

### Principles for All Chronic Non-Cancer Pain Patients

1. **Self-care is the foundation for effective chronic non-cancer pain care** - Patient efforts to remain active and sustain rewarding life activities usually matter more than treatments prescribed for chronic pain.
2. **Your relationship with the patient supports effective self-care** - Listening, empathy, and encouraging patients to remain active and sustain rewarding life activities characterizes excellent care for patients with chronic pain.
3. **Guide care by progress toward resuming activities** - To track outcomes, have patients rate their ability to participate in rewarding life activities that pain makes difficult on a 0-10 scale (where 0 is “no difficulty” and 10 is “extreme difficulty”). Monitor return to work. For sedentary patients, consider tracking gradual increases in walking. Guiding care by changes in pain intensity should not be the primary indicator of successful care.
4. **Prioritize long-term effectiveness over short-term pain relief** - Differentiate treatments offered for short-term pain relief from steps patients take to resume activities. Short-term pain relief can be helpful, but long-term benefits of medications for chronic non-cancer pain are often modest, and risks may outweigh potential benefits.

### Principles When Considering Long-term Use of Opioids

1. **Put patient safety first** - Find common ground with patients by emphasizing their safety. Risks of long-term opioid use are significant, while benefits are typically modest. Possible adverse effects include addiction, overdose, dependence, depression, cognitive impairment, chronic constipation, motor vehicle accidents, and serious fractures due to falls, among others.
2. **Think twice before prescribing long-term opioids for axial low back pain, headache and fibromyalgia** - The long-term benefits of opioids for these conditions are unproven, while risks of addiction, overdose and other serious adverse effects are significant.
3. **Systematically evaluate risks** - Do not consider a therapeutic trial of opioids for chronic non-cancer pain before assessing risks of opioid misuse and abuse by taking a thorough history, reviewing the medical record, and checking Prescription Drug Monitoring Program data. Ask about past or current alcohol, tobacco and drug abuse, and mental health problems. Do not overestimate your ability to identify high risk patients. Risks of long-term opioid use are substantial, so be cautious when considering chronic opioid therapy, especially for higher risk patients.
4. **Consider intermittent opioid use** - Continuous use of long acting opioids has not been proven more effective or safer than intermittent use of short-acting opioids. Time-scheduled opioid prescribing has not been proven to reduce risks of opioid misuse or addiction. Higher doses with around-the-clock use may increase risks. Consider PRN prescriptions of short acting opioids to minimize risks of tolerance, dependence and dose-related medical risks of opioids. When opioids are prescribed for short-term pain management, set clear expectations for duration of use. Prescribe no more than needed for acute pain management--often a few days to a one week supply.
5. **Do not sustain opioid use long-term without decisive benefits** – Initial evaluation of long-term opioid use should be based on a therapeutic trial lasting no more than 90 days, preferably less. Long-term use of opioids should only be continued if decisive benefits are observed during the trial. Opioids should not be continued if improved function is not sustained. Involve the patient in determining functional goals for therapy. Continually monitor the benefit-to-harm ratio as benefits may decrease while harms accrue over time.
6. **Keep opioid doses as low as possible** - Reaching doses of 50 to 100 milligrams morphine equivalents or higher should trigger re-evaluation of the therapy. Risks increase with dose, but benefits of higher doses have not been established. Discontinuation is substantially more difficult at high dose.

\* These principles are not intended for palliative care of chronic pain at end of life.

### Principles for Patients Using Opioids Long-term

1. **Clearly communicate standardized expectations to reduce risks** - *Opioids have important hazards for patients, for family members, and for the community. Set clear expectations for use to reduce patient risks and for protecting others from unintentional or intentional diversion. Expectations should be standardized across all clinicians in your practice setting and communicated to patients verbally and with simple written materials.*
2. **Adhere to recommended precautions** - *Close and sustained monitoring of chronic opioid therapy is the standard for care. This includes asking about potential opioid misuse and about adverse behavioral, psychological and medical effects of opioids. Check urine drug screening results and Prescription Drug Monitoring data periodically. These precautions should increase in frequency and stringency for patients on regimens of 50 to 100 milligrams morphine equivalent dose or greater, and for patients with risk factors for opioid misuse. These safety precautions do not guarantee patient safety, so vigilance and caution are essential.*
3. **Avoid prescribing opioids and sedatives concurrently** - *Concurrent use of opioids and other CNS depressants increases risks of overdose and other adverse effects. Prescribing opioids and sedatives concurrently is not recommended.*
4. **Revisit discontinuing opioids or lowering dose** - *Regularly reassess whether doses can be reduced or opioids discontinued entirely. Many patients using opioids long-term are ambivalent about opioid use. Patients may be open to a trial of a slow taper. Opioids should be tapered when problems arise or if decisive benefits for function are not sustained. If a patient is diverting or engaging in high risk opioid misuse, discontinuation is mandatory. Non-fatal overdose should prompt immediate reduction of opioid dose or tapering off completely.*
5. **Identify and treat prescription opioid misuse disorders** – *When identified, patients with prescription opioid abuse or addiction should be treated rather than discharged from care. Know locally available referral options for addiction treatment including buprenorphine/naloxone treatment, methadone maintenance and counseling. Detoxification is not the standard of care, and is not supported by evidence, as the primary option for prescription opioid addiction.*

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