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| Project: C. Diff Penn Pathway | Final | Comments |
| Date: 31 Jan 2019 |  |  |
| Recommendations |  |  |
| D1: Pathway Inclusion: Begin C. diff pathway if inpatient, positive C. diff test AND clinical signs/symptoms consistent with CDI |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * Three conditions, clinical signs/symptoms needs clarification * Which C. diff test (any?) * Helpful to clarify if positive C diff test is only serology; also helpful to list main clinical signs/symptoms might want to define clinical signs and symptoms of CDI Clinical signs/symptoms could be interpreted differently by different providers. Could also interpret positive test differently, given some patients are positive by EIA, and some by PCR. * Some might hesitate to start as other causes are ruled out, especially if the patient has stabilized before beginning treatment Would be helpful to give guidance on clinical signs/symptoms; or when this doesn’t apply. what are clinical signs/symptoms? |
| 13) Are all reasonable combinations of conditions addressed? | NA | * Handling of positives tests and negative symptoms needs to be done. * There is a separate pathway for diagnosing C. Diff. |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * this should be done- do not treat colonized patients |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | yes | * Does ICU and Inpatient treat differently inpatient vs outpatient vs ER setting * 'Inpatient' is not defined. What about bedded outpatients (obs) patients, ER patients (technically outpatients, some facing long periods of boarding waiting for rooms). * I think the ER desperately needs to use a guideline-based therapy but as worded they would not be included, and inpatient therapy tends to follow what the ER starts. |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * clinical signs/symptoms will need to be rephrased to make completely computable * Unclear if clinical signs and symptoms are available in structured format might want to define clinical signs and symptoms of CDI * In particular + C. diff assays from our referring institutions will be missed, as will preceding days of CDI therapy outside our system. * Patients on extended vancomycin for CDI diagnosed outside of MUSC will need this continued at inpatient hospitalization, and their diarrhea may be long-resolved yet with a legitimate reason for continued therapy. |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * might want to define clinical signs and symptoms of CDI Clinical signs/symptoms not specific * Signs and symptoms need to be much more explicit. * Providers should be prompted to consider toxic megacolon, acute abdomen, and abrupt cessation of prior diarrhea as potential presentations of fulminant CDI |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| D2: Pathway Inclusion: Begin C. diff pathway if inpatient and high clinical suspicion (e.g. fever, high white blood cell count, >= 3 documented liquid stools in 24 hours) |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * Would be better if it said high clinical suspicion- defined as either Fever, OR elevated wbc OR >= 3 liquid stools. * I think that this is intended to target patients who have not yet had the test sent or resulted but who should potentially be empirically started on treatment, but that is not clear here. Also having a high clinical suspicion is very subjective and while there is some detail, it is not clear if these are the only indicators for high clinical suspicion. high clinical suspicion is ambiguous with eg The criteria given might result in half of hospitalized ICU patients getting on the pathway. |
| 13) Are all reasonable combinations of conditions addressed? | NA |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | NA |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * Liquid stool may be normal for some patients. * Patients with no Leukocytosis. * Patients with AML/ALL this is about inclusion criteria |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * Not sure realistic to identify patients for whom there might be a clinical suspicion of C. diff without a positive test. But if this were possible, could track beginning the pathway in Dorsata. way to measure beginning? * not possible to know if a provider used a pathway for a patient |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * All listed examples of high clinical suspicion are there, but are there others (e.g.) Unsure about Liquid stools (unless the same as diarrhea) * Documentation of liquid stools not consistent in chart and can be hard to find Diarrhea/stool frequency is very poorly documented in our EHR |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * Again, unsure about liquid stools * May be challenging given clinical suspicion is somewhat subjective, but seems possible. definition for high WBC definition of fever * Fever and leukocytosis need to be defined. These are extremely non-specific signs of CDI, and I would consider them as triggers for empiric therapy ONLY if there were other epi features putting the patient at high risk for CDI (age >65, previous abx use in 90 days, previous inpatient stay in prior 90 days, history of prior CDI diagnosis in prior 90 days, use of PO extended PO vancomycin in prior 90 days etc.). Allowance for leukopenia (particularly in BMT populations) as a cardinal sign of CDI should also be considered |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O1: Stop Antibiotics: When starting the C. diff pathway if possible STOP precipitating antibiotic(s). Discontinue therapy with inciting antibiotic agent(s) as soon as possible, as this may influence the risk of CDI recurrence. |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | no | * what is '˜ASAP'˜ '˜Inciting antibiotics'˜ -- would there be particular antibiotics someone would be on that you would definitely not blame? * If a patient is on multiple non-C. diff antibiotics, it may be confusing to know what is the highest risk/the '˜precipitating'˜ antibiotic. if possible ambiguous |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * Could be helpful to clarify "if possible" * Different providers might interpret "if possible" in different ways. Also, might interpret "precipitating" antibiotic differently. * COULD GET LIST OF ANTIBIOTICS TO TRIGGER THE THOUGHT |
