VA/DoD Clinical Practice Guidelines

VA/DoD Clinical Practice Guideline for the Management of Chronic Multisymptom Illness

Provider Summary

Version 3.0 | 2021

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF CHRONIC MULTISYMPTOM ILLNESS

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.

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 3.0 – 2021

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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) The 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 October 2014, the VA and DoD published a CPG for the Management of Chronic Multisymptom Illness (2014 CMI CPG), which was based on evidence reviewed through October 2013. Since the release of that CPG, a growing body of research has expanded the evidence base and understanding of chronic multisymptom illness (CMI). Consequently, a recommendation to update the 2014 CMI CPG was initiated in 2019.

This CPG provides an evidence-based framework for evaluating and managing care for adults 18 years or older who are eligible for care in the VA and/or DoD healthcare systems, and who have a diagnosis of CMI.

Successful implementation of this CPG will:

- Enhance the assessment of the patient's condition
- Enhance collaboration with the patient, family, and caregivers to determine optimal management
- Minimize preventable complications and morbidity of CMI
- Optimize individual health outcomes and quality of life for patients with CMI

The full VA/DoD CMI CPG, as well as additional toolkit materials including a pocket card and provider 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 Appendix A in the full VA/DoD CMI CPG). 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).

Recommendations are presented as treatment for CMI in general, which includes FMS, IBS, and ME/CFS. Then, recommendations focus on CMI and symptoms consistent with FMS, IBS, and/or ME/CFS. The recommendation order is depicted by Figure 1. Interventions are then organized by type (i.e., pharmacotherapy, behavioral health, CIH, physical exercise).

Figure 1. Recommendation Organization Flowchart

CMI
Recommendations 1-6

And symptoms consistent with:

FMS	IBS	ME/CFS

See Recommendations:

7-17	7-9, 18-27	28-29

Recommendations are presented in Table 1.

Table 1. Recommendations

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of CMI	a. Pharmacotherapy	1.	We recommend against the long-term use of opioid medications for the management of chronic pain in patients with CMI.	Strong against	Reviewed, Amended
		2.	We recommend against offering mifepristone for patients with CMI.	Strong against	Reviewed, New-added
	b. Behavioral Health	3.	We suggest offering cognitive behavioral therapy for CMI and symptoms consistent with fibromyalgia, irritable bowel syndrome, or myalgic encephalomyelitis/chronic fatigue syndrome.	Weak for	Reviewed, New-replaced
		4.	We suggest offering mindfulness-based therapies for patients with CMI and symptoms consistent with fibromyalgia, irritable bowel syndrome, or myalgic encephalomyelitis/chronic fatigue syndrome.	Weak for	Reviewed, New-replaced
		5.	There is insufficient evidence to recommend for or against the use of biofeedback modalities in patients with CMI and symptoms consistent with fibromyalgia, irritable bowel syndrome, or myalgic encephalomyelitis/chronic fatigue syndrome.	Neither for nor against	Reviewed, New-added

