going to get to the point where you haven't used opiates in three years, you're doing great. You may want to try tapering off your medication. You may not. You may want to stay in maintenance, but you're going to live another 50 years. It's not if, but when, somewhere along the way you're going to have physical or mental pain, and you're going to be at extraordinarily high risk for relapse and you're going to want to have a plan in place for how else are you going to deal with that physical or emotional pain, because it happens." (8).* While other interviewees didn't describe it quite in this way, it was evident from our conversations that the line between appropriate and inappropriate use was not always clear.

(New) Awareness of Opioid Harms

More newly trained prescribers had been warned of the dangers of opioids early on, including opioid-induced hyperalgesia, risk of addiction, risk of diversion to people other than the patient for whom the medication was prescribed, and risk of death or injury from overdose. Many interviewees mentioned the risk of opioid-induced hyperalgesia (i.e., increased sensitivity to pain), particularly at larger doses, something they attempted to discuss with patients, often unsuccessfully. All were familiar with opioid dependence, and many had observed addictive behaviors as well in their patients, or treated patients with past addiction to opioids. All were aware of the risks of death or injury from overdose. Some had suspicion of illicit use or diversion among their patients. Most had not experienced an overdose among their own patient

population, and none mentioned experiencing a patient overdosing on medications that the interviewee had prescribed.

- One prescriber described the negative side effects of opioids: *"there is a downside that's inherent in opiates that can cause the patient a lot of grief. Opiates at higher doses can cause the opposite effect. They don't take away the pain, they make the pain worse, for example. … Or you can develop seizure disorders or develop certain movement disorders from the toxicities of opiates over the long-term. Nobody really knows if there is a dose where their potentially long-term toxicities are permanent with the use of opiates.... They're kind of a necessary evil because they don't cause end organ damage, and what I mean by that is they don't affect the kidneys or the liver. They're not toxic to some of those important organs. They can be toxic if you want to look at it this way; to the brain in that they can cause confusion or loopiness or some of these cognitive side effects that we hear about that can occur with somebody, maybe even a loved one that you've had experience with who is on opiates. And then of course the other big downside is the potential for addiction and even death if they're taken irresponsibly." (20)*
- Another interviewee talked about the difficulty of the conversation about negative side effects: *"it's our responsibility as medical providers to be very straightforward about the risk and benefits. I think the hardest piece of that conversation is we know that chronic use of opioids creates significantly hyperalgesia. … there is evidence that suggests that you're more likely to die and more likely to suffer if you take opiates in the long-term. But each individual patient has the experience of, I had pain, I took this medication, I have now taken it for a long time. When I don't take it, I have terrible pain. When I do take it, that terrible pain goes away. Therefore, the way our brains are wired, I conclude that I need this medication to treat my terrible pain. Giving to the point of, if and when we can get your receptors back to normal, your pain probably wouldn't be any worse than anyone else with your condition. And you would have decreased the risk of morbidity and mortality. That's a really hard place to get to in a conversation. Takes a whole lot of continuity of care and continuing to have that same conversation over and over again. You have to wait for the patient to sort of be ready and notice the harm the medication is causing them." (8)*

Striving to Balance Harms and Benefits of Opioid Prescribing

Interviewees' prescribing decisions depended on what they believed about the potential benefits of opioids versus the potential harms to patients by not prescribing. Differences in their views and experiences led to different philosophies of opioid prescribing. Many explicitly mentioned an inherent duty to avoid suffering in patients—from pain, including the pain or potential adverse outcomes of withdrawal symptoms--and felt that prescribing opioids was part of that responsibility. Those who perceived less benefit from opioids were less likely to prescribe them,

and were less concerned about avoiding withdrawal symptoms in patients. Several prescribers were very concerned about diversion, feeling that they would have responsibility (not in a legal, but rather a moral sense), if a medication they prescribed was sold or misused by someone other than the patient for whom they prescribed it. Several mentioned that they were either considering, or actually offering or prescribing naloxone for patients getting opioid prescriptions, particularly those at higher dosages.

Reduction/Avoidance of Opioid Prescribing

Data from the New Jersey prescription monitoring program show opioid dispensations declining in 2016, 2017 and 2018 after a high in 2015. Interviewees mentioned a decreasing willingness to prescribe opioids among their colleagues, including some who have decided not to prescribe opioids at all.

