The NEATS (EM) Study: Rating the Trustworthiness of (Emergency Medicine) CPGs

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McMaster University

Standard 1: Funding Disclosure

1. Disclosure of Guideline Funding Source

Reference IOM Standard *The processes by which a clinical practice guideline (CPG) is funded should be detailed explicitly and publicly accessible.*
Please rate on this criterion: **The clinical practice guideline (CPG) discloses and states explicitly its funding source.**

Please review the description and guidance below and then choose one option:

YES	NO
○	○

Description

This standard asks for information regarding the funding of the guideline's development. Implicit in this standard is the notion that transparency of funding "gives users confidence that guidelines are... largely free from bias... and therefore trustworthy." (IOM 2011, p. 77) The clinical practice guideline (CPG) or supporting documents should list the funding source(s) for its development. This information should be publically available.

Standard 1 – ACEP BAT CPG

- Pg 2.

changes significantly. ACEP is the funding source for this clinical policy.

- Answer: YES

Standard 2: Conflicts of Interest

2. Disclosure and Management of Financial Conflicts of Interests (COIs)

Reference IOM Standard

- *Prior to selection of the guideline development group (GDG), individuals being considered for membership should declare all interests and activities potentially resulting in COI with development group activity, by written disclosure to those convening the GDG. Disclosure should reflect all current and planned commercial (including services from which a clinician derives a substantial proportion of income), non-commercial, intellectual, institutional, and patient–public activities pertinent to the potential scope of the CPG.*
- *Disclosure of COIs within GDG: All COI of each GDG member should be reported and discussed by the prospective development group prior to the onset of his or her work. Each panel member should explain how his or her COI could influence the CPG development process or specific recommendations.*

Please rate on this criterion:

Financial conflicts of interest of guideline development group (GDG) members have been disclosed and managed.

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Standard 2:

Description

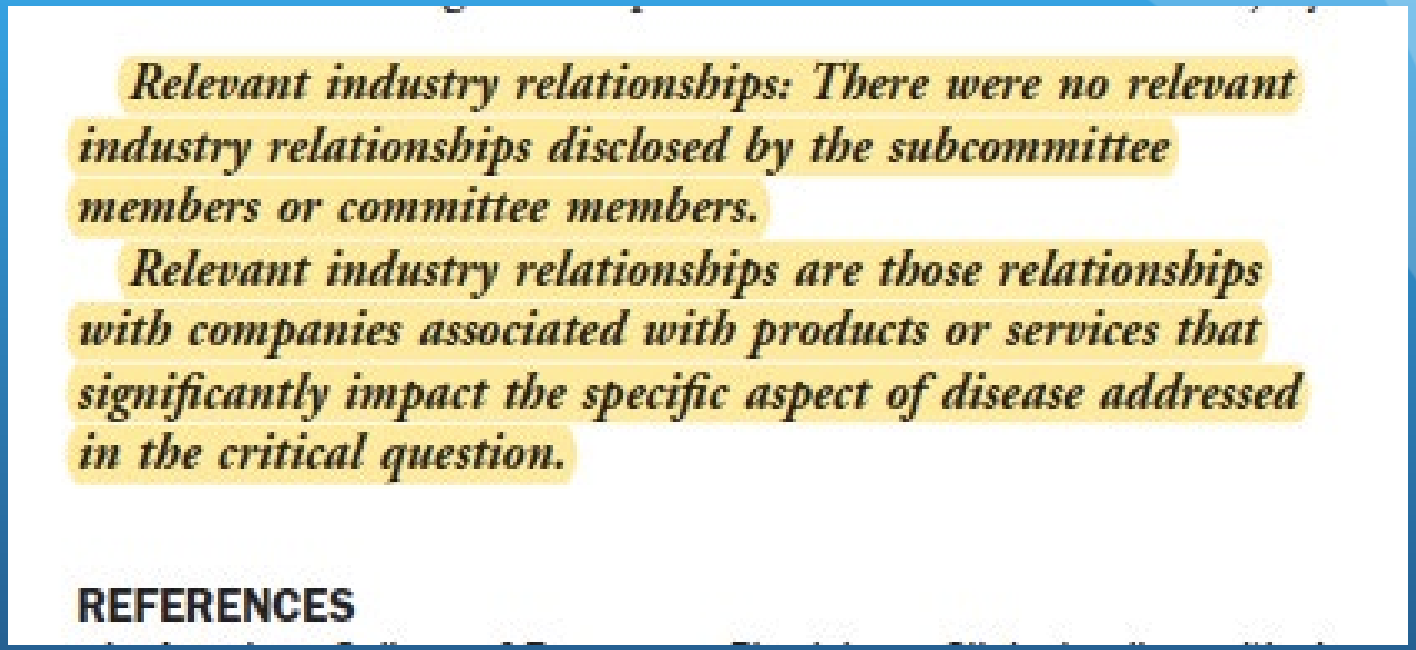
This standard addresses the issue of actual or potential relationships between members of the GDG and entities, commercial or otherwise, with financial or intellectual interests in the CPG topic.