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of CMI (cont.)	c. Complementary and Integrative Health	6.	There is insufficient evidence to recommend for or against the use of manual musculoskeletal therapies for patients with CMI and symptoms consistent with fibromyalgia, irritable bowel syndrome, or myalgic encephalomyelitis/chronic fatigue syndrome.	Neither for nor against	Reviewed, New-added
Treatment of CMI and Symptoms Consistent with FMS or IBS	a. Behavioral Health	7.	We suggest considering an emotion-focused therapy for patients with CMI and symptoms consistent with fibromyalgia or irritable bowel syndrome.	Weak for	Reviewed, New-replaced
	b. Complementary and Integrative Health	8.	There is insufficient evidence to recommend for or against offering relaxation therapy for patients with CMI and symptoms consistent with fibromyalgia or irritable bowel syndrome.	Neither for nor against	Reviewed, New-replaced
		9.	There is insufficient evidence to recommend for or against the use of guided imagery and hypnosis modalities in patients with CMI and symptoms consistent with fibromyalgia or irritable bowel syndrome.	Neither for nor against	Reviewed, New-added
Treatment of CMI and Symptoms Consistent with FMS	a. Pharmacotherapy	10.	There is insufficient evidence to recommend for or against offering a trial of mirtazapine, selective serotonin reuptake inhibitors, or amitriptyline for the treatment of pain and improved functional status in patients with CMI and symptoms consistent with fibromyalgia.	Neither for nor against	Reviewed, New-replaced
		11.	We suggest offering a trial of serotonin-norepinephrine reuptake inhibitors for the treatment of pain and improved functional status in patients with CMI and symptoms consistent with fibromyalgia.	Weak for	Reviewed, New-replaced
		12.	We suggest offering pregabalin for the treatment of pain in patients with CMI and symptoms consistent with fibromyalgia.	Weak for	Reviewed, Amended
		13.	We suggest against offering nonsteroidal anti-inflammatory drugs for the treatment of chronic pain related to CMI and symptoms consistent with fibromyalgia.	Weak against	Reviewed, New-replaced
	b. Complementary and Integrative Health	14.	We suggest offering yoga or tai chi for patients with CMI and symptoms consistent with fibromyalgia.	Weak for	Reviewed, New-replaced
		15.	We suggest offering manual acupuncture as part of the management of patients with CMI and symptoms consistent with fibromyalgia.	Weak for	Reviewed, New-replaced
		16.	There is insufficient evidence to recommend for or against the use of deep tissue massage modalities in patients with CMI and symptoms consistent with fibromyalgia.	Neither for nor against	Reviewed, New-added

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of CMI and Symptoms Consistent with FMS (cont.)	c. Physical Exercise	17.	We suggest offering physical exercise for patients with CMI and symptoms consistent with fibromyalgia.	Weak for	Reviewed, New-replaced
Treatment of CMI and Symptoms Consistent with IBS	a. Pharmacotherapy	18.	There is insufficient evidence to recommend for or against offering tricyclic antidepressants for the management of gastrointestinal symptoms for patients with CMI and symptoms consistent with irritable bowel syndrome.	Neither for nor against	Reviewed, New-added
		19.	There is insufficient evidence to recommend for or against the use of antispasmodics for gastrointestinal symptoms for patients with CMI and symptoms consistent with irritable bowel syndrome.	Neither for nor against	Reviewed, New-replaced
		20.	We suggest offering linaclotide and plecanatide for patients with CMI and symptoms consistent with irritable bowel syndrome with constipation who do not respond to a trial of osmotic laxatives.	Weak for	Reviewed, New-replaced
		21.	There is insufficient evidence to recommend for or against offering lubiprostone for patients with CMI and symptoms consistent with irritable bowel syndrome with constipation who do not respond to a trial of osmotic laxatives.	Neither for nor against	Reviewed, New-replaced
		22.	There is insufficient evidence to recommend for or against offering eluxadoline for patients with CMI and symptoms consistent with irritable bowel syndrome with diarrhea.	Neither for nor against	Reviewed, New-replaced
		23.	We suggest offering a 14-day course of rifaximin for gastrointestinal symptoms for patients with CMI and symptoms consistent with irritable bowel syndrome without constipation.	Weak for	Reviewed, New-added
		24.	There is insufficient evidence to recommend for or against offering soluble fiber supplements for gastrointestinal symptoms for patients with CMI and symptoms consistent with irritable bowel syndrome.	Neither for nor against	Reviewed, New-replaced

