

VA/DoD Clinical Practice Guidelines



The Use of Opioids in the Management of Chronic Pain



VA/DoD Evidence-Based Practice

Provider Summary

Version 4.0 | 2022



VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE USE OF OPIOIDS IN THE MANAGEMENT OF CHRONIC PAIN

Department of Veterans Affairs

Department of Defense

Provider Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation with a patient-centered approach.

These guidelines are not intended to represent Department of Veterans Affairs or TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil by contacting your regional TRICARE Managed Care Support Contractor.

Version 4.0 – 2022

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Introduction

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Evidence-Based Practice Work Group (EBPWG) was established and first chartered in 2004, with a mission to advise the Health Executive Committee (HEC) “... on the use of clinical and epidemiological evidence to improve the health of the population ...” across the Veterans Health Administration (VHA) and Military Health System (MHS), by facilitating the development of clinical practice guidelines (CPGs) for the VA and DoD populations.⁽¹⁾ Development and update of VA/DoD CPGs is funded by VA Evidence Based Practice, Office of Quality and Patient Safety. The system-wide goal of evidence-based CPGs is to improve patient health and well-being.

In February 2017, the VA and DoD published a CPG on Opioid Therapy for Chronic Pain (2017 VA/DoD Opioids CPG), which was based on evidence reviewed through December 2016. Since the release of that CPG, a growing body of research has expanded the evidence base and understanding of the use of opioids in the management of chronic pain. Consequently, the VA/DoD EBPWG initiated the update of the 2017 VA/DoD Opioids CPG in 2020. This updated CPG’s use of Grading of Recommendations Assessment, Development and Evaluation (GRADE) reflects a more rigorous application of the methodology than previous iterations. Consequently, the strength of some recommendations may have been modified due to the confidence in the quality of the supporting evidence (see Evidence Quality and Recommendation Strength in the full CPG).

This CPG provides an evidence-based framework for evaluating and managing care for patients with chronic pain who are on or who are being considered for prescribed opioids toward improving clinical outcomes. Successful implementation of this CPG will:

- Assess the patient’s condition and collaborate with the patient, family, and caregivers to determine optimal management of patient care
- Emphasize the use of patient-centered care and shared decision making
- Minimize preventable complications and morbidity
- Optimize individual health outcomes and quality of life (QoL)

The full VA/DoD Opioids CPG, as well as additional toolkit materials including a pocket card and patient summary, can be found at: <https://www.healthquality.va.gov/index.asp>.

Recommendations

The following evidence-based clinical practice recommendations were made using a systematic approach considering four domains as per the GRADE approach (see [Methods](#)). These domains include: confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient values and preferences, and other implications (e.g., resource use, equity, acceptability).

Table 1. Recommendations

Topic	Sub-topic	#	Recommendation	Strength ^a	Category ^b
Initiation and Continuation of Opioids		1.	We recommend against the initiation of opioid therapy for the management of chronic non-cancer pain (for non-opioid treatments for chronic pain, see the VA/DoD CPGs for Low Back Pain, Headache, and Hip and Knee Osteoarthritis). ^c	Strong against	Reviewed, New-replaced
		2.	We recommend against long-term opioid therapy, particularly for younger age groups, as age is inversely associated with the risk of opioid use disorder and overdose.	Strong against	Reviewed, New-replaced
		3.	We recommend against long-term opioid therapy, particularly for patients with chronic pain who have a substance use disorder (refer to the VA/DoD CPG for the Management of Substance Use Disorders). ^d	Strong against	Reviewed, New-replaced
		4.	For patients receiving medication for opioid use disorder, there is insufficient evidence to recommend for or against the selection of any one of the following medications over the other for the management of their co-occurring chronic pain: methadone, buprenorphine, or extended-release naltrexone injection. Treat the opioid use disorder according to the VA/DoD CPG for the Management of Substance Use Disorders. ^d	Neither for nor against	Reviewed, New-replaced
		5.	For patients receiving daily opioids for the treatment of chronic pain, we suggest the use of buprenorphine instead of full agonist opioids due to lower risk of overdose and misuse.	Weak for	Reviewed, New-added
		6.	We recommend against the concurrent use of benzodiazepines and opioids for chronic pain (refer to Recommendation 10 in the VA/DoD CPG for the Management of Substance Use Disorders ^d for further guidance related to tapering one or both agents).	Strong against	Reviewed, Amended

