SUPPORTING STATEMENT

Part B

Identifying and Testing Strategies for Management of Opioid Use and Misuse in Older Adults in Primary Care Practices

Version: *April 1, 2020*

Agency for Healthcare Research and Quality (AHRQ)

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B. Collections of Information Employing Statistical Methods

The purpose of the data collection efforts are to 1) assess and describe current perceptions of the challenges associated with managing opioid use, misuse and abuse in older adults; 2) test strategies adopted by primary care practices (PCPs) in the learning collaborative and 3) create a final, public-facing Compendium of Strategies for the management of opioid use, misuse and abuse in older adults in PCPs. This program and the information gathering described here are conducted in fulfillment of the mission that the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (see https://www.ahrq.gov/policymakers/hrqa99a.html), is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions.

The data collection activities planned to achieve the project goals are inclusive of:

1. A randomly selected national **survey of primary care clinicians** who care for older adults. The purpose of the survey is to assess primary care clinician experiences caring for older adult patients with chronic pain on opioids.
2. **Interviews with nine exemplar practices** that have developed and/or are implementing innovative approaches to managing opioid medications for chronic pain, particularly relevant for older adults. To identify the exemplar practices, we posted a 45-day notice in the Federal Registry.[i] From the responses to the Federal Registry notice, the team will select the nine most relevant, innovate strategies and conduct informal telephone interviews. Since we will be conducting interviews with no more than nine practices, we will not discuss the methods further in this supporting statement.
3. **Primary and secondary data collected from 24 primary care practices participating in two learning collaboratives including: a survey, interviews, a self-assessment, QI measures, and practice documents.** The aim of the evaluation of the strategies implemented by the participating practices is to investigate the feasibility and determinants of success in implementing the strategies and the effectiveness of the strategies in improving clinical processes and intermediate outcomes. The survey and QI measures collected will employ statistical methods and are described below.

1. Respondent Universe and Sampling Methods

1. Primary Care Clinician Survey - Sample

We will use a national database of health care providers maintained by IQVIA, a private health care data company, for the survey sample. The IQVIA database includes all clinicians in the U.S. who prescribe drugs or who bill to Medicare. The database comprises a diverse set of providers with respect to their occupation (i.e., physicians, nurse practitioners, physician assistants), geographic region, and

practice type (i.e., private small, private large, public, hospital affiliated, VA), as these characteristics have been associated with differences in opioid prescribing practices. The database includes mailing addresses for all these providers and email addresses for over 70% of providers.

For the survey sample, we will ask IQVIA to draw a random sample of 5,000 primary care clinicians (general internal medicine, geriatrics, family medicine, nurse practitioners, and physician assistants) who practice in outpatient PCPs in the U.S. This sampling strategy will allow the survey to collect responses from primary care clinicians throughout the U.S., while minimizing the amount of data needing to be requested from a third-party for the project. In addition to clinician names and contact information, IQVIA will also provide data on clinician age, clinician gender, clinician location (state, census region), clinician specialty, practice setting, and practice ownership.

2. Learning Collaborative: Primary Care Practice - Selection

We will employ a purposive recruitment strategy to allow us to identify primary care practices whose leadership is committed to improving their opioid use and misuse among older adults. We will also seek to have the practices represent diversity in terms of geography and practice characteristics (e.g., type, size, teaching, safety-net, geographic region, urban/rural). We will select 12 practices for each of two learning collaboratives, for a total of 24 practices. Note that practices may consist of more than one clinic that is centrally supported and governed (e.g., their opioid prescribing policies, support of quality improvement efforts).

For the proposal, we identified over 40 clinics that expressed potential interest in participating in the learning collaborative. These practices provided letters of interest. Six months prior to the launch of the first learning collaborative, we will confirm with these practices their interest in participating and assess their readiness. We will also pursue new practices through AHRQ recruitment opportunities (e.g., AHRQ posting "a call" thru the AHRQ primary care, practice-based research network and related listservs).