Reduction/avoidance seemed to stem from at least three causes, according to our discussions with interviewees:

1) Increased awareness of the potential for harm with opioid prescriptions—from hyperalgesia even if taken as indicated, illicit use either by the person to whom they prescribed it or someone else, and overdose.
2) The logistical burdens in complying with New Jersey's 2017 law and other changes in organizational procedures or professional norms that called for more investigation and documentation in opioid prescribing.
3) Stigmatization of patients asking for pain relief. As noted earlier, one of our interviewees mentioned having noted such stigmatization 10-15 years ago when he was in a position to be meeting doctors throughout the state, and one long-term practitioner likened current events to a resurgence of opiophobia from 20 or more years ago. So while the stigmatization may not be new, the opioid crisis may reinforce a preexisting tendency to stigmatize.

One of our prescribers, while noting having been affected by the increasing unwillingness of primary care providers in particular to prescribe opioids, thought it was not necessarily all bad, because some providers did not have a good knowledge base for opioid prescribing.

In addition to prescriber reluctance, some interviewees mentioned reluctance among patients or their families to using opioids. In some instances the interviewee seemed to feel neutral or positive about this. However, in other cases the interviewee believed that the reluctance impeded patient care: "*I'm seeing [reluctance] in most of my cancer patients. But with some gentle discussion and some time in getting to know them and learning about what they've tried to do, I usually am successful in getting patients to go with some kind of a conservative measure*

that they're comfortable with. And that pays off a lot of times. But I'm absolutely on a greater level concerned about that. … All of this stuff to me is a big distracter. It increases the stigma that they have to go through in dealing with it. I have to reassure people about what they're doing all the time because of that. I mean, even from their own family members. From the pharmacists. It's unfortunate. … I can't overemphasize to you how important it is to understand that the use of opiates is a legitimate medical practice. And I have that discussion all the time with patients. I try to get them comfortable with it, because there's this whole other side which is the downside. Which we've already discussed and know a lot about. But I want people to feel that this is legitimate medical practice. This is standard of care. This is how we do it. And these are the up points and these are the good sides, these are the down sides. These are the risks, these are the benefits. We have all of that informed consent discussion. But it is legitimate medical care. And I'm afraid that even that is threatened. I have a partner who feels that they're evil." (20)

Doubts about Opioid Efficacy for Chronic Pain

Many of our interviewees doubted that opioids were very useful in the treatment of chronic pain due to tolerance or the development of hyperalgesia, in which a patient's pain could become worse. However, most interviewees, and particularly those who focused more on pain treatment, seemed to feel that in some cases, opioids were the best choice available: *"There's always going to be a certain subset of the chronic pain players who, no matter what you do for them, they're going to have to be on narcotics." (17)*

However, there was general agreement with the CDC guidelines that opioids should not be the first-line treatment for chronic pain. Their doubts, as well as their decisions to continue to use opioids in some cases, are borne out by the literature regarding pain medications. One prescriber noted that bridging research evidence with individual patient experience was a challenge: "*People who are on opiates for chronic pain, their daily pain scores are as bad or worse than people with comparable conditions who are not on chronic opiates. That's clearly demonstrated by the evidence. … I think the individual patient experience is a very different thing and that's where the conversations get so challenging. … that doesn't mean that we have a great solution for all the people who are already on them." (8)*

Gaps in Pain Treatment

Pain is a common condition. Many of our interviewees noted gaps in pain treatment for patients, in several respects:

