Canadian Task Force on Preventive Health Care

We're back!

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In 2010 the Canadian Task Force on Preventive Health Care (CTFPHC) was reconstituted through a funding agreement between the Public Health Agency of Canada (PHAC) and the Canadian Institutes of Health Research. Its mandate is to develop and disseminate clinical practice guidelines for primary and preventive care, based on systematic analysis of scientific evidence.

The CTFPHC (formerly the Canadian Task Force on the Periodic Health Examination) was originally established in 1976. The initial series of recommendations, the first of its kind, was published as a 61-page peer-reviewed paper in the *CMAJ* in 1979.[1] Subsequently, in 1994, the CTFPHC published 81 of its recommendations in a compilation called *The Canadian Guide to Clinical Preventive Health Care*.[2]

The CTFPHC has had an international reputation for providing outstanding guidance for practitioners using rigorous, high-quality methods. Its reports have been used by many agencies around the world, including the US Preventive Services Task Force (which developed its approach based on CTFPHC methods). Originally, funding was provided by a partnership between the federal and the provincial and territorial governments, but when funding expired in 2005, the CTFPHC was disbanded. Since then, the primary care community has been without a national preventive care guideline group, although many local and provincial organizations have partly filled the void.

Need for a national guideline group

Family physicians are inundated with guidelines of varying quality from many different groups, developed using differing methods and grading systems, and often making conflicting recommendations.[3,4] There is also increasing concern about the ties of guideline writers to those who might financially benefit from the recommendations.[5] While guidelines are useful educational tools, recommendations are often not implemented in practice for various reasons, limiting any potential to change practice.[6,7]

The CTFPHC aims to overcome many of these barriers. The recommendations focus on practical guidance for Canadian family physicians in typical practice contexts. In addition, an evidence-based knowledge translation strategy is included in the development process to facilitate implementation in primary care. Finally, the CTFPHC is partnering with other guideline groups to minimize the potential for conflicting messages and duplication of effort.

Members of the new CTFPHC

The CTFPHC comprises 14 members—7 are family physicians and the remainder are other medical specialists and allied health practitioners with interests in preventive care and methodology. Members must provide full disclosure of conflicts of interest and must recuse themselves from any decisions in which there is evidence of such a conflict. The primary care physicians are all in clinical practice and have skills in evidence appraisal and guideline development. All have experienced the challenges of applying multiple practice guidelines during daily patient care.

The CTFPHC is supported by the independent Evidence Review and Synthesis Centre at McMaster University, which conducts the evidence reviews, and the Task Force Office at the PHAC, which provides technical, administrative, and scientific support. The PHAC has no direct influence on topic selection or editorial control over recommendations.

Process of guideline development

The CTFPHC uses rigorous methods to assess evidence and guide preventive care. The current approach to guideline development takes advantage of improved technology and innovations in critical appraisal throughout the development process—from identifying priority topics to the strategy for knowledge translation and exchange.

Topic prioritization. The CTFPHC developed a list of topics in consultation with primary care physicians and potential partner organizations. A topic-prioritization working group asked members to rank the initial list independently, and then a final list was developed by consensus with the broader task force. The CTFPHC continues to solicit topic suggestions from primary care practitioners, partner organizations, and the public online (**www.canadiantaskforce.ca**). Prioritization takes into account burden of illness; potential effects on disease burden and morbidity, mortality, or quality of life; public or provider interest; variation in care delivery; sufficiency of the existing evidence; and development of new evidence in the field.

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Methodology. The CTFPHC uses a structured approach to assess evidence and provide guidance for preventive care in practice. The task force will develop de novo recommendations when other guidelines do not exist. When there are existing systematic reviews or guidelines from other groups such as the US Preventive Services Task Force, the CTFPHC will build on these by conducting relevant evidence updates. When recent evidence-based guidelines already exist, the CTFPHC will verify their quality with a system that assesses the content and development process of the guideline with tools such as AGREE II (Assessment of Guidelines Research and Evaluation)[8], and endorse or adapt the guidelines.

The CTFPHC uses a rigorous method for framing and developing the key questions and analytic framework of the review, as well as a new approach to assessing the quality of evidence and formulating the recommendations. The search protocol, the analytical framework, and the key questions are all sent to peer reviewers (including family physicians) to ensure that they capture the questions and outcomes that clinicians and patients see as important.

GRADE evidence summaries. To determine the quality of evidence and formulate recommendations, the CTFPHC uses the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology to enhance rigour and transparency.[9] The GRADE methodology has already been adopted by more than 50 organizations. While this system is new to most clinicians, the CTFPHC believes it is currently the best method for framing guideline recommendations and that it will ultimately provide better guidance for physicians and patients.

The GRADE approach assesses the quality of the evidence and the strength of the recommendation. Quality of evidence for important prespecified outcomes for patients—both desirable (benefits) and undesirable (harms)—is graded as high, moderate, low, or very low, and reflects its certainty. For example, if evidence is of high quality, further research is unlikely to change the estimate of effect; if evidence is of very low quality, the estimate of effect is very uncertain and could be changed by more research.