The final 24 practices will be selected from among those interested in participating. The final selection will represent diversity in terms of geography and practice characteristics (e.g., type, size, and teaching). We will schedule calls with the leads from a practice to assess readiness. During each call, we will discuss expectations, honoraria, and timeline; determine the extent of leadership support, available organizational resources, staff availability, and quality improvement (QI) champion(s); and, identify potential barriers that may impede implementation (e.g., new electronic health record system). To secure commitment, we will ask a representative from each practice to sign a memorandum of understanding (MOU) outlining what the Abt Associates Team will provide, expectations for the practices, and timeline. Additional selection criteria and conditions of participation include:

- At least 30% older adult or Medicare patient population for effective testing of strategies and data collection.

- QI commitment. A high level of QI experience will not be required. Rather, a commitment to QI involves interest and readiness to participate in QI activities. QI commitment can be demonstrated by previous LC experience, embedded QI infrastructure (data system) and/or staff commitment.
- Commitment from practice leadership (e.g., Chief Executive Officer, Chief Medical Officer, Clinic Manager, or QI Director) to provide time and resources for key staff to participate in all LC activities for the duration of the project.
- Identification of a champion and commitment from an interdisciplinary team of PCP staff members to engage in monthly webinars and calls to review the key performance indicators and discuss both system and clinical issues.
- Readiness, willingness, and capacity to implement a set of strategies to address one or more identified needs related to the opioid use and misuse in older adults and along the prevention, management, treatment continuum.
- Commitment to collect and report QI measures, and cooperate with evaluation data collection efforts (e.g., survey, interviews).

3. Learning Collaborative: Participating Primary Care Practices' Clinical Staff Survey - Selection

The respondents for the clinical staff survey of participating practices are intended to be all clinical staff, including clinicians (e.g., physicians, physicians' assistants, nurse practitioners) and other health care professionals (e.g., nurses, pharmacists, behavioral health providers, medical assistants) within the participating practices.

We make no claim that the results from this study will be generalizable. Rather, our small sample of information-rich cases will be illustrative of the kinds of barriers, facilitators and results that practices may experience in implementing the opioid use and misuse strategies for older adults.

2. Information Collection Procedures

1. Primary Care Clinician Survey

a. Primary Care Clinician Survey: Instrument

A brief provider survey will be sent to the 5,000 randomly selected primary care clinicians. The survey instrument (**Attachment A**) will include no more than 29 items. The survey specifically addresses the following domains relating to clinician experiences in caring for older adults with chronic pain on opioids: (1) Perceptions, attitudes, and awareness; (2) Clinician treatment patterns; (3) Practice or system processes; and (4) Clinician and practice characteristics. The survey is expected to take approximately 15 minutes to complete.

b. Primary Care Clinician Survey: Administration and Data Collection

The provider survey will be conducted electronically (web-based) or by telephone. We will send survey invitations via email and by mail, providing two approaches for contacting respondents.

The table below summarizes the survey administration timeline.

Table: Survey Administration Timeline

Survey Activity	Timeline
Advance survey notification email sent to all providers with an email address	3 business days before survey launch
Initial survey invitation letter including URL link mailed to all providers	Day 0 (survey launch)
Email invite containing URL link sent to all providers with email addresses	Day 3
Reminder email 1 sent to all non-respondents with an email address	Day 10
Reminder letter 1 mailed to non-respondents with mail address only and those for whom emails were determined to be undeliverable	Day 14
Reminder email 2 mailed to all non-respondents	Day 21
Reminder letter 2 mailed to all non-respondents	Day 28
Reminder email 3 sent to all non-respondents	Day 35
Reminder email 4 mailed to all non-respondents	Day 49
Survey closes	Day 64

c. Primary Care Clinician Survey: Analyses and Statistical Power Calculations

The goal of this provider survey is to describe clinician experiences caring for older adult patients with chronic pain on opioids throughout the United States. To meet this goal, we will conduct the analyses described below.

Non-response

We will provide a description of non-response patterns, and implications for representativeness of the survey responses to the clinicians included in the entire survey sample. Characteristics of respondents and non-respondents will be compared.

We will also calculate non-response weights, to adjust analyses of survey responses for differences between respondents and non-respondents in geographic region and clinician characteristics (i.e., clinician specialty, and practice type). In calculating non-response weights, we will weight the characteristics of the survey respondents to reflect the characteristics of all clinicians included in the survey sample as closely as possible, while

minimizing design effects. Design effects increase as the variance of a weight increases, resulting in reduced statistical power.