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of CMI and Symptoms Consistent with IBS (cont.)	*a. Pharmacotherapy (cont.)*	25.	There is insufficient evidence to recommend for or against offering alosetron for gastrointestinal symptoms for patients with CMI and symptoms consistent with irritable bowel syndrome.	Neither for nor against	Reviewed, New-added
		26.	There is insufficient evidence to recommend for or against offering selective serotonin reuptake inhibitors for the management of gastrointestinal symptoms for patients with CMI and symptoms consistent with irritable bowel syndrome.	Neither for nor against	Reviewed, New-added
	b. Behavioral Health	27.	There is insufficient evidence to recommend for or against offering psychodynamic therapies for patients with CMI and symptoms consistent with irritable bowel syndrome.	Neither for nor against	Reviewed, New-replaced
Treatment of CMI and Symptoms Consistent with ME/CFS	*a. Pharmacotherapy*	28.	There is insufficient evidence to recommend for or against offering duloxetine for patients with CMI and symptoms consistent with myalgic encephalomyelitis/chronic fatigue syndrome.	Neither for nor against	Reviewed, New-replaced
		29.	We recommend against offering stimulants for treatment of fatigue in patients with CMI and symptoms consistent with myalgic encephalomyelitis/chronic fatigue syndrome.	Strong against	Reviewed, New-replaced

[a] For additional information, see Grading Recommendations in the full VA/DoD CMI CPG.

[b] For additional information, see Recommendation Categorization and Appendix D in the full VA/DoD CMI CPG.

Algorithm

This CPG's algorithm is designed to facilitate understanding of the clinical pathway and decision making process used in managing patients with CMI. This algorithm format represents a simplified flow of the management of patients with CMI and helps foster efficient decision making by providers. It includes:

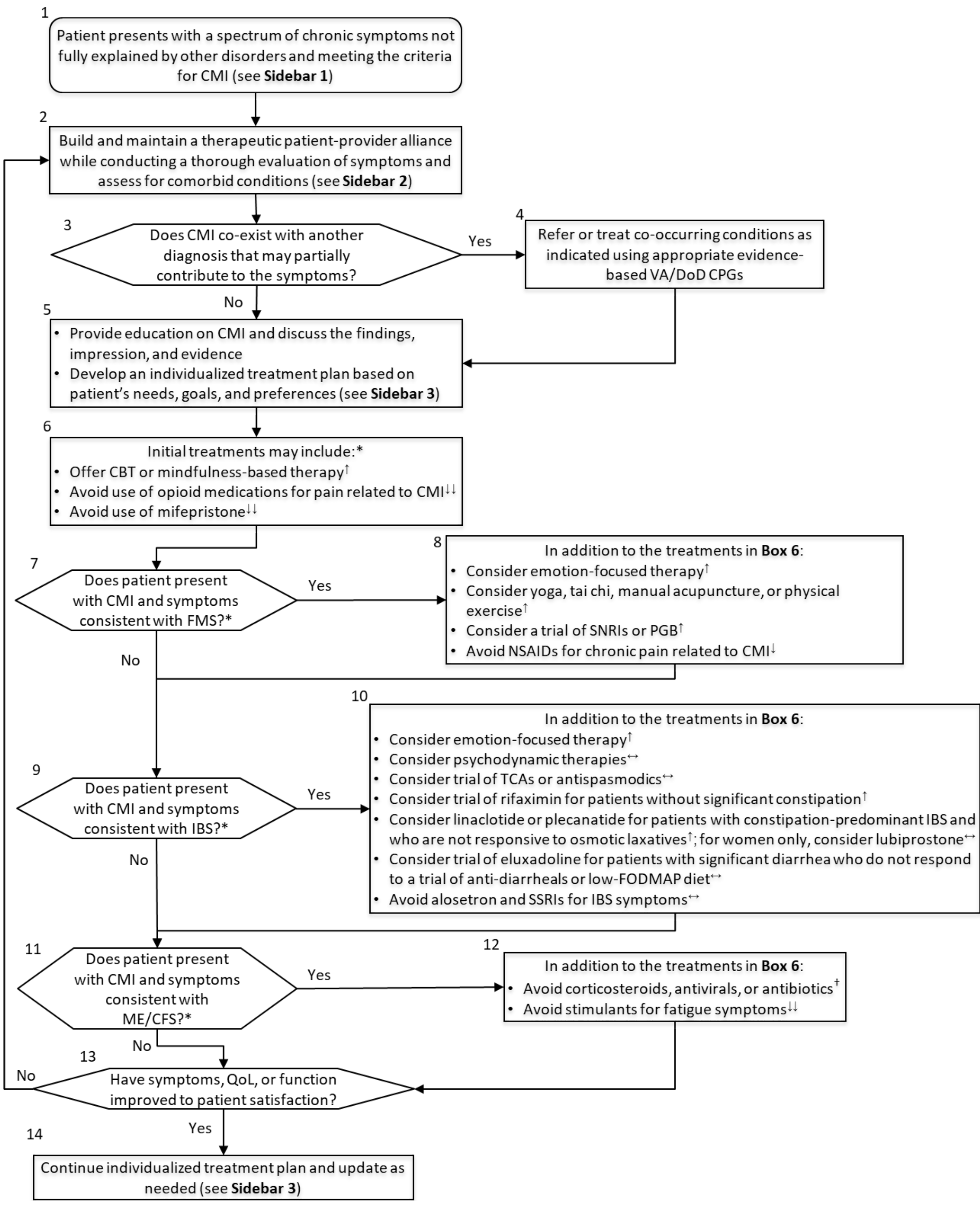
- An ordered sequence of steps of care
- Decisions to be considered
- Recommended decision criteria
- Actions to be taken