Previous CTFPHC recommendations have mainly taken into consideration reductions in morbidity or mortality for the disease or condition being prevented. The imperfect nature of prevention and screening means that often many more people are identified for further investigation or treatment than will actually benefit from it.[10] The harm caused by these false-positive results varies, but sometimes it is substantial (eg, being diagnosed with cancer and treated with surgery, radiotherapy, or chemotherapy).[11] The GRADE approach provides explicit guidance so that when doctors offer tests or preventive maneuvers, they are in a better position to inform patients about benefits and harms. This will result in people making different decisions based on personal attitudes and preferences in the context of the information they are given.

Recommendations are determined to be either strong or weak based on the balance between desirable and undesirable effects, the quality of evidence, and other important factors such as patient preferences and cost.[12]

Final recommendations will include ratings of the quality of evidence and the strength of the recommendations, presented using GRADE evidence summary tables (to show the magnitude of effect on each important outcome) and the GRADE quality rating (with notations to explain the rating). This process will often result in recommendations that are different from what practitioners are used to. For example, a screening test could be given a weak recommendation based on moderate-quality evidence, if the effect is small, or if patient preferences are especially likely to influence the decision to undergo screening (**Table 1**).[9]

Recommendations from the CTFPHC are guidelines and not prescriptions for managing patients—they will present factors that family physicians should consider when counseling patients about screening or preventive maneuvers. In the long term, patient participation in these decisions should improve satisfaction with care and perhaps enhance the uptake of beneficial services. Although these discussions might require more time from busy family doctors, they are important as people become more knowledgeable about health care choices.[13]

Contextual issues. Although the evidence supporting preventive care is derived from the worldwide scientific literature, the effects of these data for formulating and implementing recommendations for practice require consideration of the Canadian context. Factors that might be considered include effects on quality of life or psychological distress; sociodemographic, ethnic, and cultural factors (such as the increased risk of hypertension in South Asians[14] or the lower screening rates among First Nations people[15]); living in urban, rural, or remote environments[16]; multiple comorbidities[17]; and issues of equity and resource use. For each relevant contextual issue identified, a literature search is done as part of guideline development. As this type of evidence often is limited, qualitative in nature, or found in the gray literature, narrative summary is the only practical way to assess and present this evidence.

Once the synthesis review is complete, draft recommendations are produced by the topic working group and presented to the full committee for debate. The full review and recommendations are sent to external topic-specific expert peer reviewers (including family physicians) for feedback.

Knowledge transfer and exchange. An integrated knowledge translation strategy is incorporated into all guidelines, based on the Knowledge to Action framework.[18] Primary care practitioners are the main target for the guidelines, but other health care groups, policy makers, and the public

Table 1. Interpreting strong and weak recommendations using the GRADE method[9]

TARGET AUDIENCE	STRONG RECOMMENDATION*	WEAK RECOMMENDATION†
Patients or the public	We believe most people in this situation would want the recommended course of action and only a small number would not	We believe that most people in this situation would want the recommended course of action, but many would not; different choices are acceptable and clinicians should support patients and discuss values and preferences to reach decisions; decision aids might support people in reaching these decisions
Clinicians	The recommendation applies to most individuals; formal decision aids are not likely needed to help individuals make decisions consistent with their values and preferences	We recognize that different choices might be appropriate for individual patients; clinicians should support each patient in reaching a decision consistent with his or her values and preferences; decision aids might support individuals in reaching such decisions
Policy makers and developers of quality measures	The recommendation can be adopted as policy in most situations; adherence to this recommendation according to the guideline could be used as a quality criterion or performance indicator	Policy making will require substantial debate and involvement of various stakeholders. An appropriately documented decision-making process could be used as quality indicator

GRADE—Grading of Recommendations Assessment, Development and Evaluation.
*Strong recommendations are those for which we are confident that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation for) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation against).
†Weak recommendations are those for which the desirable effects probably outweigh the undesirable effects (weak recommendation for) or undesirable effects probably outweigh the desirable effects (weak recommendation against) but uncertainty exists. Weak recommendations result when the difference between desirable and undesirable effects is small, the quality of evidence is lower, or there is more variability in the values and preferences of individuals.

are engaged through an interactive website. The synthesis reviews and full guideline statements will be published in peer-reviewed journals. Summary statements will be published elsewhere and will be available on the CTFPHC website. In addition to academic publication, decision aids will be created to help clinicians and patients understand the issues for informed decision making. The knowledge translation strategy will involve development of point-of-care tools, which can be used in conjunction with electronic medical records, and use of social media to disseminate guidelines to health professionals and the public.

Performance measurement. The CTFPHC is extremely interested in how the guidelines perform in the real world of primary care, as well as their effects on policy makers and other organizations. Each guideline includes performance measurements that can assess the effectiveness of the guideline at these different levels. This evaluation will help improve the guidelines and monitor their effects.

The CTFPHC has developed partnerships with other preventive care organizations, based on the principles of excellence, credibility, and strategic links. These partnerships will ensure that guidance is maximally effective for improving the care of Canadians. Partners will be able to engage in guideline development and review, in dissemination and evaluation, or in an advisory capacity.

The way forward

The revitalized CTFPHC has sustainable funding and will strive to be the leading source of screening and prevention advice for primary care practitioners and all Canadians. Our first guideline in 2011 addressed breast cancer screening. Recommendations for type 2 diabetes, cervical cancer, hypertension, and depression will follow. We are also working on guidelines related to obesity in adults and children and are evaluating several recent guidelines for potential task force endorsement. The CTFPHC is back.

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Competing interests
None declared

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