

Appendix 1. Original source guideline, type of recommendation, level and grade of evidence, and corresponding references (as supplied by the authors)

Source Guideline	Type:	Recommendation	References
Obesity Canada	Body habitus	Height, weight and waist circumference should be measured and body mass index calculated for all adults. (Grade A, Level 3)	1–4
Obesity Canada	Body habitus	History and a general physical examination to exclude secondary (endocrine or syndrome-related) causes of obesity and obesity-related health risks and complications. (Grade A, Level 3)	1,2,5–8
Obesity Canada	Body habitus	Measuring body mass index (BMI; weight [kg] , height [m ²]) in all adults, and children and adolescents (aged 2 years and older). (Grade A, Level 3)	1–4
Obesity Canada	Body habitus	Screening for eating disorders, depression and psychiatric disorders, as appropriate. (Grade B, Level 3)	1,9–20
Obesity Canada	Body habitus	Additional investigations, such as liver enzyme tests, urinalysis and sleep studies (when appropriate), to screen for and exclude other common obesity-related health problems. (Grade B, Level 3)	1,21–23
CACR	Cardiac rehab	All cardiac rehabilitation patients should be asked at the intake assessment about current and recent levels of alcohol consumption. (Requisite)	24
CACR	Cardiac rehab	All cardiac rehabilitation patients should undergo screening for active and historical depression and anxiety at the time of the intake assessment. (Requisite)	24–30
CACR	Cardiac rehab	All cardiac rehabilitation patients should undergo screening for potential sleep disorders (Requisite)	24
CACR	Cardiac rehab	All patients entering cardiac rehabilitation programs should be asked about their smoking status (smoker, former smoker, never smoked, passive smoker) and this should be documented on their health record. (Requisite)	31
CACR	Cardiac rehab	All patients entering cardiac rehabilitation programs must have a medical assessment and undergo determination of their cardiometabolic fitness prior to the initiation of therapy. (Requisite)	32
CACR	Cardiac rehab	A directly supervised GXT is recommended as part of the initial cardiac rehabilitation assessment prior to the initiation of therapy. (Requisite)	32
CDA	Coronary artery disease	In the following individuals, in addition to CAD risk assessment, a baseline resting ECG should be performed in: all individuals > 40 years of age; all individuals with duration of diabetes > 15 years; all individuals (regardless of age) with hypertension, proteinuria, reduced pulses or vascular bruits; a repeat resting ECG should be performed every 2 years in people considered at high risk for CV events. (Grade D)	33
CDA	Diabetes	All individuals should be evaluated annually for type 2 diabetes risk on the basis of demographic and clinical criteria. (Grade D)	34
CDA	Diabetes	Screening for diabetes using an FPG should be performed every 3 years in individuals 40 years of age. More frequent and/or earlier testing with either a fasting plasma glucose test or a 2hPG in a 75-g OGTT should be considered in people with additional risk factors for diabetes. These risk factors include: first-degree relative with type 2 diabetes; member of high-risk population (e.g., people of Aboriginal, Hispanic, Asian, South Asian or African descent); history of IGT or IFG; presence of complications associated with diabetes; vascular disease (coronary, cerebrovascular or peripheral); history of gestational diabetes; mellitus; history of delivery of a macrosomic infant; hypertension; dyslipidemia; overweight; abdominal obesity; polycystic ovary syndrome; acanthosis nigricans; schizophrenia; and other risk factors (see CDA Guidelines) (Grade D)	34,35
CDA	Diabetes	Testing with a 2hPG in a 75-g OGTT should be undertaken in individuals with an FPG of 6.1 to 6.9 mmol/L in order to identify individuals with IGT or diabetes. (Grade D)	34,36
CDA	Diabetes	Testing with a 2hPG in a 75-g OGTT may be undertaken in individuals with an FPG of 5.6 to 6.0 mmol/L and ≥ 1 risk factors in order to identify individuals with IGT or diabetes. (Grade D)	34,36
Obesity Canada	Obesity	Fasting plasma glucose level and determining lipid profile (total cholesterol, triglycerides, LDL-C, HDL-C and TC:HDL-C ratio). (Grade A, Level 3)	1
CHEP	Hypertension	Blood pressure of all adults should be measured whenever it is appropriate by	37

		health care professionals using standardized techniques. (Grade D)	
CCS dyslipidemia	Lipid screening	Screening of the plasma lipid profile is recommended in adult men who are at least 40 years of age, and in women who are at least 50 years of age or postmenopausal (class I, level C).	38