Topic	Sub-topic	#	Recommendation	Strength ^a	Category ^b
Dose, Duration, and Taper of Opioids	Dose and Duration	7.	If prescribing opioids, we recommend using the lowest dose of opioids as indicated by patient-specific risks and benefits.	Strong for	Reviewed, Amended
		8.	If considering an increase in opioid dosage, we recommend reevaluation of patient-specific risks and benefits and monitoring for adverse events including opioid use disorder and risk of overdose with increasing dosage.	Strong for	Reviewed, New-replaced
		9.	When prescribing opioids, we recommend the shortest duration as indicated.	Strong for	Reviewed, New-replaced
		10.	After initiating opioid therapy, we recommend reevaluation at 30 days or fewer and frequent follow-up visits, if opioids are to be continued.	Strong for	Reviewed, New-replaced
		11.	We recommend against prescribing long-acting opioids: <ul style="list-style-type: none"> • For acute pain • As an as-needed medication • When initiating long-term opioid therapy 	Strong against	Reviewed, Amended
	Tapering	12.	We suggest a collaborative, patient-centered approach to opioid tapering.	Weak for	Reviewed, New-replaced
		13.	There is insufficient evidence to recommend for or against any specific tapering strategies.	Neither for nor against	Reviewed, New-replaced
Screening, Assessment, and Evaluation		14.	We recommend assessing risk of suicide and self-directed violence when initiating, continuing, changing, or discontinuing long-term opioid therapy (refer to the VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide for guidance on intervention timing and strategies). ^e	Strong for	Reviewed, New-replaced
		15.	For patients with chronic pain, we recommend assessing for behavioral health conditions, history of traumatic brain injury, and psychological factors (e.g., negative affect, pain catastrophizing) when considering long-term opioid therapy, as these conditions are associated with a higher risk of harm.	Strong for	Reviewed, New-added
		16.	For patients with acute pain when opioids are being considered, we suggest screening for pain catastrophizing and co-occurring behavioral health conditions to identify those at higher risk for negative outcomes.	Weak for	Reviewed, New-added
		17.	For patients on opioids, we suggest ongoing reevaluation of the benefits and harms of continued opioid prescribing based on individual patient risk characteristics.	Weak for	Reviewed, New-replaced
Risk Mitigation		18.	We suggest urine drug testing for patients on long-term opioids.	Weak for	Reviewed, New-replaced
		19.	We suggest interdisciplinary care that addresses pain and/or behavioral health problems, including substance use disorders, for patients presenting with high risk and/or aberrant behavior.	Weak for	Not reviewed, Amended
		20.	We suggest providing patients with pre-operative opioid and pain management education to decrease the risk of prolonged opioid use for post-surgical pain.	Weak for	Reviewed, New-added

^a For additional information, see Determining Recommendation Strength and Direction in the full VA/DoD Opioids CPG

^b For additional information, see Recommendation Categorization and Appendix G in the full VA/DoD Opioids CPG

^c Other VA/DoD CPGs are available at: <https://www.healthquality.va.gov/>

^d See the VA/DoD CPG for the Management of Substance Use Disorders, available at: <https://www.healthquality.va.gov/>

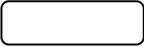
^e See the VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide, available at: <https://www.healthquality.va.gov/>

Algorithm

This CPG’s algorithm is designed to facilitate understanding of the clinical pathway and decision making process used in managing patients prescribed opioids for chronic pain. This algorithm format represents a simplified flow of the use of opioids in the management of chronic pain and helps foster efficient decision making by providers. It includes:

- An ordered sequence of steps of care
- Decisions to be considered
- Recommended decision criteria
- Actions to be taken

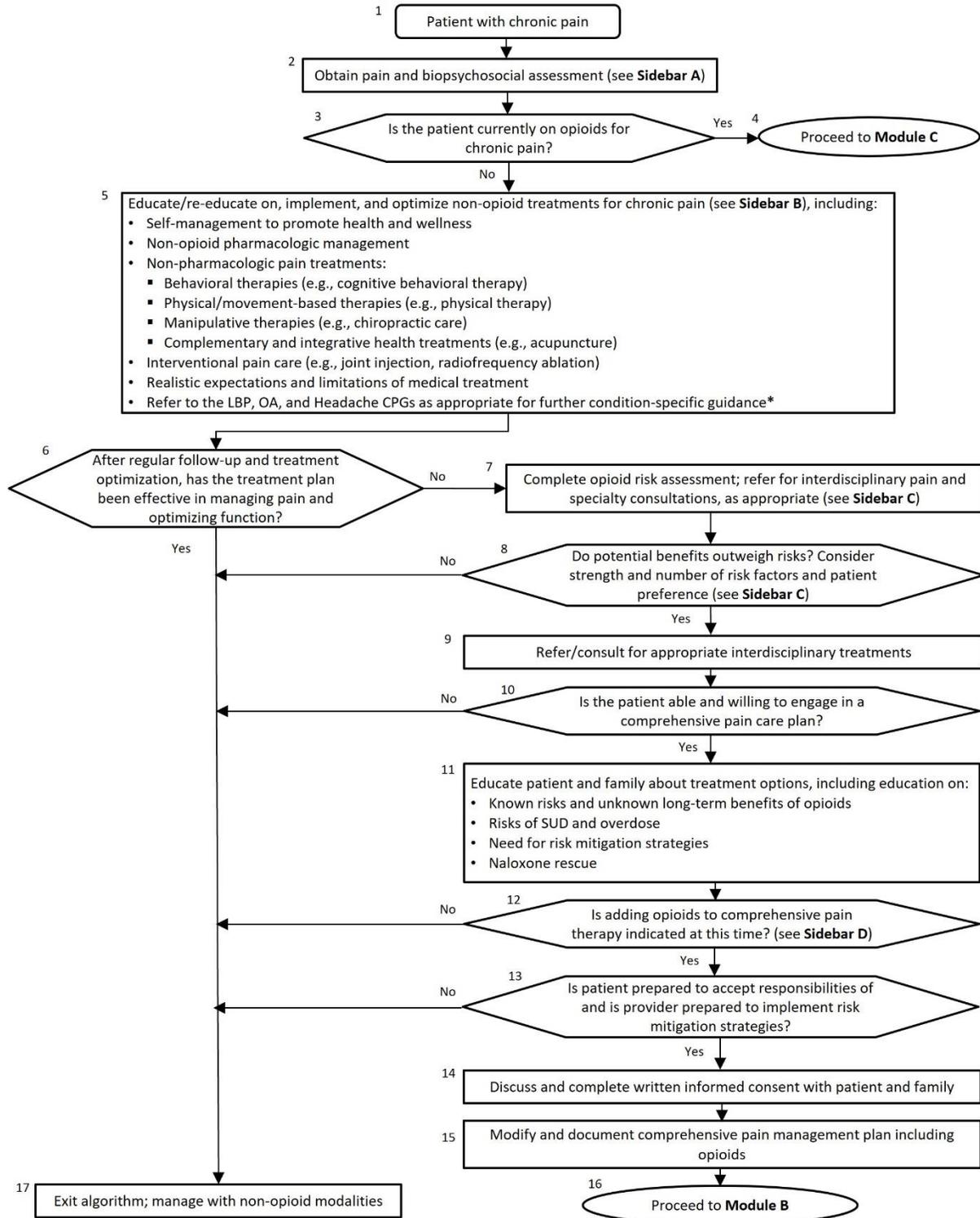
The algorithm is a step-by-step decision tree. Standardized symbols are used to display each step, and arrows connect the numbered boxes indicating the order in which the steps should be followed.⁽²⁾ Sidebars provide more detailed information to assist in defining and interpreting elements in the boxes.

