POLICY: Clinical Practice Guidelines	**POLICY NUMBER:** ADM_039_CL
CATEGORY: Medical Staff Policies and Procedures	**EFFECTIVE DATE: 7/20/2011**
CHAPTER:	**SUPERSEDES:** 12/29/2004, PE_004_01_PC, July 2003

I. POLICY:

It is the policy of YKHC to adapt and utilize clinical practice guidelines in accordance with recognized need for the best quality of care for promoting the health and care patients.

II. PURPOSE:

To describe how clinical practice guidelines are initiated; The procedure to be followed in developing guidelines and the process for tracking and revising guidelines as required.

III. PROCEDURE-New Guidelines:

A. MSEC initiates topics for a clinical practice guidelines based on high-volume or high-risk issues identified by outcomes data and trending research. These guidelines will be based on the current needs of our population and will help to create more uniform practices that will minimize inefficiency, decrease errors and improve quality of care that benefits the patient.

B. When a guideline topic has been approved by MSEC, the committee will task a multidisciplinary Clinical Practice Guideline Team (CPGT) to start the clinical practice guideline formation process via ***medical staff office and performance improvement departments.***

1. This group will consist of at least one physician plus a combination of physician assistant, nurse practitioner, nursing, pharmacy, laboratory and or radiology staff and other members as may be indicated.

C. The Clinical Practice Guideline Team (CPGT) will follow the outlined procedure for developing a Clinical Practice Guideline stated below:

1. Produce a Cause and Effect Diagram outline for the specific topic noting desired and undesired outcomes.
2. Generate a flow chart of the current processes contributing to the negative and positive outcomes are generated.
3. Do a focused, best practice, evidence based literature review for the chosen topic. (There must be at least 3 reputable references before beginning the guideline.) If appropriate research is not available, then expert panel reviews can be used or the research and expertise of local or regional clinical entities can be utilized.
4. Develop the Clinical Guidelines using an approved flow chart format
5. After development of the guideline, team will compare systems, processes, and practices that will change based on the new guidelines and determine those that are affected.
6. Draft Guidelines will be reviewed by the majority of users and applicable consultants for comment and feedback.

7. The guideline will be revised as the CPGT committee feels appropriate
8. A process for information rollout and implementation to appropriate users will be outlined.

D. The guideline, report and suggested a quality indication to monitor is submitted to MSEC for approval. This report must consist of:

1. An Executive Summary explaining why the guideline was started, how this guideline will help the population, the validity of the guideline, who it affects, the implementation plan, and the measurement tool for evaluating effectiveness (i.e. quality indicator date to review)
2. Cause and Effect Diagram
3. Applicable Flow Charts
4. Bibliography of References
5. Constituents involved in final reviews and their approval i.e. OB Committee, Surgery and Anesthesia Committee, ER staff and Service Chief, etc
6. Measurements for usage and positive outcomes recommended be added to the clinical indicators report that is generated monthly from the Performance Improvement Department

E. MSEC reviews and approves the new clinical guideline for implementation:

III. PROCEDURE- Review and Revision of Established Clinical Guidelines:

A. All guideline outcome measurements are included in the clinical indicators report pulled off monthly by Performance Improvement data is then submitted to the Medical Staff PI Team for Review and directives for action as needed
B. All Clinical Guidelines are reviewed and revised as necessary based on outcomes data, provider feedback and changing recommendations as needed and at least every ***two years*** in accordance with evidence based practices

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Committee Approval:

JCAHO STANDARD REFERENCE: _____

Department Director Signature: _____ Date: _____

MSEC President's Signature: _____ Date: _____

Governing Body Chair Signature: _____ Date: _____

P&P Committee Signature: _____ Date: _____

Vice President Signature: _____ Date: _____

If policy crosses divisions additional signatures needed.

Vice President Signature: _____ Date: _____

Vice President Signature: _____ Date: _____

Vice President Signature: _____ Date: _____

Vice President Signature: _____ Date: _____

President/CEO Signature: _____ Date: _____