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

For alternative text descriptions of the algorithm, please refer to Appendix G in the full VA/DoD CMI CPG.

Algorithm: Management of CMI



* Recommended interventions are not rank-ordered; consider interventions based on individual patient needs, goals, and preferences.

† There has been no new evidence since the 2014 CMI CPG to suggest any benefit for steroids, antivirals, or antibiotics. As such, the Work Group recommends against using these agents to treat CMI and symptoms consistent with ME/CFS.

↑ Indicates a "Weak for" recommendation strength; ↓ Indicates a "Weak against" recommendation strength; ↓↓ Indicates a "Strong against" recommendation strength; ↔ Indicates a "Neither for nor against" recommendation strength

Abbreviations: CBT: cognitive behavioral therapy; CMI: chronic multisymptom illness; CPG: clinical practice guideline; DoD: Department of Defense; FMS: fibromyalgia syndrome; FODMAP: fermentable oligo-, di-, mono-saccharides, and polyols; IBS: irritable bowel syndrome; ME/CFS: myalgic encephalomyelitis/chronic fatigue syndrome; NSAID: nonsteroidal anti-inflammatory drug; PGB: pregabalin; QoL: quality of life; SNRI: serotonin-norepinephrine reuptake inhibitor; SSRI: selective serotonin reuptake inhibitor; TCA: tricyclic antidepressant; VA: Department of Veterans Affairs

Sidebar 1: Case Definition of CMI
Chronic multisymptom illness is characterized by multiple, persistent symptoms (e.g., fatigue, headache, arthralgias, myalgias, concentration and attention problems, and gastrointestinal disorders) across more than one body system. The symptoms must be present or frequently recur for more than six months and should be severe enough to interfere with daily functioning.

Sidebar 2: Elements of Assessment
• Obtain medical history and military/deployment history • Conduct psychosocial assessment including psychological trauma history • Conduct physical examination • Consider diagnostic studies, as indicated, for rule-out of alternative diagnoses only; avoid any tests for which there may be limited additional benefit • Consider additional and/or longer duration encounters

Sidebar 3: Individualized Treatment Plan
• Using a whole/holistic health approach, identify individual treatment goals (e.g., return to work, improved QoL, resumption of recreational activities) • Describe treatment options and engage in shared decision making discussion and shared goal setting in support of the individual's aspiration and purpose for health and well-being • Maximize use of non-pharmacologic therapies (e.g., CBT, CIH interventions,* aerobic exercise) • Develop personal health plan and timeline for follow-up and monitor progress toward personal goals • Maintain continuity and caring relationship via in-person and/or virtual modalities • Provide education (both for improved health literacy and whole/holistic health self-care) and engage families/caregiver/support person, if available • Based on patient needs, consider referral to case manager and establish interprofessional care team

