Education/re-educate on, implement, and optimize non-opioid treatments for chronic pain (see Sidebar B), including:

- Complementary and integrative health treatments (e.g., acupuncture)
- Physical/movement-based therapies (e.g., physical therapy)
- Behavioral therapies (e.g., cognitive behavioral therapy)

Sidebar B: Non-opioid Treatments for Chronic Pain

- 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, 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.

Sidebar C: 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

Additional Sidebars referenced throughout the algorithm can be found in the full guideline (on pages 32-3).

Abbreviations: CBT: cognitive behavioral therapy; CPGs: VA/DoD Clinical Practice Guidelines; LBP: low back pain; MAT: medication assisted treatment; MDD: major depressive disorder; MRI: magnetic resonance imaging; OA: osteoarthritis; OEND: Overdose Education and Naloxone Distribution; OUD: opioid use disorder; PMP: Prescriptions Monitoring Program; SUD: substance use disorders; UDT: urine drug testing; VA/DoD SUP CPG: VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders

Access to the full guideline and additional resources are available at: https://www.healthquality.va.gov/
Module B: Initiation of Treatment with Opioids

- Candidate for opioids with consent (begin a trial in conjunction with comprehensive pain care plan)

- Reevaluation as needed clinically and based on patient risk factors (e.g., 1-4 weeks after initiation of opioids, not later than 30 days)
  - Assess:
    - Function, plan, risks, and benefits of opioids
    - Adverse effects
    - Adherence to treatment plan
    - Complications or co-occurring conditions (e.g., medical, behavioral health, and/or SUD)
    - Patient preference
  - Complete risk mitigation strategies (see Sidebar E)
  - Use lowest effective dose, recognizing that no dose is completely safe
  - Initiate opioids using the following approach:
    - Use short duration (e.g., 1-week initial prescription)
    - Use lowest effective dose, recognizing that no dose is completely safe
    - A strategy of escalating dose to achieve benefit increases risk (see Recommendation 11 and Appendix D)
    - Has not been shown to improve function
    - Long-acting opioids should not be prescribed for opioid-naïve individuals (see Recommendations 11 and Appendix D)
    - Consider alternatives to methadone and transdermal fentanyl (see Appendix D)
    - Assess improvement in pain and functional status and adverse effects
    - Complete risk mitigation strategies (see Sidebar E)
    - Provide medication and overdose education, offer naloxone prescription

- Consider one or more of the following:
  - Shortening prescribing interval
  - Intensifying risk mitigation strategies (see Sidebar E)
  - Referring to interdisciplinary care
  - Consulting with or referring to specialty care
  - Switching to partial agonist opioids
  - See VA/DoD SUD CPG if there are indications of OUD

- Are there indications to discontinue or taper? (see Sidebar F)
  - No
    - Taper to reduced dose or taper to discontinuation; proceed to Module C
  - Yes
    - Are there factors that increase risks of opioids (e.g., non-adherence, co-occurring conditions, indications of OUD)?
      - No
        - Reassess in 1-3 months or more frequently as determined by patient risk factors (see Sidebar G)
      - Yes
        - Consider one or more of the following:
          - Managing with non-opioid modalities
          - Consult with or refer to specialty care
          - Referring to interdisciplinary care
          - Intensifying risk mitigation strategies (see Sidebar E)
          - Use lowest effective dose (recognizing that no dose is completely safe and overdose risk increases at doses >20-50 mg MEDD) (see VA/DoD SUD CPG)
          - Consult switch to partial agonist opioids or taper opioids to discontinuation (see Sidebar B)
          - Exit algorithm

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

- Indication to discontinue, continue, taper, or reduce treatment with opioids (see Sidebars H and I)
  - Yes
    - Exit algorithm
  - No
    - Reevaluation as needed clinically and based on patient risk factors (e.g., 1-4 weeks after initiation of opioids, not later than 30 days)
  - Does the patient demonstrate signs or symptoms of SUD? (see VA/DoD SUD CPG)
    - Yes
      - Is there evidence of diversion?**
        - Yes
          - Exit algorithm
        - No
          - Repeat comprehensive biopsychosocial assessment (see Sidebars A and C)
    - No
      - Is there high risk or dangerous behavior (e.g., overdose event, accidents, threatening provider)?
        - Yes
          - Exit algorithm
        - No
          - Does the patient demonstrate signs or symptoms of SUD? (see VA/DoD SUD CPG)
            - Yes
              - Exit algorithm
            - No
              - Develop individualized treatment plan (including pace of tapering if applicable and setting of care) based on patient and treatment characteristics (see Sidebars J and Recommendations 12 and 13)

- Follow-up as clinically indicated after each change in dosage and after discontinuation, considering patient and treatment characteristics
  - Consider the following at each interaction with patient:
    - Evaluate self-management and risks of opioids (see Sidebar K)
    - Optimize whole person approach to pain care
    - Optimize treatment of co-occurring behavioral health conditions
    - Optimize non-opioid pain treatment modalities
    - Reassess for OUD and readiness for OUD treatment as indicated
    - If continuing treatment with opioids, use the following approach:
      - Shortest duration
      - Use lowest effective dose (recognizing that no dose is completely safe and overdose risk increases at doses >20-50 mg MEDD) (see Sidebar L)
      - Continual assessment of improvement in pain and functional status and adverse effects

- Address safety and misuse
  - Assess for withdrawal symptoms and offer expedited taper, immediate discontinuation, or medically-assisted withdrawal as indicated
  - Continue to monitor for SUD and behavioral health comorbidities and offer treatment as indicated (see VA/DoD SUD CPG*) and Academic Detailing Tapering Document
  - Consider switch to partial agonist opioids or taper opioids to discontinuation (see Sidebar B)
  - Manage with non-opioid modalities (see Sidebar B)
  - Exit algorithm

- Are one of the following present?
  - Patient resistance to taper
  - High risk or dangerous behaviors (including elevated risk of suicide)
    - Increase in patient distress
  - Are there factors that increase risks of opioids (e.g., non-adherence, co-occurring conditions, indications of OUD)?
    - No
      - Exit algorithm
    - Yes
      - Consider one or more of the following:
        - Shortening prescribing interval
        - Intensifying risk mitigation strategies (see Sidebar E)
        - Referring to interdisciplinary care
        - Consulting with or referring to specialty care
        - Switching to partial agonist opioids
        - See VA/DoD SUD CPG if there are indications of OUD

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