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Chapter 1 : Code of Ethics Revisions Part 3 and FREE Practice Question

This Part 3 Clinical Skills Course will give delegates a unique opportunity to practise and rehearse the clinical tasks set down in the new MRCOG Part 3 oral examination.

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.

Chapter 2 : Clinical Practice Guideline Manual -- Clinical Recommendation

An alternative, 'negotiating' approach would be for the senior therapist to sit down with Peter and explain the purpose of the observation; was it part of the annual individual performance review, part of professional revalidation, or just general good practice and professional development of the clinical team?

Updated standards for CCHD screening: Click here after reading the article to take the post-test on myCME. In , the U. The final article examines improved pulse-oximetry standards that translate into more sensitive screening. The article also looks ahead to the future of CCHD screening with case studies of individual states that have started to implement programs. Detection is challenging, however, due to the subtlety of clinical presentation. For instance, half of all newborns with CCHD, particularly those with ductal-dependent defects, have no distinctive murmur, and in many cases the symptoms of CCHD do not present until after hospital discharge. Key features of the screening recommendations are outlined in Table 1. Repeat measurements when the initial screening result is positive. Adjust thresholds for positive findings in high-altitude areas. Exclude CCHD with a diagnostic echocardiogram in infants with positive screening results and no infectious or pulmonary causes of hypoxemia. Kemper AR, et al. Evolution of pulse-oximetry standards Individual hospitals, birthing centers, and other facilities are responsible for selecting appropriate equipment for screening. In practice, implementing pulse oximetry as a screening tool has been fraught with complexities due to the lack of standardization of pulse-oximetry technologies and other standards across hospital settings. Historically, commercially available pulse oximeters have been labeled by manufacturers according to generation of technology e. In , the SACHDNC, which assembled an independent group of experts in the area of CCHD screening in an advisory capacity, published technological standards for pulse-oximetry equipment to ensure reliable and reproducible outcomes with devices available at the time. Food and Drug Administration. The historical context and evolution of technological standards in pulse oximetry are described below. Concern over motion artifact with early pulse oximetry, for instance, prompted the development of motion-tolerant devices, which were recognized as the standard of care in the SACHDNC guidelines. For instance, all new devices are expected to meet federal performance standards e. The FDA, through the issuance of the guidance document, has endorsed the use of all oximetry equipment for CCHD screening that is approved for neonatal patients. Standardizing screening protocols Based on national guidance and state legislation, hospitals and birthing centers will be required to implement CCHD screening programs. The particular screening strategy should reflect the conditions within each particular facility, as well as the needs of infants, families, and the health-care providers. On a practical level, caregivers should understand the requirements related to sensor type and placement.

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Chapter 3 : PH Podcast: Dr. Peter Leary Talks in More Detail on Clinical Trials in Part 3

Purpose: Evidence-based practice (EBP) involves integrating research evidence with clinical expertise to answer clinical practice inquiries. The purpose of part 3 of this EBP series is to provide an introductory overview of the critical appraisal process, relevant clinical measurements, and critical thinking skills that can enhance nurse.

Published online May Received Aug 25; Accepted Apr This article has been cited by other articles in PMC. Abstract Background Evidence is needed to develop effective educational programs for promoting evidence based practice EBP and knowledge translation KT in physical therapy. This study reports long-term outcomes from a feasibility assessment of an educational program designed to promote the integration of research evidence into physical therapist practice. The participant-driven active learning program consisted of four consecutive, interdependent components: Results Sixteen therapists completed the long-term follow-up assessment. Eighty-nine charts were analyzed for therapist adherence to the Best Practices List. Six clinical behaviors had sufficient pre- and post-PEAK charts to justify analysis. Of those, one behavior showed a statistically significant increase in adherence, one had high pre- and post-PEAK adherence, and four were change resistant, starting with low adherence and showing no meaningful improvement. EBP knowledge and skills showed improvement from post-intervention to long-term follow-up and a trend toward long-term improvements. Future versions of the PEAK program and comparable multi-faceted EBP and KT educational programs should provide ongoing monitoring, feedback, and problem-solving to successfully promote behavior change for knowledge translation. Knowledge translation, Evidence based practice, Education, Post-graduate training, Physical therapy Background Evidence based practice EBP , the integration of research evidence, patient perspectives, and clinical expertise, has become a gold standard for physical therapist education and clinical practice around the world [1 , 2]. Knowledge translation KT has gained international acceptance as a foundation for the successful integration of research evidence into complex healthcare environments [3]. Evidence of effective educational programs for promoting EBP and KT in physical therapy practice is limited [4 , 5]. A recent systematic review by Dizon et al. While some interventions have shown short-term improvements in EBP knowledge, skills, and attitudes, there is a paucity of evidence regarding behavior change and long-term outcomes [6]. A systematic review by Menon et al. Yet, no studies monitored actual adherence to best practices. A mixed methods analysis reported feasibility of the 6-month program based on therapist-participant focus groups and short term EBP learning outcomes [8]. However, further analysis is needed to understand the feasibility of this program for producing long-term benefits and improving therapist adherence to evidence based patient care. The validity of assessing behavior solely through self-report of EBP implementation has clear limitations; observational measures of EBP behaviors are an important addition to assessment of behavioral change among clinicians [10 , 11]. A study to assess feasibility for implementing the PEAK program was conducted from among physical therapists at the University of Southern California clinical practices. Previous reports describe the program and its theoretical underpinnings [7] and a mixed-method analysis of immediate post-PEAK outcomes [8]. Methods Participants Twenty-five physical therapists practicing in three geographically dispersed USC patient care centers 2 outpatient; 1 inpatient were invited to participate through staff meetings and individual email. All participants consented to participate. Its theoretical foundations, described previously [7], are in social cognitive [12 , 13] and adult learning theories [14].