The CPG or supporting documents should provide a detailed disclosure of actual or potential financial COIs of each GDG member AND if any COIs are present, the document should describe how these conflicts may have affected the guideline process and any steps taken to manage and minimize their effect (e.g., recusal, divestment).

- **VERY controversial** area of trustworthiness
- CoI's: financial, academic, other professional, personal, etc.
- Should be explicitly managed by panel Chair(s)
- Ideal: Explicit CoI disclosures, voting inclusion/exclusion criteria

Standard 2: ACEP BAT CPG

- Pg 8



Relevant industry relationships: There were no relevant industry relationships disclosed by the subcommittee members or committee members.

Relevant industry relationships are those relationships with companies associated with products or services that significantly impact the specific aspect of disease addressed in the critical question.

REFERENCES

- Answer: 3 or 4? Only comments on industry conflicts, not other financial, academic, etc. conflicts

Standard 3a: GDG Stakeholders

3a. Guideline Development Group (GDG) Composition: Multidisciplinary

Reference IOM Standard
The GDG should be multidisciplinary and balanced, comprising a variety of methodological experts, clinicians, and populations expected to be affected by the CPG.
Please rate on this criterion: **The guideline development group (GDG) includes individuals from a variety of relevant clinical specialties and other professional groups.**

Please review the description and guidance below and then choose one option:

YES	NO	UNKNOWN
○	○	○

Description

This standard seeks to reduce the potential for bias that can sometimes result from a homogeneous GDG by encouraging a GDG comprising members from multiple disciplines. While each CPG will have a different set of clinical specialties that are relevant, a multidisciplinary GDG can include subject matter experts from a variety of professional backgrounds, paraprofessionals, statisticians, program managers, and members of the public. The GDG is multidisciplinary if more than one relevant clinical specialty is represented, based on stated disciplines (e.g., it includes representatives of more than one clinical specialty or professional group). This includes the situation when a GDG member is a nonclinical specialist.

Standard 3a: ACEP BAT CPG

From the American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on Critical Issues in the Evaluation of Adult Patients Presenting to the Emergency Department with Acute Blunt Abdominal Trauma):

Deborah B. Diercks, MD, MSc (Subcommittee Chair)
Abhishek Mehrotra, MD
Devorah J. Nazarian, MD
Susan B. Promes, MD
Wyatt W. Decker, MD (Committee Co-Chair)
Francis M. Fesmire, MD (Committee Co-Chair)

Members of the American College of Emergency Physicians Clinical Policies Committee (Oversight Committee):

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Eric J. Lavonas, MD
Gail Lenehan, EdD, RN, FAEN, FAAN (ENA Representative 2010-2011) (Nurse)
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Approved by the ACEP Board of Directors, January 13, 2011
Supported by the Emergency Nurses Association, February 16, 2011

