# Generational, bureaucratic obstacles fuel opioid crisis

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**Bruce A. Schoneboom**

Opioid abuse is taking a catastrophic toll, with recent CDC data attributing 91 deaths a day to the epidemic. Further, in 2015, 63% of the 52,404 drug overdose deaths involved heroin and opioid pain reliever medications.

**Bruce A. Schoneboom, PhD, CRNA, COL,** senior director of education and professional development, American Association of Nurse Anesthetists, told *Healio Family Medicine* that this crisis, at least in part, stems from doctors putting too much emphasis on pain. “Treating pain as the fifth vital sign has had unintended consequences like the overprescription of opioids,” he said.

A NIH review suggested integrative, alternative, complementary and holistic therapies may be efficacious in pain management. However, not all doctors seem willing to prescribe these treatments or buprenorphine, and the reasoning may be due to several potential hurdles.

### Generational, educational gaps

According to data from the Association of American Medical Colleges, in the 2001 to 2002 academic year, 38 of 125 responding medical schools required students to take a course in complementary/alternative health care. By the 2015 to 2016 academic year, the number rose to 130 of 142 responding schools. With a biennial survey indicating that the average physician age is 50.32 years, many medical professionals were not taught these techniques.

**Gary Kaplan**

“The older the physician, the less likely they are to be familiar with the research and validity of alternative therapies,” **Gary Kaplan, DO,** founder and medical director of the Kaplan Center for Integrative Medicine in McClean, Va., told *Healio Family Medicine*.

“Complementary and alternative therapies were not taught in medical school [because they] did not fit the medical model. [These therapies] were frequently ridiculed if mentioned at all and were not considered ‘real’ medicine.”

“Despite the significant body of research that has now accumulated, the mindset remains among the majority of older physicians that these approaches are not real medicine,” Kaplan, who is also a clinical associate professor of family medicine at the Georgetown University School of Medicine, Washington, D.C., added. “The bias is belief and not scientifically based.”

**David A. Thomas, PhD,** health science administrator for the National Institute on Drug Abuse, also acknowledged the educational gap.

David A. Thomas

“Generally speaking, primary care physicians don’t get much training on pain management, so they don’t understand some of the benefits of treatments, such as acupuncture and yoga, and when such treatments might be useful,” Thomas told *Healio Family Medicine*.

Heather Tick

**Heather Tick, MD,** clinical associate professor of the departments of family medicine and anesthesiology and pain medicine at the University of Washington, agreed.

“It is widely acknowledged for the past 30 years that our education system for primary care physicians is inadequate in pain management education, and yet little has changed,” Tick told *Healio Family Medicine.*

According to the Pain and Policy Studies Group, only nine states require pain management as part of practitioners’ continuing education.

To help close the educational gap, AAFP offers webcasts and reading materials on pain management and opioid abuse. Experts have told *Healio Family Medicine* that medical professionals can conduct imaging studies and query patients about the duration, location and source of pain to further determine the best course of treatment.

**Handling patients’ reliance on pills**

However, even clinicians who are fully versed in alternative, complementary and integrative therapies for chronic pain, as well as those who have made their patient fully aware of these therapies, may still encounter patients who insist on receiving a pill.

**Robert Bolash, MD,** an interventional spine pain specialist within the pain management department at Cleveland Clinic, said it is important to stress to these patients that other treatments are usually more effective.

“To simply write a prescription and send the person on his or her way will help about 20% to 30% of the time; these therapies routinely don’t get people to remission of chronic pain,” he told *Healio Family Medicine*.

“If that doesn’t work, physicians should parallel the pain to a condition that the patient might be more familiar with,” Bolash continued. “For example, you can say, ‘Yes, we can give you metformin or insulin for diabetes, but it’s only going to tackle one part of it if you don’t exercise and change your diet.’”

**Bureaucratic, administrative obstacles**

Ronald Glick

Another obstacle to the utilization of complementary and alternative medicine is that most insurance companies do not cover these therapies, **Ronald Glick, MD,** medical director of the Center for Integrative Medicine at the University of Pittsburgh Medical Center, told *Healio Family Medicine.*

“In California, New York and Philadelphia, there’s a modest amount of insurance coverage for complementary services, but most of the rest of the country is a desert,” he said. “If the services aren’t covered, alternative therapies are often inaccessible for the very patients who are most likely to be impacted by the opioid crisis.”

Kaplan added that the low reimbursement rates and high costs of these therapies limit how often they are prescribed or implemented.

“Insurance will rarely pay for these therapies — and poorly when they do — and as such, physicians are economically discouraged from incorporating them into their treatment programs,” he said. “Without insurance coverage, these programs are only available to those who can afford to pay out of pocket.”

According to Kaplan, other factors also play a role in a physician’s reluctance to prescribe complementary and alternative therapies.

“Physicians are under huge and increasingly more severe economic pressure. Insurance companies do not value time and as a result we now have 8- to 10-minute medical appointments,” he said. “Procedures are economically rewarded and as such nerve blocks and dorsal column stimulators are the rage. Creating a comprehensive pain program that incorporates multiple complimentary therapies is very time and personnel intensive. The early data on these comprehensive pain programs is very encouraging, but they are very costly.”

Tick addressed another system-based change that has to occur for physicians to begin prescribing the complementary and alternative therapies.

“We have to start measuring success differently. We need a value-based care system instead of one that rewards volume of patients seen and rushed through office visits,” she said.

Health insurance officials who spoke to *Healio Family Medicine* said there must be significant and substantial data to support a therapy before it will be covered.