Shape	Description
	Rounded rectangles represent a clinical state or condition
	Hexagons represent a decision point in the process of care, formulated as a question that can be answered “Yes” or “No”
	Rectangles represent an action in the process of care
	Ovals represent a link to another section within the algorithm

For alternative text descriptions of the algorithm, see Appendix J in the full VA/DoD Opioids CPG.

Module A: Determination of Appropriateness for Opioids for Chronic Pain

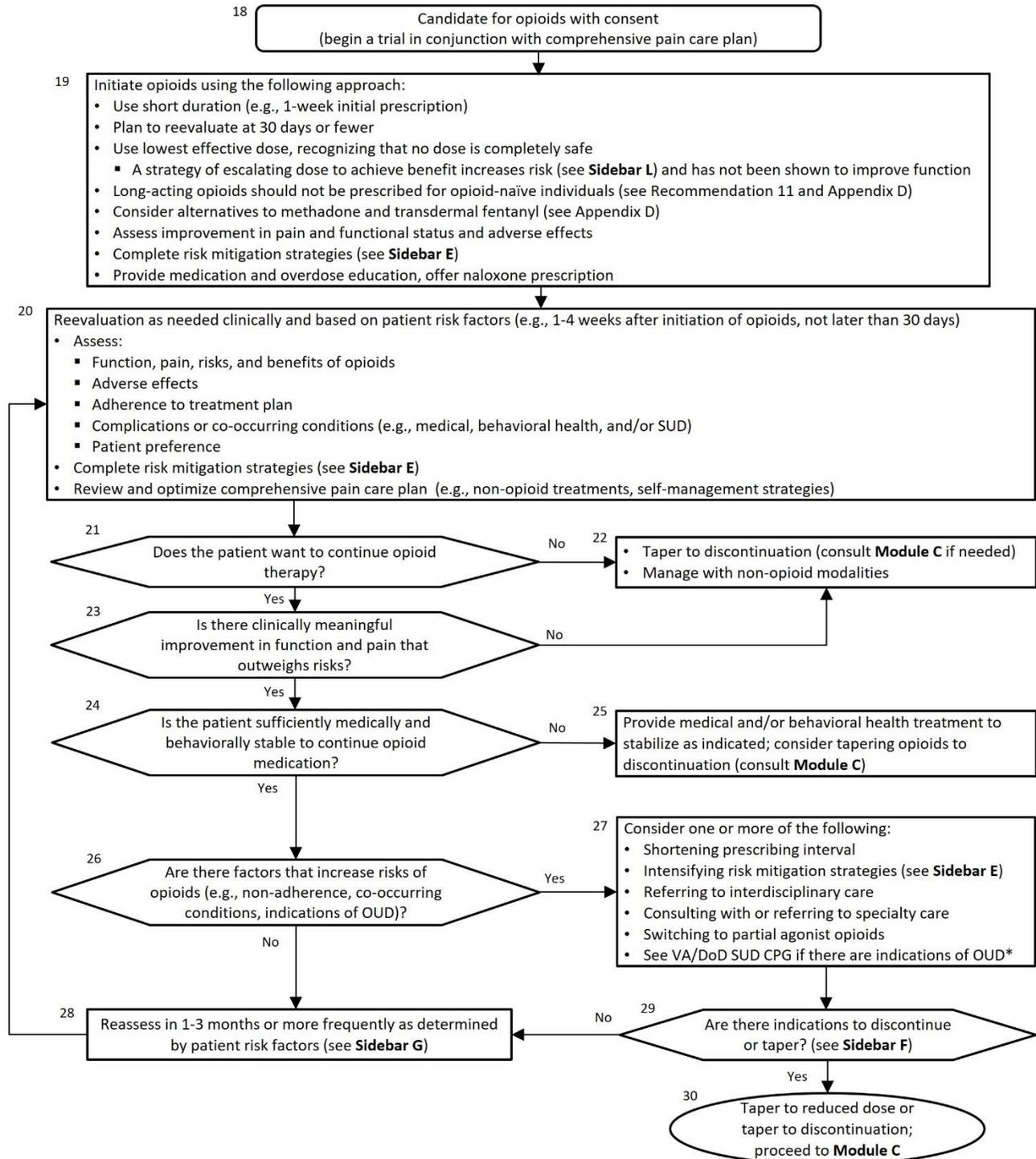
Note: Non-pharmacologic and non-opioid pharmacologic treatments are preferred for chronic pain



