Informed Directions™
Tools for Healthcare Decisions

# The Group Health Guide to Choosing Clinical Practice Guidelines

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## Executive Summary

Medical practice guidelines developed through an ***"explicit"* evidence-based** process may give you the best results for patient outcomes, resource management and satisfaction at all levels — provider, patient *and* organization.

This process uses a systematic and rigorous analysis of evidence based on the concept that higher grades of evidence result in more reliable prediction of outcomes, thus ensuring incorporation of scientific information with minimal bias. This process also includes a projection of impacts — **benefits, harms, and costs** — of anticipated clinical practice change on healthcare outcomes for populations. Additionally, the process makes all assumptions explicit, providing for complete documentation and putting healthcare providers directly in touch with the data.


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As a provider of healthcare services, you need what every healthcare provider needs — the best possible outcomes for health status and patient satisfaction coupled with the best possible outcomes for cost and utilization. Not only that — you also need to achieve provider satisfaction and positive organizational outcomes along the way. For these and other reasons, many providers are turning to clinical practice guidelines which are systematic statements to help providers and patients make informed choices about specific healthcare issues.

But of the myriad of guidelines available, there are huge differences.

- So are guidelines for you?
- If so, how do you choose?

## About Clinical Practice Guidelines

First, what a clinical practice guideline is not — a clinical practice guideline is not a standard.

Standards are "rules" in which —

- outcomes are known,
- there is unanimous agreement, and
- exceptions are rare.

Guidelines can be developed for those conditions for which —

- there are no standards, and outcomes are mixed,
- there is majority agreement, and
- exceptions are common.

The reason for majority agreement is that the evidence convinces us that the guideline improves the care we give. But because exceptions are common, guidelines cannot be considered "rules." Instead, guidelines are concise summaries to *assist* physicians and their patients in making informed choices.

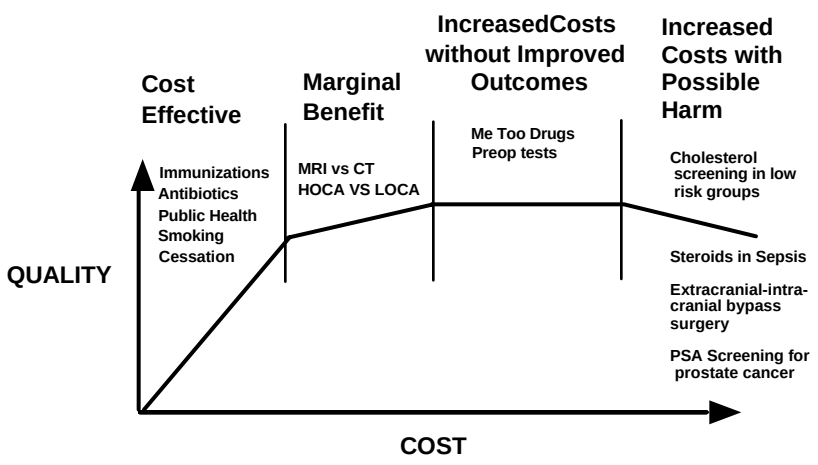
## What a Clinical Practice Guideline Can do for You

**The right guideline can improve quality while containing costs.** In addition to helping you meet the rigorous requirements of various review and regulatory bodies, such as NCQA, a smartly constructed clinical practice guideline can —

- **Improve clinical decision-making.**
  How many of us can carry two million pieces of information in our head? Yet providers everywhere attempt to do this all the time. With this amount of information needed to manage patients — *and* be kept up-to-date and be the *right* information in the first place — a soundly constructed guideline in a user-friendly format can prove a huge boon to the clinician and to the patient under his or her care.

- **Aid in managing individual patients and patient populations.**
  Variations in care, as well as variations in expert opinion, are well documented. In addition to helping the individual physician provide care, a guideline based on reliable information can help organizations manage populations of patients by providing guidance on clinical practice, thus reducing marked variations in care — costly in both patient outcomes and budget management.