CACR	Smoking cessation	All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. (Evidence Level A)	39–48
Stroke Network	Stroke rehabilitation	All people at risk of stroke should have their blood pressure measured at each health care encounter, but no less than once annually. (Evidence Level C)	49–52
Stroke Network	Stroke rehabilitation	People at risk of stroke and patients who have had a stroke should be assessed for vascular disease risk factors and lifestyle management issues (diet, sodium intake, exercise, weight, smoking and alcohol intake). They should receive information and counselling about possible strategies to modify their lifestyle and risk factors. (Evidence Level B)	49,51,53–55
2. DIAGNOSTIC			
CHEP	Hypertension	Routine laboratory tests that should be performed for the investigation of all patients with hypertension include: i) urinalysis; (Grade D) ii) blood chemistry (potassium, sodium, and creatinine) (Grade D); iii) fasting blood glucose (Grade D) ; iv) fasting serum total cholesterol and high density lipoprotein cholesterol, low density lipoprotein cholesterol and triglycerides (Grade D); and v) standard 12-lead electrocardiography.(Grade C)	37
CHEP	Hypertension	Patients with hypertension and evidence of heart failure should have an objective assessment of left ventricular ejection fraction, either by echocardiogram or nuclear imaging. (Grade D)	37
CHEP	Hypertension	The use of home blood pressure monitoring on a regular basis should be considered for patients with hypertension, particularly those with: a. diabetes mellitus (Grade D); b. chronic kidney disease (Grade C); c. suspected non-adherence (Grade D); d. demonstrated white coat effect (Grade C); and e. blood pressure controlled in the office but not at home (masked hypertension) (Grade C).	37
3. RISK STRATIFICATION			
CACR	Cardiac rehabilitation	All patients entering cardiac rehabilitation programs must have a medical assessment and undergo determination of their cardiometabolic fitness prior to the initiation of therapy. (Requisite)	32
CDA	Diabetes	Assessment for coronary artery disease risk should be performed periodically in people with diabetes and should include: CV history (dyspnea, chest discomfort); lifestyle (smoking, sedentary lifestyle, poor eating habits); duration of diabetes; sexual function history; abdominal obesity; lipid profile; blood pressure; reduced pulses or bruits; glycemic control; presence of retinopathy; estimated glomerular filtration rate and random albumin to creatinine ratio; periodic electrocardiograms as indicated. (Grade D)	56
CDA	Diabetes	The following individuals with diabetes should be considered at high risk for CV events: men age ≥ 45 years, women aged ≥ 50 years (Grade B, Level 2); men < 45 years and women < 50 years with ≥ 1 of the following (Grade D, Consensus): macrovascular disease (e.g., silent myocardial infarction or ischemia, evidence of peripheral arterial disease, carotid arterial disease or cerebrovascular disease); microvascular disease (especially nephropathy and retinopathy); multiple additional risk factors, especially with a family history of premature coronary or cerebrovascular disease in first-degree relative; extreme level of a single risk factor (e.g., LDL-C > 5.0 mmol/L, systolic BP > 180 mm Hg); duration of diabetes > 15 years with age > 30 years	56
4. TREATMENT TARGETS			
Stroke prevention	Alcohol consumption	Two or fewer standard drinks per day; and fewer than 14 drinks per week for men; and fewer than 9 drinks per week for women. (Evidence Level C)	49,52,57–62
CHEP	Body habitus	Maintenance of a healthy body weight (body mass index 18.5 to 24.9 kg/m ² , and waist circumference less than 102 cm for men and less than 88 cm for women) is recommended for nonhypertensive individuals to prevent hypertension (Grade C) and for hypertensive patients to reduce blood pressure (Grade B). All overweight hypertensive individuals should be advised to lose weight. (Grade B)	63
CDA	Body habitus	Adults with class III obesity (BMI ≥ 40.0 kg/m ²) or class II obesity (BMI 35.0 to 39.9 kg/m ²) with other comorbidities may be considered for bariatric surgery when other lifestyle interventions are inadequate in achieving weight goals. (Grade C, Level 3)	64,65
Obesity Canada	Body habitus	A nutritionally balanced diet (designed to reduce energy intake) should be combined with other supportive interventions to achieve a healthy body weight in overweight and obese people of all ages and to ensure the maintenance of growth in adolescents and youth. (Grade C, Level 4)	66–71
CDA	Diabetes	Glycemic targets must be individualized; however, therapy in most individuals	72–77