Descriptive Analysis of Primary Care Clinician Survey Responses

We will descriptively analyze the survey data to describe clinician awareness and use of strategies. Descriptive statistics (mean, standard deviation, and distribution for continuous variables; frequencies and percentages for categorical and binary variables) will be reported in tables and visualized in figures and graphics. All analyses will be adjusted using non-response weights. We will also code responses to open-ended survey questions thematically and describe common themes, along with demonstrative examples of responses under each theme.

Power calculation: We anticipate a 30% response rate, resulting in 1,500 completed surveys. Most survey measures will be coded as binary or categorical measures. Taking a binary measure with a base rate of 50%, assuming power of 80% and an alpha of 0.05, a sample size of 1,500 survey responses will provide a margin of error of 3.6% for descriptive analyses.[1] This margin of error will allow for meaningful descriptive estimates of clinician experiences caring for older adult patients with chronic pain on opioids, as collected through the survey.

Subgroup and Multivariate Analyses of Provider Survey Responses

We will also stratify measures of clinician experiences caring for older adult patients with chronic pain on opioids by geographic region, clinician specialty, practice type, and other clinician characteristics as relevant. Stratified analyses will be bivariate (survey responses stratified by a given clinician characteristic). We will also explore the feasibility of conducting multivariate analyses, to adjust for multiple provider characteristics concurrently. Multivariate analyses can also improve statistical power in some cases. All stratified analyses will be adjusted using non-response weights.

Power calculation: For bivariate analyses of a binary outcome measure, stratifying by two groups, and assuming power of 80% and an alpha of 0.05, a sample size of 750 responses per group will provide a minimum detectable difference of 5.7% between groups. A 5.7% minimum detectable difference would allow us the ability to identify moderate and large differences between groups as statistically significant.

[1] We used a rate of 50% for all power calculations, because this is the most conservative assumption. Survey measures with rates less than 50% or greater than 50% will have better power and lower margins of error or minimum detectable differences.

2. Learning Collaborative: Participating Practices' Clinical Staff Survey

a. Learning Collaborative Clinical Staff Survey: Survey Instrument

This brief survey will be sent to all clinical staff in the participating practices at two time points – prior to their practice initiating efforts to implement strategies for opioid use and misuse in older adults (baseline), and at the end of their participation in the collaborative (approximately 15 months later).

We assumed 20 clinical staff per practice and 24 practices overall for a total of 480 staff. We assumed 360 clinical staff will complete the survey at each time point based on 75% response rate. However, among the expected 360 respondents who complete the first survey, we expect a 75% response rate at the second time point, which would result in approximately 270 survey pairs across both time points.

The survey addresses the following domains: clinicians' individual characteristics, the clinic environment and burnout, prescribing and caring for patients on opioids, clinic-level opioid policies and practices, and challenges in prescribing opioids and managing pain. The survey is expected to take approximately 15 minutes to complete.

b. Learning Collaborative Clinical Staff Survey: Administration and Data Collection

Clinical staff will be invited to participate in the clinical staff survey by email. We will obtain a list of email addresses for clinical staff from the organizational liaison. Our survey recruitment strategy will include a 3-step email process. First, the medical director or practice manager at each organization will email clinical staff to introduce the survey and stress the importance of completion, informing staff that a follow-up email will be sent from a member of the project team and will contain a link to the online survey. The second email will reintroduce the survey and contain the live survey link. A third, reminder email will be sent to all clinical staff who did not respond about a week after the second email reminding them to complete the survey if they have not done so, and will again contain the live survey link. The online survey is estimated to take no longer than 15 minutes to complete.

c. Learning Collaborative Clinical Staff Survey: Analyses

As described in Summary Statement Part A, some of the data collected will be analyzed using quantitative methods. These quantitative analyses include univariate statistics (e.g., average clinician self-efficacy around safe opioid prescribing) and, where appropriate, statistical tests to assess differences in survey responses at baseline and post-implementation.

