



Clinical Practice Guidelines & Toolkits

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VA Central Office
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- **“Guidelines, recommendations for the performance or exclusion of specific procedures or service derived through a rigorous methodological, are an important clinical strategy to build quality of care into our system. As such, they must become very much a part of what we do everyday in our clinical care. approach that includes the following:**
- **Guidelines**
 - assure that the appropriate amount of care is provided (addressing both under & over utilization),
 - reduce errors & promote patient safety,
 - ensure predictable & consistent quality,
 - promote learning & research, and
 - facilitate patient & family education.”

Dr. Kenneth W. Kizer, 1st National Education Program on Implementation of Clinical Practice Guidelines, June, 1997



CPGs in VHA

- **Initial efforts in Guideline development included:**
 - **Rehabilitation of Amputation & Stroke**
 - **Care Guide RT (Ischemic Heart Disease)**
 - **Diabetes Mellitus**
 - **Asthma & COPD**
 - **Major Depressive Disorder**



VA/DoD CPG Working Group

- **Since 1998, the VA and DoD have enjoyed a meaningful partnership regarding guideline development & implementation designed to improve the quality of care and health management across both systems.**
- **An update of the Charter re-constituting the Work Group was signed September 7, 2004 to assure continuation of the effort.**



VA/DoD Working Group Charter

- **Vision**

- “advise ... on the use of practice guidelines to improve the quality of health and support population health management”

- **Purposes**

- advise the VA/DoD Executive Council
- identify areas for guideline adaptation
- facilitate adaptation process
- identify maintenance process
- champion the integration into information systems
- ensure integration
- encourage research