		with type 1 or type 2 diabetes should be targeted to achieve an $A_{1C} \leq 7.0\%$ in order to reduce the risk of microvascular (Grade A, Level 1A) and, in individuals with type 1 diabetes, macrovascular complications. (Grade C, Level 3)	
CDA	Diabetes	A target A_{1C} of $\leq 6.5\%$ may be considered in some patients with type 2 diabetes to further lower the risk of nephropathy (Grade A, Level 1A), but this must be balanced against the risk of hypoglycemia (Grade A, Level 1A) and increased mortality in patients who are at significantly elevated risk of cardiovascular disease. (Grade A, Level 1A)	72,76,77
5. HEALTH BEHAVIOUR INTERVENTIONS			
Stroke Network	Diet	In all adults High in fresh fruits, vegetables, low-fat dairy products, dietary and soluble fibre, whole grains and protein from plant sources and low in saturated fat, cholesterol and sodium, in accordance with Canada's Food Guide to Healthy Eating. (Evidence Level B)	49,52,55,57-61
CHEP	Diet	In hypertension For prevention and treatment of hypertension, a dietary sodium intake of 1500 mg (65 mmol) per day is recommended for adults age 50 years or less; 1300 mg (57 mmol) per day if age 51 to 70 years; and 1200 mg (52 mmol) per day if age greater than 70 years.	52
CDA	Diet	In diabetes Adults with diabetes should consume no more than 7% of total daily energy from saturated fats and should limit intake of trans fatty acids to a minimum. (Grade D, Consensus)	78
CACR	Diet	All patients should be asked about their dietary habits on a regular basis and this should be documented on their health record.	79
CHEP	Diet	Sodium: The recommended daily sodium intake from all sources is the adequate intake by age. For persons 9-50 years, the adequate intake is 1500 mg. Adequate intake decreases to 1300 mg for people 50-70 years and to 1200 mg for people > 70 years. A daily upper consumption limit of 2300 mg should not be exceeded by any age group. (Evidence Level B)	63,80
Obesity Canada	Diet	An optimal dietary plan for achieving healthy body weight and dietary counseling for adults should be developed with a qualified and experienced health professional (preferably a registered dietitian) together with the individual and family to meet their needs. (Grade B, Level 2)	66,81-83
Obesity Canada	Diet	A nutritionally balanced diet (designed to reduce energy intake) should be combined with other supportive interventions to achieve a healthy body weight in overweight and obese people of all ages. (Grade C, Level 4)	66
Obesity Canada	Diet	A high-protein or a low-fat diet (within acceptable macronutrient distribution ranges indicated in the Dietary Reference Intakes) is suggested as a reasonable short-term (6-12 months) treatment option for obese adults as part of a weight-loss program. (Grade B, Level 2)	66,85,86
Obesity Canada	Diet	Meal replacements may be considered as a component of an energy-reduced diet for selected adults interested in commencing a dietary weight-loss program. (Grade C, Level 2)	66,86,87
CCS Dyslipidemia	Dyslipidemia	Treatment target is based on the person's risk level. High risk: LDL-C < 2.0 mmol/L or 50% in LDL-C; alternate target: apoB < 0.80 g/L. Moderate risk: LDL-C < 2.0 mmol/L or 50% in LDL-C; alternate target: apoB < 0.80 g/L. Low risk: If LDL-C ≥ 5.0 mmol/L, reduce LDL-C $\geq 50\%$; apoB < 0.90 g/L.	38
CHEP	Hypertension	Antihypertensive therapy should be strongly considered if systolic blood pressure readings average 140 mm Hg or higher in the presence of macrovascular target organ damage. (Grade C for 140 mm Hg to 160 mm Hg; Grade A for higher than 160 mm Hg)	63
CHEP	Hypertension	For patients with nondiabetic chronic kidney disease, target blood pressure is < 130/80 mm Hg. (Grade C)	63
CHEP	Hypertension	People with diabetes mellitus should be treated to attain systolic blood pressures of less than 130 mm Hg (Grade C) and diastolic blood pressures of less than 80 mm Hg (Grade A). (These target blood pressure levels are the same as the blood pressure treatment thresholds.)	63
CHEP	Hypertension	Antihypertensive therapy should be strongly considered if diastolic blood pressure readings average 90 mm Hg or higher in the presence of macrovascular target organ damage or other independent cardiovascular risk factors. (Grade A)	63
Obesity Canada	Obesity	Adults with class III obesity (BMI ≥ 40.0) or class II obesity (BMI 35.0 to 39.9) with other comorbidities may be considered for bariatric surgery when other lifestyle interventions are inadequate in achieving weight goals. (Grade B,	88,89

		Level 2)	
Obesity Canada	Obesity	The initial weight loss goal in obese individuals should be 5% to 10% of baseline body weight. (No Grade or Level assigned)	90
Obesity Canada	Obesity	Primary care health professionals are encouraged to create a nonjudgmental atmosphere when discussing weight management. (Grade C, Level 4)	66
