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Chapter 1 : A Manual of the Practice of Medicine. | JAMA | JAMA Network

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Clinical practice guidelineâ€"systematic review intersection; Establishing evidence foundations for and rating strength of recommendations; Articulation of recommendations; External review; and Updating. The AAFP may participate with other medical organizations in the development of clinical practice guidelines also known as practice parameters or clinical policies when appropriate criteria are met. AAFP Board approval is obtained for topic nomination and collaborators. Include key clinical questions and parameters with patient-oriented outcomes prioritized ii. SCPG members and content experts assist in drafting and providing feedback on the key questions iii. Include collaborators for co-nomination if applicable b. The draft report can be used to begin development of the draft CPG iii. A COI has been defined as a set of conditions in which professional judgment concerning a primary interest guideline recommendations , is unduly influenced by a secondary interest financial or intellectual interests Norris et al and Thompson DF www. The chair or co-chairs should not be a person s with COI. The chair or co-chairs should remain conflict free for one year following publication. Disclosures should include activities that may be considered financial or intellectual COI as defined below: Review and Management of COIs Disclosures for each potential member will be reviewed by staff and the chair of the GDG prior to placement on the panel. Clinical Practice Guideline Panel Collaboration a. Clinical practice guideline time-line and expectations AAFP staff members, in collaboration with the GDG chair, will develop a time-line for the guideline being developed. Though this time-line is developed with the goal of adherence, it is recognized that circumstances during the development process may affect the time-line. Thus, this is a living document throughout the guideline process and should be updated as appropriate. Writing assignments may be made throughout the guideline development process. GDG members will be asked to volunteer for certain tasks and may be assigned to subgroups to develop recommendations and write supporting evidence for those recommendations. Clear deadlines will be agreed upon during the process of guideline development. However, as stated above, circumstances during the CPG development process may arise that warrant adjusting deadlines. The outline will include the key questions from the evidence report, the potential draft recommendations, key points for supporting text, and identification of potential information for shared decision-making tables and implementation algorithms. Conference calls Conference calls will be convened at the start of the guideline development process and throughout as needed. When a member cannot be present on a call, that member will be provided opportunities to provide any written comments prior to the call and feedback to the meeting summary after the call. Electronic communication Electronic communication will be used throughout the guideline process. Reasonable response times are expected for electronic communications and deadlines for requested action items will be clearly stated in the communications from AAFP staff members. All parties will agree to the publication plan. Dissemination activities should also be identified early on to facilitate work load and collaboration. These activities can include one or more of the following: Once the systematic review has been completed, a draft evidence report is published by AHRQ. The GDG reviews the draft evidence report to determine if applicable for development of a guideline. Systematic literature review performed by the AAFP If more than 12 months has passed between the publication of an AHRQ evidence review and development of the guideline, an update of the systematic review will be conducted. The librarian will use the same search criteria that were used in the AHRQ systematic review. Inclusion and exclusion criteria will be set a priori to determine which studies will be reviewed for quality. AAFP staff members review the updated search results and obtain articles relevant to the systematic review. The AAFP also uses this as a guide to ensure the systematic literature reviews we are performing or that we are using for guideline development are compliant with the best standards available. Conducting a comprehensive search for the evidence. This step will likely include: Working with a librarian, and b. Searching appropriate databases, citation indexes and other sources for relevant information. Taking