1) <u>Tendency of Primary Care Practitioners to Refer Patients to Pain Management Practices for Treatment of Pain.</u> This was not necessarily a problem in and of itself, except that there were many perceived gaps in the availability of pain management care and limitations in the populations served by pain management practices. Several primary care

providers told us they had few options for pain management referrals for their Medicaid patients, and one pain management doctor noted that reimbursement was poor, so that some of his colleagues did not accept Medicaid. One primary care interviewee who was willing to prescribe for pain with consultation from a pain management practitioner described frustration in his attempts to develop good working relationships with any such practitioners (due to limited numbers of such practitioners in his area that accepted Medicaid patients, his primary constituency, and the focus of practitioners on procedures rather than development of a treatment plan that could include a primary care practitioner): *"Pain management virtually doesn't exist..... when you can get somebody into pain management, a lot of times the pain management doctors refuse to do any sort of oral medications. All they want to do is just do injections, and they'll tell patients that, which, honestly, is just absurd because if pain management as a specialty doesn't manage pain management in a comprehensive way, then who is supposed to do that? It's like the cardiologists deciding that they just don't want to treat atrial fibrillation anymore, right? "We're just not going to do that because we think it's too high risk." It's like, if they don't do it, who does this? It tends to fall down to another primary care. Unfortunately, Medicaid patients get stuck, and we get stuck as well." (9)*

2) Limits on Insurance Coverage, Particularly for Medicaid Patients. Many interviewees reported (and we found in our recruiting efforts) that many pain management practices did not accept Medicaid, leaving Medicaid patients with few choices. This was also true for non-opioid pain treatments like physical therapy, acupuncture, chiropractic care, massage, and non-opioid medications such as Lyrica®, lidocaine, and diclofenac.
    - One interviewee noted: *"I find the biggest issue to be about approval of these non-opiate medications … a lot of times we've actually gone by what [the insurance company has] asked … which medicines they want us to try … at which milligram. … And yet, we still, after following all of their step one, two, three process, we still end up at the same point where they just don't approve of it. So it's very hard to treat a patient effectively." (12)*
    - Another noted: *"since before the legislation, definitely it has gotten harder to get nonopioid medications covered, which really doesn't make sense to me … They don't want us to prescribe opioids, yet they won't cover other medications that are effective and nonaddicting and non-abusable. It's like, what do you do? You have these patients on opioids, you want to get them off, but there's no alternatives because their insurance is not covering it. … the reimbursement rate for interventional pain management procedures is extremely low for Medicaid patients, so that's why our surgery centers don't participate with Medicaid as a primary." (15)*

3) The Concentration of Pain Management Practices on Procedures, Often with the Exclusion of Medication or Behavioral Interventions. If the procedures offered did not work for patients, or they did not wish to undergo procedures, there were few choices for patients to help manage pain. Several interviewees, including those offering such procedures, noted that procedures held potential risk as well as potential rewards. Prescribers looking to refer patients for pain management, including narcotics if necessary, described frustration at their perception of the procedural concentration of pain management practices. Two prescribers tempered their frustration with the realization that pain management practitioners were making practice decisions for what the interviewees felt were legitimate reasons. Two pain management prescribers acknowledged some concentration of the field on procedures but noted reasons other than reimbursement for this, including better results and avoiding opioids: *"it [procedures] definitely pays better. Two, it's gratifying, you get an immediate response. Sometimes, so that is part of it. And, three, as we said it's becoming more regulatory with the narcotics and if you can't do that, what are you gonna offer them? … there are some things that can be really really helpful, and other things that are going to be subject to abuse. People will do them inappropriately, because it generates money for a practice. You kind of see every variation, but I would say in a properly selected patient, under confident hands, with someone who's well trained, takes the time to get retrained, and keep up with things they can be really helpful. And, potentially dangerous." (10)*
4) A Lack of Effective Treatments for Chronic Pain. None of our interviewees seemed to believe that opioids should be a front-line treatment for chronic, non-cancer pain, but they did note that in some cases it was the best option to improve patient functioning.

Given all the points raised above, a primary care provider noted, *"maybe we need to build pain management into primary care in a better way and reimburse that differently, reimburse comprehensive pain management evaluation in a different way, because it takes a while. Maybe we need to be talking about how we reimburse mental health professionals for helping with pain management. We're currently happy to use our substance abuse money and our behavioral health funds to treat addiction, but we're not using it at the beginning which is somebody has chronic low back pain, what do we do? How do we help that person deal with it? Maybe it's medical marijuana, maybe it's chiropractor care, or maybe it's some low dose NSAID, maybe it's an antidepressant, maybe it's something else. Maybe it's some topical treatment. Topical NSAIDs are not covered, we can't get Voltaren patch through Medicaid. Why not? Why can't we get a Lidoderm® patch, why isn't that on the formulary, I can get oxycodone, but I can't get something that's completely benign for a patient, so getting very simple pharmacologic changes that other modalities would be helpful, because the issue really is pain management at the outset. That's the root cause here. It's not opiate addiction. Opiate addiction doesn't just magically appear. If*