**Figure 1.**
**Looking at Cost and Quality Simultaneously**





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- **Maximize value by guiding clinical choices to more cost effective care while maximizing healthcare outcomes.**
  There is nothing more troubling — and potentially harmful — to both patients and budgets in these times of limited resources, than inappropriate tests and interventions. Many instances are well documented where drug therapies, screening tests or types of surgery have had bad results. A guideline that has appropriately evaluated tests and treatments can steer healthcare providers and organizations away from costly and dangerous interventions with questionable outcomes. (See Figure 1.)

**Further, a well constructed guideline can —**

- **Expand the role of the physician beyond the individual patient encounter.**
  A patient comes into the office and presents with a problem. Screening takes place. One thing leads to another, and another, and another. And the attending physician – and patient – feel taken unaware by the cascading screening or treatment options resulting downstream. A guideline with an easy to follow algorithm, presenting pathways of screening and treatment, can help both patients and physicians better anticipate what to expect when embarking on a course of action. *And* help improve patient and provider satisfaction along the way.

- **Support patient choice.**
  Today's patient is more educated than ever about healthcare and, more than expects — rightfully demands — to be a partner in decisions about his or her care. A guideline that quantifies risks and benefits, with shared decision-making in mind, can go a long way in creating satisfied, educated patients. Indeed, patients are frequently less enthusiastic about tests and treatments when they understand *actual* likelihood of benefit may be slim. In our experience, providers frequently *overestimate* benefits and *underestimate* harms. A guideline can help by providing quantitative information.

- **Close the gaps.**
  A clinical practice guideline can serve you by helping to close the gap between current clinical practice and better practice. And in so doing, close the gap between current outcomes and improved outcomes.

And so you can see why the right guidelines — in the right format — can improve quality and improve patient and provider satisfaction while containing costs and enhancing positive organizational outcomes — all at the same time.

## Attributes of a Smartly Constructed Clinical Practice Guideline

To truly accomplish these things, a clinical practice guideline must provide useful clinical information that is —

- relevant,
- valid,
- quickly accessible with minimal effort, and
- have the patient-as-participant in mind.

To be relevant and valid, a clinical practice guideline must —

- clearly define the population,
- provide genuine guidance,
- describe exceptions,
- be current,
- be clear,
- be flexible,
- be implementable, and
- be measurable.

And above all, it must be ***truly*** *evidence-based.*

## Healthcare Decisions Need to be Based on the Best Available Evidence

Not all evidence is alike. Only randomized controlled trials can control for selection bias. Other studies with non-experimental designs, such as population-based studies, are important; but without a truly experimental design, inappropriate comparisons can easily be made.

For these reasons, all evidence needs to be critically appraised or "graded" to rank the evidence by study design to give first priority to those studies which have been organized in the best possible way. (See Figure 2.)

But not all randomized controlled trials are equal or even superior to all case-control studies. Subsequent to grading, the research methodology of each study needs to be carefully scrutinized by epidemiological experts to uncover any critical weaknesses and to assure that the study design is material to the question being asked. For example, a cross-sectional study is the optimal study design for evaluating a diagnostic test.

Thus, only by a rigorous, scientific assessment of the literature can the best possible evidence be identified in an attempt to find the best answers and reduce bias, thereby providing more reliable predictions of outcomes.

But what if there is not strong evidence? Or a mix? The very


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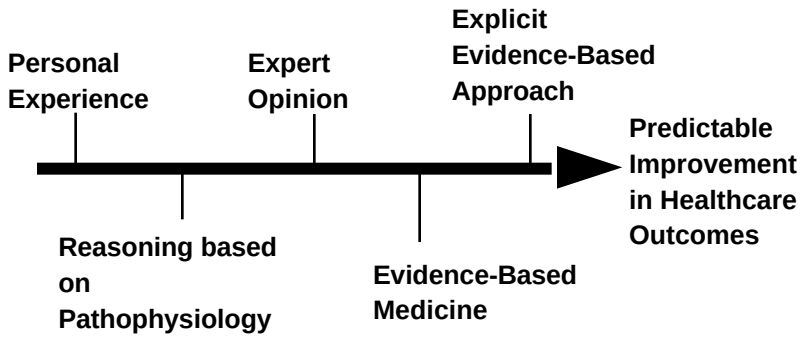
Figure 2.
## Basic Evidence Grading Strategy