Standard 3a: ACEP BAT CPG

- Pg 2

- Answer: **YES**; most clinically relevant groups are addressed based on PICOT questions asked

The reasons for developing clinical policies in emergency medicine and the approaches used in their development have been enumerated.[5] This policy is a product of the ACEP clinical policy development process, including expert review, and is based on the existing literature; when literature was not available, consensus of emergency physicians was used. Expert review comments were received from individual physicians in the fields of emergency medicine, surgery, and radiology and from individual members of the American College of Surgeons Committee on Trauma, the Society for Academic Emergency Medicine, ACEP's Emergency Medical Services Committee, ACEP's Emergency Ultrasound Section, ACEP's Quality and Performance Committee, and ACEP's Trauma and Injury Prevention Section. Their responses were used to further refine and enhance this policy; however, their responses do not imply endorsement of this clinical policy. Clinical policies are

Standard 3b: Methodology

3b. Guideline Development Group (GDG) Composition: Methodologist

Reference IOM Standard
The GDG should be multidisciplinary and balanced, comprising a variety of methodological experts, clinicians, and populations expected to be affected by the CPG.
Please rate on this criterion: **The guideline states that it included a methodological expert in the guideline development group (GDG) and it identifies the methodologist.**

Please review the description and guidance below and then choose one option:

YES	NO	UNKNOWN
○	○	○

Description

This standard seeks to ensure that the guideline was developed with the participation of a methodological expert. As described by the IOM, "methodologists (e.g., epidemiologists, biostatisticians, health services researchers) perform much of the research on the conduct of systematic reviews (SRs) and are likely to stay up-to-date with the literature on methods. Their expertise includes decisions about study design and potential for bias and influence on findings, methods to minimize bias in the SR, qualitative synthesis, quantitative methods, and issues related to data collection and data management." (IOM [Institute of Medicine]. *Finding What Works in Health Care: Standards for Systematic Reviews.* Washington (DC): The National Academies Press. 2011)

The CPG or supporting documents should make clear that methodologists were involved in the CPG development process, specifically listing methodologists and detailing their specific roles.

Standard 3b: ACEP BAT CPG

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- Answer: YES? (Not explicit as role of Methodologist)

Standard 4: Patient/Public Perspectives

4. Patient and Public Perspectives

Reference IOM Standard
Patient and public involvement should be facilitated by including (at least at the time of clinical question formulation and draft CPG review) a current or former patient, and a patient advocate or patient/consumer organization representative in the GDG.
Please rate on this criterion: **The guideline development group (GDG) sought the views, perspectives, and preferences of patients, patient surrogates (parents, caretakers), patient advocates, and/or the public intended to represent those who have experience with the disease, its treatments, or complications, or those who could be affected by the guideline.**

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Standard 4: Patient/Public Perspectives

Description

This standard seeks that the perspectives of the target population be included in the guideline development process. The target population includes patients, patient surrogates (parents, caregivers), patient advocates, and/or the public, i.e., those who have experience with the disease, its treatments, or complications, or those who could be impacted by the guideline. While the original IOM standard prioritizes patient or surrogate representation in the GDG, we have broadened our assessment to encompass incorporation of patient perspectives in other ways and at various points in the guideline development process, as well.

Inclusion of patient perspective can take many forms: a patient representative on the GDG, consultation with patients to set priorities for topics, and external review by stakeholders, the public, or consumers, including drafts available for public comment (Please note for drafts for public comment, it must be clear that public comment specifically involved patients and that those comments were addressed). In addition, incorporating literature published on patient preferences and perspectives that relate to the guideline's recommended care is also acceptable.