you talk to people who are addicted to opiates, the vast majority of them got hooked because of some orthopedic injury, had a car accident, had a football injury, and all sorts of stuff.... over half the patients have the exact same story. It's like, "Oh, yeah, I was in a car accident, broke my leg, and then I got on some Percocet® and just got on more and more and more, and then I couldn't afford it, and then I got on heroin, and now heroin's got fentanyl in it, so people are dying." But if we can learn how to treat pain better in the beginning, I think we can not even get on that opiate path." (9)

Medical Marijuana

Though most of our interviewees were not involved in prescribing it, medical marijuana was raised by several interviewees as a topic of interest among prescribers and patients. One had reviewed existing literature and thought it held a lot of promise, and one had positive reports from patients who used it, but another felt that their patients who used it were overcharged and did not benefit. Several thought it was cost-prohibitive for Medicaid patients. Two were skeptical given the lack of clinical research.

Barriers to Addiction Treatment

Other than several FQHCs or prescribers who were already providing addiction treatment, prescribers we interviewed were generally not interested in taking on medication assisted treatment in their practices. There were various reasons for this, including a lack of staff to implement the more intensive counseling needed, a perceived lack of expertise in treating addiction, and fears of the type of patient population that such an offering would attract. Some examples:

- *"I'm not really qualified to deal with those kinds of things. So those kinds of patients wouldn't come to me. … I don't have any desire to get into this kind of thing … the last thing I wanna be is a magnet for people who want pain meds. … I don't want that kind of population. I have more than enough work as it is. If I have patients of mine that have a problem, I'll try to help them out. But... I already have more than enough business." (1)*
- *" I would have if we had a practice that was set up to handle that. But … when I see patients I'm all by myself. … you need a nurse practitioner or a PA, somebody to see the patient on a weekly basis, do the urine drug screen, see them when they're in withdrawal, do the induction. I'm not equipped for that." (15)*
- *"I don't have a license to write for Suboxone. It's not something I'm really planning on doing. The problem I have with that is... You kind of draw the crazies out sometimes. People find out you're writing for Suboxone or you're writing for medical marijuana ... And I'm not ready to go down that road with people." (17)*

Phone surveys with substance use treatment facilities in New Jersey in 2018 showed that only about half of them offered medication assisted treatment (Clemans-Cope, Epstein & Winiski 2019). Our interviewees who provided substance use treatment were serving mostly Medicaid patients and were significantly burdened by prior authorization requirements (which, as noted above, were removed in April 2019, after our interviews) as well as trouble gaining approval for extended release buprenorphine injections for patients who had trouble taking medication in a timely way or for whom there were diversion concerns. On the positive side, Medicare and Medicaid data for New Jersey show an uptick in MAT medications (Agrawal et al. 2019), and the New Jersey Department of Human Services (which oversees Medicaid) is actively encouraging addiction treatment with buprenorphine with enhanced rates and technical assistance, with positive early results (NJ DHS 2019a, 2019b).

Interviewees in FQHCs faced long waiting periods to become fully licensed to offer substance use treatment. There seemed to be differences of opinion as to what the specific requirements were. Some FQHCs offered treatment without getting the certification.

Limits on coverage for opioid alternatives (discussed earlier) raised challenges for how to treat pain for patients receiving addiction treatment.

