

## Definition

- As defined by the Institute of Medicine, **Clinical Practice Guidelines** are “statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.” Guidelines are one way of increasing implementation of evidence into practice. They can serve as a guide to best practices, a framework for clinical decision making, and a benchmark for evaluating performance.
- Guidelines benefit patients through promotion of better outcomes, fewer ineffective or unnecessary interventions, and greater consistency of care. Guidelines also promote creation of secondary implementation materials (pamphlets, videos, etc.) to further patient education and informed decision-making. Clinicians can use guidelines to make decisions based on best evidence, initiate quality improvement efforts, and support coverage for appropriate services.

## Purpose

Address a limited number of identified sentinel/significant disease processes or procedures using up to 18 “Key Action Statements,” followed by action statement profiles that rate the quality of evidence and strength of recommendation. Physicians use guidelines to optimize patient care. Payers use guidelines as a basis for policy.

## Level of Evidence

Highest level of evidence available based on systematic review of the literature. Ideally includes randomized trials, when available. Risk of bias is minimized through explicit and transparent methodology consistent with Institute of Medicine standards for trustworthy guidelines.

## Process to Create

Guidelines may be specialty-specific or multidisciplinary, developed with input from a wide array of medical specialties, nurses, consumers and other allied health professionals where appropriate. An explicit and transparent process is used to minimize biases, distortions, and conflict of interests. See the AAO-HNS Guideline Manual at: [http://bit.ly/CPG\\_Manual](http://bit.ly/CPG_Manual)

## Examples

- Sudden Hearing Loss
- Polysomnography for Sleep Disordered Breathing Prior to Tonsillectomy in Children
- Tonsillectomy in Children

*\*Disclaimers for all Guidance Documents are included. To view specific documents and the disclaimer, visit: <http://bit.ly/aaohnsCPGandCCS>*

## Review Cycle

Every 5 years or less if warranted by new evidence.



AMERICAN ACADEMY OF  
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HEAD AND NECK SURGERY

FOUNDATION

## Definition

- A **Clinical Consensus Statement (CCS)** reflects opinions synthesized from an organized group of experts into a written document. CCSs should reflect the expert views of a panel of individuals who are well-versed on the topic of interest while carefully examining and discussing the scientific data available. They are not to be confused with a formal evidence review and are not developed in accordance with clinical practice guidelines. Additionally, Consensus Statements are not intended as a legal documents or a primary source of detailed technical information.
- A Consensus Method (CM) is a formal process that allows information to be synthesized into the CCS for topics where evidence is insufficient to support formal guideline development. Furthermore, CMs allow the insights of appropriate experts to be solicited and may fill the gap for areas void of quality research evidence.

## Purpose

Physician use CCSs to improve patient care, reduce variations in practice, and minimize complications.

## Level of Evidence

Level of evidence will vary based on the quality and consistency of the supporting literature. Risk of bias is reduced through formal consensus processes, but is higher than that associated with guidelines.

## Process to Create

Clinical Consensus Statements are developed with input from primarily otolaryngologists, but may include other medical specialists, nurses, allied health professionals where appropriate. Three common methods for creating a CCS are: 1) The Delphi Method, 2) The Nominal Group Technique, and 3) The Consensus Development Conference. The AAO-HNS uses a modified Delphi Method and is in the process (March 2013) of finalizing an explicit development manual.

## Examples

- Tracheostomy Care
- CT Imaging Indications for Paranasal Sinus Disease
- Diagnosis and Management of Nasal Valve Compromise

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## Review Cycle

As Needed



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F O U N D A T I O N

## Definition

- **Clinical Indicators** define a basis of medical necessity for a range of procedures, thereby placing greater importance on the quality of the history, physical examination, and diagnostic tests. The justification (argument) is restricted to specific procedures and diagnoses described in the 2012 AMA CPT (Clinical Procedural Terminology) and ICD-9 (International Classification of Disease) code books. Also included are procedure-specific postoperative observations and outcome issues suggested for use by institutions and surgeons.
- The Patient Information sections contain information that can be shared with patients during surgical counseling or provided to a primary care practitioner so that they are aware of the procedures and can use the CI to explain to patients what they can expect when referred to a specialist. The CI intent is to help practitioners engage in the best practices, reduce errors, and improve value received as much as possible. CI's are suggestions, not rules, and are modified by users and the Academy when opportunities for improvement are discovered.

## Purpose

Physicians use CIs to serve as reasonable thresholds and indications for procedures, and to provide procedural information to primary care practitioners and/or patients. Payers use CIs as a basis for policy, especially determinations of medical necessity (which should not be based exclusively on the limited statements made in guidelines).

## Level of Evidence

Opinion; Consensus-based, incorporating best evidence from the medical literature plus any relevant systematic reviews, guidelines, or consensus statements. Risk of bias is higher than guidelines or consensus statements.

## Process to Create

Clinical Indicators for Otolaryngology -Head and Neck Surgery are generated from within AAO-HNS/F committees, in consultation with the Guideline Task Force. Clinical Indicators should be consistent with existing quality measures (guidelines and clinical consensus statements), when available, but extend beyond the limited advice in these measures to provide comprehensive situations in which a procedure would be appropriate and medically necessary.

## Examples

- Acoustic Neuroma Surgery
- Auditory Brainstem
- Mastoidectomy

## Review Cycle

Every 4 years.

\*Disclaimers for all Guidance Documents are included. To view specific documents and the disclaimer, visit: <http://bit.ly/ClinicalIndicators>



## Definition

A **Position Statement** is used to designate a statement, policy, or declaration of the American Academy of Otolaryngology—Head and Neck Surgery, and Foundation (AAO-HNS/F) on a particular topic or topics. Statements are created to formalize the AAO-HNS/F position on a clinical procedure or medical service with third party payers, for use in state and federal regulatory or advocacy efforts, or to clarify the AAO-HNS/F approval or disapproval of certain practices in medicine.

## Purpose

Used as a response to a payer payment action; to publicize our position to support a procedure for use in advocacy efforts with state and federal regulatory and federal policy or law; or to clarify the Academy's position on certain practices within the specialty.

## Level of Evidence

Based on an informal process of expert or committee consensus that draws upon best available evidence and quality products.

## Process to Create

Position statements are generated from within AAO-HNS/F committees. Once approved by the Academy or Foundation Board of Directors, they become policy and are added to the existing policy statement library.

## Examples

- Allergy
- Ambulatory Procedures
- Botulinum Toxin Treatment

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## Review Cycle

Every 4 years



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