Abbreviations: CBT: cognitive behavioral therapy; CIH: complementary and integrative health; QoL: quality of life

*See https://www.va.gov/wholehealth/

Behavioral Health Interventions for CMI

Table 2. Behavioral Health Interventions for CMI

Class	Intervention	Description
Cognitive Behavioral Therapy	Traditional cognitive behavioral therapy	Cognitive behavioral therapy (CBT) is a problem-oriented strategy. It focuses on current problems and finding solutions to them. Unlike psychoanalysis, for example, it does not deal primarily with the past. Cognitive behavioral therapy is much more concerned with current problems. Traditional CBT mainly deals with identifying and changing current distressing thought and behavioral patterns.(3)
	Acceptance-based behavior therapy	Acceptance-based behavior therapy (ABBT) was developed based on the theory that generalized anxiety disorder is maintained through a reactive and fused relationship with internal experiences and a tendency toward experiential avoidance and behavioral restriction. Acceptance-based behavior therapy specifically targets these elements. The focus of treatment is not on eliminating worry, but rather on decreasing the distress and interference associated with this cognitive activity.(4)
Mindfulness-based Therapy	Mindfulness-based stress reduction	Mindfulness-based stress reduction (MBSR) therapy is a meditation therapy. Although originally designed for stress management, it is being used to treat a variety of illnesses. It employs mindfulness meditation to alleviate suffering associated with physical, psychosomatic, and psychiatric disorders.(5)
	Meditation awareness training	Meditation awareness training (MAT) is generally delivered over eight weeks and follows a comprehensive approach to meditation whereby mindfulness is an integral part, but does not form the exclusive focus, of the program. In addition to mindfulness, MAT incorporates practices that would traditionally be followed by meditation practitioners including techniques aimed at cultivating generosity, patience, and compassion. Meditation awareness training also integrates techniques that encourage the participant to investigate and come to an understanding of complex concepts such as impermanence and emptiness.(6)
	Mindfulness-based cognitive therapy	Mindfulness-based cognitive therapy incorporates elements of CBT with MBSR into an 8-session group program. It focuses on encouraging patients to adopt a new way of being and relating to their thoughts and feelings, while placing little emphasis on altering or challenging specific cognitions.(7)
Emotion-focused Therapy	Emotional awareness and expression therapy	Emotional awareness and expression therapy is designed to help patients attribute their pain and other symptoms to emotionally-activated central nervous system mechanisms and become aware of, experience, and adaptively express their emotions stemming from adversity, trauma, or conflict.(8)
	Attachment-based compassion therapy	Comprises eight sessions each lasting two and a half hours, and includes exercises of mindfulness training and compassion such as receiving and offering compassion to friends, individuals deemed to be problematic, unknown individuals, and oneself.(9)
Relaxation Therapy	Manual muscular relaxation therapy	Manual muscular relaxation therapy is an auditory relaxation technique, practiced individually and in silence. It focuses on the psychoneuroimmunological link between mind and body, and incorporates guided imagery, muscular relaxation, and breathing exercises, and implies full engagement and autonomy. The stress-related posture is thought to increase muscle tension and influence the nervous and endocrine systems, as well as cause muscle stiffness and dystonic patterns.(10)