The GDG or companion documents should include at least one patient, surrogate (parents, caretakers) or advocate AND the CPG should be clear about how those individuals contributed (e.g., clinical question formulation, review of draft CPG). If utilized, the CPG should also provide detailed information about how patient perspectives (i.e., studies regarding patient preference) were incorporated.

Standard 4: ACEP BAT CPG

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Wyatt W. Decker, MD (Committee Co-Chair)
Francis M. Fesmire, MD (Committee Co-Chair)

No Patients/Caregivers?

Members of the American College of Emergency Physicians Clinical Policies Committee (Oversight Committee):

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Standard 4: ACEP BAT CPG

- Pg 2

- Answer: 1 - Lowest adherence?

The reasons for developing clinical policies in emergency medicine and the approaches used in their development have been enumerated.[5] This policy is a product of the ACEP clinical policy development process, including expert review, and is based on the existing literature; when literature was not available, consensus of emergency physicians was used. Expert review comments were received from individual physicians in the fields of emergency medicine, surgery, and radiology and from individual members of the American College of Surgeons Committee on Trauma, the Society for Academic Emergency Medicine, ACEP's Emergency Medical Services Committee, ACEP's Emergency Ultrasound Section, ACEP's Quality and Performance Committee, and ACEP's Trauma and Injury Prevention Section. Their responses were used to further refine and enhance this policy; however, their responses do not imply endorsement of this clinical policy. Clinical policies are

Standard 5a: Evidence Search

5a. Use of a Systematic Review of Evidence – the Search Strategy

Reference IOM Standard

Clinical practice guideline developers should use systematic reviews that meet standards set by the Institute of Medicine's Committee on Standards for Systematic Reviews of Comparative Effectiveness Research.

Please rate on this criterion:

The CPG or a related companion document describes a search strategy that includes a listing of database(s) searched, a summary of search terms used, the specific time period covered by the literature search including the beginning date (month/year) and end date (month/year).

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Standard 5a: Evidence Search

Description

This standard expects that guidelines based on a systematic review of the evidence describe in detail the search strategy. This should include a listing of database(s) searched, a summary of search terms used, the specific time period covered by the literature search including the beginning date (month/year) and end date (month/year).

The CPG or companion documents should provide a detailed description of the search strategy that includes a listing of database(s) searched, a summary of search terms used, the specific time period covered by the literature search including the beginning date (month/year) and end date (month/year). The information should be well-described and complete, with multiple databases searched and specific search terms. The CPG may include additional details such as extensive search terms, MeSH terms, key questions, or other specific details of the search strategy.

Standard 5a: ACEP BAT CPG

METHODOLOGY

This clinical policy was created after careful review and critical analysis of the medical literature. Multiple searches of MEDLINE and the Cochrane database were performed. All searches were limited to English-language sources, human studies, and adults. Specific key words/phrases and years used in the searches are identified under each critical question. In addition, relevant articles from the bibliographies of included studies and more recent articles identified by committee members or peer reviewers were included.

- Likely 3-4? – SR/MA methods somewhat limited? Electronic databases, English-language only…

Standard 5b: Study Selection

5b. Use of a Systematic Review of Evidence – the Study Selection

Reference IOM Standard
Clinical practice guideline developers should use systematic reviews that meet standards set by the Institute of Medicine's Committee on Standards for Systematic Reviews of Comparative Effectiveness Research.
Please rate on this criterion: **The CPG or a related companion document describes the study selection that includes the number of studies identified, the number of studies included, and a summary of inclusion and exclusion criteria.**

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard expects that guidelines based on a systematic review of the evidence describe in detail the study selection. This should include the number of studies identified by search, the number of studies included, and a summary of the inclusion and exclusion criteria.

The CPG or companion documents should provide a description of study selection that includes the number of studies identified, the number of studies included, and a detailed summary of inclusion and exclusion criteria. The number of documents identified and included may be listed in the results section and may also be displayed in a flowchart (e.g., PRISMA flowchart).