Most data will be analyzed at the clinic level, and consist primarily of descriptive statistics due to the small sample size. The quantitative analysis approach will entail running descriptive statistics – mean, median, standard

deviation, and plots of distributions for continuous variables, and frequency tables and plots for categorical variables.

Survey data will be pooled across practices to perform statistical tests. We will use paired-samples t-tests to compare continuous and Likert-scale outcomes (e.g., items of self-efficacy), between the two time points. If we find that the proportion of respondents vary considerably by certain characteristics, such as geographic location and/or size, we will adjust for these characteristics, for example by using ANOVA or a multivariable model. We will use binomial tests to compare binary outcomes (e.g., use of a patient registry, buprenorphine waivered status), between the two time points. For statistical tests will use a significance level of 0.05. All statistical tests will be computed in SAS.

3. Learning Collaborative: QI Measures

a. Learning Collaborative QI Measures: Administration and Data Collection

Aggregate reports for QI measures of process and intermediate outcomes will be collected quarterly from each of the participating practices. We will ask each practice to report these measures at the clinic level. For example, if a practice actually has five clinics, we will request these measures be reported for each clinic. The following is the list of potential QI measures that will be collected from practices (TBD based on final selected strategies to be implemented):

1. Number and percentage of clinical staff that completed training on opioids and older adults
2. Number and percent of patients who are on opioid medication
3. Number and percentage of patients who are on opioid medication for pain
4. Number of patients on long-term opioid therapy (LTOT)
5. Number of patients tapered off LTOT/discontinued opioids
6. Number of older adult patients on LTOT
7. Number and percentage of patients in which the was used PEG with older adults to assess pain and function
8. Percentage of older adult patients on LTOT who are on greater than 50 morphine milligram equivalents (MMEs)
9. Percentage of older adult patients on LTOT who are co-prescribed a benzodiazepine
10. Percentage of older adult patients on LTOT who had the prescription drug monitoring program (PDMP) checked
11. Percentage of older adult patients on LTOT who have had a urine drug screen

12. Number and percentage of providers assessed older adult patients for OUD
13. Of the older adult patients with OUD, the percentage that are prescribed or referred to MAT
14. Percentage of older adults patients on LTOT who are prescribed naloxone
15. Number of BH providers engaged in pain management/opioid use

b. Learning Collaborative QI Measures: Analyses

While the QI measures will be used largely to support practices in monitoring their improvements in care, we will report the mean, median, standard deviation, frequencies, histograms across participating clinics. Additionally, we will assess organizational-level changes in QI measures (of proportions) over time, from baseline measure results reported to the final QI measure results reported (15-months post implementation) using paired t-tests.

3. Methods to Maximize Response Rates

1. Provider Survey

Given our recent experience with clinician web surveys, and using email addresses provided by IQVIA, we believe a 30% response rate is achievable.[2] While response rates in surveys of physicians and other clinicians have declined in recent years,[3] we will use the following approaches to improve the survey response rate and reduce bias from survey non-response:

- The survey questionnaire will be brief, having 29 or fewer items. The questionnaire will also include items that are relevant to primary care clinicians, as informed by cognitive testing and discussions with experts.
- We will provide $25 to clinicians as a token of appreciation for participating.
- We will collect survey responses using a web survey format optimized for mobile devices.
- Respondents will receive invitations with unique links to the web survey, sent to providers via both email and mail. Multiple follow-up reminders

[2] For a recent survey of orthopedic surgeons, for the CMS Evaluation of the Comprehensive Care for Joint Replacement Model, we obtained a response rate of 29%. The study sent paper questionnaires to all participants, in addition to the option of taking the survey online, but roughly 70% of responses were provided through the web survey.

[3] McLeod CC, Klabunde CN, Willis GB, Stark D. Health care provider surveys in the United States, 2000–2010: a review. Evaluation & the health professions. 2013 Mar;36(1):106-26.

will be sent using both modes.[4] A two-month period for data collection will allow busy clinicians flexibility in responding to the survey.

- Email and paper letters with attractive design and AHRQ logo. Invitation letters will emphasize importance of feedback for setting policy to address real-world challenges. We will also explore the possibility of including letters of support from AHRQ.