* Other VA/DoD CPGs are available here: <https://www.healthquality.va.gov/>

Abbreviations: CPGs: VA/DoD Clinical Practice Guidelines; LBP: low back pain; OA: osteoarthritis; SUD: substance use disorders

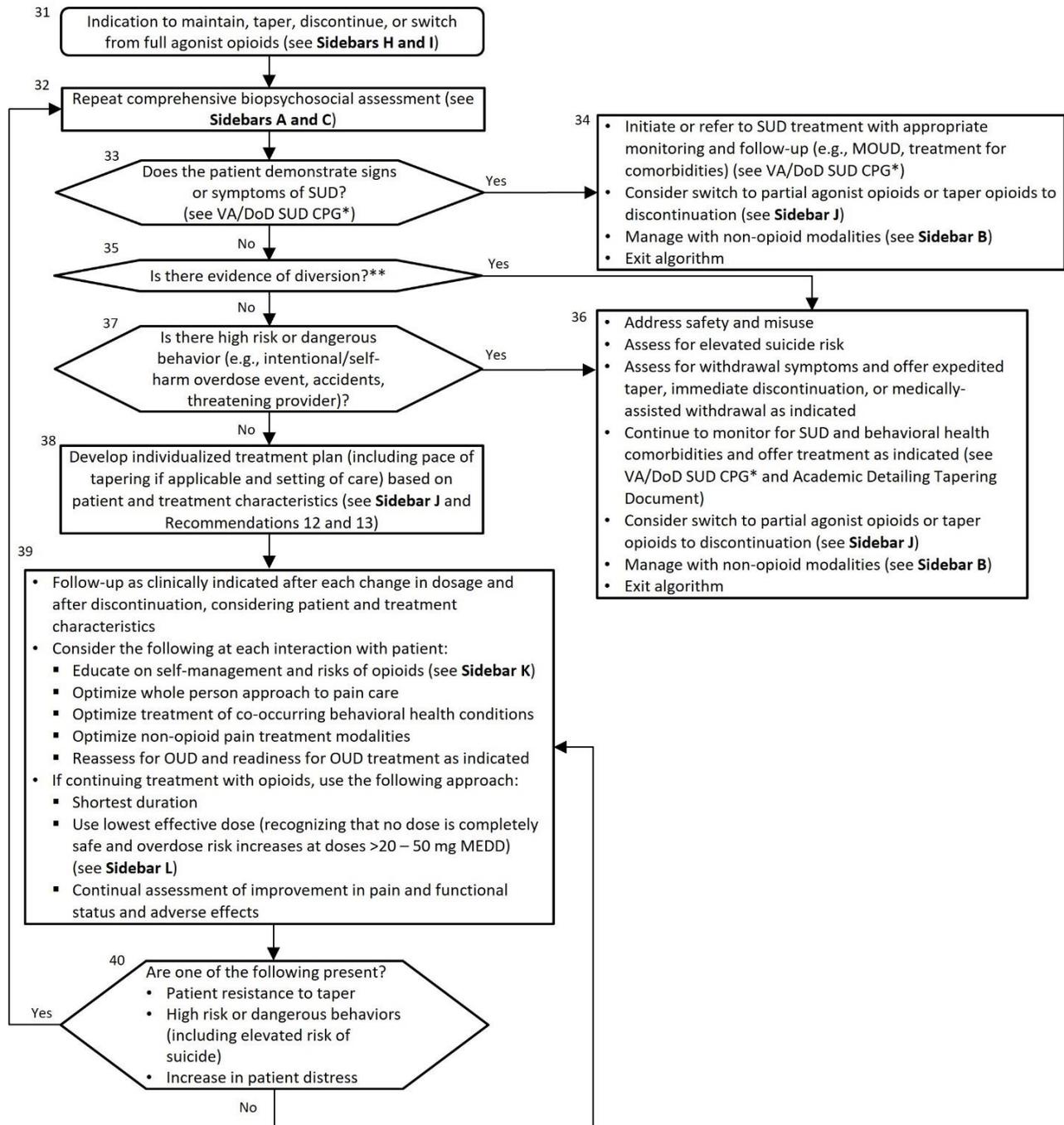
Module B: Initiation of Treatment with Opioids