Standard 5b: ACEP BAT CPG

METHODOLOGY

This clinical policy was created after careful review and critical analysis of the medical literature. Multiple searches of MEDLINE and the Cochrane database were performed. All searches were limited to English-language sources, human studies, and adults. Specific key words/phrases and years used in the searches are identified under each critical question. In addition, relevant articles from the bibliographies of included studies and more recent articles identified by committee members or peer reviewers were included.

- Evidentiary table of all included studies at end of manuscript (pgs 10-17); no PRISMA flow diagram describing studies excluded vs those included?
- Maybe 3?

Standard 5c: Evidence Synthesis

5c. Use of a Systematic Review of Evidence – the Synthesis of Evidence

Reference IOM Standard

Clinical practice guideline developers should use systematic reviews that meet standards set by the Institute of Medicine's Committee on Standards for Systematic Reviews of Comparative Effectiveness Research.

Please rate on this criterion:

The CPG or a related companion document provides a synthesis of evidence from the selected studies, i.e., an analysis of individual studies and the body of evidence, in the form of a detailed description or evidence tables, or both.

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard expects that guidelines based on a systematic review of the evidence describe in detail the synthesis of evidence from the studies that were selected. This means that the CPG or a related companion document should include an analysis of individual studies and also an analysis the body of evidence taken as a whole. This could take the form of a detailed narrative description of the nature and quality of studies or evidence tables that capture such details about the studies, or both.

The CPG or companion documents should provide a synthesis of the evidence from the selected st that includes well-crafted, detailed evidence tables and a thorough narrative description and discus of the evidence.

Standard 5c: ACEP BAT CPG

- Pg 2
- Description of 2+ members reviewing the articles, strength of evidence based on 6 domains, then final grading I/II/III/X
- Likely 4-5…

All articles used in the formulation of this clinical policy were graded by at least 2 subcommittee members for strength of evidence and classified by the subcommittee members into 3 classes of evidence on the basis of the design of the study, with design 1 representing the strongest evidence and design 3 representing the weakest evidence for therapeutic, diagnostic, and prognostic clinical reports, respectively (Appendix A). Articles were then graded on 6 dimensions thought to be most relevant to the development of a clinical guideline: blinded versus nonblinded outcome assessment, blinded or randomized allocation, direct or indirect outcome measures (reliability and validity), biases (eg, selection, detection, transfer), external validity (ie, generalizability), and sufficient sample size. Articles received a final grade (Class I, II, III) on the basis of a predetermined formula, taking into account design and quality of study (Appendix B). Articles with fatal flaws were given an "X" grade and not used in formulating recommendations in this policy. Evidence grading was done with respect to the specific data being extracted and the specific critical question being reviewed. Thus, the level of evidence for any one study may vary according to the question, and it is possible for a single article to receive different levels of grading as different critical qu[illegible] are answered. Question-specific level of evidence gradi[illegible]e found in the Evidentiary Table included at the end of [illegible] policy.

Standard 6: Evidence Quality/Strength

6. Grading or Rating the Quality or Strength of Evidence

Reference IOM Standard

For each recommendation, the following should be provided:

- *A rating of the level of confidence in (certainty regarding) the evidence underpinning the recommendation.*

Please rate on this criterion:

The CPG provides a grading or rating of the level of confidence in or certainty regarding the quality or strength of the evidence for each recommendation.

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard asks that evidence be graded or rated according to a scheme that takes into account the quality of and level of confidence or certainty regarding the evidence. Note that this domain item is a grading or rating of the strength of evidence underpinning recommendations.

The CPG's recommendations should be accompanied by a grade or rating of the evidence derived from clear and well-described scheme of the level of confidence in (or certainty regarding) the evidence. Th grade or rating should be linked clearly and directly to the recommendation(s).

