Running out of Options: Is Access to Non-pharmacologic Pain Management Treatments Linked to Opioid Prescriptions?

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Abstract
The high prevalence of chronic pain and the rising opioid prescription rate impact the quality of life of older adults. Clinical guidelines recommend non-pharmacologic treatments over opioids for chronic pain. Evidence shows that opioids are used more than non-pharmacologic treatments, and opioid prescription practices differ geographically. Healthcare system characteristics can encourage or deter pain management practices. Therefore, the research objective was to understand if and how access to non-pharmacologic pain treatments is associated with opioid prescriptions patterns for older adults with a new episode of persistent musculoskeletal pain (lasting ≥ three months).

From a 5% sample of fee-for-service Medicare beneficiaries enrolled from 2007–2014, we constructed a cohort of beneficiaries over 65 with a new episode of persistent musculoskeletal pain and no opioid prescriptions within the prior six months. Using claims data and the Area Health Resource File, we defined access as the provider supply and service use for two common non-pharmacologic services, physical therapy (PT) and mental health (MH). In Aim 1, greater supply of non-pharmacologic providers was associated with lower odds of an opioid prescription in the first three months of an episode. PT during the first three months of an episode was associated with lower odds of an opioid prescription in following three months. In Aim 2, greater supply of MH providers was associated with lower odds of long-term prescriptions (≥ 90 days' supply) and high-dose prescriptions (≥ 50 Milligrams Morphine Equivalent).

In Aim 3, we explored how primary care providers in North Carolina operationalize caring for chronic pain patients as discrete responsibilities and the needs, supports, barriers, and priorities for change associated with each responsibility. Provider reported struggling to avoid prescribing opioids while trying to recommend non-pharmacologic treatments and discuss the relationship between pain and MH. Common supports included published literature, patient education, allied health professionals, electronic health records, and prescribing policies. Key barriers included poor insurance coverage and limited time. Priorities to improve chronic pain care were better patient education materials and more MH professionals.

Taken together, the findings support polices that reduce shortages and engage patients in non-pharmacologic services to improve opioid prescribing practices for chronic pain.

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