* VA/DoD SUD CPG is available here: <https://www.healthquality.va.gov/>

Abbreviations: OUD: opioid use disorder; SUD: substance use disorders; VA/DoD SUD CPG: VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders

Module C: Maintaining, Tapering, Discontinuing, or Switching from Full Agonist Opioids



* VA/DoD SUD CPG is available here: <https://www.healthquality.va.gov/>

** According to the CDC, drug diversion is when prescription medicines are obtained or used illegally.

Abbreviations: MEDD: morphine equivalent daily dose; mg: milligram(s); MOUD: medication for opioid use disorder; OUD: opioid use disorder; SUD: substance use disorders; VA/DoD SUD CPG: VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders

Sidebar A: Components of Pain/Biopsychosocial Assessment

- Conduct a pain assessment (e.g., information about the onset of pain, location, duration, exacerbating factors, relieving factors, whether there is radiation [location of the radiation and what triggers the radiation], 24 hour pain pattern, quality of pain)
- Assess history of previous treatments and effect on pain
- Assess impact of pain on daily functioning and quality of life (e.g., pain interference, family, education, work, community, social activities, sleep quality)
- Assess patient’s functional goals
- Evaluate psychological/behavioral factors, including suicide risk,^a that may affect treatment (e.g., pain avoidance, pain catastrophizing)
- Evaluate social factors that may affect treatment (e.g., employment, homelessness)
- Assess current and past co-occurring conditions (medical and behavioral health comorbidities)
- Conduct physical exam
- Confirm diagnosis (review previous diagnostic studies)
- Consider consultations and referrals
- Patient beliefs and understanding of:
 - ◆ The cause of their pain
 - ◆ Their treatment preferences
 - ◆ The perceived efficacy of various treatment options

For patients already on prescribed opioids, see **Module C**.

^a See the VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide, available at: <https://www.healthquality.va.gov/>

Sidebar B: Non-opioid Treatments for Chronic Pain

- Rehabilitation and manipulative therapies (e.g., provided by physical therapists, occupational therapists, chiropractors)
- Pharmacologic therapy (e.g., over-the-counter medications, non-opioid prescription pain medications)
- Interventional procedures (e.g., trigger point injections, joint injections, acupuncture)
- Psychological and behavioral interventions (e.g., motivational interviewing, CBT)
- Complementary and integrative treatments (e.g., yoga, tai chi)

Abbreviations: CBT: cognitive behavioral therapy

Sidebar C: Opioid Risk Assessment

Examples of contraindications to initiating opioids for chronic pain:

- SUD, not in remission
- Elevated suicide risk^a
- Concomitant use of benzodiazepines

If patient is already on prescribed opioids, is there evidence of OUD, such as:

- Self-escalating dose
- Early refills
- Difficulty tapering
- Cravings
- Continued use despite medical or psychological consequences
- Interpersonal or social problems related to opioid use

Screening tools and predictive models (repeat as clinically indicated). Examples include:

- [RIOSORD](#)
- [STORM](#)

^a See the VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide, available at: <https://www.healthquality.va.gov/>

Abbreviations: OUD: opioid use disorder; RIOSORD: Risk Index for Overdose or Serious Opioid-induced Respiratory Depression; STORM: Stratification Tool for Opioid Risk Mitigation; SUD: substance use disorders

Sidebar D: Consideration Checklist for Prescribing Opioids for Chronic Pain

- Risks do not outweigh potential functional benefits
- Patient has a condition that is:
 - ◆ Causing severe chronic pain
 - ◆ Interfering with function and quality of life
 - ◆ Failing to adequately respond to indicated non-pharmacologic and non-opioid pharmacologic therapy
- Clear and measurable functional goals are established
- Patient is willing and able to access adequate follow-up for prescribed opioids
- PDMP and UDT are concordant with expectations (no aberrant behavior)
- Patient is fully informed and consents to treatment with opioids

Abbreviations: PDMP: prescription drug monitoring program; UDT: urine drug testing

Sidebar E: Risk Mitigation Strategies

- UDT
- PDMP
- Informed consent
- OEND
- Provider follow-up (in-person or video-based) with frequency determined by risk

Abbreviations: OEND: overdose education and naloxone distribution; PDMP: prescription drug monitoring program; UDT: urine drug testing

Sidebar F: Considerations for Tapering, Dosage Reduction, and Discontinuation

- Patient preference
- Patient characteristics and needs
- Lack of clinically meaningful improvement in functional goals (review treatment goals at onset of treatment)
- Concomitant use of medications that increase risk of overdose
- Co-occurring medical or behavioral health conditions, including SUD, that increase risk
- Patient non-compliance with opioid safety measures and opioid risk mitigation strategies
- Patient non-participation in a comprehensive pain care plan
- Higher dosage which increases risk of adverse events (see **Sidebar L**)
- Pain condition not effectively treated with opioids (e.g., back pain with normal MRI; fibromyalgia)
- Improvement in the underlying pain condition being treated
- Significant side effects
- Experiences overdose or other serious adverse events
- Diversion