Class	Intervention	Description
Relaxation Therapy (cont.)	Functional relaxation therapy	Functional relaxation (FR) therapy is a body-oriented psychologic intervention, which was found to be effective particularly for tension headaches, noncardiac chest pain, and psychosomatically-influenced asthmatic diseases. According to Marianne Fuchs, FR is a body-oriented psychotherapy that involves teaching the patient a type of relaxation technique aimed at maintaining equilibrium of the nervous system.(11, 12)
	Autogenic therapy	The autogenic therapy (AT) relaxation approach focuses on relaxing the entire body through breathing and relaxation exercises, by the repetition of verbal formula.(13)
Guided Imagery	Guided imagery relaxation therapy	Guided imagery with relaxation (GIR) is a cognitive behavioral intervention. Guided imagery with relaxation is used to reduce pain based on the biopsychosocial theory of chronic pain. It utilizes guided cognition to increase focus and relaxation. Response imagery is used and involves imagining oneself in a pleasant scene. Verbal suggestions are given to produce a flow of thoughts that focus the individual's attention on imagined visual, auditory, tactile, and/or olfactory sensations.(14)
	Guided affective imagery	Guided affective imagery (GAI) is a type of psychotherapy that involves focusing on mental images to induce relaxation. The principle behind GAI is the interruption of stress-provoking thoughts with a relaxing image, inducing relaxation.(15, 16)
Clinical Hypnosis	Clinical hypnosis	Clinical hypnosis is a group of techniques that utilizes hypnosis to treat health-related conditions. It assumes that through concentration and relaxation processes, the individual may be able to change undesired conditions and behaviors.(17)
Psychodynamic Therapy	Psychodynamic therapy	Psychodynamic therapy seeks to understand the unconscious processes that impact interpersonal relationships and day-to-day functioning. This assists the individual in becoming aware of these processes so they can modify their responses and behaviors.(18, 19)

Abbreviations: ABBT: acceptance-based behavior therapy; AT: autogenic therapy; CBT: cognitive behavioral therapy; FR: functional relaxation therapy; GAI: guided affective imagery; GIR: guided imagery with relaxation; MAT: meditation awareness training; MBSR: mindfulness-based stress reduction

Scope of the CPG

This CPG is based on published clinical evidence and related information available through April 7, 2020. It is intended to provide general guidance on best evidence-based practices (see Appendix A in the full VA/DoD CMI CPG for additional information on the evidence review methodology). This CPG is not intended to serve as a standard of care.

This CPG is designed primarily to assist healthcare providers and teams in managing patients with CMI and related conditions. This guideline seeks to inform providers with practical evidence-based recommendations for the most common scenarios involving patients with CMI.

The patient population of interest for this CPG is adults 18 years or older who are eligible for care in the VA and/or DoD healthcare systems, and who have a diagnosis of CMI.

Methods

The methodology used in developing this CPG follows the *Guideline for Guidelines*, an internal document of the VA and DoD EBPWG updated in January 2019 that outlines procedures for developing and submitting VA/DoD CPGs.(20) The *Guideline for Guidelines* is available at http://www.healthquality.va.gov/policy/index.asp. 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 conflicts of interest [COI], interdisciplinary stakeholder involvement, use of systematic review, and external review).(21) Appendix A in the full VA/DoD CMI 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 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 Grading Recommendations in the full VA/DoD Abbreviation CPG).(22)

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.(23) 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).

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 3).

Table 3. 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 …

The GRADE of each recommendation made in the 2021 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 CMI CPG.

The Work Group developed both new and updated recommendations based on the evidence review conducted for the priority areas addressed by the KQs. A set of recommendation categories was adapted from those used by the National Institute for Health and Care Excellence (NICE).(24, 25) The categories and definitions can be found in Table 4.

Table 4. 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) (24) and Garcia et al. (2014) (25)

[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 5. Guideline Work Group and Guideline Development Team

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Patient-centered Care

Guideline recommendations are intended to consider patient needs and preferences and 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 health/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.(26, 27) 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 gender, culture, ethnicity, and other differences.

Shared Decision Making

This CPG encourages providers to practice shared decision making. Shared decision making was emphasized in *Crossing the Quality Chasm,* an IOM (now NAM) report, in 2001.(28) 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.

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