| GRADE OF EVIDENCE | DESCRIPTION | COMMENTS |
|---|---|---|
| GRADE 1 | Randomized controlled trials | RCTs can control for selection bias. |
| GRADE 2 | Non-randomized controlled studies | These studies compare contemporary patients who did and did not receive the intervention. Selection bias may result from unrecognized or recognized differences between the study and comparison group. Only through randomization can unknown selection bias be controlled. |
| GRADE 3 | Non-randomized historical cohort studies<br>Other studies with non-experimental designs (e.g., population-based studies, case control studies) | Comparisons between current patients who did receive the intervention and former patients who did not receive the intervention. Selection bias, confounding caused by non-randomization and biases resulting from inappropriate comparisons over time are possible. |
| GRADE 4 | Case Series | The reader is simply informed of the fate of a group of patients. Series may provide useful information about clinical course and prognosis but can only hint at efficacy. |
| GRADE 5 | Expert Opinion | Expert opinion is not evidence but is included to assure that when it is considered we place more emphasis on evidence than opinion in determining appropriateness of care. |

Figure 3.
## Continuum of Clinical Decision Making





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best guidelines are "***explicit***" **evidence-based.** In other words, the very best guidelines organize all pertinent information for you in such a way that you can evaluate the strength of the evidence yourself. These evidence-based guidelines make explicit which evidence meets which test. Explicit guidelines also make quantitative estimates of the impact on care. And the very best guidelines actually **give you the evidence directly** so that you can see exactly for yourself how the guideline was derived — you can go directly to the evidence; not have to rely on someone else's interpretation.

Ultimately "explicit" evidence-based guidelines can help you achieve your goal.

**The Goal: To achieve *predictable* improvement in healthcare outcomes.**

- How else can you manage care to achieve the best possible patient outcomes that evidence suggests?
- How else can you manage your costs?
- How else can you achieve true patient, provider ***and*** organizational satisfaction?
- And how else can you achieve predictability?

You can achieve these goals with **rigorous, scientifically-based, systematically analyzed guidelines** where evidence is graded to identify the best available evidence, and where you can have direct access to all the pieces. (See Figures 3 & 4.)

## How Guidelines are Developed (or "Why not all guidelines which claim to be 'evidence-based' truly are")

***Classification by development process***

**I. No process of development is evident** Guidelines from specialty groups frequently fall into this category.

**II. Global consensus of experts — the most common form of guideline**

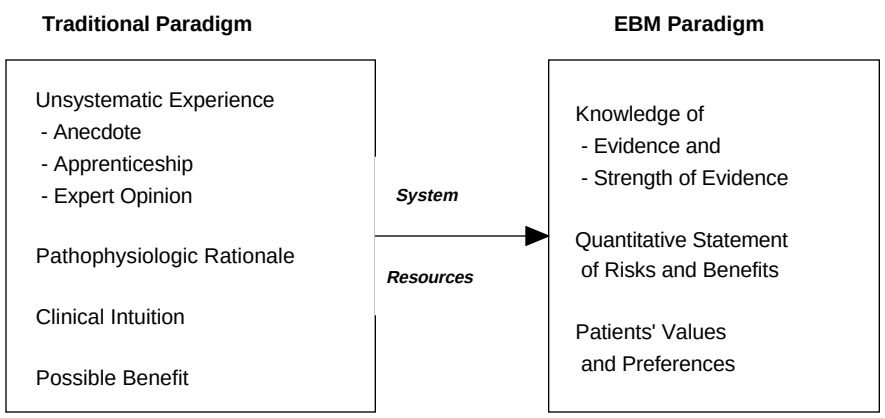
Unfortunately, there are some problems with this kind of guideline.