Abbreviations: MRI: magnetic resonance imaging

Sidebar G: Factors That May Indicate Need for More Frequent Follow-up

- Non-adherence to comprehensive pain care plan (e.g., attendance at appointments)
- Unexpected UDT and PDMP results
- Non-adherence to opioid prescription (e.g., using more than prescribed and/or running out early)
- Higher risk medication characteristics (e.g., higher-dose opioids [see **Sidebar L**], combination of opioids and benzodiazepines)
- Patients with co-occurring medical and behavioral health conditions, including SUD, that increase risk for adverse outcomes

Abbreviations: PDMP: prescription drug monitoring program; SUD: substance use disorders; UDT: urinary drug testing

Sidebar H: Factors Requiring Immediate Attention and Possible Discontinuation or Switch to Safer Regimen

- Untreated SUD
- Unstable other behavioral health disorder
- Medical condition that acutely increases opioid risks (e.g., compromised or worsening cognitive or cardiopulmonary status, acute liver or renal disease)
- Other factors that acutely increase risk of overdose:
 - ◆ Recent overdose
 - ◆ Current sedation
 - ◆ Concomitant medications (e.g., benzodiazepines) and/or alcohol use
- Acutely elevated suicide risk
- Diversion

^a See the VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide, available at: <https://www.healthquality.va.gov/>

Abbreviations: SUD: substance use disorders

Sidebar I: Considerations During Reassessment

Risks

- Increase in all-cause mortality
- Increased risk of overdose (including overdose death)
- Increased risk of developing OUD
- Risk of developing or worsening:
 - ◆ Depression
 - ◆ Nausea
 - ◆ Falls
 - ◆ Constipation
 - ◆ Fractures
 - ◆ Dry mouth
 - ◆ Sleep disordered breathing
 - ◆ Sedation
 - ◆ Worsening pain
 - ◆ Cognitive dysfunction
 - ◆ Motor vehicle accidents
 - ◆ Immune system dysfunction
 - ◆ Hypogonadism
 - ◆ Reduction in function
 - ◆ Prolonged pain
 - ◆ Reduction in quality of life

Benefits

- Modest short-term improvement in pain
- Possible short-term improvement in function

If risks outweigh benefits, consider tapering, discontinuing, or switching from full agonist opioids (see [Module C, Box 36](#)).

Abbreviations: OUD: opioid use disorder

Sidebar J: Tapering Treatment

- Safety permitting, a gradual taper rate (consider a 5-20% reduction every 4 weeks or longer, adjust or pause as needed) allows time for neurobiological, psychological, and behavioral adaptations
- Tapering plans should be individualized based on patient goals and concerns, treatment characteristics, and safety considerations
- The VHA PBM Academic Detailing Service offers example tapers for opioids in their [Opioid Taper Decision Tool: A VA Clinicians Guide](#). Examples are provided for four taper rates: slowest, slower, fast, and rapid tapers.
- When there are concerns regarding risks of tapering (e.g., unmasked OUD, exacerbation of underlying behavioral health conditions), consider interdisciplinary services that may include behavioral health, specialty SUD, primary care, specialty pain care, and complementary and integrative health interventions
- Provide patient education to address concerns that may negatively impact taper (e.g., inability for adequate follow-up, inability to provide adequate treatment for co-occurring medical and behavioral health conditions, including SUD, address anxiety concerns)

Patient and treatment characteristics to consider when determining tapering strategy:

- Opioid dose
- Duration of therapy
- Type of opioid formulation
- Psychiatric, including SUD, and medical comorbidities
- Other patient risk factors (e.g., non-adherence, high-risk medication-related behavior, strength of social support, coping)
- Response/tolerance to prior tapers (e.g., withdrawal symptoms)
- Level of engagement in non-pharmacologic pain treatments
- Access to facilities and/or telehealth for monitoring and follow up

Abbreviations: OUD: opioid use disorder; PBM: Pharmacy Benefits Management; SUD: substance use disorders; VHA: Veterans Health Administration

Sidebar K: Talking Points for Providers When Recommending Changes to Patients Currently on Opioids

In the context of motivational interviewing and shared decision making:

- “Evidence shows that the best treatments for chronic pain are options such as behavioral interventions, rehabilitation therapies, and non-opioid medications.”
- “Science has demonstrated that long-term opioid use can lead to multiple problems including loss of pain-relieving effects, increased pain, unintentional death, OUD, and problems with sleep, mood, hormonal dysfunction, and immune dysfunction. I am concerned about your health and safety.”
- “While opioids were prescribed to you, we now understand in general that the risks outweigh the benefits when opioids are used long-term. Let’s work on reducing your dosage of opioids and discuss other treatment options.”