2. Learning Collaborative: Participating Practices' Clinical Staff Survey

The practice leaders, for example the Medical Director, practice manager or QI Lead, will be asked to encourage completion of the Clinical Staff Survey, which should help maximize the response rate. Although clinical staff surveys (conducted online or using other methods) often suffer from low response rates, AHRQ expects a better than average return rate for this survey because the distribution will be targeted to clinical staff working in practices that are implementing strategies to improve opioid use and misuse in older adult patients. Also, we will use a recommended, 3-step email approach demonstrated to improve response rates[5].

4. Tests of Procedures

1. Provider Survey

All of the data collection protocols have been reviewed by the project partners (e.g., Technical Expert Panel members) who have experience obtaining, improving and studying opioid prescribing practices and processes. This review helps establish the face and content validity of the protocols. Additionally, the survey instrument will be cognitively tested on five primary care clinicians, to ensure clarity and relevance.

The survey instrument also adapted existing items from previously tested and validated instruments, to the extent possible. In particular, many of the survey items were adapted from the Clinical Staff Survey used in the AHRQ Six Building Blocks (6BB) study, which were developed based on the content in the 6BBs How-to-Guide and prior 6BBs studies. That survey underwent OMB Review in 2019, and was pre-tested with several staff from AHRQ's contractors who are clinicians (at Abt Associates and the University of Washington) to identify wording issues and improve clarity, verify the length of time needed to complete the survey, and assess the content validity of each survey item.

2. Learning Collaborative: Participating Practices' Clinical Staff Survey

The survey will be reviewed by the technical expert panel and project to help establish the face and content validity. Additionally, the survey uses items from the provider survey described above, and adapts items from previously fielded

[4] Dillman, D.A., 1978. *Mail and telephone surveys: The total design method* (Vol. 19). New York: Wiley.

[5] Dillman, D.A., 1978. *Mail and telephone surveys: The total design method* (Vol. 19). New York: Wiley.

surveys of clinical staff regarding opioid management practices including a survey of primary care practices for another AHRQ contract (Six Building Blocks) that was approved by OMB in January 2020.

5. Statistical Consultants

Abt Associates is the contractor who will facilitate health care organizations' data collection and analysis on behalf of AHRQ. The professionals from Abt Associates have over 40 years of experience providing high quality, timely and cost effective data collection for federal agencies. Abt Associates employs many statisticians, economists and experienced research methodologists. The following skilled health services researchers, survey researchers and skilled quantitative analysts designed or reviewed the proposed statistical analyses, including Sean McClellan, PhD; Douglas McDonald, PhD; Giulia Norton, PhD; and Sarah Shoemaker-Hunt, PhD, PharmD. Collectively, they have designed dozens of rigorous research studies for AHRQ, CMS and other federal agencies. They are available should any questions regarding the statistical analyses for this project arise. The key project contact at Abt Associates is Rosanna M. Bertrand. Following is her contact information:

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OMB
Attachment A

Survey of Primary Care Clinicians about Opioid Use among Older Adults

Please return this survey in the enclosed envelope to:

Abt Associates
10 Fawcett Street, Ste. 5
Cambridge, MA 02138

DIRECTIONS

This survey is for clinicians who treat older adults in primary care settings in the United States. We would like to know about your experiences caring for older adults with chronic pain on opioids. Your participation in this survey is greatly appreciated!

- This survey is supported by the Agency for Healthcare Research and Quality (AHRQ) and is designed to assess **clinician experiences caring for older adult patients with chronic pain on opioids**. Abt Associates, a private research company, is conducting this study on behalf of AHRQ. You were randomly selected to participate in the survey. We anticipate that it will take you roughly **15 minutes** to complete the survey and are **offering $25** as a token of our appreciation for completing the survey.
- The survey is **voluntary**, but your input is critical for helping us understand and support clinicians in caring for patients with chronic pain on opioids.
- If you participate, you do not have to answer every question. However, we encourage you to respond to this survey as completely and accurately as possible.
- **Your answers to this survey will be kept private and secure and will be confidential**, and only combined with other survey responses and presented in aggregate form in our reports. Abt Associates, and AHRQ are committed to protecting data confidentiality and privacy.
- This survey and the answers you provide will reside in a secure, protected computing environment, and measures are in place to prevent a breach of the information collected.