Julie Kessel

“There isn’t any specific threshold; there’s no set number of studies we require, although ideally there would be more than just one or two,” **Julie Kessel, MD,** senior medical director, Cigna, told *Healio Family Medicine*. “What matters most is the overall quality of the study — its design, the number of subjects enrolled, the clinical relevance of what it measured, and what statistics were used to assess the relationship between the intervention and the clinical outcome.

“The peer-review process is critical as well, and where the study is published matters. A peer-reviewed study in a highly regarded journal like the *New England Journal of Medicine* carries more weight than non-peer-reviewed anecdotal evidence in a newsletter,” Kessel, who is also head of Cigna’s coverage policy unit, added.

**Geoffrey Crawford, MD, MS,** medical director for medical policy and technology assessment at Anthem, agreed.

“Medical policy is based on evidence-based medicine. It’s challenging for us to view a service as medically necessary if the appropriate research hasn’t been conducted to confirm that the service has a positive impact on patient outcomes,” Crawford said in an interview.

“Anthem develops medical policy on new or existing procedures, devices and technologies by relying on scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, as well as evidence that the procedures, devices and technologies improve net health outcomes and will be as beneficial as any established alternative,” he continued.

Glick said the Academic Consortium for Integrative Medicine and Health is trying to “build the case” to insurance companies that evidence does exist for covering these therapies. According to the group’s website, one of its goals is to distribute information on rigorous scientific research and inform health care policy and practice.

**Unwillingness to prescribe buprenorphine**

Further compounding the opioid crisis is that not all physicians may utilize all the resources at their disposal to help their patients.

According to an *Annals of Family Medicine* study published earlier this year, fewer than one in three rural physicians who have a waiver to prescribe buprenorphine for opioid use disorder do so. In the study, **C. Holly A. Andrilla, MS,** of the WWAMI Rural Health Research Center, University of Washington School of Medicine, Seattle, and colleagues found that some of the most common reasons physicians cited for not prescribing the medication were not wanting to attract drug users to their practices and a lack of time.

Thomas was not part of that research, but he reviewed Andrilla’s article for *Healio Family Medicine* and said the findings were troubling.

“It doesn’t surprise me, but it does concern me,” he said. “You wouldn’t use those excuses for other diseases. Primary care physicians should be doing their job and be responsible caregivers. Anybody who takes care of somebody in pain should know what they’re doing.

“[PCPs] should get adequate training, so they are aware of different treatment modalities and know how to use opioids in combination with other therapies,” Thomas, who is also a representative to the NIH Pain Consortium, continued. “These physicians should know how opioids work for pain, the side effects and the potential for abuse. All of this should just go with the territory. I wish that was the norm, but obviously it’s not; it’s the exception.”

Andrilla and colleagues’ findings were not unique. A survey reported on at the 125th Annual Convention of the American Psychological Association, found that of those physicians who had the waiver and were underprescribing buprenorphine, more than half said nothing would decrease their reluctance to prescribe to capacity.

**Lucinda A. Grande**

**Lucinda A. Grande, MD,** a physician with Pioneer Family Practice in Lacey, Wash., co-authored a study in the *Journal of the American Board of Family Medicine* that suggested doctors need to do more to help their patients.

“[We] believe that obtaining a waiver — or working with someone who has a waiver and is accepting patients — is the responsibility of every provider who prescribes opioids or discontinues prescribing them,” Grande told *Healio Family Medicine*. “Simply advising a patient to get treatment is not useful and leaves the patient at risk. Clinics should ensure an adequate number of waivered providers to meet the needs of their clinic.”

However, **Jack Westfall, MD, MPH,** project principal investigator for the Implementing Technology and Medication Assisted Treatment and Team Training in Rural Colorado program, told *Healio Family Medicine* there are many constraints on physicians’ schedules.

“Even amongst providers and practices that want to provide this care, finding the time for education and training can be tricky,” Westfall said. “That is why our program brings the training to the practice, offers training to everyone in the practice and helps integrate this unique care into the broader context of integrated primary care practice.”

Westfall commented on some of the obstacles surrounding writing buprenorphine prescriptions.

“Inertia may be a great barrier,” he said. “Treating substance abuse disorders in the primary care practice does require a bit of preparation. [Obtaining the waiver] requires extensive education and training. Nurses and staff need knowledge and skills related to caring for patients in withdrawal and mental, emotional and behavioral health problems. This preparation and training take time that, in a busy practice, is tough to carve out.”

**Change in mindsets**

Thomas said that addressing the opioid crisis will also require a “cultural shift” in many professionals’ medical attitudes.

“We need to start thinking of opioid use disorder as a disease,” he said. “Too often, addiction is thought of as a moral failing of the afflicted individual. But addiction is a disease and people struggling with opioids need help. Primary care physicians should approach the treatment of opioid use disorder as they would any other disease: They should work with patients to help them and do approximate referrals if needed.”

He added that both the previous and current presidential administrations have addressed the opioid crisis, which may also help bring it under control.

“There’s a recognition across the government, across the country and across many countries that we have a serious problem here,” Thomas said. “Is it going to take a lot of effort [to fix the problem]? Absolutely. Is it going to take a lot of money? Absolutely. But ... finally, there’s awareness across organizations and the government that we can’t ignore this problem.”

However, most government policies, even those with the best of intentions, can be slow to come to fruition.

Physicians must do something in the interim, Thomas said.

“The opioid crisis is not going away without us doing something significant. We can’t stay like this — something has to be done,” he said. – *by Janel Miller*

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