| 13) Are all reasonable combinations of conditions addressed? | NA |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * The "if possible" suggests that for some patients it will not be possible. settings where it may not be possible to stop |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | yes | * ID consult may be indicated where uncertainty about antibiotic prescribing exists |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * Would be challenging to measure how often non-C. diff antibiotics should be stopped compared to how often they are stopped, given subjectivity in assessment of how necessary they are. * But would be able to review orders in C. diff patients to see if antibiotics were discontinued. * adherence threshold would be <100% |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | yes |  |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * See above concerns about "if possible" * Also, "as soon as possible" not clear * The condition "if possible" is a more subjective condition but the electronic health record could be utilized to present current antibiotic orders if possible definition * The "if possible" is a universe of issues best sorted out on a case-by-case basis. |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O2: Stop laxatives: When starting the C. diff pathway if possible STOP laxatives |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | no | * what denotes possible "If possible" unclear what would make it impossible? criteria? |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes | * remove if possible. * Add statement on not for bowel regimen. |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * criteria as previous for when possible and not |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes | * Would just need a marker for '˜not possible'˜ BPA would work well. |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | yes |  |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * Again, unsure about "if possible" previous- define possible |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O3: Avoid anti-peristaltic age: When starting the C. diff pathway avoid anti-peristaltic agents |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | no | * Avoid new or stop current and don’t order more? * Although would be clearer to state, "do not prescribe anti-peristaltic agents" I think it is clear to not start new anti-peristaltic agents, but does this also mean to stop them if they are already started? * avoid= minimize? stop? do not start? |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes | * COULD REWORD AND ADD AVOID ANTI-PARYSTOLTIC AGENTS THROUGH COURSE OR Stop current anti-peristaltic |
| 13) Are all reasonable combinations of conditions addressed? | no | * what about after starting after therapy has begun |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | NA |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | no |  |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | yes |  |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * Not sure that the audience is going to know what "anti-peristaltic agents" is. * It will not be clear to the audience what "when starting" is. The first 5 days? The first week? * There is decent evidence that loperamide use is safe in CDI once therapy is well-underway. * how to know when pathway is started |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes | * Revised wording improved |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| D3: Dx Recurrent CDI: Does the current CDI episode meet criteria for recurrent CDI as defined by positive C. diff test with recurrent symptoms attributable to CDI within 8 weeks of successfully completing treatment for previous CDI that was associated with interval improvement. |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | no | * No action recommended asks a question need to provide definitions for recurrent symptoms * CAN BE RESOLVED WITH WORD CHANGE |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | no | * No action recommended no action, but does define an action one might take (e.g. initiate recurrent CDI treatment) * should include info about s/sx of CDI and date of last episode of CDI. * Would be helpful to clarify '˜recurrent symptoms attributable to CDI'˜; also -- what is the action one the user should take? |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes | * add in statement about without alternative etiology for diarrheal illness. * PCR can stay positive after resolution of illness. * Point to C. diff Testing Pathway. |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | no | * need all to qualify missing AND for successful treatment AND interval improvement |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * what about underlying GI illness that does not correlate with improvement? * How is improvement defined |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * No action recommended here. * Could potentially assess how providers interpret the recurrent CDI definition in a sample patient population to assess reliability measurement difficult to measure adherence * No clear action suggested. |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | no | * Process Rec No action recommended here. * But could potentially measure clinical outcomes in patients with recurrent CDI. * Could also look at appropriate treatment as a process measure in recurrent CDI. not documented anywhere |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * Prior episodes of CDI diagnosed elsewhere not always electronically available. * Some data will be in the local MUSC lab record, but as a tertiary center much will be at outlying institutions or local commercial labs * no criteria for improvement should define s/sx for providers * Prior diagnosis of CDI is available, but doubt that "Interval improvement" is coded |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * What if this time there is fever and last time it was abd pain with stools? * Not sure - "recurrent symptoms attributable to CDI" and "interval improvement" may not be specific enough for electronic implementation. * see above, improvement criteria should define s/sx * Prior diagnosis of CDI is available, but doubt that "Interval improvement" is coded |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | no | * No action recommended * As above would split this up and clarify. * First question is has the patient ever had CDI before? * If yes, was it more than 8 weeks ago? 12 weeks ago? * If yes, these people can be split into those with a remote h/o of CDI vs those who have been treated with a continuous string of CDI episodes by asking questions about therapy. see above, improvement criteria * Again, no clear action associated here. |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | no | * No action recommended question rather than an action |
| D4: Dx Refractory CDI: Does the current CDI episode appear to be refractory CDI as defined by lack of symptomatic improvement to appropriate prescribed treatment for CDI. |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | no | * No action recommended no action need to provide definitions for recurrent symptoms Unclear what the '˜action'˜ to do is * CAN BE RESOLVED WITH WORD CHANGE |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | no | * No action recommended how long should treatment occur without improvement? * should include info about s/sx of CDI and date of last episode of CDI. Unclear what the '˜action'˜ to do is |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * Lack of symptomatic improvement could be interpreted differently - both regarding how to define improvement and over what time period. * This is also confusing about whether it refers to improvement in the current episode or the prior episode what is improvement! lack of improvement is defined as 5 days * WOULD CONSIDER MOVING ON PATHWAY |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * symptomatic improvement is subjective see prior comments - immunosuppression, acid suppression, other GI illnesses |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * refractory CDI is not an ICD code No action recommended here. * Could potentially assess how providers interpret the refractory CDI definition in a sample patient population to assess reliability measurement * No recommended action difficult to measure adherence * Because no action stated |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | no | * Process Rec * No action recommended here. But could potentially measure clinical outcomes in patients with refractory CDI. * not documented anywhere * Because no action stated |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * May need to ask patient additional information about their history, but generally, yes, should be available symptom improvement defined * Suspect no code for "lack of symptomatic improvement" |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * Refractory CDI may be difficult to define specifically enough for electronic implementation * refractory and recurrent? * should define s/sx for providers * Suspect no code for "lack of symptomatic improvement" |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | no | * No ICD -10 i believe * No action appears to result from this question. * The very existence of "refractory" CDI is debatable. * If a patient is not improved after 7 days of PO vancomycin (absent surgical complications), almost all of these patients have an alternative cause of diarrhea. * no recommendation offered * Unclear what action is |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | no | * no recommendation Unclear what action is |
| C1: Manage of Refract. CDI: If refractory CDI is suspected consider alternative causes for infection |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | no | * some examples of alternative Dx would be nice. * consider as the what is a bit ambiguous * recommend including definition for refractory * I think most people would understand that they are supposed to consider the differential |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | no | * Not sure - no suggestions about what alternatives to consider. Also note that it says "alternative causes for infection," when it might not necessarily be an infection causing the appearance of refractory CDI (eg inflammatory bowel disease) * Would define as failure of CDI therapy to effect improvement within 7 days what does that evaluation entail? * only other infectious etiologies? * add who to consult * Unclear what criteria for refractory CDI are |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * Refractory CDI interpretation may vary. * See D4 Unclear definition of "refractory" unclear definition of suspected |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * Specific populations like IBD, microscopic colitis, patients with known IBS are probably worth mentioning here. Of note, these are alternative causes "of diarrhea" not "for infection" which needs to be re-worded in C1 to be valid * what about noninfectious etiologies? * what about noncompliance? * other reasons for treatment failure? * I suppose these are implied by the "alternate causes of infection" |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | no | * no way to test considerations |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * Can’t measure consideration directly, possibly look at unrelated lab/test workups? * Difficult to measure adherence to this given there is no clear action related to it * consider is difficult to measure * difficult to measure adherence * Not enough detail to know |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | no | * No clear baseline, * possibly consider patients with refractory CDI ultimately found to have unrelated Dx but what if it is just refractory. * Difficult to measure