Standard 6: ACEP BAT CPG

Clinical Policy

Appendix A. Literature classification schema.*

Design/Class	Therapy†	Diagnosis‡	Prognosis§
1	Randomized, controlled trial or meta-analyses of randomized trials	Prospective cohort using a criterion standard or meta-analysis of prospective studies	Population prospective cohort or meta-analysis of prospective studies
2	Nonrandomized trial	Retrospective observational	Retrospective cohort Case control
3	Case series Case report Other (eg, consensus, review)	Case series Case report Other (eg, consensus, review)	Case series Case report Other (eg, consensus, review)

*Some designs (eg, surveys) will not fit this schema and should be assessed individually.
†Objective is to measure therapeutic efficacy comparing interventions.
‡Objective is to determine the sensitivity and specificity of diagnostic tests.
§Objective is to predict outcome, including mortality and morbidity.

Appendix B. Approach to downgrading strength of evidence.

	Design/Class		
Downgrading	**1**	**2**	**3**
None	I	II	III
1 level	II	III	X
2 levels	III	X	X
Fatally flawed	X	X	X

Appendix C. Likelihood ratios and number needed to treat.*

LR (+)	LR (–)	
1.0	1.0	Useless
1–5	0.5–1	Rarely of value, only minimally changes pretest probability
10	0.1	Worthwhile test, may be diagnostic if the result is concordant with pretest probability
20	0.05	Strong test, usually diagnostic
100	0.01	Very accurate test, almost always diagnostic even in the setting of low or high pretest probability

*Number needed to treat (NNT): number of patients who need to be treated to achieve 1 additional good outcome; NNT=1/absolute risk reduction×100, where absolute risk reduction is the risk difference between 2 event rates (ie, experimental and control groups).

**Likely 4-5

Standard 7: Rec Benefits/Harms

7. Benefits and Harms of Recommendations

Reference IOM Standard

For each recommendation, the following should be provided:

- *An explanation of the reasoning underlying the recommendation, including a clear description of potential benefits and harms*

Please rate on this criterion:

The potential benefits and harms of recommended care are clearly described for the recommendations.

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard expects developers to consider and describe explicitly the potential benefits and harms as they arrive at the CPG's recommendations. Potential harms may include risk of side effects or complications.

The CPG should describe clearly and in detail the potential benefits and harms of recommendations AN[illegible] also link explicitly this information to specific recommendations.

Standard 7: ACEP BAT CPG

This policy is not intended to be a complete manual on the evaluation and management of adult patients with acute blunt abdominal trauma but rather a focused examination of critical issues that have particular relevance to the current practice of emergency medicine.

It is the goal of the Clinical Policies Committee to provide an evidence-based recommendation when the medical literature provides enough quality information to answer a critical question. When the medical literature does not contain enough quality information to answer a critical question, the members of the Clinical Policies Committee believe that it is equally important to alert emergency physicians to this fact.

Recommendations offered in this policy are not intended to represent the only diagnostic and management options that the emergency physician should consider. ACEP clearly recognizes the importance of the individual physician's judgment. Rather, this guideline defines for the physician those strategies for which medical literature exists to provide support for answers to the crucial questions addressed in this policy.

Standard 7: ACEP BAT CPG

- Multiple discussions re: diagnostic utility and limitations of different imaging modalities for evaluating BAT patients (US, CT-contrast) and for safe discharge of stable patients with isolated BAT and negative findings…

- Likely a higher adherence score – 4 or 5?

- Depends on the nature of the interventions being recommended, and the robustness of the evidence /depth of analysis of benefits vs harms…

Standard 8: Evidence to Recs

8. Evidence Summary Supporting Recommendations

Reference IOM Standard

For each recommendation, the following should be provided:

- *An explanation of the reasoning underlying the recommendation, including a summary of relevant available evidence (and evidentiary gaps), description of the quality (including applicability), quantity (including completeness), and consistency of the aggregate available evidence.*

Please rate on this criterion:

A summary of the relevant supporting evidence is explicitly linked to recommendations.