- There is no way to remove the bias of the participants.
- These guidelines lack any extrapolation of the impact on healthcare outcomes to assess benefits, harms and costs. Without this step, it is not usually possible to make informed decisions about value – in other words, are the improvements in care worth the resources they would require? Such guidelines may fall into the trap of basing recommendations on statistically significant relative risk reduction rather than looking to see if the changes are also clinically important. (Double a little, and you still have little.) Nor do they examine impacts of the entire process (e.g., feasibility of implementation).

**III. "Evidence-based" Guideline without Extrapolation of Impacts**

+ Use a systematic analysis of evidence (evidence grading).
- Do not consider the impacts of guideline implementation on healthcare outcomes (see issues already cited above).
- Further, some "evidence-based" guidelines **may not** be based on a thorough review of the literature, but may be structured around a few or even a single piece of evidence, thus being no better than expert opinion.

**Figure 4.**
**Paradigm Shift**





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**IV. "Explicit" Evidence-based Guidelines**

+ Use all available information regarding the effectiveness of a clinical practice to determine the impacts of implementation on four healthcare outcomes:
  - Health status
  - Patient satisfaction
  - Provider satisfaction
  - Cost/utilization
+ Use a systematic approach to review the medical literature, selecting studies with good results, which allows for more reliable prediction of outcomes.
+ Project impacts — **benefits, harms and costs** — of clinical practice change on healthcare outcomes for populations.
+ Make all assumptions explicit.

**Examples —**

- Consensus of Experts —
  NIH Consensus Conferences
- Evidence-based w/o Extrapolation of Impacts —
  AHCPR Guidelines
- Explicit Evidence-based —
  Group Health Cooperative Clinical Practice Guidelines

## What You Need to Accomplish Explicit Evidence-Based Guideline Work

Developing guidelines requires a large investment in resources.

Resources — time *and* experts.
Information — quality literature reviews.

Creating **explicit evidence-based** clinical practice guidelines requires much hard work, clear definition of roles and responsibilities, and **substantial** organizational support. Ideally clinical, epidemiologic, analytic and information retrieval experts are involved in the development process along with opinion leaders and key staff members who can address organizational issues, such as experts in pharmacy administration and nursing.

**Developing a Plan**

First, a plan is essential to determine whether a guideline is needed or even doable. Such a plan needs to identify possible **gaps** between current practice and better practices. It also needs to screen for **suitability** of a guideline.

**Key Questions**

- **How big is the gap between current and optimal practice?**
- **How much effort will it take to close the gap?**
- **Will the guideline result in sufficient changes in outcomes to justify the efforts?**
- **Will the hoped for change be measurable?**
  Before significant resources are allocated to a guideline development project, it is important to determine if there will be a resulting benefit for patients. To answer this question, you must determine whether outcomes can be measured and, if so, whether the data can be captured.
- **Will the development project have an "owner?"**
  Projects that have an identified and motivated owner with appropriate expertise and sufficient time available are more likely to be completed.
- **Is there a reasonable likelihood you can implement the change?**

**Literature Review**

Medical literature needs to be the primary source of external evidence. Obtaining relevant studies begins with extensive searches of the major bibliographic databases. The best search results are achieved when a medical librarian or similar expert in searching bibliographic databases works with the development team to pose the questions to the literature so that significant studies are not missed and so that the search is appropriately focused, thus avoiding a flood of non-relevant studies.

**Evidence Review**

Clinical epidemiologic and statistical expertise are required to review the potential mountain of literature that can result and to systematically appraise and grade the evidence available by reviewing study methodologies and searching out problems in design. As an example, for our guideline on depression over 6,000 studies were reviewed.

Evidence grading is only one part of the process whereby the best available evidence is assigned a grade.

Following grading, clinical and epidemiologic expertise are needed to critically appraise each study for —

- validity, or closeness to truth, and
- usefulness, or clinical applicability.

