4.	**Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain.** Self-management approaches should be recommended to all patients with chronic pain. Self-management refers to management of the pain, its symptoms, and of one's relationship with the symptoms. (Evidence shows self-management approaches improve self-efficacy in multiple chronic

	conditions[19 20 21]and that opioid treatment of chronic pain may undermine self-care.[22] Many non-pharmacological therapies, including physical therapy, weight loss, psychological therapies (e.g. cognitive behavioral therapy) and multidisciplinary rehabilitation can ameliorate pain and function.[13 23 24 25 26] Spinal manipulation, massage and acupuncture may be helpful in some chronic pain conditions.[27 28 29] Non-opioid pharmaceuticals (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) may also be helpful for a variety of chronic pain conditions.[30 31 32 33 34 35 36 37 38 39 40 41] Due to the favorable benefit-to-risk profile, these noninvasive, non-opioid therapies are preferred and should be offered to all patients with chronic pain. There is a lack of evidence showing any sustained functional benefit of long-term opioid therapy for chronic pain, but there is evidence of dose- and duration-dependent harms (see *Guideline #5*). **DO IT »** Create acute and chronic pain order sets that include non-pharmacologic treatment, non-opioid treatment and common referral sources (such as physical therapy, psychotherapy, substance use treatment, addiction specialists, pain medicine specialists, etc.).
5.	**Do not initiate long-term opioid therapy for most patients with chronic pain.** While benefits for pain relief, function and quality of life with long-term opioid use for chronic pain are uncertain, risks associated with long-term opioid use are significant and increase with increasing dose and duration of opioid use. [12 42 43] Risks to patients include overdose, overdose death, addiction, depression, opioid induced hypogonadism, opioid-induced hyperalgesia, and worsening function.[18 44 45 46 47 48 49 50 51 52 53] A 2017 Cochrane Review found good-quality evidence that use of opioids for greater than 2 weeks is associated with a significantly increased risk of experiencing an adverse event when compared to use of a placebo and non-opioid pharmacotherapy, and identified a very high absolute rate (78%) for adverse events.[54] Due to this unfavorable balance of risks compared to benefits, initiating opioid therapy for common causes of chronic pain including low back pain, osteoarthritis pain, fibromyalgia, neuropathy and headache is not recommended. The decision to initiate opioid therapy must be made on a case-by-case basis after carefully weighing the known risks against possible benefits. **DO IT »** Develop a system for opioid stewardship, i.e. monitoring opioid prescribing practices, outcomes and provider alignment with guidelines and best available evidence. • See *References, Veterans' Administration 2017 Clinical Practice Guideline for Opioid Therapy, "*Recommendation 1) We recommend against initiation of long-term opioid therapy for chronic pain."
6.	**Coordinate interdisciplinary care for patients with higher complexity chronic pain to address pain, substance use disorders and behavioral health conditions.** There is an increased risk of poor outcomes including opioid overdose, opioid use disorder and death, for patients taking opioids that have substance use disorders or behavioral health conditions.[7 8 55 56 57] These clinical situations can be challenging to manage, and are further complicated by the possibility of providers inadvertently exposing the patient to dangerous drug-drug interactions. Interdisciplinary care for patients is advised, even as more research is needed on efficacy and feasibility of arranging such care. The key disciplines that benefit patients with higher complexity chronic pain include primary care, substance use specialties, pain medicine, mental health, dieticians, health coaching and movement specialties (e.g. physical therapy). If interdisciplinary care is not available in a single care setting, it should be coordinated virtually between distinct care sites. **DO IT »** Use available case management resources, which may be offered by facilities, insurance companies, accountable care organizations or other local resources.