outcome to this given there is no clear action related to it what the evaluation entails is unclear not documented anywhere |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * cannot easily encode, no ICD * Not sure what data would be necessary here refractory definition * Presumably clinical information necessary to assess if refractory CDI is present in chart |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * cannot easily encode, no ICD * Probably not - same issues as in D4 with defining refractory CDI using electronic health record data * refractory definition * Unclear definition of refractory, |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | no | * cannot encode * Potentially - the only action is to "consider," so perhaps more difficult to implement electronically * It would be helpful here to show the ordering provider an electronically-abstracted list of alternative diagnoses that could be considered, particularly recent enteral feeding initiation, promotility drugs, laxative administration in the last 4-5 days etc. what tests, what orders should be enacted? * Unclear how to consider alternative causes |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | no | * how should you consider orders or additional guidance displays? assumed via order entry |
| R1: Manage of Refract. CDI: If refractory CDI is suspected consult infectious disease |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * Same issues as in D4 with subjectivity in defining refractory CDI * define refractory * Refractory not defined define suspected |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | no |  |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | yes | * if ID consult not available? |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes | * if can determine refractory CDI |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * no code for refractory CDI, otherwise yes * Can measure ID consults placed, but same issues with identifying a refractory CDI population for whom the consult should be called because of subjectivity in defining refractory CDI * difficult to measure adherence. * would need to be documented in the EHR * define refractory * (Presuming you know which patients could be refractory) |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | no | * no code for refractory CDI, otherwise yes * Yes, if can solve 22 * difficult to measure adherence. * would need to be documented in the EHR |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * no code for refractory CDI, otherwise yes * Not sure that information about refractory CDI would be entirely obtainable from electronic health record * refractory definition * This clinical information is present the EHR, although doubt there is a specific code for refractory. |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * no code for refractory CDI, otherwise yes * Same as above I would define this as CDI with symptoms that are not improved by the 7th day of therapy. * not documented in a discrete field in the EMR * see above- refractory definition * Doubt there is a code for "refractory" |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| L1: Evaluation, first Episode: If first (i.e. non-recurrent or refractory) CDI obtain OR ensure has obtained within the last 24 hours CBC and BMP |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * Same concerns as in previous questions about interpreting recurrent and refractory * I suspect it would not be clear what refractory means... * define nonrecurrent and refractory * MOVE Dx Tests to EARLIER on pathways to account for all CDI |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | no |  |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes | * if can determine first CDI |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | no | * no outcomes associated with this |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | yes |  |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | yes |  |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes | * Caveat: Inpatient orders for CBC do exist, but what you mean here is an order for CBC/differential to look for L shift and bandemia. Also, serum albumin is critical for assessing CDI severity in several validated scoring criteria and should be recommended. |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| D5: Dx CDI Severity Non-Severe: Diagnose patient presenting with non-recurrent or refractory CDI as "CDI, non- severe" if WBC<15,000 cells/mL AND Cr <1.5 mg/dl |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * History of CKD or WBC>15 at baseline? * leukopenia or neutropenia in WBC<4k creatinine <1.5 but significant AKI (eg from 0.5 baseline to 1.4) |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * Only If severity of CDI is documentable * Potentially but would need to specify where to document the DX * define recurrent/refractory |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | no | * process rec * if the dx is documented * diagnose not associated with outcome without an action |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | yes |  |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | yes |  |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | no | * may be overly granular * No clear action to be executed here * need to decide how this will be addressed in the EMR - notes? field? problem list? * diagnose via what mechanism in an EMR |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | no | * No clear action to be executed here * need to decide how this will be addressed in the EMR - notes? field? problem list? * Unclear what diagnose looks like in the EHR diagnose - add to problem list? take to pathway? |
