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Letter to the Editor
The Journal of the American Medical Association

RE: 'Specialty Society Clinical Practice Guidelines: Time for Evolution or Revolution?'

To whom it may concern:

In their recently published Viewpoint on specialty society clinical practice guidelines (CPGs), Classen and Mermel call for CPGs that are practical, implementable, tied to outcomes assessment, and updated with suitable frequency.[1] We agree, and offer the Canadian Hypertension Education Program (CHEP) Recommendations as an example of the embodiment of these principles.

First published in 1999, the CHEP Recommendations are rigorously reviewed and evidence-based clinical practice guidelines, intended to inform primary care practitioners and allied health professionals, including the general public, in hypertension diagnosis and management (www.hypertension.ca/en/chep).[2] The Recommendations Task Force (RTF) is comprised of over 80 expert volunteers who dedicate their time to improving hypertension care. The CHEP process includes annual updates; search strategies guided by a Cochrane Collaboration trained librarian; a requirement for ≥70% consensus to adopt a proposed recommendation; open access publication; extensive implementation and knowledge translation by a separate committee; and outcomes assessment by a distinct Outcomes Research Task Force.[3]

Epidemiological surveillance and outcomes assessment is performed continuously and has demonstrated that The CHEP process' introduction was associated with increases in antihypertensive drug prescriptions, reductions in cardiovascular mortality, and decreases in

[1] Classen DC, Mermel LA. Specialty society clinical practice guidelines. JAMA 2015;314:871-872.
[2] Daskalopoulou SS, Rabi DM, Zarnke K, for the Canadian Hypertension Education Program. The 2015 Canadian Hypertension Education Program recommendations for blood pressure measurement, diagnosis, assessment of risk, prevention, and treatment of hypertension. Can J Cardiol 2015;31:549-568.
[3] McAlister FA. The Canadian Hypertension Education Program--a unique Canadian initiative. Can J Cardiol 2006;22:559-564.

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hospitalizations for cardiovascular disease.[4] Canada now has one of the highest rates of hypertension control globally, with 65% of hypertensive individuals controlled to target.[5]

Several mechanisms counter bias and potential or perceived conflicts of interest. RTF subgroups craft initial recommendations. These are then vetted by the Central Review Committee, comprised of members with epidemiological and methodological expertise and who are free of industry conflict. The process is supported by staff of and funded by Hypertension Canada, a non-profit organization established in 1979 with a professional membership of the nation's leading clinical and scientific experts. CHEP RTF members report potential conflicts annually; disclosures are published on Hypertension Canada's website and appended to the Recommendations manuscript. Needs-driven formation is key to the Recommendations' value and wide use: the RTF Chair meets annually with stakeholders and professional societies to determine future needs. In the forthcoming year, mechanisms will be implemented to receive ongoing feedback from patients and caregivers.

CHEP RTF leaders are often sought out to assist other countries in the establishment of similar national programs. Furthermore, CHEP has received national and international recognition for its achievements. We feel that the CHEP process is a model worthy of emulation and contains all of the foundational elements important for developing effective CPGs.

Sincerely,

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[4] Campbell NRC, Brant R, Johansen H, et al. Increases in antihypertensive prescriptions and reductions in cardiovascular events in Canada. Hypertension 2009;53:128-134.
[5] McAlister FA, Wilkins K, Joffres M, et al. Changes in the rates of awareness, treatment and control of hypertension in Canada over the past two decades. CMAJ 2011;183:1007-1013.