If you have any questions about this survey, please do not hesitate to contact us at OpioidsOlderAdults@abtassoc.com.

Instructions (paper survey only):

When providing each response:

- Please read each question carefully and shade in the circle next to the response that most closely represents your experience.
- Please shade only one circle for each question, unless asked to mark all that apply.
- Please use a PENCIL in case you want to change your answer.
- Please do NOT use felt tip pens.
- Please erase cleanly or white out any marks you wish to change.

Opioid Prescribing and Managing Opioids in Your Practice

We would like to know about your personal experience caring for patients with chronic pain on opioids.

1. What is the approximate age distribution of your patients? *Your best estimate is fine.*

17 years old or younger	18 to 64 years old	65 to 79 years old	80 years old or older	
%	%	%	%	= 100%

2. In a typical work week, about how much of your time is spent on the following?

	Almost all of my time	Most of my time	Some of my time	Hardly any of my time	None of my time
Caring for patients with chronic pain	o	o	o	o	o
Caring for patients with chronic pain <u>on opioids</u>	o	o	o	o	o → **GO TO #24**

3. In the last three months, have you prescribed opioids to patients with chronic pain?

O Yes

O No

4. Approximately what proportion of the patients aged 65 or older that you saw in the last six months were currently prescribed opioids by you or someone else?

O I do not treat patients aged 65 or older → **GO TO #24**

O No patients aged 65 or older were prescribed opioids → **GO TO #24**

O 1-5% of all patients aged 65 or older were prescribed opioids

O 6-10% of all patients aged 65 or older were prescribed opioids

O 11-25% of all patients aged 65 or older were prescribed opioids

O 26-50% of all patients aged 65 or older were prescribed opioids

O 51-100% of all patients aged 65 or older were prescribed opioids

5. Thinking about your patients aged 65 or older who are currently on opioids, approximately what proportion <u>have been taking opioids for three months or more</u>?

O No patients aged 65 or older currently taking opioids have used them for 3 months or more

O 1-5% of patients aged 65 and older currently taking opioids have used them for 3 months or more

O 6-10% of patients aged 65 and older currently taking opioids have used them for 3 months or more

O 21-25% of patients aged 65 and older currently taking opioids have used them for 3 months or more

O 26-50% of patients aged 65 and older currently taking opioids have used them for 3 months or

more

O 51-100% of patients aged 65 and older currently taking opioids have used them for 3 months or more

6. When caring for patients aged 65 and older with chronic pain on opioids in the last three months, about how often did you or your team conduct these specific aspects of care? *Please answer each item thinking specifically about your patients aged 65 and older.*

	Always	**Often**	**Sometimes**	**Rarely**	**Never**
Discuss risks and benefits of opioid therapy with patients	O	O	O	O	O
Discuss a treatment agreement (pain contract)	O	O	O	O	O
Discuss storage and disposal of opioids	O	O	O	O	O
Engage in shared decision making with patients regarding treatment of chronic pain	O	O	O	O	O
Refer patients to physical therapy for pain	O	O	O	O	O
Refer patients to acupuncture for pain	O	O	O	O	O
Refer patients to other non-pharmacologic therapies for pain	O	O	O	O	O
Check patients' records in the Prescription Drug Monitoring Program (PDMP)	O	O	O	O	O
Order and/or interpreting urine drug test results	O	O	O	O	O
Assess for constipation	O	O	O	O	O
Assess for fatigue	O	O	O	O	O
Assess for confusion	O	O	O	O	O
Assess for functional status decline	O	O	O	O	O
Assess for depression and/or anxiety	O	O	O	O	O
Assess for decreased cognition	O	O	O	O	O
Assess for drug-drug interactions	O	O	O	O	O
Assess patients' current and past use of benzodiazepines, other sedatives, and/or controlled substances	O	O	O	O	O
Assess patients' current and past use of alcohol or illicit drugs	O	O	O	O	O
Assess whether patients are taking more opioids than prescribed	O	O	O	O	O
Assess patients for opioid use disorder	O	O	O	O	O
For patients with opioid use disorder, refer to or treat them with medication assisted treatment (MAT)	O	O	O	O	O
Prescribe or refer patients for naloxone (overdose reversal drug)	O	O	O	O	O