The regulation of methadone clinics was perceived by the few who had experience with it as overly rigid and segregated from other sources of care, which prevented it from being optimally effective because methadone providers can't discuss pain or other issues the patient may be having and adjust the dosage accordingly: *"the field of addiction medicine where we had methadone clinics is still clinging to … outdated models of addiction medicine … the average provider in methadone … is not going to be able to have those more sort of evidence-based conversations about well, what are we going to do about your pain? What are we going to do about the fact that you are not adequately dosed at a hundred milligrams, but my guidelines say I can't go above a hundred milligrams because you're still using cocaine, etc., etc. They're very bound by a very tight set of regulations, which are understandable again, given the harm of methadone, the potential harm. But that potential harm isn't fixed by those regulations, just like the potential harm of prescribing opiates isn't fixed by what we've done with legislation at the state level. Any time you tighten things up, then you need to have an alternate structure for treating those people who you're going to lose with that tightening up. … Unfortunately, if you take a methadone clinic, most of the regs they have are not going to allow them to do" [things like harm reduction, peer or peri-support, and motivational interviewing]. (8)*

Insufficient Access to Behavioral Health Treatment, Particularly in Medicaid

Several interviewees noted that behavioral health co-morbidities appeared to them to exacerbate chronic pain conditions in their patients, but they had a difficult time finding psychiatric treatment for patients. This shortfall was felt most acutely by those trying to find psychiatric care for their Medicaid patients. One interviewee noted: *"the key I think to reducing overuse of narcotic analgesics is actually more effective treatment of depression … depressed people …have distorted pain sensation. So if you can treat depression, that probably would do a lot to reduce the narcotic problem. … I can barely get psychiatric help for patients. It's extremely difficult, especially if people have poor insurance, finding a psychiatrist is like pulling teeth." (1)*

Barriers for Medicaid Patients

In addition to barriers mentioned earlier with respect to a general shortage of specialists serving Medicaid patients and lack of access to treatments requiring out-of-pocket payments due to the limited financial resources of Medicaid patients, interviewees mentioned pain management and orthopedic specialists as difficult to find: *"limited access still in … County for orthopedic doctors for Medicaid patients, so we have only one place we can go for somebody that has a back injury, and that's … Ortho Clinic for Medicaid patients." (13).* Some also raised the HMO structure of Medicaid as restrictive (requires referrals and an assigned primary care provider). Interviewees also mentioned other barriers, including transportation, housing, food, access to employment and a reliable schedule.

Conclusion

While not a statistically representative sample, the 22 interviewees with whom we spoke in late 2018 constituted a diverse group of New Jersey opioid prescribers (see Appendix Table A1). Their orientation toward prescribing was driven by their clinical knowledge and experience, organizational policies, and the overall policy and regulatory environment, including New Jersey's law, passed and implemented in 2017, which restricts initial opioid prescriptions for acute pain to a 5 day supply and requires monitoring for longer-term usage among patients not meeting exemptions such as active cancer treatment or hospice.

Prescribers we interviewed agreed with 2016 CDC guidelines that opioids should not be the first choice for treatment of chronic (and, in many cases, acute) pain, but struggled with a lack of good solutions for chronic pain treatment, including lack of existing modalities, lack of insurance coverage for alternatives to opioids, and gaps in availability of pain management treatment, particularly for patients covered by Medicaid.

Opinions among our interviewees were somewhat divided as to the utility of the 2017 legislation, though most agreed that there was a need for limitation on opioid prescribing and for monitoring of long-term opioid usage.

Some, though not all, prescribers were interested in providing treatment for substance use disorder, including medication assisted treatment (MAT). A barrier to MAT for Medicaid patients was lifted a few months after the conclusion of our interviews when Medicaid eliminated prior authorization requirements for MAT, which some of our interviews had found quite burdensome and potentially harmful to patients. The Murphy administration has also tried to increase interest in the provision of MAT by offering technical assistance and incentives.[6] Some licensing/regulatory barriers, highlighted by Jacobi et al. (2016) remain, but the Murphy administration recognizes the importance of integrating physical and mental health care to improve treatment of opioid use disorder as well as better support health generally.[7]

[6] See January 2019 press release https://www.state.nj.us/humanservices/news/press/2019/approved/20190125.html.
[7] See 2020 State of the State Address, https://www.nj.gov/governor/news/addresses/approved/20200114_sos.shtml.

References

Agrawal M, K Lloyd, JC Cantor, J Farnham, and M Koller. 2019a. *Trends in Medicaid-Reimbursed Outpatient Buprenorphine, Naltrexone, and Naloxone Prescriptions following New Jersey P.L. 2017, c.28*. New Brunswick, NJ: Rutgers Center for State Health Policy.

