

# Letters

## RESEARCH LETTER

### Patient-Centered Prescription Opioid Tapering in Community Outpatients With Chronic Pain

The risks associated with prescription opioids are well described.<sup>1,2</sup> Although reducing opioid use is a national priority, existing opioid tapering models use costly interdisciplinary teams that are largely inaccessible to patients and their physicians.<sup>3,4</sup> Patients and physicians need solutions to successfully reduce long-term prescription opioid dosages in settings without behavioral services. We conducted a study of voluntary, patient-centered opioid tapering in outpatients with chronic pain without behavioral treatment.

**Methods** | Patients with non-cancer-related chronic pain prescribed long-term opioids at a community pain clinic were provided education about the benefits of opioid reduction (reduced health risks without increased pain) by their prescribing physician. Physicians offered to partner with patients to slowly reduce their opioid dosages over 4 months. The only exclusion was current treatment for substance use disorder. The study was approved by the Stanford University institutional review board; participants provided written or electronic informed consent, and no compensation was provided to participants.

Of the 110 eligible patients, 82 (75%) agreed to taper their opioid dosages; of those, 68 provided baseline demographics,

information on opioid use, pain, marijuana use and psychosocial measures. Patients received a self-help book on reducing opioid use, and a slow, individually designed taper. Opioid dosages were reduced up to 5% for up to 2 dose reductions in month 1 to minimize negative physical and emotional response, withdrawal symptoms, and to facilitate patient confidence in the process. In months 2 to 4, patients were asked to further reduce use by as much as 10% per week; dose decrements were tailored to the patient. Patient responses were monitored with close clinical follow-up (at least monthly) and doses adjusted accordingly. Follow-up surveys were administered at 4 months; patients who provided data at 4 months were considered study completers. We confirmed patient-reported opioid prescription with medical record review. We documented patient compliance and accuracy of reported medication use with periodic urine drug testing and continuous monitoring of the state Prescription Drug Monitoring Program (PDMP). No compliance issues or aberrant prescriptions were noted. We converted opioid doses to morphine equivalent daily dose (MEDD). Change in MEDD from baseline was the primary outcome and pain intensity was a secondary outcome. Kruskal-Wallis rank sum test was used for continuous variables and  $\chi^2$  test for polychotomous variables.

**Results** | The patients' mean (SD) age was 51 (12) years, and 41 (60%) were female. Thirty-one of 82 enrolled patients

Table. Characteristics and Outcomes<sup>a</sup>

| Variable                         | Completers (n = 51) |    |               |    |                      | Dropouts <sup>b</sup> |    |                      |
|----------------------------------|---------------------|----|---------------|----|----------------------|-----------------------|----|----------------------|
|                                  | Baseline            |    | 4 mo          |    | P Value <sup>c</sup> | Baseline              |    | P Value <sup>d</sup> |
|                                  | Median (IQR)        | NA | Median (IQR)  | NA |                      | Median (IQR)          | NA |                      |
| Age                              | 52 (43-50)          | 1  |               |    |                      | 57 (50-63)            | 0  | .12                  |
| Opioid duration <sup>e</sup>     | 6 (3-11)            | 10 |               |    |                      | 6 (5-8)               | 4  | .57                  |
| Opioid dose <sup>f</sup>         | 288 (153-587)       | 0  | 150 (54-248)  | 0  | .002                 | 244 (147-311)         | 1  | .45                  |
| Pain intensity                   | 5.0 (3.0-7.0)       | 0  | 4.5 (3.0-7.0) | 3  | .29                  | 3.5 (3.0-6)           | 1  | .10                  |
| PCS                              | 22 (10-30)          | 1  | 15 (7-23)     | 5  | .04                  | 22 (20-30)            | 0  | .39                  |
| Fatigue <sup>g</sup>             | 60 (54-65)          | 4  | 59 (51-65)    | 3  | .64                  | 63 (59-66)            | 2  | .45                  |
| Anxiety <sup>g</sup>             | 60 (53-64)          | 1  | 54 (46-62)    | 3  | .06                  | 62 (59-63)            | 1  | .35                  |
| Depression <sup>g</sup>          | 56 (49-64)          | 1  | 55 (48-61)    | 2  | .31                  | 62 (57-65)            | 1  | .05                  |
| Sleep disturbance <sup>g</sup>   | 59 (54-70)          | 2  | 56 (50-64)    | 2  | .13                  | 62 (53-67)            | 1  | .66                  |
| Pain interference <sup>g</sup>   | 63 (58-67)          | 1  | 63 (57-67)    | 2  | .44                  | 66 (61-68)            | 1  | .13                  |
| Pain behavior <sup>g</sup>       | 60 (57-63)          | 2  | 59 (56-64)    | 2  | .47                  | 62 (60-64)            | 1  | .14                  |
| Physical function <sup>g,h</sup> | 39 (34-41)          | 1  | 39 (34-43)    | 2  | .78                  | 36 (34-41)            | 1  | .07                  |

Abbreviations: IQR, interquartile range; NA, not applicable; PCS, Pain Catastrophizing Scale.