This expertise is needed to identify strengths and weaknesses of each study. Pitfalls need to be addressed or avoided:

- Paying undue attention to relative risk reduction rather than absolute risk reduction and the number needed to treat to achieve clinical significance.
- Application to unlike populations where evidence is misapplied to patients who are unlikely to benefit, such as children compared to elderly.
- Incomplete or no evidence available.
- Data torturing, such as the testing of new hypotheses after data collection or *post hoc* subgroup analysis, resulting in potential confusion between "findings of chance" and real effects.


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**Evidence Summarization**
Data need to be converted into an evidence "table" not only to summarize the evidence that will be used in the guideline, but also to nail down the studies to keep team focus directed on the actual results.

**Quantification of Benefits, Harms and Costs**
A wide range of expertise is needed to then convert the data into a "balance" sheet which projects anticipated benefits, harms and costs of a clinical practice change.

The balance sheet is a highly useful tool for projecting – and then evaluating – the anticipated effects of practice change – positive and negative – on a variety of factors such as patient outcomes and cost. Implementing a change may be so cost prohibitive that an adjustment needs to be made to create a more appropriate equilibrium between cost and patient outcomes. A balance sheet can help facilitate this by evaluating the changes and then evaluating prospective adjustments. The balance sheet also helps an organization anticipate and plan for the impacts that guideline implementation may bring.

**Decision Support Tools**
Expertise is also needed to create appropriate and useful decision-support tools for providers and patients. Health education experts are important for constructing patient communications with a patient-centered approach.

**Measurement Plans**
A measurement plan needs to be developed. This requires skills and available resources in data analysis along with staff familiar with organizational systems and processes who can identify appropriate streams for capturing data.

**Updates**
To remain current, guidelines must be updated on a regular basis.

**Guideline Team Management**
And to make all this happen, expertise is needed in the process of guideline development, group process management and information management.

## The Benefits of Adapting Outside Guidelines

Most organizations will need to decide if they will invest resources in developing guidelines or whether they prefer to evaluate and adapt outside guidelines for their use.

Evaluating guidelines —
- requires smaller investment in resources than development, and
- requires fewer skills than developing guidelines — at a minimum, the skills needed are those for evaluating guidelines, leading small group processes and managing information.

Many organizations will benefit from developing a relationship with other organizations to access seed guidelines and regular updates.

## How to Evaluate a Clinical Practice Guideline

You need to evaluate a guideline to —
- **Anticipate impacts of implementation on —**
  Health status outcomes, and
  Cost and utilization.

- **Plan coherent implementation.**

To evaluate a guideline, you need to ask a series of questions:
- **Do we need this guideline?**
  Does it address a clinically important condition?
  Is there uncertainty in care for this population?
  Has new research become available?
  Is there an undesirable variation in clinical practice?
  Are there significant cost implications?

- **Will this guideline close the gaps? How would the measurable clinical outcomes in our population be improved?**

- **How would the guideline impact patient and provider satisfaction?**

- **What would be the resulting effects on the healthcare team?**

- **What are the cost implications of adopting this guideline?**

- **What would be the resulting organizational impacts?**

- **Who developed the guideline? Are all requisite clinical perspectives represented? Are the sponsors identified? Are there potential conflicts of interest?**


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- **Why did they develop the guideline?**
  To improve quality of care?
  To alter utilization?
  To decrease cost?
  To solve a local problem?

- **How did they develop the guideline? Did they describe the development process? What was that proces**
  No process defined?
  Global subjective consensus of experts?
  Evidence-based and on what evidence? Thorough, systematic review or on a limited study basis?
  Explicit evidence-based?

- **Does the guideline possess the attributes of a good guideline?**
  Is it current?
  Is it clear and brief?
  Is it flexible enough for you to adapt to your own local uses?
  Does it provide genuine clinical guidance?
  Is it flexible enough to allow for professional judgment?
  Does it clearly define the population?
  Does it describe exceptions to your satisfaction?
  Has the guideline been successfully implemented or piloted?
  Can you implement it?
  Can the change in care be measured?
  Is it evidence-based?
  Does it make that evidence explicit?

- **What is the strength of the evidence?**
  Is there a description of the strategy used to obtain information from the literature?

  Is there a description of the strategy used to critically appraise and synthesize the evidence?