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Chapter 4 : EMDR Basic Training: Part 3 - Advanced Clinical Workshop & Refresher Course - Laurel Parne

Background. Evidence based practice (EBP), the integration of research evidence, patient perspectives, and clinical expertise, has become a gold standard for physical therapist education and clinical practice around the world [1, 2].

Instruction focuses on using EMDR with complex cases, resource development and installation, target development, and cognitive interweaves. This course is limited to mental health professionals who are licensed to provide treatment. Through lecture, hands-on practice, and demonstrations, participants will learn to: Cite protocols and procedures for using EMDR with a wide range of diagnostic categories Identify client selection criteria and cautions necessary for safe use of EMDR Practice techniques for working with blocked processing and abreactions catharsis Employ imaginal and cognitive interweaves Use EMDR with adults traumatized as children Review standard protocol and procedure Describe modified protocol and when to use it Apply techniques for target development Use techniques for resource development and installation Practice the advanced use of interweaves Work more effectively with complex cases This course has been approved by the EMDR International Association EMDRIA. You will be required to submit documentation of having completed these requirements before attending. Participants who have completed EMDR Basic Training elsewhere are welcome to enroll in this course for advanced training and as a refresher. You agree that you are psychologically stable enough to take on a client role in this setting, and that you will do what is needed to take care of yourself if any discomfort arises as a result. Accommodations and facilities at Esalen must be paid for separately after registering for the training. For details and costs, see Esalen Partner Program Pricing. To register for this training, you must have an active license, certification, or the equivalent, to practice as a mental health professional per the guidelines of your state, province, or country. Interns are not eligible to participate. After completing your registration on this page, you will be asked to submit licensure documentation. Once licensure documentation is approved, you will be given a password to secure your Esalen accommodations. If you must cancel after that, no refunds are available, but you may send a qualified colleague in your place. You will be required to sign this consent upon when you arrive at the training registration. If I leave early or do not complete the training, I will not be eligible for a refund. Parnell Institute, LLC reserves the right to determine whether I am eligible to continue the training at any stage. Although it happens rarely, the Parnell Institute sometimes determines that a participant is not able to participate fully, has not mastered the material adequately, or is too disruptive to continue. If this were to occur, Parnell Institute would provide an opportunity to improve and return at a later date. However, I understand that this would be done at my own expense. The grievance policy for trainings provided by the Parnell Institute and Laurel Parnell is available here. This event is co-sponsored by R. Cassidy Seminars Satisfactory Completion Participants must have paid tuition fee, signed in, attended the entire seminar, completed an evaluation, and signed out in order to receive a certificate. Failure to sign in or out will result in forfeiture of credit for the entire course. No exceptions will be made. Partial credit is not available. Cassidy Seminars maintains responsibility for this program. Cassidy Seminars maintains responsibility for the program. April 15, April 15, Social workers should contact their regulatory board to determine course approval. Social workers participating in this course will receive 26 continuing education clock hours. This program is approved for 26 contact hours Live. See those approvals under Psychologists and Social Workers. If your state is not specifically listed, nearly all state Counselor and MFT boards accept either APA or ASWB approval, or are reciprocal with other state licensing board approvals, such as those listed below. Check with your board to be sure. The Ohio Board includes Counselors. Provider for 26 CE hours. Creative Arts Therapists NY: Chemical Dependency Counselors CA: Many state nursing boards are reciprocal with those of other states. Check your licensing board to be sure. This course is 26 CE Hours. Disability Access â€" If you require ADA accommodations please contact our office 30 days or more before the event. We cannot ensure accommodations without adequate prior notification.