Obesity Canada	Obesity	Health care professionals are encouraged to consider the barriers people might have concerning obesity and its management. (Grade C, Level 4)	66
Obesity Canada	Obesity	A comprehensive healthy lifestyle intervention is recommended for overweight and obese people. (Grade A, Level 1)	66, 91–94
Obesity Canada	Obesity	All those considering initiating a vigorous exercise program are encouraged to consult their physician or health care team professionals. (Grade C, Level 4)	66
Obesity Canada	Obesity	Long-term, regular physical activity is suggested, which is associated with maintenance of body weight or a modest reduction in body weight for all overweight and obese people. (Grade B, Level 2)	67,95,96
Obesity Canada	Obesity	Physical activity and exercise should be sustainable and tailored to the individual. The total duration should be increased gradually to maximize the weight-loss benefits. (Grade A, Level 2)	97–99
CSEP	Physical activity	Adults aged 18–64 years and older adults 65 and over should accumulate 150 minutes/week of moderate intensity physical activity in periods of at least 10 minutes each. Greater amounts of activity and more vigorous activity provide additional benefits. (Grade A, Level 2)	100–104
CSEP	Physical activity	Engage in resistance activities on 2–4 days per week. (Grade A, Level 2)	100–106
CSEP	Physical activity	Engage in flexibility activities 4–7 days per week. (Grade A, Level 3)	100–106
CACR	Smoking cessation	All smokers should receive nonjudgmental, clear, and unambiguous advice to consider making a quit attempt using a clear, personalized message. (Requisite)	31,39
CACR	Smoking cessation	All physicians, nurses and other health care workers should strongly advise all patients who smoke to quit and provide brief advice. (Requisite)	31,39
CACR	Smoking cessation	All patients entering cardiac rehabilitation should be asked about their smoking status (smoker, former smoker, never smoked, passive smoker) and this should be documented on their health record. (Requisite)	31,39
CHEP	Stroke rehabilitation	Following the acute phase of a stroke, patients should have their blood pressure chronically controlled to a target of less than 140/90 mm Hg. (Grade C)	63
6. PHARMACOLOGIC THERAPY			
CDA	Diabetes	As beta blockers provide similar or enhanced survival benefit in patients with diabetes and MI compared to patients without diabetes, they should be prescribed and not withheld because of concern about the risks associated with hypoglycemia. (Grade D, consensus)	107
CDA	Diabetes	Unless contraindicated, metformin may be used in people with type 2 diabetes and heart failure. (Grade C, Level 3)	108–110
CCS Dyslipidemia	Dyslipidemia	LDL Therapies. Statin monotherapy is the initial treatment of choice in patients whose LDL level is elevated based on their level of CVD risk (moderate and high-risk patients LDL > 2.0 mmol/L or Apo-B > 0.80: (Class 1, Level A); low risk patients.	38
CCS Dyslipidemia	Dyslipidemia	HDL Therapies. No current pharmacological interventions for increasing HDL are available.	38
CCS Dyslipidemia	Dyslipidemia	Triglyceride therapies. In patients with extreme hypertriglyceridemia (>10.0 mmol/L), fibrates may prevent pancreatitis (Class IIB, Level C)	38,111
CCS Dyslipidemia	Dyslipidemia	Combination therapies. A minority of patients requiring pharmacological therapy will require combination therapy (cholestyramine, ezetimibe, niacin, fibrates) to achieve, or move closer to, LDL treatment targets. (No Grade or Level assigned)	38
CHEP	Hypertension	Initial therapy should consist of monotherapy with a thiazide diuretic (Grade A); a beta blocker (in patients younger than 60 years) (Grade B); an ACE inhibitor (in non-blacks) (Grade B); a long acting CCB (Grade B); or an ARB (Grade B). If there are adverse effects, another drug from this group should be substituted. Hypokalemia should be avoided in patients treated with thiazide diuretic monotherapy. (Grade C)	63
CHEP	Hypertension	Additional antihypertensive drugs should be used if target blood pressure levels are not achieved with standard dose monotherapy (Grade B). Add-on drugs should be chosen from first line choices (Grade D). Useful choices include a thiazide diuretic (Grade C) or CCB with an ACE inhibitor (Grade B), ARB or a beta blocker (Grade D). Caution should be exercised in combining a nondihydropyridine CCB and a beta blocker (Grade D). The combination of an ACE inhibitor and ARB is not recommended. (Grade A)	63
CHEP	Hypertension and chronic kidney disease	Thiazide diuretics are recommended as additive antihypertensive therapy. For patients with chronic kidney disease and volume overload, loop diuretics are an alternative. (Grade D)	63