Abbreviations: OUD: opioid use disorder

Sidebar L: Risks of Prescription Opioid Overdose and Overdose Death at Selected Morphine Equivalent Daily Dose Intervals

Study	Main outcome measure	Expression of risk	MEDD (mg)				
			0	1 to 19	20 to <50	50 to <100	>100
Turner and Liang (2015)^{a,e} (3)	All overdose	AOR (95% CI)	1	0.80 (0.50-1.27)	1.54 (1.23-1.94)	2.08 (1.61-2.69)	4.34 (3.37-5.57)
Zedler et al. (2014)^{a,b,c,e} (4)	All overdose	OR (95% CI)	–	1	1.5 (1.1-1.9)	2.2 (1.5-3.2)	4.1 (2.6-6.5)
Bohnert et al. (2011)^{a,c,f} (5)	Unintentional overdose death	HR (95% CI)	–	1	1.88 (1.33-2.67)	4.63 (3.18-6.74)	7.18 (4.85-10.65)
Bohnert et al. (2011)^{b,c,f} (5)	Unintentional overdose death	HR (95% CI)	–	1	1.74 (0.69-4.35)	6.01 (2.29-15.78)	11.99 (4.42-32.56)
Dunn et al. (2010)^{a,e} (6)	All overdose	HR (95% CI)	0.19 (0.05-0.68)	1	1.19 (0.40-3.60)	3.11 (1.01-9.51)	11.18 (4.80-26.03)
Ilgen et al. (2016)^{a,c,d} (7)	Overdose with suicidal intent	HR (95% CI)	–	1	1.59 (1.12-2.27)	1.74 (1.09-2.76)	2.09 (1.22-3.56)

^a Chronic non-cancer pain

^b Chronic cancer pain

^c Study conducted in U.S. Veterans

^d Intentional overdose

^e Drug overdose per ICD-9-CM codes

^f Overdose death

Abbreviations: AOR: adjusted odds ratio; 95% CI: 95% confidence interval; HR: hazard ratio; MEDD: morphine equivalent daily dose; mg: milligram(s); OR: odds ratio

Scope of the CPG

This CPG is based on published clinical evidence and related information available through April 9, 2021. It is intended to provide general guidance on best evidence-based practices (see Appendix A in the full VA/DoD Opioids CPG for additional information on the evidence review methodology). This CPG is not intended to serve as a standard of care.

This CPG is intended for use by VA and DoD PCPs and other clinicians, including physicians, nurse practitioners, physician assistants, physical therapists, nurses, psychologists, dietitians, pharmacists, social workers, and others, involved in the healthcare team caring for patients prescribed opioids for chronic pain. Additionally, this CPG is intended for community-based clinicians involved in the care of Service Members, Veterans, or beneficiaries prescribed opioids for chronic pain.

The patient population of interest for this CPG is adults who are eligible for care in the VA or DoD healthcare delivery systems and those who receive care from community-based clinicians with chronic pain or acute pain who are on or being considered for prescription opioid therapy. It includes Veterans and Service Members as well as their beneficiaries.

Methods

The methodology used in developing this CPG follows the *Guideline for Guidelines*, an internal document of the VA/DoD EBPWG updated in January 2019 that outlines procedures for developing and submitting VA/DoD CPGs.(8) The *Guideline for Guidelines* is available at <https://www.healthquality.va.gov/>. This CPG also aligns with the National Academy of Medicine’s (NAM) principles of trustworthy CPGs (e.g., explanation of evidence quality and strength, the management of potential conflicts of interest [COI], interdisciplinary stakeholder involvement, use of systematic review [SR], and external review).(9) Appendix A in the full VA/DoD Opioids CPG provides a detailed description of the CPG development methodology.

The Work Group used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to craft each recommendation and determine its strength. Per the GRADE approach, recommendations must be evidence-based and cannot be made based on expert opinion alone. The GRADE approach uses the following four domains to inform the strength of each recommendation: confidence in the quality of the evidence, balance of desirable and undesirable outcomes, patient values and preferences, other considerations as appropriate (e.g., resource use, equity) (see Determining Recommendation Strength and Direction in the full VA/DoD Opioids CPG).(10)

Using these four domains, the Work Group determined the relative strength of each recommendation (*Strong* or *Weak*). The strength of a recommendation is defined as the extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects and is based on the framework above, which incorporates the four domains.(11) A *Strong* recommendation generally indicates *High* or *Moderate* confidence in the quality of the available evidence, a clear difference in magnitude between the benefits and harms of an intervention, similar patient values and preferences, and understood influence of other implications (e.g., resource use, feasibility).

In some instances, there is insufficient evidence on which to base a recommendation for or against a particular therapy, preventive measure, or other intervention. For example, the systematic evidence review may have found little or no relevant evidence, inconclusive evidence, or conflicting evidence for the intervention. The manner in which this is expressed in the CPG may vary. In such instances, the Work Group may include among its set of recommendations a statement of insufficient evidence for an intervention that may be in common practice even though it is not supported by clinical evidence, and particularly if there may be other risks of continuing its use (e.g., high opportunity cost, misallocation of resources). In other cases, the Work Group may decide to not include this type of statement about an intervention. For example, the Work Group may remain silent where there is an absence of evidence for a rarely used intervention. In other cases, an intervention may have a favorable balance of benefits and harms but may be a standard of care for which no recent evidence has been generated.

Using these elements, the Work Group determines the strength and direction of each recommendation and formulates the recommendation with the general corresponding text (see [Table 2](#)).

