LETTER FROM THE EDITOR-IN-CHIEF

Clinical Practice Guidelines: Holy Grail or Holy %&$#!@?

Clinical practice guidelines have been gaining interest, along with a little ire, over the last decade. Fueled by Medicare reform, the Affordable Care Act, Meaningful Use, and value-based reimbursement models, clinical practice guideline development has been envisioned as a critical way to achieve consistent care quality in a cost-effective and evidence-based way.

This is nothing new of course. I remember memorizing the U.S. Preventive Services Task Force Screening Guidelines in residency in preparation for boards. I recall with fascination the lectures in medical school describing how screening guidelines are developed, sacrificing individual opportunity for the public good, and some fairly arbitrary cost-of-care thresholds.

Imperfect by nature and rather socialist in their ideal, practice guidelines are once again exerting their influence in an utterly exhausted healthcare economy grasping for sustainable solutions. Some physicians have expressed grief over the "cookie cutter" medicine that these seem to promote. The same providers bemoan loss of control and professional intrusion. And they do have a point. But the train is out of the station on this issue and technology will almost certainly have it picking up speed. Thus, it is incumbent on us to seize control of the process and determine our own "best practice" standard.

The Institute of Medicine (IOM) defines clinical practice guidelines as "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."

Most specialty societies develop practice guidelines on behalf of their members and practicing providers at large. While these efforts vary in how they adopt the IOM standards, they are all directionally correct: Creating a reasonable best practice standard that applies to "most," though not all, patients with specific conditions and presentations.

There are so many practice guidelines available, the federal government deemed it necessary to create the National Guideline Clearinghouse just to keep track of them all. And, because each needs to withstand the scrutiny of the scientific community, they are invariably bloated with data and detail that can blur their intended purpose of mass appeal and application.

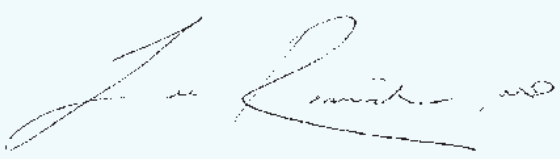
In an effort to track and apply relevant practice guidelines for urgent care, I regularly scan and monitor the specialty societies for conditions and presentations that we see with regularity in our setting. From the Infectious Diseases Society of America and the National Heart, Lung, and Blood Institute (NHLBI) to the American Academy of Pediatrics and American College of Emergency Physicians, there is no shortage of recommendations to review. Every few months there is a new guideline released or old guideline revised with relevance to urgent care: bronchiolitis, gonorrhea, urinary tract infections, and community-acquired pneumonia, to name just a few.

What I have found through this effort is encouraging, but more work needs to be done. There are two recurring challenges:

1. "TMI" (too much information): The NHLBI asthma guidelines are 440 pages long. The 74-page "Summary Report" seems slender by comparison. Filtering these guidelines for practical advice is a tall task for any practitioner.
2. Relevance: Clinical guidelines are only valuable if they are relevant to your practice. For example, best practice in urgent care is necessarily different than that of primary care. The availability of testing and treatment varies in each of these settings, as do the follow-up and disposition decisions.

So, for these efforts to be meaningful to urgent care providers, we must spend time interpreting and filtering the existing guidelines. This is a big project, but the good news is that we do not need to reinvent the guidelines themselves. A little bit of reorientation for our setting, a little trim and an edit here and there, and we will have a nice library for urgent care practice.

If we overthink or overreach on this, we will be left holding the bag. This is a real opportunity for defining our own best practice, before someone else does it for us. Stay tuned....■



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