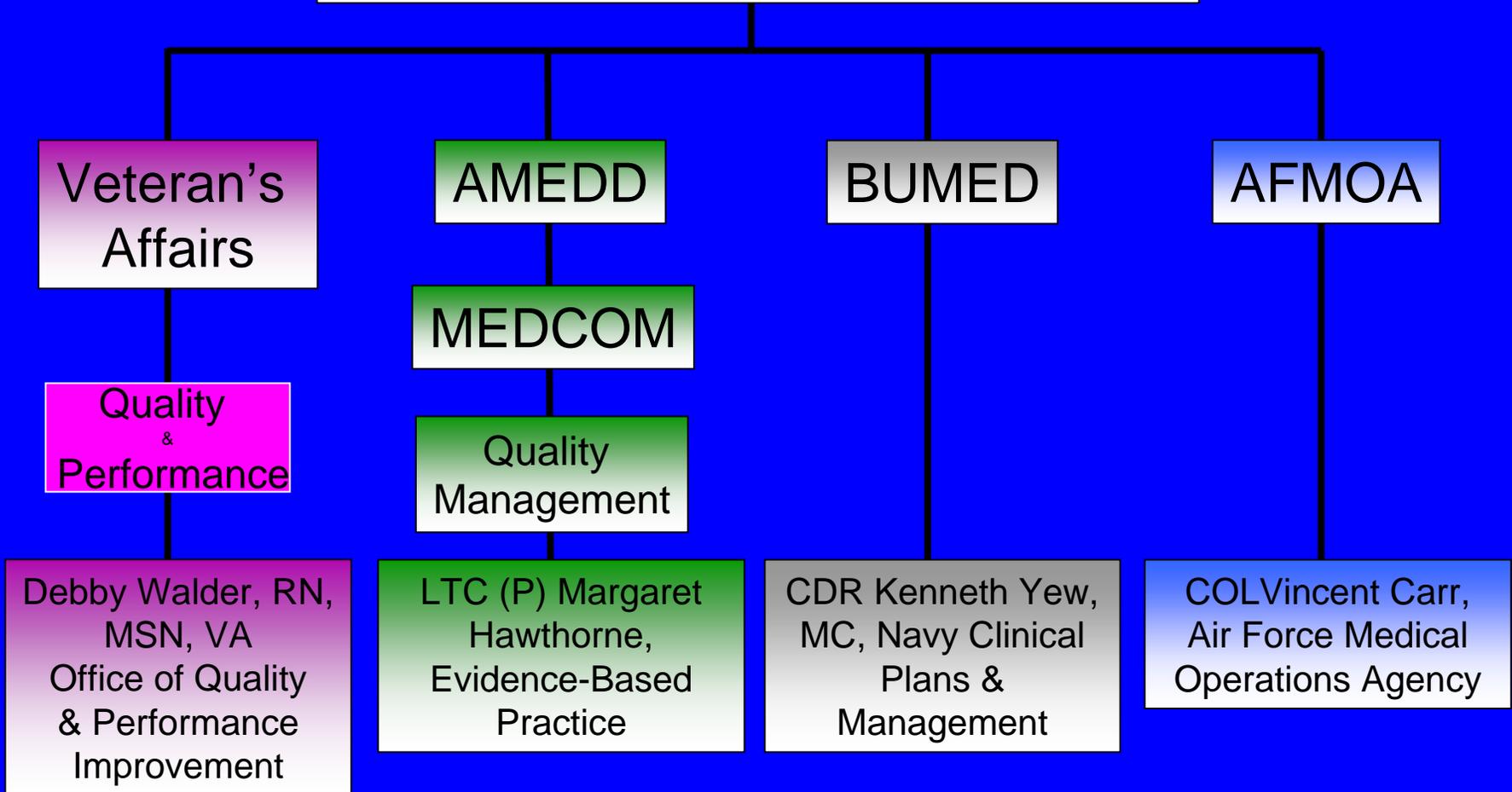


VA/DoD Executive Council

VA/DoD CPG Working Group

Co-chaired by

Dr. Leonard Pogach & COL Lee Bennett





Collaborative Efforts

CPGs posted to the Agency for Healthcare Research & Quality National Clearing House.

- Tobacco Use Cessation
- Hypertension
- Low Back Pain
- Asthma
- Diabetes Mellitus
- COPD
- Major Depressive Disorder
- Dyslipidemia
- Ischemic Heart Disease
- Chronic Heart Failure
- Post-Operative Pain
- GERD
- Post-Deployment Health
 - Screening Health Exam
 - Medically Unexplained Symptoms: Chronic Fatigue & Pain
- Psychosis
- Substance Abuse
- Clinical Preventive Services
- Dysuria in Women
- Uncomplicated Pregnancy
- Stroke Rehabilitation
- Opioid Therapy in Chronic Pain
- PTSD
- Psychoses

Biological, Chemical, and Radiation-Induced Illnesses Pocket Cards with links to CDC, NEJM, JAMA, NBC, and others.



Upcoming VA/DoD CPGs

- **New Obesity Guideline**
- **Updates of**
 - **Dyslipidemia**
 - **Post-Deployment (including Amputations)**
 - **COPD & (Asthma)**



Feedback on CPGs

- **Guidelines being considered for implementation are distributed for feedback at several points.**
 - when a draft of the guideline, with the Tables of Evidence, is available
 - when the final draft is ready for field testing
- **Each guideline is reviewed by at least three independent reviewers prior to review by the National Council**



Learning from our own experiences

- **Systems responsibility: Longitudinal data tracking, timely feedback, & accountability**
- **Buy-in at all levels: No one person can do it all -> team work is necessary**
- **Facility level: Multiple strategies are better**
 - computerized reminders
 - patient engagement
 - nursing participation
 - leadership support
 - barrier removal



Web Resources

www.OQP.MED.VA.gov/cpg

www.QMO.amedd.army.mil

Clinical Practice Guidelines

Office of Quality and Performance

CPG Home

- Contact
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CARDIOVASCULAR

- Chronic Heart Failure (CHF)
- Hypertension (HTN)
- Ischemic Heart Disease (IHD)
- Dyslipidemia (LDLPS)

ENDOCRINE

- Diabetes Mellitus (DM)

EYE

- Glaucoma

GENITOURINARY TRACT

- Benign Prostatic Hyperplasia (BPH)
- Dysuria
- Erectile Dysfunction (ED)
- Pre-End-Stage Renal Disease (ESRD)

MENTAL HEALTH

- Major Depressive Disorder (MDD)
- Psychosis (PSYCH)
- Substance Use Disorder (SUD)

MUSCULOSKELETAL

- Low Back Pain (LBP)

OB/GYN

- Uncomplicated Pregnancy (UP)

PULMONARY

- Asthma
- Tobacco Use Cessation (TUC)
- Chronic Obstructive Pulmonary Disease (COPD)

OTHER

- Post-Deployment Health Evaluation & Management
- Medically Unexplained Symptoms: Chronic Pain & Fatigue
- Post Operative Pain
- Biological, Chemical, and Radiation Induced Illnesses
- Terrorism Pocket Guide - Non VA Ordering Information

What's New!

- Diabetes Mellitus (DM)
- Post Operative Pain
- Chronic Obstructive Pulmonary Disease (COPD)
- Health Tips for CHF
- Chronic Heart Failure (CHF)
- Dyslipidemia (LDLPS)
- Erectile Dysfunction (ED)
- Low Back Pain (LBP)

Clinical Practice Guidelines

Implementation of evidence-based clinical practice guidelines is one strategy which has been shown to improve care by reducing variation in practice and systematizing "best practices". Guidelines are general tools to improve the processes of care for patient cohorts, serve to reduce error, and provide consistent quality of care and utilization of resources throughout the system. Guidelines also are cornerstones for accountability and facilitate learning and the conduct of research. The guidelines on this site are those endorsed by VHA's National Clinical Practice Guidelines Council.