7. Do you conduct any of the above aspects of care with **only** patients aged 65 and older (i.e., not with patients younger than 65

O No

O Yes, please describe: _____

_____

8. On a scale from 1 to 5, how confident are you in your ability to conduct each of the following clinical care activities *with patients aged 18 to 64* and *65 or older* with chronic pain on opioids?

	Patient age group	1 Not at all confident	2	3	4	5 Very confident
Provide care according to regulations and guidelines for patients with chronic pain on opioids	18-64	O	O	O	O	O
	65+	O	O	O	O	O
Develop a *taper* plan collaboratively with the patient when appropriate	18-64	O	O	O	O	O
	65+	O	O	O	O	O
Engage in difficult conversations with patients (e.g., tapering, urine drug test or prescription drug monitoring program results)	18-64	O	O	O	O	O
	65+	O	O	O	O	O
Diagnose co-occurring behavioral or mental health conditions among patients with chronic pain on opioids	18-64	O	O	O	O	O
	65+	O	O	O	O	O
Identify patients with chronic pain on opioids who are misusing opioids	18-64	O	O	O	O	O
	65+	O	O	O	O	O
Diagnose opioid use disorder (OUD),distinguishing it from physical dependence, among patients with chronic pain on opioids	18-64	O	O	O	O	O
	65+	O	O	O	O	O
Prescribe or refer patients for medication-assisted treatment (MAT) like buprenorphine/naloxone or naltrexone	18-64	O	O	O	O	O
	65+	O	O	O	O	O

9. When caring for patients with chronic pain on opioids during the last three months, how often have you observed the following *with patients aged 18 to 64 and 65 or older*?

	Patient age group	Always	Often	Sometimes	Rarely	Never
Misuse of opioids[1]	18-64	O	O	O	O	O
	65+	O	O	O	O	O
Challenges with side-effects related to opioids[2]	18-64	O	O	O	O	O
	65+	O	O	O	O	O
Patient experiencing confusion	18-64	O	O	O	O	O

	65+	o	o	o	o	o
Patient experiencing fatigue	18-64	o	o	o	o	o
	65+	o	o	o	o	o
Patient is willing to try non-pharmacologic therapy for pain	18-64	o	o	o	o	o
	65+	o	o	o	o	o

1. Misuse of opioids can include taking too much medicine, taking someone else's medicine, taking it in a different way than you are supposed to, or taking the medicine to get high. Citation: National Library of Medicine (NLM), MedlinePlus. "Opioid Misuse and Addiction."
2. Side-effects related to opioids can include drowsiness, mental fog, nausea, constipation, and slowed breathing. Citation: National Library of Medicine (NLM), MedlinePlus. "Opioid Misuse and Addiction."

10. Are you waivered to prescribe buprenorphine to patients with opioid use disorder?

O Yes

O No → **GO TO #12**

11. In the last three months, have you prescribed buprenorphine or methadone to patients with opioid use disorder? *Please select all that apply*.

O Yes, including for patients aged 18-64

O Yes, including for patients aged 65 or older

O No

12. Before reading each of the following statistics on opioid use and misuse in older adults, how aware were you about these statistics?

	Not at all aware	**Slightly aware**	**Somewhat aware**	**Moderately aware**	**Very aware**
During 2018, an estimated 35% of persons aged 65 or older in the United States reported any opioid use during 2018[3]	O	O	O	O	O
In 2018, it was estimated that 1.3% (681,000) persons aged 65 or older in the United States misused prescription pain relievers during the prior year[4]	O	O	O	O	O
In 2017, there were 1,724 opioid-related overdose deaths among persons aged 65 or older in the United States[5]	O	O	O	O	O