<sup>a</sup> Completers provided 4-month data, dropouts enrolled but did not provide month 4 data.

<sup>b</sup> Thirty-one enrolled; 17 provided the baseline data.

<sup>c</sup> Probability of difference between week baseline and 4 months for completers where null hypothesis is true.

<sup>d</sup> Probability of baseline difference between completers and dropouts where null hypothesis is true.

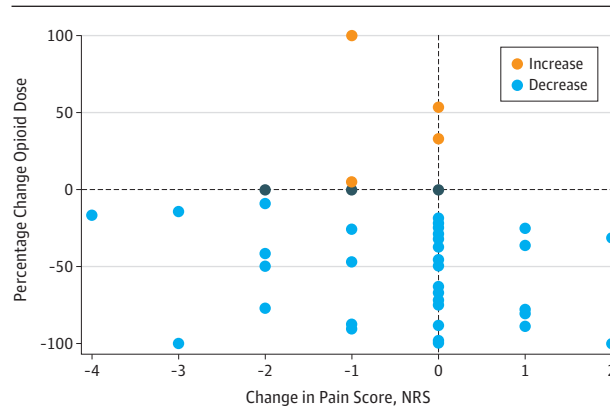
<sup>e</sup> Opioid duration (years taking opioids).

<sup>f</sup> Opioid dose (morphine equivalent daily dose).

<sup>g</sup> Patient Reported Outcomes Information System (PROMIS) measure.

<sup>h</sup> Lower scores reflect worse function, pain (numeric rating scale).

**Figure. Change in Opioid Morphine Equivalent Daily Dose and Absolute Change in Pain Intensity Score From Baseline to Month 4 for Study Completers**



NRS indicates numeric rating scale.

(38%) did not complete a 4-month follow-up survey and therefore were considered to have dropped out of the study. Depression negatively correlated ( $P = .05$ ) and baseline marijuana use positively correlated ( $P = .04$ ) with study completion. The Table provides characteristics and results for the sample; we found no sex association with study completion or opioid reduction.

Among study completers ( $n = 51$ ) baseline median MEDD (interquartile range [IQR]) was 288 (153-587) mg, with a median 6-year duration (IQR, 3-9) duration of opioid use. Median pain intensity was moderate (5 out of 10 on a numeric pain rating). After 4 months, the median MEDD was reduced to 150 (IQR, 54-248) mg ( $P = .002$ ). The likelihood of a greater than 50% opioid dose reduction was not predicted by starting dose, baseline pain intensity, years prescribed opioids, or any psychosocial variable. Neither pain intensity ( $P = .29$ ) nor pain interference ( $P = .44$ ) increased with opioid reduction. The Figure shows the relationship between percentage change in MEDD and pain intensity in study completers.

**Discussion** | Our findings suggest that a substantial fraction of patients at a pain clinic may wish to engage in voluntary opioid tapering. Our data challenge common notions that patients taking high-dose opioids will fail outpatient opioid tapers or that duration of opioid use predicts taper success. Combining patient education about the benefits of opioid reduction with a plan that reduces opioids more slowly than current tapering algorithms<sup>5</sup> with close clinician follow-up may help patients engage and succeed in voluntary outpatient tapering. Because our data are generated from a single pain clinic, studies are needed to assess how well our protocol would generalize to other types of patients and settings.

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**Published Online:** February 19, 2018. doi:10.1001/jamainternmed.2017.8709

**Open Access:** This article is published under the JN-OA license and is free to read on the day of publication.

**Accepted for Publication:** December 23, 2018.

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**Conflict of Interest Disclosures:** None reported.

**Funding/Support:** We acknowledge support from National Institutes of Health (NIH): National Center for Complementary and Integrative Health (NCCIH) grants PO1AT006651S1 and NCCIH R01AT008561 (Dr Darnall), and NIH grant T32 035165 (Dr Ziadni).

**Role of the Funder/Sponsor:** The funding source had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

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### Using Chaplains to Facilitate Advance Care Planning in Medical Practice

Although many patients do not want aggressive care at the end of life (EoL),<sup>1</sup> such care is not uncommon<sup>2</sup> and may be associated with poorer quality of life and psychological distress.<sup>3</sup> Advance care planning (ACP) permits patients to express preferences for EoL care and increase concordance between care that is desired and care that is delivered at EoL.<sup>4</sup> Rather than waiting for an urgent health crisis, regular office visits are a preferred time for ACP discussions.<sup>4</sup> With the new Centers for Medicare policy, lack of reimbursement for time spent in ACP discussions should no longer be a barrier to conducting them.<sup>5</sup> However, other structural (eg, competing demands) and professional barriers (eg, lack of