| D6: Dx CDI Severity Severe: Diagnose patient presenting with non-recurrent or refractory CDI as "CDI, severe" if WBC>=15,000 cells/mL or Cr >=1.5 mg/dl |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | yes |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * fulminant leukopenic AKI |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * not sure severity of CDI is documentable but would need to specify where to document the DX * define recurrent/refractory |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | yes |  |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | yes |  |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | no | * see previous notes * No clear action to be executed here * need to decide how this will be addressed in the EMR - notes? field? problem list? diagnose with what action? |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | no | * No clear action to be executed here * need to decide how this will be addressed in the EMR - notes? field? problem list? what does diagnosis entail? |
| D7: Dx CDI Severity Fulminant: Diagnose patient presenting with non-recurrent or refractory CDI as "CDI, fulminant" if sepsis with acute organ dysfunction OR septic shock OR abdominal signs/symptoms (vomiting, distention) concerning for ileus, toxic megacolon |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes | * Point to sepsis |
| 13) Are all reasonable combinations of conditions addressed? | yes | * REWORD sepsis DUE TO CDI |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | yes |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * CDI precedes sepsis? non CDI causes of abdominal symptoms? |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * no ICD for fulminant? * Might be difficult to measure given subjectivity in determining some of the criteria but would need to specify where to document the DX define recurrent/refractory |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | no | * does recognition impact outcomes * If solved 22 * if the dx is documented * no intervention |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * abdominal signs/symptoms (vomiting, distention) concerning for ileus, toxic megacolon unlikely to be in electronic format * Some might need to be assessed through patient contact * define recurrent/refractory |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * need further definition of sepsis, * abdominal signs/symptoms (vomiting, distention) concerning for ileus, toxic megacolon unlikely to be in electronic format * Abdominal signs/symptoms concerning for ileus or toxic megacolon 00 not sure this is encoded (it involves a judgement regarding degree of vomiting/distention abdominal * signs/symptoms not discrete |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O4: Non-Fulminant CDI, off ABX: Treat with vancomycin, PO, 125 mg q6h for 10 days |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | no | * WHAT TO DO IF no PO/enteral access, vanco allergy (red man vs. anaphylaxis) |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | yes |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * What about Vanco Allergy * What about patients who cannot tolerate PO (perhaps for some other, unrelated condition) * vans allergy * no enteral access |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | yes |  |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | yes |  |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O5: Non-Fulminant CDI, on ABX: Treat with vancomycin, PO, 125 mg q6h for 10 days AND consider extending the treatment course for 7 days beyond the current course of treatment |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | no | * beyond the current course of treatment is ambiguous * which antibiotics to extend? * consider extending is vague * Unclear what the clinician should use to "consider" extending treatment-- based on clinical response, presumably? * MEANS THE CURRENT COURSE OF NON C. DIFF TREATMENT * Judgement call if on very narrow spectrum ABX * Could use mechanism in EPIC to group ABX |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes | * REWORDED - Non CDI Systemic Antibiotics |
| 13) Are all reasonable combinations of conditions addressed? | yes | * This is first CDI * Judgement calls for extending course for narrow ABX |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | no | * consider may/can (optional) or should (recommended) or must (required) |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * type of ABx and whether the patient can effectively come off it. * Also what about prophylactic ABx (Sickle Cell/VUR/other) * Does Abx include ALL antibiotics? (e.g. prophylactics like Bactrim) recurrent? |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * as consider is not measurable * See O4 * yes, but DX would need to be structured data * Unsure how you can measure if someone considered extending treatment * consider extension |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * duration of treatment with other Abx * See O4 * DX would need to be structured data. * Unclear which ABX should be extended * define fulminant |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * duration of treatment with other ABx * See O4 * Unclear which ABX should be extended * Doubt there is a code for "non-fulminant CDI" although possible to ask for CDI without sepsis etc. But again, not sure if vomiting or distention w/o concern for toxic megacolon or ileus can be coded |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | no | * duration, cumulative, of Vanco * Unclear which ABX should be extended * "Consider" is too vague |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes | * While technically feasible, this will be difficult to implement. |