  Is the evidence presented in terms of absolute differences in outcome (as compared to relative differences)?

  Are the major recommendations of the guideline based on high quality evidence?

  If the guideline is a *consensus guideline*, you should always conduct a literature evaluation to ensure you are confident in the outcomes.

  If the guideline is *evidence-based*, but has *not* been developed through an *explicit* evidence-based process, a literature evaluation may be necessary. (If the guideline is coming from a trusted source and has gone through an appropriate development process, this may decrease the likelihood for your need to reevaluate the literature.)
  If the guideline is *"explicit" evidence-based*, you have direct access to the documentation.

  At Group Health, we document the process we use to search the literature and produce evidence tables summarizing the key papers. In published form, our guidelines include a reference list and selected evidence on tables covering both key and controversial issues.

- **Would the guideline be accepted by providers?**
  Will it be seen as a resource rather than a restriction? How can you achieve a positive outcome for physician satisfaction by your implementation plan? **Evidence** can help you build necessary trust.

- **What changes would be required to adapt the guideline to local practice?**

- **Should we implement this guideline?**
  In other words, will implementing the guideline improve outcomes enough to justify the efforts?

## Conclusion

Medicine is rapidly changing. Clinicians can no longer rely on textbooks which are frequently out of date, not evidence-based or are based on "expert opinion." Because we can now connect with large databases, such as Medline with nine million articles, we can pose questions to the literature, then acquire, appraise and synthesize evidence, and create evidence-based summaries and recommendations (clinical guidelines) which provide quantitative information about benefits, harms and costs. As providers — and recipients — of healthcare services, we can then make truly informed choices.


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# A Message from Group Health Cooperative

We hope this paper has provided you with helpful guidance on key factors in deciding whether to embark on a guideline development process or evaluate already established guidelines. We wish you every success in your endeavors to provide the best quality care for your patients.

Should you wish, we have tools available which may assist you in achieving your goals.

## *About Us*

### Group Health Cooperative of Puget Sound

Serving nearly 700,000 enrollees, Group Health Cooperative of Puget Sound is the nation's largest member-governed healthcare organization. Group Health is a nationally recognized innovator in guideline development, prevention, research and quality improvement. We provide care through an extensive network of hospitals and clinics in the Pacific Northwest. We are a not-for-profit managed healthcare system founded in 1947 and have become a recent affiliate of Kaiser Permanente.

We are frequently cited as one of the nation's top HMOs.

- Group Health has a full 3-year accreditation from the National Committee for Quality Assurance (NCQA).*

- Group Health has come out on top again in ratings performed by two nationally respected research organizations.

  The Sachs Group has awarded Group Health its Seal of Excellence. This award, made in late 1997, recognizes those plans doing an outstanding job in satisfying their members, and in the face of intense competition.

  In November 1997, we were named a "Quality Leader" by the National Research Corporation (NRC) for the second year in a row based on marks Group Health earned in NRC's annual, nationally syndicated survey to assess consumer opinion of quality of care and service.

- In October 1997, we made the honor roll of *US News & World Report*, ranking 15 of the 38 HMOs selected for that honor from over 200 HMOs reviewed across the country.

- American Health for Women ranked us as the second friendliest HMO for women in their February 1998 review.

Our quality is due in good measure to our cutting-edge explicit evidence-based guidelines.

*Effective through November 27, 1998.


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Informed Directions™ Tools for Healthcare Decisions.

## About *Informed Directions*™ Clinical Practice Guidelines

***Informed Directions***™ from Group Health Cooperative of Puget Sound, delivers "explicit" evidence-based guidelines designed to improve health outcomes, satisfaction, and resource management. Our guidelines are developed with the primary goal of improving quality of care at Group Health Cooperative. They are designed to meet the criteria for excellence in clinical practice guidelines. Patients are our focus. Our development process makes all the difference.

### OUR PROCESS

includes rigorous systematic review by an epidemiologist working with experienced clinicians to find the best available evidence, create complete documentation, and projections of benefits, costs and harms of practice change.