3. Substance Abuse and Mental Health Services Administration (SAMHSA). 2018 National Survey on Drug Use and Health (NSDUH), Public Online Data Analysis System. Retrieved from: https://pdas.samhsa.gov/#/survey/NSDUH-2018-DS0001?column=AGE2&results_received=true&row=PNRANYYR&run_chisq=false&weight=ANALWT_C
4. Substance Abuse and Mental Health Services Administration (SAMHSA). 2018 National Survey on Drug Use and Health (NSDUH), Public Online Data Analysis System. Retrieved from: https://pdas.samhsa.gov/#/survey/NSDUH-2018-DS0001?column=AGE2&results_received=true&row=OPINMYR&run_chisq=false&weight=ANALWT_C
5. Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;67:1419–1427. Available at: https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm

Available Practice or System Resources Related to Chronic Pain or Opioids

We would like to know whether the following resources are available in your practice.

13. Does your practice or health care system have policies or guidelines related to providing care for patients with chronic pain on opioids?

O Yes

O No → **GO TO #15**

O Don't know → **GO TO #15**

14. Does your practice or health care system have policies or guidelines related to providing care for patients with chronic pain on opioids **that are specific to adults aged 65 and older**?

O Yes

O No

O Don't know

15. Does your practice or health care system have a standardized treatment agreement (pain contract) for patients with chronic pain on opioids?

O Yes

O No → **GO TO #17**

O Don't know → **GO TO #17**

16. Does your practice or health care system have a standardized treatment agreement (pain contract) for patients with chronic pain on opioids **specific to adults aged 65 and older**?

O Yes

O No

O Don't know

17. Does your practice or health care system have electronic health record tools (e.g., notes templates, alerts, clinical decision-support tools) to support care for patients with chronic pain on opioids?

O Yes

O No

O Don't know

18. Does your practice or health care system use a registry or other tracking system to help care for patients with chronic pain on opioids?

O Yes

O No

O Don't know

19. Does your practice or health care system provide financial or administrative support to clinicians to apply for a buprenorphine waiver? *Please select all that apply.*

O Yes, financial support

O Yes, administrative support

O No

O Don't know

20. If your practice is part of a health care system, does your system have any policies, guidelines or quality improvements efforts related to opioids that is specifically focused on older adults? If so, please briefly describe:

_____

_____

_____

21. What strategies has your practice successfully used to improve opioid prescribing and pain management practices *specifically for adults aged 65 and older*?

_____

_____

_____

22. What resources or supports do you feel would most improve your ability to prescribe and manage opioids, manage opioid use disorder (OUD), and/or manage chronic pain *specifically for adults aged 65 and older*?

_____

_____

_____

23. Is there anything else that would be helpful to understand about your experience providing care to patients on opioids, *specifically for adults aged 65 and older*?

_____

_____

_____

About You and Your Practice

Finally, please tell us a little about you and your practice.

24. What is the approximate racial distribution of your patients? *Your best estimate is fine.*

Asian	Black or African American	White	Other	
%	%	%	%	= 100%

25. Approximately what percent of your clients identify as Hispanic? *Your best estimate is fine.*

☐☐☐ %

26. Do you have a specialty in or are you credentialed in geriatrics?

O Yes

O No

27. When caring for patients aged 65 or older, are you able to consult in-person or by phone, as needed, with the following staff **working at your practice**? *Please select all that apply.*

O Geriatrician or geriatric nurse practitioner (NP)

O Clinical pharmacist

O Pain management specialist

O Addiction specialist

O Mental health clinicians (e.g., therapists, psychologists, psychiatrists)

28. Currently, how many physicians work in your practice, across all locations, including both full and part-time physicians? *Your best estimate is fine.*

☐☐☐☐ # physicians

29. Which of the following best describes your practice's ownership?

O Clinician-owned solo or group practice

O Hospital/health system owned

O Health Maintenance Organization

O Federally Qualified Health Center or look-alike

O Non-federal-government clinic (e.g., state, county, city, public health clinic, etc.)

O Academic health center/faculty practice

O Federal (military, Veterans Administration, Department of Defense)

O Other

Thank you very much.

We greatly appreciate your participation in this survey.

Citations

[i] https://www.govinfo.gov/content/pkg/FR-2020-03-18/pdf/2020-05612.pdf