| O6: Fulminant CDI: If diagnosed with fulminant CDI, start antibiotics empirically. |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | NA | * Antibiotics discussed in another recommendation |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | NA |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | NA |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * see later recommendations for divergent treatment with Fulminant CDI already positive CDI test? |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * no Dx for fulminant CDI * See O4 DX * would need to be structured data * define fulminant |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * See O4 * DX would need to be structured data * Unsure about abdominal symptoms concerning for ileus/toxic megacolon, which is part of definition of fulminant CDI |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes | * Defined elsewhere |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O7: Fulminant CDI: If diagnosed with fulminant CDI, AND no C. diff test positive during current illness order a C. diff test to confirm. |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | yes |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * ileus with no stool |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | no | * this is really just documentation. * If solve 22 yes, * if DX was documented as structured data will it change implication to treat? |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * no diagnosis of fulminant CDS available * DX would need to be structured data * Provided you can describe what fulminant is * define fulminant |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * DX would need to be structured data * Suspect no code for fulminant CDI * Would need to determine how to define "current illness" * define fulminant |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O8: Fulminant CDI: If diagnosed with fulminant CDI, abdominal x-ray or CT is recommended if abdominal signs/symptoms (vomiting, distention) concerning for ileus, toxic megacolon. |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes | * XR or CT is a judgement call, but most providers would be able to handle making this decision |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes | * However, could be improved with discussion of type of XR and CT with oral contrast and IV contrast if CR clearance can tolerate. |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | no | * Could be more clearly worded * Would be clearer if phrased: if fulminant CDI and abdominal symptoms concerning for ileus, toxic megacolon, then order abdominal X-ray or CT |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | no | * could be divergent strength between CT and XR |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | no |  |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | yes |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * S/Sx notoriously hard to elicit * See O4 * DX would need to be structured data * Define fulminant |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * See above * See O4 * DX would need to be structured data * Unclear " abdominal signs/symptoms (vomiting, distention) concerning for ileus, toxic megacolon" * no code for fulminant CDI |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | no | * Need more details on imaging modality options exact radiology test |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| R2: Fulminant CDI: If diagnosed with fulminant CDI, surgical and infectious disease consults are recommended |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes | * Yes, although wording could be clearer (e.g. consult surgery and infectious disease) |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | yes |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | no |  |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * But yes if we can isolate Fulminant CDI * Same as previous questions regarding fulminant CDI * yes, but DX would need to be structured data * define fulminant |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * fulminant CDI * See O4 * DX would need to be structured data No code for fulminant CDI * define fulminant |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * see above See O4 * As above |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O9: Fulminant CDI: If diagnosed with fulminant CDI, and NO significant abdominal findings (i.e. ileus, toxic megacolon, findings suggestive for risk of perforation) treat with vancomycin 500 mg PO/NG Q6h x14 days AND metronidazole 500 mg IV Q8H x 14 days |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes | * Just wondering if any qualifications for patients allergic to Vanco? |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * One thing not addressed is if a patient gets better very quickly - can this treatment course be varied? Do they have to get all 14 days of IV metronidazole? |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * issues with findings suggestive of risk of perforation * See previous yes, but DX would need to be structured data * define fulminant |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * see findings suggestive for risk of perforation * See O4. * "Significant abdominal findings" also could be a challenging patient population to identify for implementation. * DX and abdominal finding results would need to be structured data * define fulminant |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * See above * DX and abdominal finding results would need to be structured data * Doubt there is code for fulminant CDI; also, "findings suggestive for risk of perforation" should be clarified discrete elements for abdominal findings * define fulminant |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O10: Fulminant CDI: If diagnosed with fulminant CDI, and significant abdominal findings treat with vancomycin 500 mg PO/NG Q6h x14 days AND vancomycin retention enema 500 mg in 100 mL sterile water q6h x14 days AND metronidazole 500 mg IV Q8H x 14 days |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | yes |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * what if patient has ostomy, how to do enema? |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | yes | * should patients remain inpatient for the duration of IV metro? |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * issues with significant abdominal findings * See O9 * yes, but DX would need to be structured data * If you specify significant abdominal findings * significant abdominal findings is vague |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * fulminant CDI, and significant abdominal findings likely not available * See O9 * DX and abdominal findings would need to be structured data |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * significant abdominal findings insufficiently granular * See O9 * DX and abdominal findings would need to be structured data * Doubt code for fulminant CDI or significant abdominal findings * define fulminant CDI and significant abdominal findings |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| M1: Monitoring: If following CDI pathway and no improvement within 5 days consider alternative diagnosis and consult infectious disease |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes | * what alternative diagnoses - short list could be helpful |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * what is "no improvement" * "No improvement" could be interpreted variably, though most would likely interpret in fairly similar ways. * what constitutes no improvement? diarrhea alone, inflammatory markers alone? |
