9/27/26
CVS - Jessica Stine PharmD

Re: Why many of my patients travel more than 50 miles to my practice

Dear Jessica Stine PharmD,

Thank you for your diligence and our shared commitment to safe dispensing. You have asked why a number of my patients travel more than 50 miles to reach my clinic. I am glad to answer that question directly and in full. While I do not believe a physician should have to be on the defensive to explain why patients seek out specialized care, I welcome the opportunity to give you the objective context — because once the reasons are understood, I am confident the travel distances make clear clinical sense.

Let me begin with the affirmative reasons patients travel to my practice, and then turn to the 50-mile policy itself.

1. My practice is a unique and comprehensive resource that is not otherwise available to these patients.

I am, to my knowledge, the only fully integrative pain management specialist in the state offering this breadth of education and treatment options, integrated with longitudinal medical management [7]. This is expressly not opioid-centric care; the purpose of the integrative framework is to keep opioid doses and quantities as low as each patient's condition allows. It includes:

- Foundational diet, weight loss, exercise, and lifestyle optimization as first-line components of every plan.
- Individualized, evidence-based nutraceutical protocols built on my 4-Domain model of chronic pain, which targets the systemic inflammation, neuroinflammation, oxidative stress, and mitochondrial dysfunction that drive the transition from acute to chronic pain and central sensitization — allowing less reliance on opioids and offering the potential to mitigate opioid analgesic tolerance and opioid-induced hyperalgesia.
- Mind-body and mindfulness training, which in a meta-analysis of 60 trials (6,404 patients) was associated with reduced pain intensity and reduced opioid dose [12].
- Acupuncture and other complementary modalities, which the CDC's evidence review found can improve pain and function [1].
- Medical cannabis where appropriate; in a prospective, pharmacist- and clinician-involved program, cannabis participation was associated with a clinically significant reduction in daily MME [13].

Patients reasonably travel to reach this combination of care, which is not replicated by a procedure-focused practice closer to home.

2. The depth, continuity, and advocacy of my care draw patients to me — and make that care safer.

- I see patients every 30 days over many years and deliberately involve spouses and family in a team approach. This continuity is a safety asset, not merely a convenience: higher continuity of care is associated with delayed opioid initiation

and less inappropriate prescribing [14], and the patient–clinician therapeutic alliance is independently associated with improved pain outcomes [15][16].

- A significant number of my patients also receive urgent-care and primary-care services from me. Like a family physician, I know their comorbidities, medications, families, and social circumstances in detail — which is both a reason they travel and a reason my assessments and risk stratification are more thorough than a visit-limited procedural model allows.
- Patients travel because of the active role I take advocating for their care. I routinely review my patients' care by other physicians and send coordinated-care letters to primary care providers regarding findings on laboratory reports, history, or examination. Because postoperative pain management for opioid-tolerant patients is frequently inadequate, I provide guidance letters for my patients to give their surgeons on appropriate perioperative management. I have also met with a state senator to address barriers my patients face — including difficulty accessing abuse-deterrent opioids (e.g., Hysingla, Xtampza) and pharmacies' frequent inability or unwillingness to stock safer agents such as Belbuca because of reimbursement losses.

Patients regularly cite this depth of engagement as the reason they choose my practice, often stating no prior physician had done this for them.

3. Louisiana is a rural, medically underserved state, so long travel for specialized pain care is the norm, not an anomaly.

- Chronic pain affects more than one in five U.S. adults, and prevalence is rising — from 20.5% in 2019 to 24.3% in 2023, with high-impact chronic pain reaching 8.5% — and is consistently higher among adults in poverty, on public insurance, and in rural areas, all overrepresented in Louisiana [8][9]. Applied to Louisiana's adult population, these national rates imply roughly 731,000–850,000 residents with chronic pain.
- Applying the Institute of Medicine's estimate of more than 28,500 chronic-pain patients per board-certified pain physician to that population implies only roughly 26–30 such physicians statewide even at the national (already shortage-level) staffing rate. Specialist supply lags demand severely.
- The pain-specialist pipeline is shrinking, not growing: total pain medicine fellowship applications fell from 520 in 2019 to 442 in 2025, with anesthesiology applicants down roughly 70% (from 351 to 106) — signaling worsening future access, particularly in underserved rural states [10][11].
- Rural residents travel more than twice as far as urban residents for medical care, and Louisiana ranks among the states with the most health care deserts, compounded by low household internet access that limits telehealth as a substitute.
- Rural counties consistently show higher opioid prescribing driven by these access disparities — not by aberrant prescribing [2][3][4][5].

I have documented these reasons on my website and in patient handouts (available since early 2025), and a survey of my patients confirms that specialized/integrative care, loss of prior local pharmacy access, and rural scarcity are what drive their travel.

4. Given all of the above, the 50-mile figure should prompt further assessment — not serve as a metric against me or my practice.