action to address potential bias in reporting of research results. Screening and selecting relevant studies. Here it is very important to include and exclude studies based on a priori specified criteria developed in the protocol. It is recommended that two or more people screen studies and that these reviewers are tested for accuracy and consistency in their reviews. Documenting the search strategy, including dates of searches and how each item identified in the search was addressed. If excluded, include the reason for exclusion. If data is extracted for a meta-analysis, data collection should be managed appropriately. The IOM standards recommend that systematic review developers: Use two or more researchers to extract relevant data from a report; b. Link publications from the same studies to avoid duplication of data; and c. Use data extraction forms that are pilot tested. Finally, at least two reviewers should critically appraise each study using the specified protocol and forms derived for the review. The quality of the evidence should be linked to the strength of the recommendations in that guideline. Consistent with the IOM standards for systematic reviews, the AAFP uses a specified framework for assessing the quality of studies and providing strength for each recommendation. The GRADE system provides a transparent process and framework for developing evidence-based recommendations using the following system to rate the quality of evidence: High Quality Level A: Further research is very unlikely to change our confidence in the estimate of effect. Moderate Quality Level B: Further research is likely to have an important impact on our confidence in the estimate of effect, and may change the estimate. Low Quality Level C: Further research is very likely to have an important impact on our confidence in the estimate of effect, and is likely to change the estimate. Very Low Quality Level D: Any estimate of effect is very uncertain. Recommendations can be either for or against an intervention or testing modality. The AAFP prefers the strength of the recommendation be consistent with the quality of the evidence such that strong recommendations are based on moderate to high quality evidence and weak recommendations are based on low to moderate quality evidence. Very low-quality evidence should be considered insufficient for a recommendation except when the benefits greatly outweigh the harms. The strength of evidence should also reflect the degree to which there is evidence of improved patient oriented outcomes such as morbidity, mortality, quality of life, or symptoms as opposed to only disease oriented outcomes such as blood pressure or hemoglobin A1C. Strong recommendations should be based on high quality evidence of improved patient oriented outcomes. Weak recommendations should be supported by some evidence of improvement in patient oriented outcomes; although, the evidence may be inconsistent, of lower quality, or rely on an indirect chain linking surrogate outcomes to patient oriented outcomes. These should be used sparingly in guidelines. Upgrading and downgrading evidence: Evidence may be downgraded due to the following reasons: Inconsistency of findings across a number of studies must be explained. Were the interventions really the same? Inconsistencies that cannot be explained make it very difficult to assess the true effect of the treatment. Directness refers to the extent to which two interventions are being compared to each other in similar populations. Two types of indirectness exist. The first includes indirect comparisons. Publication bias may also exist. Evidence may be upgraded based upon the following factors: A large effect is much less likely to be spurious than a small effect. In observational trials, it is particularly difficult to measure and control for all plausible confounding. Writing the Guideline a. This includes, but may not be limited to the appropriate users of the guideline, situations in which the guideline should be used, and appropriate patient populations for the guideline. It is worth noting that moving from examining the evidence to making a recommendation is where much of the disagreement happens in guideline development. Different groups that develop guidelines may disagree on how much weight they give to lower-level evidence; may not fully take into account benefits and harms, costs or burdens; and may give differing emphasis on patient or provider preferences and values. However, all of these factors should be considered when making recommendations. The AAFP strives to only make strong recommendations based on high-level evidence. However, there are few instances where strong recommendations can be made based on moderate or low-level evidence. In these instances, there must be certainty that benefits outweigh harms. Recommendations made include an explanation of the reason for the recommendation; description of benefits and harms; a summary of the relevant available evidence; any explanation of values and preferences that went into the recommendation; a rating of the level of evidence and strength of recommendation; and differences in opinions of GDG panel members, if they exist, for that

recommendation. Recommendations made are specific and actionable and worded in a way that is clear that they are 1 strong recommendations, 2 weak recommendations, or 3 good practice points. Panel assignments With direction from the GDG chair, members of the GDG will be given writing assignments to complete during guideline development. When possible, GDG members will be asked for preferences regarding sections of the guideline they would like to write. Making the CPG implementable i. For implementation, the recommendations should be specific and provide clear direction. The number of recommendations should be kept to a minimum. Access to the guideline should be provided through publication in a journal, the AAFP website, and the guideline clearinghouse. Additional implementation methods include mass media campaigns news article, leadership blog, other avenues as suggested by the AAFP content strategy teamâ€"see dissemination section , and interactive educational meetings with quality improvement resources as appropriate expanded learning session at Family Medicine Experience [formerly Assembly], workshops e. Most often, staff members at the AAFP will compile all sections of the draft guideline and the chair will review the draft s before it is sent to other members of the panel.

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A manual of the practice of medicine. by Tanner, Thomas Hawkes, Publication date Topics Medicine -- Practice. Publisher Philadelphia, Lindsay.

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