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VHA's Clinical Practice Guidelines are recommendations for the performance or evaluation of specific procedures or services for specific disease entities. These recommendations are derived through a rigorous methodological approach that includes a systematic review of the evidence to evaluate recommended practice. Guidelines are frequently displayed in the form of an algorithm, which is a set of rules, in a familiar format, for solving a problem in a finite number of steps. Clinical guidelines are used by many as a potential solution to infrequency and inappropriate variation in care. However, it is acknowledged that the use of guidelines must always be applied in the context of a provider's clinical judgment for the care of a particular patient. For that reason, the guidelines may be viewed as an educational tool analogous to textbooks and journals, but in a more user-friendly format.

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November 22, 2002

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Tuesday, September 17, 2002

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Please scroll down on each page to see complete list of information and links.

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- TUC
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Office of Quality and Performance

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Clinical practice guidelines initially evolved in response to studies demonstrating significant variations in risk-adjusted practice patterns and costs. Researchers hypothesized that establishing criteria for the appropriate use of procedures and services might decrease inappropriate utilization and improve patient outcomes.

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ACUTE INTOXICATION

- The most common signs and symptoms involve disturbances of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior.
- Patients should be medically observed at least until the blood alcohol level (BAL) is decreasing and clinical presentation is improving.
- Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at BALs well above the legal limit (e.g., 80 or 100 mg percent).
- Consider withdrawal risk from each substance for patients using multiple substances.

HAZARDOUS ALCOHOL USE

Definition	Comments
<p>Typical Drinks per week</p> <p>Male: ≥14 Female: ≥7</p>	<p>Standard Drinks</p> <ul style="list-style-type: none"> • 0.5 fluid ounces of absolute alcohol • 12 ounces of beer • 5 ounces of wine • 1.5 ounces of 80-proof spirits
<p>Maximum drinks per occasion</p> <p>Male: ≥5 Female: ≥4</p>	<p>May vary depending on age, ethnicity, medical and psychiatric comorbidity, pregnancy, and other risk factors.</p>

RISK OF RELAPSE

A simple and brief patient inquiry will often suffice, such as "Have you had any 'close calls' with drinking or other drug use?"

DSM-IV CRITERIA (APA, 1994)

Substance Abuse

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:
 - Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; or neglect of children or household)
 - Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine)
 - Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
 - Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication or physical fights)
2. These symptoms must never have met the criteria for substance dependence for this class of substance.

Substance Dependence

- A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following seven criteria, occurring at any time in the same 12-month period:
1. Tolerance, as defined by either of the following:
 - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - Markedly diminished effect with continued use of the same amount of the substance.
 2. Withdrawal, as defined by either of the following:
 - The characteristic withdrawal syndrome for the substance (refer to DSM-IV for further details).
 - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
 3. The substance is often taken in larger amounts or over a longer period than was intended.
 4. There is a persistent desire or there are unsuccessful efforts to cut down or control substance use.
 5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances to see one), use the substance (e.g., chain smoking), or recover from its effects.
 6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
 7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Remission

Dependence exists on a continuum of severity; remission requires a period of at least 30 days without meeting full diagnostic criteria and is specified as Early (first 12 months) or Sustained (beyond 12 months) and Partial (some continued criteria met) versus Full (no criteria met)

CARE MANAGEMENT

Care management is a clinical approach to the management of chronic SUDs where full remission (e.g., abstinence) is not a realistic goal or one the patient endorses. Conceptually, the care management approach is similar to managing other chronic illnesses, such as diabetes or schizophrenia. Practically, the care management framework provides specific strategies designed to enhance motivation to change, relieve symptoms and improve function where possible, and monitor progress towards goals. Care management is a flexible approach that may be integrated into medical and psychiatric care in any setting. In some cases, care management will lead to remission of the SUD or referral for specialty care/rehabilitation, while in other cases it serves a more palliative function.

CARE MANAGEMENT COMPONENTS INCLUDE THE FOLLOWING:

- Document specific substance use at each contact by patient report (e.g., number of drinking or substance-using days in the past month, typical and maximum number of drinks per occasion).
- Monitor and discuss biological indicators (e.g., transaminase levels and urine toxicology screens)
- Encourage reduction or cessation of use at each visit and support motivation to change.
- Recommend self-help groups
- Address or refer for social, financial, and housing problems.
- Coordinate treatment with other care providers
- Monitor progress and periodically assess for possible referral to specialty rehabilitation.

FOLLOW-UP

- Monitor substance use and encourage continued reduction or abstinence.
- Educate about substance use and associated problems.
- For DoD active duty, keep the commanding officer informed of progress, or lack thereof

VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders(SUD) Primary Care Pocket Guide



Regarding DoD Active Duty

Referral to addictions specialty care for assessment is required for all active duty patients in an incident involving/suspected to involve legal/illegal substances.