Agrawal M, K Lloyd, JC Cantor, J Farnham, and M Koller. 2019b. *Trends in Medicaid-Reimbursed Outpatient Opioid Prescriptions following New Jersey P.L. 2017, c.28*. New Brunswick, NJ: Rutgers Center for State Health Policy.

Cicero TJ, and MS Ellis. 2017. Understanding the Demand Side of the Prescription Opioid Epidemic: Does the Initial Source of Opioids Matter? *Drug and Alcohol Dependence* 173(S1):S4-S10.

Clemans-Cope L, M Epstein, and E Winiski. 2019. Monitoring Patient Access to Facility-Based Opioid Use Disorder Treatment in New Jersey. Urban Institute, Health Policy Center.

Dowell D, TM Haegerich, and R Chou. 2019. No Shortcuts to Safer Opioid Prescribing. *New England Journal of Medicine* April 24 p1904190.

FDA (U.S. Food & Drug Administration). 2019. FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering. FDA Drug Safety Communication, 4-9-2019.

Foglia MB. 2019. When People You Love Are the Unintended Consequences of Opioid Policy. *Health Affairs, Narrative Matters* 38(12):2105-2108.

Jacobi JV, TA Ragone, and K Greenwood. 2016. *Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey*. Newark, NJ: Seton Hall University School of Law, Center for Health & Pharmaceutical Law & Policy.

NJ DHS. 2019a. Office Based Addiction Treatment. Medical Assistance Advisory Council Presentations, October 24, 2019, Slides 56-57. https://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_10-24-19.pdf.

NJ DHS. 2019b. NJ MATrx Model Concept. Medical Assistance Advisory Council Presentations, April 25, 2019, Slides 29-50. https://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_4_25_19.pdf.

Throckmorton D. 2019. Statement by Douglas Throckmorton, M.D., Deputy Center Director for Regulatory Programs in FDA's Center for Drug Evaluation and Research, on new opioid analgesic labeling changes to give providers better information for how to properly taper patients who are physically dependent on opioids. FDA Statement, Press Announcements, April 09, 2019.

U.S. Department of Health and Human Services, Working Group on Patient-Centered Reduction or Discontinuation of Long-term Opioid Analgesics. 2019, October. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. Accessed October 15, 2019 from: https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf.

Appendix: Interviewee Characteristics

Table A1: Interviewee Characteristics

	Number	Percent
Total Interviewed	22	
Phone	21	95.5%
E-mail	1	4.5%
Men	13	59.1%
Women	9	40.9%
Physicians	20	90.9%
Advanced Practice Nurses	2	9.1%
Practice setting/context (not mutually exclusive)		
Physician-owned practice	7	31.8%
Academic appointment/setting	7	31.8%
Federally qualified health center (FQHC)	6	27.3%
Hospital system/setting	7	31.8%
Specialties (not mutually exclusive)		
Internal medicine	11	50.0%
Pain management (3 Anesthesiologists, 1 Physical Medicine & Rehabilitation)	4	18.2%
Addiction medicine	3	13.6%
Palliative care and/or hospice	2	9.1%
HIV	2	9.1%
Emergency medicine	1	4.5%
Geriatrics	1	4.5%
Neurology	1	4.5%
Oncology	1	4.5%
Oral surgery	1	4.5%
Psychiatry	1	4.5%
Rheumatology	1	4.5%

Continued on next page

Table A1: Interviewee Characteristics (continued)

	Number	Percent
Years of Experience		
1-4	2	9.1%
5-9	3	13.6%
10-14	4	18.2%
15-19	5	22.7%
20-29	4	18.2%
30+	4	18.2%
Region		
North	7	31.8%
Central	6	27.3%
South	9	40.9%

Note: "not mutually exclusive" means that interviewees could belong to more than one of the categories noted (for instance, those with an academic appointment may, in addition, practice in another setting; also, practitioners sometimes had more than one specialty area).

RUTGERS

Center for State Health Policy

Center for State Health Policy
Rutgers, The State University of New Jersey
112 Paterson Street, 5th Floor
New Brunswick, NJ 08901

p. 848-932-3105 f. 732-932-0069
cshp_info@ifh.rutgers.edu
www.cshp.rutgers.edu