CHEP	Hypertension & diabetes	For persons with diabetes and normal urinary albumin excretion and without chronic kidney disease, with BP \geq 130/80 mm Hg, despite lifestyle interventions: any of the following medications (listed in alphabetical order) is recommended, with special consideration to ACE inhibitors (Grade A for 55 and older; Grade B under 55) and ARBs (Grade A; Grade B) given their additional renal benefits; thiazide-like diuretic. If the above drugs are contraindicated or cannot be tolerated, a cardioselective beta blocker or non-DHP CCB can be substituted; additional antihypertensive drugs should be used if target BP levels are not achieved with standard-dose monotherapy. Add-on drugs should be chosen from the first-line choices listed above. (Grade A; Grade B)	63
CHEP	Hypertension & diabetes	Alpha-blockers are not recommended as first-line agents for the treatment of hypertension in persons with diabetes. (Grade A)	63
CHEP	Hypertension & heart disease	In patients with systolic dysfunction, an ARB is recommended if ACE inhibitors are not tolerated. (Grade A)	63
CHEP	Hypertension & heart disease	For hypertensive patients with heart failure whose blood pressure is not controlled, an ARB may be added to an ACE inhibitor and other antihypertensive drug treatment (Grade A). Careful monitoring should be used if combining an ACE inhibitor and an ARB due to potential adverse effects such as hypotension, hyperkalemia and worsening renal function (Grade C). Additional therapies may also include dihydropyridine CCBs. (Grade C)	63
CHEP	Hypertension & heart disease	An ACE inhibitor or ARB is recommended for most patients with hypertension and coronary artery disease. (Grade A)	63,112–116
CHEP	Hypertension & heart disease	In high-risk coronary artery disease patients, when combination therapy is being used, choices should be individualized. The combination of an ACE inhibitor and a dihydropyridine CCB is preferable to an ACE inhibitor and a diuretic in selected patients. (Grade A)	63,113–116
CHEP	Hypertension & heart disease	For patients with stable angina, beta-blockers are preferred as initial therapy (Grade B). CCBs may also be used. (Grade B)	63,112–116
CHEP	Hypertension & heart disease	For patients with recent myocardial infarction, initial therapy should include both a beta-blocker and an ACE inhibitor (Grade A). An ARB can be used if the patient is intolerant of an ACE inhibitor. (Grade A)	63,112–116
CHEP	Hypertension & stroke	For patients with stroke, the combination of an ACE inhibitor and ARB is not recommended. Treatment with an ACE inhibitor/diuretic combination is preferred. (Grade B)	63
Stroke Network	Atrial fibrillation & stroke	For the secondary prevention of stroke, patients with atrial fibrillation who have had a stroke/TIA should be treated with warfarin at a target international normalized ratio of 2.5, range 2.0 to 3.0, (target international normalized ratio of 3.0 for mechanical cardiac valves, range 2.5 to 3.5) if they are likely to be compliant with the required monitoring and are not at high risk for bleeding complications. (Grade A)	49,57–63,117–128
CHEP	Hypertension & stroke	Strong consideration should be given to the initiation of antihypertensive therapy after the acute phase of a stroke or transient ischemic attack.	63
CHEP	Stroke	Antiplatelet therapy: All patients with ischemic stroke or transient ischemic attack should be prescribed antiplatelet therapy for secondary prevention of recurrent stroke unless there is an indication for anticoagulation. (Level A)	49,51,57–61,117,118,123
CHEP	Stroke	ASA, combined ASA (25 mg) and extended-release dipyridamole (200 mg), or clopidogrel 75 mg are all appropriate options and selection should depend on the clinical circumstances. (Evidence Level A)	57–61,63,117,118,123
2hPG = 2-h postchallenge glycemia test, apoB = apolipoprotein B, BP = blood pressure, CACR = Canadian Association of Cardiac Rehabilitation, CAD = coronary artery disease, CCB = calcium channel blocker, CCS = Canadian Cardiovascular Society, CDA = Canadian Diabetes Association, CHEP = Canadian Hypertension Education Program, CSEP = Canadian Society for Exercise Physiology, CV = cardiovascular, DHP = dihydropyridine, ECG = electrocardiogram, FPG = fasting plasma glucose test, GXT = graded exercise test, HDL-C = high-density lipoprotein cholesterol, IGT = impaired glucose tolerance, IFG = impaired fasting glycemia, LDL-C = low-density lipoprotein cholesterol, MI = myocardial infarction, OGTT = oral glucose tolerance test, TC = total cholesterol.			

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