Table 2. Strength and Direction of Recommendations and General Corresponding Text

Recommendation Strength and Direction	General Corresponding Text
Strong for	We recommend ...
Weak for	We suggest ...
Neither for nor against	There is insufficient evidence to recommend for or against ...
Weak against	We suggest against ...
Strong against	We recommend against ...

It is important to note that a recommendation’s strength (i.e., *Strong* versus *Weak*) is distinct from its clinical importance (e.g., a *Weak* recommendation is evidence-based and still important to clinical care). The strength of each recommendation is shown in the [Recommendations](#) section.

The GRADE of each recommendation made in the 2022 CPG can be found in the section on [Recommendations](#). Additional information regarding the use of the GRADE system can be found in Appendix A in the full VA/DoD Opioids CPG.

Recommendation categories were used to track how the previous CPG’s recommendations could be reconciled. These categories and their corresponding definitions are similar to those used by the National Institute for Health and Care Excellence (NICE, England).([12](#), [13](#)) [Table 3](#) lists these categories, which are based on whether the evidence supporting a recommendation was systematically reviewed, the degree to which the previous CPG’s recommendation was modified, and whether a previous CPG’s recommendation is relevant in the updated CPG.

Additional information regarding these categories and their definitions can be found in Recommendation Categorization the full VA/DoD Opioids CPG. The 2022 CPG recommendation categories can be found in [Recommendations](#). Appendix G in the full VA/DoD Opioids CPG outlines the 2017 VA/DoD Opioids CPG’s recommendation categories.

Table 3. Recommendation Categories and Definitions^a

Evidence Reviewed	Recommendation Category	Definition
Reviewed^b	New-added	New recommendation
	New-replaced	Recommendation from previous CPG was carried forward and revised
	Not changed	Recommendation from previous CPG was carried forward but not changed
	Amended	Recommendation from previous CPG was carried forward with a nominal change
	Deleted	Recommendation from previous CPG was deleted
Not reviewed^c	Not changed	Recommendation from previous CPG was carried forward but not changed
	Amended	Recommendation from previous CPG was carried forward with a nominal change
	Deleted	Recommendation from previous CPG was deleted

^a Adapted from the NICE guideline manual (2012) (12) and Garcia et al. (2014) (13)

^b The topic of this recommendation was covered in the evidence review carried out as part of the development of the current CPG.

^c The topic of this recommendation was not covered in the evidence review carried out as part of the development of the current CPG.

Abbreviation: CPG: clinical practice guideline

Guideline Work Group

Table 4. Guideline Work Group and Guideline Development Team

Organization	Names*
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Patient-centered Care

Guideline recommendations are intended to consider patient needs and preferences. Guideline recommendations represent a whole/holistic health approach to care that is patient-centered, culturally appropriate, and available to people with limited literacy skills and physical, sensory, or learning disabilities. VA/DoD CPGs encourage providers to use a patient-centered, whole/holistic health approach (i.e., individualized treatment based on patient needs, characteristics, and preferences). This approach aims to treat the particular condition while also optimizing the individual’s overall health and well-being.

Regardless of the care setting, all patients should have access to individualized evidence-based care. Patient-centered care can decrease patient anxiety, increase trust in clinicians, and improve treatment adherence.(14, 15) A whole/holistic health approach (<https://www.va.gov/wholehealth/>) empowers and equips individuals to meet their personal health and well-being goals. Good communication is essential and should be supported by evidence-based information tailored to each patient’s needs. An empathetic and non-judgmental approach facilitates discussions sensitive to sex, culture, ethnicity, and other differences.

Shared Decision Making

This CPG encourages providers to practice shared decision making, which is a process in which providers and patients consider clinical evidence of benefits and risks as well as patient values and preferences to make decisions regarding the patient’s treatment.(16) Shared decision making was emphasized in *Crossing the Quality Chasm*, an Institute of Medicine (IOM) (now NAM) report in 2001 (17) and is

inherent within the whole/holistic health approach. Providers must be adept at presenting information to their patients regarding individual treatments, expected risks, expected outcomes, and levels and/or settings of care, especially where there may be patient heterogeneity in risks and benefits. The VHA and MHS have embraced shared decision making. Providers are encouraged to use shared decision making to individualize treatment goals and plans based on patient capabilities, needs, and preferences.

Patients with Co-occurring Conditions

Co-occurring conditions can modify the degree of risk, impact diagnosis, influence patient and provider treatment priorities and clinical decisions, and affect the overall approach to the use of opioids in the management of chronic pain. Many Veterans, Service Members, and their families have one or more co-occurring conditions. Because chronic pain is sometimes accompanied by co-occurring conditions, it is often best to make decisions about use of opioids in the management of chronic pain collaboratively with other care providers. Some co-occurring conditions may require early specialist consultation to determine any necessary changes in treatment or to establish a common understanding of how care will be coordinated. This may entail reference to other VA/DoD CPGs (e.g., for Major Depressive Disorder [MDD], SUD, and Suicide¹).

¹ Other VA/DoD CPGs are available at: <https://www.healthquality.va.gov/>

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*Access to the full guideline and additional resources are available
at the following link:*

<https://www.healthquality.va.gov/>