VA access to us gateway: <http://www.ehealth.va.gov>
 DoD access to us gateway: <http://www.ehealth.dod.mil>
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Guideline Reference		Download Center	
	View Online	word	pdf
OVERVIEW	Information about the MDD guideline	<input checked="" type="checkbox"/>	
GUIDELINE	Complete guideline online (Interactive site)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
ALGORITHMS	The MDD-CPG algorithms: Module A - Primary Care Module B - Outpatient Specialty Care Module C - Inpatient Specialty Care	<input checked="" type="checkbox"/>	
SUMMARY	Summary of recommendations: Module A - Primary Care Module B - Outpatient Specialty Care Module C - Inpatient Specialty Care		A- <input checked="" type="checkbox"/> B- <input checked="" type="checkbox"/> C- <input checked="" type="checkbox"/>
POCKET CARD	MDD - Primary Care - [PDF format] MDD - Mental Health Outpatient Care [PDF format] MDD - Mental Health Inpatient Care [PDF format]		A- <input checked="" type="checkbox"/> B- <input checked="" type="checkbox"/> C- <input checked="" type="checkbox"/>
KEY POINTS	The key points addressed by Module A -Primary Care The key points addressed by Module B -Outpatient The key points addressed by Module C -Inpatient		A- <input checked="" type="checkbox"/> B- <input checked="" type="checkbox"/> C- <input checked="" type="checkbox"/>
REMINDERS	N/A		
ARCHIVE	N/A		
		Help	

Related Performance Issues	
MEASURES	The MDD measures - Technical Manual (March 8, 2002)
DATABASE QUESTIONS	EPRP database question FY2002 Q3- PI module
OTHER	N/A

Related Guidelines	
	Psychosis
	Substance Use Disorders
	Medically unexplained symptoms:Chronic Pain & Fatigue

Guideline Community	
RELATED RESOURCES	
	MDD QUERI - www.mentalhealth.med.va.gov/mhq/
	Charles P. Shade, MD, MPH, Everett R. Jones, Jr., MD, and Byron Wittlin, MD. A Ten-Year Review of the Validity and Clinical Utility of Depression Screening. The Journal of Psychiatric Services. 1998, (49) [MEDLINE]
	John W. Williams, Jr. MD, MHS, Cynthia D. Mulrow, MD, MSc, et. Al. Case-Finding for Depression I Primary Care: A Randomized Trial, American Journal of Medicine, 1999, (106), 36-42 [MEDLINE]
	Mary A. Whooley, MD, Andrew L. Avins, MD, et.al . Case-Finding Instruments for Depression: Two Questions Are as Good as Many. Journal of General Internal Medicine, Volume 12, 1997 [MEDLINE]
	Pharmacy Benefits Management (PBM) - MDD Pharmacotherapy
BENCHMARK	
FEEDBACK	
IMPLEMENTATION STRATEGIES	
GUIDELINE CHAT	

EDICATIONS:

Take your medicines, including your over-the-counter medications, as directed by your provider.

Do not stop or start medicines without asking your provider first.

If you forget to take your medicine, take it as soon as you remember, if it is within a few hours of the missed dose. If you do not remember until it is almost time for the next dose, just take the next dose as prescribed. Do not double the next dose.

Order your refills at least 1-2 weeks before you run out.

Take enough pills with you when you travel, and keep them with you in a carry-on bag.

If you are taking additional over-the-counter medications or dietary supplements (e.g. vitamins, herbs, health food preparations), please discuss this with your provider.

To help you remember, write down the name and strength of the medicines you take and carry the list with you everywhere you go. Also write down when you take each medicine.

HEALTHCARE PROVIDER NAME:

TELEPHONE #:

HEALTH TIPS FOR HEART FAILURE



Heart Failure is a condition when the heart does not pump as well as expected and is not able to keep up with your body's needs as it should. Heart failure does not



mean that your heart stops working, but it does mean that under certain conditions your heart cannot pump enough blood, food, and oxygen to your body. This may cause you to feel tired or weak. In addition, fluid can build up in your legs and ankles, causing swelling. In some cases, fluid also builds up in your lungs and can cause you to cough or feel short of breath.

There are different types of heart failure and different causes. Common causes include high blood pressure, heart attack and, sometime, heavy alcohol use.

Although heart failure is a chronic condition that cannot be cured, it can be treated. Part of a good treatment plan means seeing your health care provider regularly and knowing who and when to call if a problem occurs.

Call 911 if you have severe chest pain, trouble breathing, or severe dizziness or fainting!

Version 1.0

Access this document for downloading at
http://www.oqp.med.va.gov/cpg/CHF/P/Health_Tips_for_Heart_Failure4.doc



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Keys of Success

- **Dedication of care providers to improving quality care**
- **Leadership support**
- **Commitment of VA & DoD**
- **Link to performance measurement system of accountability**





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