### RESULTS IN

evidence-based clinical recommendations backed by direct evidence references, with the chance of benefits/harms quantified in absolute terms for shared decision-making with patients.

### Highlights of *Informed Directions*™ Clinical Practice Guidelines

With a focus on improved patient outcomes and with an orientation toward shared decision-making, not all, though many, of our guidelines result in direct cost-savings to our organization. But because of improvements in health outcomes, all are efficient uses of our resources. We have experienced considerable savings, however, along with improved patient outcomes. Here are just a few examples **taken from experience or projections in our own organization** (data as of September 1997):

**Gallstones Guideline** - *Assists patients and providers in determining appropriate care for patients with gallstones.* When fully implemented at Group Health, estimates of improved outcomes include increased patient satisfaction, along with decreased cholecystectomies and ultrasounds that could result in an estimated cost savings to Group Health of $120,000 annually. (***This guideline is available free, as a demonstration, upon request***.)

**Dysuria Guideline** - *Offers a simple approach to the management of suspected UTIs in women at low risk.* Anticipated outcomes include decreased health complications with no increase in untoward effects. Patient satisfaction is high. Cost savings to the organization are estimated at $500,000 to $800,000 annually. (***Publication may be available as a free reprint while supplies last***.)

**Dyspepsia Guideline -** *Recommends an approach to the management of dyspepsia,* helicobacter pylori *and peptic ulcer disease.* When fully implemented, we anticipate improved patient outcomes and estimated cost savings to Group Health of $750,000 annually.

**Primary Prevention of Coronary Artery Disease Guideline** - *Provides individualized strategies for decreasing 5-year risk of CAD.* For Group Health, over 70 fewer incidences of non-fatal MI and CHD are predicted, resulting in a minimum savings of $300,000 over 5 years.

**Diabetic Eye Screening Guideline** - *Provides recommendations for screening.* Up to 90 percent of blindness caused by diabetic retinopathy may be prevented with full guideline implementation at Group Health.

**Diabetic Screening: Microalbuminuria Guideline** - *Provides recommendations for screening.* For Group Health, decreases in the number of cases of renal failure are predicted within three years of full guideline implementation, with long-term savings projected at over $1,000,000 annually.


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# Features of *Informed Directions*™ Clinical Practice Guidelines

Our guidelines offer concise, clear and flexible decision-support for providers and patients. They are consistently characterized as succinct yet comprehensive, complete and user-friendly. All evidence is **directly referenced** so that clinicians can review the actual evidence rather than having to rely on interpretation.

## Decision Support

tools are included in ***Informed Directions*™** guidelines to assist providers and patients in making decisions. For example, one page evidence summaries, diagnostic tools, risk calculators and algorithms are available in many of the guidelines.

**Specialized Tools** include:

- Stratification tool for coronary artery disease.
- Validated 5-question scale for depression severity.
- Osteoporosis risk calculator. And more.

## Patient Education

materials come with many of our guidelines. These materials are carefully crafted by healthcare providers and are reviewed and edited by health educators with expertise in writing for patient populations.

## Unique Features

are available with most ***Informed Directions*™** guidelines. These include:

- Balance sheet templates to help you anticipate benefits, costs, harms of practice change.
- Implementation plans.
- Measurement plans.

These three tools are among the ***most unique features*** available for **most** of our guideline licenses and, depending upon the internal data you have available, are potentially of great benefit to you. These tools are constructed to allow organizations to quantify **customized** projections of the costs and benefits of implementing specific practice changes on local factors such as patient and cost outcomes, *and* to make appropriate adjustments. They provide suggestions for implementation based on the experience of Group Health Cooperative, a national leader in disease management. And, they set forth prescriptions for minimal yet potentially highly meaningful guideline implementation measurement plans that we use ourselves.

## Other Guidelines

In addition to our "explicit" evidence-based guidelines, we have developed other guidelines using other approaches. These are either evidence-based, but the evidence is not completely explicit, or are based on guidelines generally produced by national authorities for which we have developed "explicit" evidence-based sections. As with our "explicit" evidence-based guidelines, we project benefits, harms and costs. Plus we package them in a user-friendly format.