Only after establishing the legitimate reasons patients travel does it make sense to consider the 50-mile flag itself, and in that context its proper role becomes clear:

- A geographic red flag derives from the pharmacist's corresponding responsibility to ensure a controlled substance is issued for a legitimate medical purpose. It is rooted in the early-2010s "pill-mill" era, when patients traveled long distances to bypass pharmacies — a pattern now largely eliminated by the prescription monitoring program (PMP), which I review before every visit. Any review of my practice will show that I am not a pill-mill and that my prescriptions serve legitimate medical purposes.
- Distance alone is not a safety assessment. It is, at most, a prompt to apply professional judgment and ask whether the distance "tells a clinically appropriate story." As the reasons above demonstrate, in my patients' case it plainly does.
- The 2022 CDC guideline argues against using any single number — a dose, a tablet count, or a mileage figure — as a substitute for individualized clinical judgment [1]. The Pain Management Best Practices Inter-Agency Task Force similarly warns against arbitrary "outlier" definitions that ignore provider expertise and patient demographics — a caution that applies directly to a rigid mileage cutoff used in isolation [6].
- Applied mechanically and in isolation, a 50-mile cutoff systematically penalizes patients for the scarcity of the very care they need. That is not a safety measure; it is a proxy that, in a rural, specialist-poor state, works against the patients it is meant to protect. Common sense and the guidelines point the same way: the distance should trigger inquiry, not disqualification.

5. My request.

Under Louisiana law the pharmacist shares corresponding responsibility to confirm a legitimate medical purpose, and the pharmacist may decline to fill based on a legitimate, objective safety evaluation. Case law reinforces that the pharmacist must make efforts to resolve a red flag through sound professional judgment and fact-based verification before refusing — including the Fifth Circuit rulings on corresponding responsibility and the February 2026 federal appeals decision involving a Louisiana pharmacy (enclosed), which underscore that a red flag must be investigated and, where possible, resolved rather than used as a reflexive basis for refusal. A travel-distance flag, standing alone and absent evidence of diversion, does not by itself justify treating a valid prescription — or the prescriber — as suspect.

I would simply ask that the distance my patients travel be understood in light of the reasons set out above, and that it be treated as a question to be answered rather than a metric applied against me personally or my practice. I fully support your duty to be comfortable dispensing, and I welcome direct contact to resolve any concern. I am confident that, once the context is understood, the distances my patients travel are readily explained and should not stand as a mark against my practice.

Respectfully,

Eric Ehlenberger MD
Accurate Clinic

References

1. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recommendations and Reports. 2022.
2. Sun F. Rurality and Opioid Prescribing Rates in U.S. Counties From 2006 to 2018: A Spatiotemporal Investigation. Social Science & Medicine. 2022.
3. Modestino AS, Young GJ, Hasan MM, Shi J, Alam MNE. Why Are Massachusetts Opioid Prescribing Rates Higher in Rural Versus Urban Areas? PLoS One. 2025.
4. Thomas JA, Benson J, Davidson P, Ward PR. Opioids and the Challenges of Managing Chronic Non-Cancer Pain in Rural Australia: A Qualitative Study. Medical Journal of Australia. 2025.
5. Keiser B, Cortez K, Hoffman E, et al. Expanding Rural Access to Chronic Pain Care Through Nurse Care Management: A Hybrid Type I Effectiveness-Implementation Trial Protocol. PLoS One. 2026.
6. The Pain Management Best Practices Inter-Agency Task Force Report. 2019.
7. Chen L, Michalsen A. Management of Chronic Pain Using Complementary and Integrative Medicine. BMJ. 2017.
8. Rikard SM, Strahan AE, Schmit KM, Guy GP. Chronic Pain Among Adults — United States, 2019–2021. MMWR Morbidity and Mortality Weekly Report. 2023.
9. Lucas JW, Sohi I. Chronic Pain and High-Impact Chronic Pain in U.S. Adults, 2023. NCHS Data Brief. 2024.
10. Wright TB, Lee SJ, Emerick T, et al. Shrinking Pipelines and Shifting Priorities: An Analysis of the 2019–2025 Pain Medicine Fellowship Match. Pain Medicine. 2026.
11. Pritzlaff SG, Singh N, Sanghvi C, et al. Declining Pain Medicine Fellowship Applications From 2019 to 2024. Pain Practice. 2025.
12. Garland EL, Brintz CE, Hanley AW, et al. Mind-Body Therapies for Opioid-Treated Pain: A Systematic Review and Meta-analysis. JAMA Internal Medicine. 2020.
13. Slawek DE, Zhang C, Dahmer S, et al. Medical Cannabis and Opioid Receipt Among Adults With Chronic Pain. JAMA Internal Medicine. 2026.
14. Jo AJ, Choo E, Kim S, Je NK, Lee IH. Continuity of Primary Care and Delayed Opioid Initiation in Non-Cancer Pain: A Cohort Study. European Journal of Pain. 2026.
15. Pasini I, Donisi V, Veneziani E, et al. The Role of the Patient–Clinician Relationship in Chronic Pain Interventions: A Systematic Review. Journal of Psychosomatic Research. 2026.
16. Makris UE, Abrams RC, Gurland B, Reid MC. Management of Persistent Pain in the Older Patient: A Clinical Review. JAMA. 2014.