| 13) Are all reasonable combinations of conditions addressed? | no | * what about getting worse at 3 days? ADD or condition deteriorating |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | yes |  |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | NA |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * Sepsis, fulminant C. diff, immunosuppressed |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no | * should they be readmitted if improved initially but then worsened? |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * yes for consult, not really for consider, difficult to measure no improvement * Challenging to identify population with '˜no improvement'˜ * yes, but pathway would need to be structured data. i.e. field to select pathway what are alternative diagnoses? * Not as currently written |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | no | * Some providers might need additional knowledge about what alternative diagnoses to consider * what constitutes no improvement * what are alternative diagnoses to consider |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * Documentation of parameters of improvement (bowel movements, abdominal distension, etc.) not always available in electronic system * DX, pathway would need to be structured data |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * "no improvement" * See 27 above * what parameters constitute no improvement * what are alternative diagnoses * Unclear what code you would use for "no improvement" |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | no | * "consider alternative diagnosis" * Considering alternative diagnoses may not be amenable for specific electronic implementation * Consider alternative diagnosis unclear |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | no | * for "consider alternative diagnosis" * alternative diagnoses * Consider alternative diagnosis unclear |
| O11: First recurrence: If recurrent CDI AND first recurrence AND NOT refractory then treat with vancomycin 125 mg PO Q6H for 10 days (especially if previously treated with metronidazole) OR vancomycin tapered regimen (see pathway). |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | no | * “especially if previously treated with metronidazole” has issues with ambiguity * Vanco 10d or taper? * '˜especially if previously treated with metronidazole'˜ is unclear * '˜Vancomycin tapered pathway'˜ unclear, and how to choose between them |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | no | * issues with identification of refractory * See previous questions regarding challenges in interpreting recurrence and refractory DX and recurrence would need to be structured data * define recurrence and refractory * Would need clear definition of refractory |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | no | * split on metronidazole for decision. * Metro to VANC; VANC to VANC or VANC taper |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | no | * wiggle room not explained * optional treatment regimen |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * Vanco allergy * fulminant CDI * Prior treatment with metronidazole |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | no |  |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | no | * do they know how to write a taper * Deciding between the 10 days of vancomycin and vancomycin taper might require additional knowledge * define recurrent and refractory |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * issues with refractory, otherwise OK * See previous * DX, recurrence, refractory would need to be structured data |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * ICD allows for recurrence specified * See previous * DX, recurrence, refractory would need to be structured data * recurrent and refractory definitions * Unclear if code for refractory |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| O12: Multiple recurrence: If recurrent CDI AND not first recurrence AND NOT refractory, then treat with vancomycin taper (see pathway) |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes |  |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | no | * Vanco allergy * definition of refractory? Other combinations addressed elsewhere |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | no | * multiple and nots within the logic statement. Would rephrase as X AND NOT (Y or Z) double negatives refractory not defined It does make sense, but it is a bit confusing at first glance, especially saying '˜and not first recurrence'˜ rather than '˜and second or additional recurrence'˜ |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | yes |  |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | yes | * Vanco allergy * no enteral access * VANCO allergy or intolerance? what if patient has a Vanco allergy, or not PO? |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | yes | * cost considerations for PO Vanco compounding agreement with vancomycin taper as protocol? * cost consideration for treatment approach order set? |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes |  |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | no | * allowable variations not included in possible adherence * refractory CDI is unlikely to be able to be identified electronically * yes, but dx and occurrence would need to be structured data * See previous |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | no | * 1) Would need to teach clinicians to recognize refractory 2) Would need to teach people how to write a taper order. 