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard seeks that recommendations have an explicit link to a summary of the relevant evidence underlying the recommendation. This differs from the synthesis of the evidence in that it ties specific evidence to specific recommendations and will generally be much briefer.

The CPG or supporting documents should provide a thoughtful summary of the relevant supporting evidence (e.g., in an explicit discussion of the evidence) AND link this information directly to recommendations.

Standard 8: ACEP BAT CPG

Clinical findings and strength of recommendations regarding patient management were then made according to the following criteria:

Level A recommendations. Generally accepted principles for patient management that reflect a high degree of clinical certainty (ie, based on strength of evidence Class I or overwhelming evidence from strength of evidence Class II studies that directly address all of the issues).

Level B recommendations. Recommendations for patient management that may identify a particular strategy or range of management strategies that reflect moderate clinical certainty (ie, based on strength of evidence Class II studies that directly address the issue, decision analysis that directly addresses the issue, or strong consensus of strength of evidence Class III studies).

Level C recommendations. Other strategies for patient management that are based on Class III studies, or in the absence of any adequate published literature, based on panel consensus.

There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. Factors such as heterogeneity of results, uncertainty about effect magnitude and consequences, and publication bias, among others, might lead to such a downgrading of recommendations.

When possible, clinically oriented statistics (eg, likelihood ratios [LRs], number needed to treat) will be presente[illegible]elp the reader better understand how the results can be [illegible] the individual patient. For a definition of these stati[illegible] concepts, see Appendix C.

- Pg 2-3
- Likely 4-5?

Standard 8: ACEP BAT CPG

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2 levels	III	X	X
Fatally flawed	X	X	X

Appendix C. Likelihood ratios and number needed to treat.*

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*Number needed to treat (NNT): number of patients who need to be treated to achieve 1 additional good outcome; NNT=1/absolute risk reduction×100, where absolute risk reduction is the risk difference between 2 event rates (ie, experimental and control groups).

**Appendix B: Strength of Evidence

Standard 9: Rating Rec Strength

9. Rating the Strength of Recommendations

Reference IOM Standard

For each recommendation, the following should be provided:

- *A rating of the strength of the recommendation in light of [benefits and harms, available evidence, and the confidence in the underlying evidence].*

Please rate on this criterion:

The CPG gives a rating of the strength of the recommendation for each recommendation that takes into account benefits and harms, available evidence, and the confidence in the underlying evidence.

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard expects that the CPG provides a rating for key recommendations according to a scheme that takes into account the confidence in that evidence (e.g., quantity, quality, and consistency of the available evidence), and the balance of benefits and harms.

The CPG should provide a rating for the strength of each recommendation that is based on a clear and well-described grading scheme that takes into account the confidence in the evidence and the balanc of benefits and harms.

Standard 9:

CRITICAL QUESTIONS

1. In a hemodynamically unstable patient with blunt abdominal trauma is bedside ultrasound the diagnostic modality of choice?

Level A recommendations. None specified.

Level B recommendations. In hemodynamically unstable patients (systolic blood pressure ≤90 mm Hg) with blunt abdominal trauma, bedside ultrasound, when available, should be the initial diagnostic modality performed to identify the need for emergent laparotomy.

Level C recommendations. None specified.

- Similar writing for Q1-Q4
- Likely 3-4? Does not specify Level of supporing evidence (I/II/III/X), or confidence in evidence estimate

Standard 10: Rec Articulation

10. Specific and Unambiguous Articulation of Recommendations

Reference IOM Standard

Recommendations should be articulated in a standardized form detailing precisely what the recommended action is and under what circumstances it should be performed.

Please rate on this criterion:

The recommendations are specific and unambiguous, stating what action should or should not be taken in what situations and for what population groups. Where the CPG recommendations are intentionally vague or underspecified, the CPG clearly describes the rationale behind those recommendations.