## Computer and Hardcopy Versions

***Informed Directions*™** guidelines come in **hardcopy** and **HTML format** designed by experienced webmaster and design staff for ease of use which allows for direct and effortless access to key clinical notes and evidence. Our computer versions are suitable for use on **personal computers** or **intranets**.


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## Other Tools & Services Which May Be Available

- Single-page Laminated Guideline Summaries
- Evidence-based Medicine Handbook
- Clinical Pathways and Recommendations
- Patient Education Materials (in addition to those included with the guidelines)
- Guideline Development Process Minutes
- Web-based Clinical Homepage Template
- Educational Conferences
- Licenses to Sublicense ***Informed Directions™*** Products

And more . . .


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## Department of Provider Education & Guidelines

With experience since 1978, the department is the focal point for guideline development work in the Cooperative, assuring development, implementation and measurement of clinical guidelines. As part of the Clinical Planning & Improvement Division, the department is recognized for its innovative approach to identifying gaps in current and optimal practice and closing those gaps through our explicit evidence-based process.

The department provides scientific and clinical leadership to guideline teams established throughout Group Health, selected to include key opinion leaders, clinical experts – often nationally recognized — and staff from the delivery and administration systems representing those services needed for developing a quality, implementable guideline. Involvement can be far-reaching. Clinicians are always included on guideline development teams. In addition, other staff are involved at times from such fields as nursing, pharmacy, health education, measurement analysis, CQI and purchasing. The department also provides superior continuing education for healthcare professionals to continuously improve quality and maximize use of resources in healthcare. Guideline training and education in the explicit evidence-based process is a key component of our educational efforts. Annually, the department sponsors a two-day course in Seattle and a four-day conference in a resort area where training on our process and guidelines is emphasized.

### Department Staff

The department is staffed to provide the necessary leadership and technical support for Group Health's guideline development efforts. Staff include —

**Michael Stuart, MD**
Director of the department since 1984, faculty at the University of Washington and a director on the Board of Kaiser's Care Management Institute, Dr. Stuart has presented and consulted extensively on evidence-based medicine. He also presents and consults routinely on related topics such as guideline implementation, population-based care, managing for clinical outcomes and facilitating provider behavior change.

**Matt Handley, MD**
Associate Director for Guideline Development, Dr. Handley, like Dr. Stuart, is frequently sought to address and consult on evidence-based medicine and related topics. In 1997, Dr. Handley was invited to work with the New Zealand Ministry of Health to advise on evidence-based medicine and to train clinicians and managers in the process of guideline development and implementation. Dr. Handley also directs Group Health's "Guideline Clearinghouse," an effort to bring clinical practice guidelines to providers and patients at the time of decision-making using print and intranet tools.

**Mick Braddick, MB, ChB**
Clinical epidemiologist for the department, Dr. Braddick is a British-educated physician trained in internal medicine and in public health medicine who has conducted research on HIV in Kenya and was a consultant in public health medicine in the Scottish Highlands. Dr. Braddick has led the development and assisted in the implementation of the majority of the clinical practice guidelines developed at Group Health.

**Jacquelyn Morton, MLS**
Director of Group Health's Medical Library, Ms. Morton is a pioneer in the field of library and information services for evidence-based medicine projects, and she is recognized as a national expert. In addition to speaking nationally about the program she developed at Group Health, Ms. Morton developed a course several years ago to meet the demand for training medical librarians.

**Additional key members** of the guideline support team include programming and analysis staff, pharmacy support, clinical webmaster, publications editor, design staff and health educators.


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# For Further Information

## Sheri Strite, CRA

As a Certified Research Administrator with over 15 years of research administration and operations experience, Sheri has the necessary general understanding of research, clinical and systems issues to answer many of your questions or field them to our clinical and scientific staff for technical advice. With her extensive business and legal experience, Sheri can help you with licensing and purchasing arrangements. Feel free to call her for more information. She will be happy to assist you.

Sheri Strite, Adminstrator
***Business Relations***

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