3) would need to ensure clinicians knew that PO should be ordered. * should define refractory * refractory not clearly stated * no PO vs IV specified |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * recurrence difficult to ascertain and number * recurrence. refractory not clear * unlikely to be able to determine refractory * See previous * DX, recurrence, refractory would need to be structured data * Provided refractory definition |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * see above * See previous * DX, recurrence, refractory would need to be structured data * Unclear if code for "refractory" |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |
| R3: Multiple recurrence: If recurrent CDI AND not first recurrence AND NOT refractory consider infectious disease consult for fecal microbiota transplantation. |  |  |
| Executability |  |  |
| Question |  |  |
| 10) Is the recommended action (what to do) stated specifically and unambiguously? That is, would the intended audience execute the action in a consistent way? | yes | * Reword as consult infectious disease for consideration of FMT * NOT refractory * consider can be removed if in statement. |
| 11) Is sufficient detail provided or referenced (about how to do it) to allow the intended audience to perform the recommended action. | yes |  |
| Decidability |  |  |
| Question |  |  |
| 12) Would the guideline's intended audience consistently determine whether each condition in the recommendation has been satisfied? That is, is each and every condition described clearly enough so that reasonable practitioners would agree when the recommendation should be applied? | yes |  |
| 13) Are all reasonable combinations of conditions addressed? | yes |  |
| 14) If this recommendation contains more than one condition, is the logical relationship (ANDs and ORs) between conditions clear? | no | * would rephrase as recurrent with more than 1 recurrent CDI and CDI is not refractory to treatment * multiple 'AND NOT'˜ |
| Validity |  |  |
| Question |  |  |
| 15) Is the justification for the recommendation stated explicitly? | NA |  |
| 16) Is the quality of evidence that supports each recommendation stated explicitly? | NA |  |
| Flexibility |  |  |
| Question |  |  |
| 17) Is the strength of each recommendation stated explicitly? Note: Strength of recommendation reflects anticipated level of adherence and is different from quality of evidence (question 16). Potential statements to satisfy this criterion might include 'Strong recommendation', 'Standard', 'Clinical option', etc. | no | * believe that consider should = May * 'deontic' consider confers a weak recommendation but consideration of FMT is likely the more reasonable option than consideration for ID consult |
| 18) Does the recommendation specify patient characteristics (such as coincident drug therapy and common co-morbid conditions) that require or permit individualization? | no | * What about prior FMT therapy? * What about ongoing systemic antimicrobials that may make FMT ineffective? |
| 19) Does the recommendation specify practice characteristics (such as location and availability of support services) that require or permit modification? | yes | * Fecal microbiota transplantation may not be available everywhere * Is FMT available in the inpatient setting? At all entities? |
| Effect On Process Of Care |  |  |
| Question |  |  |
| 20) Can the recommendation be carried out without substantial disruption in current workflow? | yes |  |
| 21) Can the recommendation be pilot tested without substantial resource commitment? For example, buying and installing expensive equipment to comply with a recommendation is not easily reversible. | yes | * quick popup to say have you considered... |
| Measurability |  |  |
| Question |  |  |
| 22) Can adherence to this recommendation be measured? Measurement of adherence requires attention to both the actions performed and the circumstances under which the actions are performed. | yes |  |
| 23) Can outcomes of this recommendation be measured? Outcomes include such things as changes in health status, mortality, costs, and satisfaction. | yes |  |
| Novelty/Innovation |  |  |
| Question |  |  |
| 24) Can the recommendation be performed by the guideline's intended users without acquisition of new knowledge or skills? | yes |  |
| 25) Is the recommendation consistent with existing attitudes and beliefs of the guideline's intended audience? | yes |  |
| 26) Is the recommendation consistent with patient expectations? In general, patients expect their concerns to be taken seriously, benefits of interventions to exceed risks, and adverse outcomes to fall within an acceptable range. | yes |  |
| Computability |  |  |
| Question |  |  |
| 27) Are all patient data needed for this recommendation available electronically in the system in which it is to be implemented? | no | * cannot determine refractory, otherwise yes * may require some evidence of prior treatments/care episodes * See previous * DX, recurrence, refractory would need to be structured data |
| 28) Is each condition of the recommendation defined at a level of specificity suitable for electronic implementation? | no | * see above, i honestly think we could leave out refractory recurrence and refractory may be difficult to define * See previous * DX, recurrence, refractory would need to be structured data * Doubt code for refractory |
| 29) Is each recommended action defined at a level of specificity suitable for electronic implementation? | yes |  |
| 30) Is it clear by what means a recommended action can be executed in an electronic setting, e.g., creating a prescription, medical order, or referral, creating an electronic mail notification, or displaying a dialog box? | yes |  |