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard expects that a CPG's recommendations are clear, concrete, and precise to facilitate its implementation. The recommendations should not be vague or open to interpretation, but instead they should say directly what action should or should not be taken in what situations and for what population groups.

The CPG's recommendations should provide a concrete and precise description of (1) what is being recommended, (2) for whom, and (3) under which circumstances. The CPG should give a clear rationa for any intentional vagueness or under-specification.

Standard 10: ACEP BAT CPG

3. In a clinically stable patient with isolated blunt abdominal trauma, is it safe to discharge the patient after a negative abdominal CT scan result?

Level A recommendations. None specified.

Level B recommendations. Clinically stable patients with isolated blunt abdominal trauma can be safely discharged after a negative result for abdominal CT with IV contrast (with or without oral contrast).

Level C recommendations. Further observation, close follow-up, and/or imaging may be warranted in select patients based on clinical judgment.

- "Can, may" is softer language; not as prescriptive as "should/should not"
- Likely 3-4?

Standard 11: External Review

11. External Review

Reference IOM Standard

External reviewers should comprise a full spectrum of relevant stakeholders, including scientific and clinical experts, organizations (e.g., health care, specialty societies), agencies (e.g., federal government), patients, and representatives of the public.

Please rate on this criterion:

The guideline has been reviewed by relevant stakeholders, including scientific and clinical experts, organizations, agencies, and patients.

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard expects that reviewers who were not involved in the guideline's development review it before publication so that the GDG can ensure "the balance, comprehensiveness, and quality" of the guideline. Reviewers can include experts in the clinical area, methodologists, and members of the public. The CPG or supporting documents should describe an external review process by specific relevant stakeholders who are outside the guideline development process and organization. This can include scientific and clinical experts, health care specialty societies, public sector agencies, and patients. Stakeholders should be named or types of stakeholders described, and the process of external review should be described.

Standard 11: ACEP BAT CPG

- Pg 2
- Not clear if various organizations participated before or after CPG development
- **NO PATIENTS/FAMILY/CAREGIVERS**
- Likely 3-4?

The reasons for developing clinical policies in emergency medicine and the approaches used in their development have been enumerated.[5] This policy is a product of the ACEP clinical policy development process, including expert review, and is based on the existing literature; when literature was not available, consensus of emergency physicians was used. Expert review comments were received from individual physicians in the fields of emergency medicine, surgery, and radiology and from individual members of the American College of Surgeons Committee on Trauma, the Society for Academic Emergency Medicine, ACEP's Emergency Medical Services Committee, ACEP's Emergency Ultrasound Section, ACEP's Quality and Performance Committee, and ACEP's Trauma and Injury Prevention Section. Their responses were used to further refine and enhance this policy; however, their responses do not imply endorsement of this clinical policy. Clinical policies are

Standard 12: Updating

12. Updating

Reference IOM Standard
The CPG publication date, date of pertinent systematic evidence review, and proposed date for future CPG review should be documented in the CPG.
Please rate on this criterion: **The CPG describes a procedure to update the guideline.**

Please review the description and guidance below and then choose one option:

Lowest Adherence				Highest Adherence
1	2	3	4	5
○	○	○	○	○

Description

This standard expects that the developers have a process in place to keep the guideline current. The CPG or supporting documents should provide a timeframe for review and updating AND should describe the process by which a decision is made to update and how the update will be conducted. These items do not need to be specific to the guideline.

Standard 12: ACEP BAT CPG

and enhance this policy; however, their responses do not imply endorsement of this clinical policy. Clinical policies are scheduled for revision every 3 years; however, interim reviews are conducted when technology or the practice environment changes significantly. ACEP is the funding source for this clinical policy.

- Pg 2
- Scheduled for revision - Did it happen?!?
- Concept of "Living Guidelines"
- Likely 3-4? Statement of intent, but no pre-planned schedule, explicit mechanism for early revisions

Thank You!!