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Letters to the Editor

LETTERS TO THE EDITOR

Opioid Prescribing Patterns by Naturopathic Physicians in Oregon

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Dear Editor,

We read the recent report by Fink et al., "Opioid Prescribing Patterns and Patient Outcomes by Prescriber Type in the Oregon Prescription Drug Monitoring Program" with great interest. We are pleased to see the inclusion of naturopathic physicians (NDs) in health services research focused on risky opioid prescribing behavior and encourage accurate representation of ND prescribing practices and their consequences.

Fink et al. [1] note that patients who saw an ND were more likely to have an inappropriate or high-dose prescription. However, critical to interpretation, only in a minority of these cases (19.1% and 34.5%, respectively) were the opioids *actually prescribed* by the ND. Notably, patients who saw NDs also had the greatest number of prescribers per patient, 6.1 on average. Thus a more accurate presentation of the results, with appropriate attribution, would read: For patients seeing NDs and multiple additional health care providers (6.1 on average), the majority of inappropriate and high-risk opioid prescribing was done by a medical clinician (80.9% and 65.5%, respectively), not the ND. Additionally, unpublished results from Fink et al. (obtained through private discussion and reported here with permission) demonstrate that among all opioid-related hospitalizations (N = 7 366), the ND was the prescriber in only 29 cases (0.66% of all opioid prescriptions by NDs, with no significant difference from the MD rate of 0.69%) and there were no opioid-related deaths in patients last prescribed opioids by an ND (N = 0, 0% of all opioid prescriptions, also not significantly different than the MD rate of 0.04%). Although all of the hospitalizations and deaths can be linked to prescription opioids, it is not clear from the available data whether illicit, nonmedical use or deviations from the original prescription signature influenced any of the adverse events.

These findings support the need for 1) greater provider communication through electronic health record (EHR) connectivity or other media (e.g., the telephone!), such that providers are aware of all patients' providers and provider prescriptions, 2) increased integration of NDs into pain management teams, such that patients are given nonpharmacologic options *earlier* in their pain management process, and 3) increased opioid training for all provider types, including "integrative opioid management" training that encourages providers to communicate with other care disciplines regarding opioids and nonopioid pain management options.

In addition to the need for increased coordination of care, the findings also represent the need to increase effectiveness and implementation research for nonopioid approaches to pain management, including complementary and integrative health (CIH) practices and CIH referrals *earlier in the pain management process*. Although there are many studies looking at different individual agents or modalities (e.g., herbal medicines, omega-3 fatty acids, acupuncture, yoga, manipulation, massage, etc.) [2–4], there are also studies examining how North American naturopathic physicians practice pain management. In general, NDs deliver dietary counseling, breathing exercises, acupuncture, clinical nutrition and dietary supplements, and herbal medicines to achieve improvement in pain scores and function [5–7]. Also, an

associated economic analysis of ND care for low back pain measured an overall cost-saving effect, with decreased absenteeism and improved presenteeism at work [8]. In our experience of Oregon's naturopathic community, the practice norm for naturopathic physicians is to preferentially apply nonpharmaceutical modalities as their primary approach to pain management, even with the broad authority to prescribe controlled substances in Oregon (a scope that is atypical in most states where NDs are licensed). Importantly, these effective, self-management-oriented approaches, used by NDs as firstline approaches in pain management for decades, are consistent with the Centers for Disease Control's 2016 guidelines on pain management, which states, "Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain," suggesting that NDs could be potent partners in meeting current guidelines [9].

Also of note, during the study period of 2011–2014, the Oregon Health Authority and the regional Coordinated Care Organizations began a dramatic overhaul of how they would cover nonpharmaceutical pain management options for Medicaid patients. They began to increase coverage for clinical services including acupuncture, physical therapy, spinal manipulation, psychotherapy, and relaxation training for chronic pain. These changes came about in part with the assistance of NDs who were actively involved in the committees developing the new protocols (e.g., co-author Bill Walter served as chair of the Trillium CCO Chronic, Nonmalignant Pain Management Committee from 2012 to 2014). NDs in Oregon continue to be engaged at the state and local levels in helping set pain management policy.

Also during and after the study period, the Oregon Board of Naturopathic Medicine demonstrated its commitment to strict professional self-regulation by taking disciplinary action against naturopathic physicians who were not adhering to opioid prescribing best practices, including fines and restrictions on prescribing controlled substances. The Oregon Association of Naturopathic Physicians and the National University of Natural Medicine (the main naturopathic medical school in Portland, OR, USA) also responded to the need for improved provider care and responsibility for opioid safety by offering numerous accredited, integrative (i.e., ND- and MD-taught) Continuing Medical Education activities on opioid prescribing best practices, as well as nonopioid approaches to pain management. We warmly welcome MDs, NPs, and all other providers to these events.

National data suggest that opioid-related harm continues to devastate families and communities [10], even as the entire health care community struggles with the clinical challenges of pain management and substance abuse. We are optimistic that the results by Fink et al. will be used to encourage improved provider communication, coordination of care, trainings on high-risk behavior, broader inclusion of NDs on pain management teams for earlier delivery of nonpharmacologic options, and increased efficacy and implementation research on complementary and integrative health options for pain management.

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