THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

CFPC Endorsement Criteria: Applicant Form

Section 1

Initial Criteria to Proceed to Review

Depending on responses for Section 1, some guidelines will not proceed to review and will not be endorsed.

1) Who funded the guideline?	

List here:

2) Explain clearly if there was funding from the health care/pharmaceutical industry	• Was there direct funding? • Was there indirect funding (for example, through a specialty society)? • What was funding for (travel, honorarium, meeting space/resources, etc.)?

Explain clearly:

3) Was funding of the guideline clearly reported in the guideline document?	**Yes (Can proceed)**	**No (Do not Proceed)**
If funding was reported in the guideline, please indicate where this is found in the document:		
4) Was there at least one family physician on the guideline committee?	**Yes (Can proceed)**	**No (Do not Proceed)**
Comment:		
5) Will the guideline, or at minimum a summary, knowledge translation or decision aid, be in both official languages?	**Yes (Can proceed)**	**No (Do not Proceed)**
Comment:		

6) Are there recommendations in this guideline that conflict with other national guidelines? If so, which recommendations and which other guidelines?

7) What other organizations have endorsed this guideline?

After completing Section 1, you may wish to submit to the CFPC to confirm if the guideline will proceed to full review. If verified, please complete Section 2.

Section 2

(Description of all criteria at the end of the document)

Relation to Family Medicine

1) Topic relevant to primary care family physicians (FP)	(High Importance)

Topic and questions relevant to FPs ☐ Moderately relevant ☐ Minimally relevant ☐

2) Guideline committee members with CCFP	(High Importance)

FPs > 30% ☐ FPs 15%–30% ☐ FPs < 15% ☐

3) Guideline committee members who are mainly primary care FP.	(High Importance)

Primary care FP > 25% ☐ FPs 10%–25% ☐ FPs < 10% ☐

4) Practical application in primary care (time and opportunity cost considered)	(High Importance)

Implementable in primary care ☐ Limited consideration ☐ Impractical to implement ☐

5) Guideline document size and primary care summary	(Moderate Importance)

Reasonable size +/- summary ☐

Large document with summary ☐ Large document without summary ☐

6) Recommendation language	(Moderate Importance)

Recommendation language adaptable and flexible ☐ Prescriptive/dogmatic language ☐

CFPC Values

7) Broad representation on guideline committee	(Moderate Importance)

Broad representation* on the Guideline Committee ☐ Mostly one group ☐

* Specialists, generalized specialists, pharmacists, NP/nurses, allied providers, methodologists, and patients

8) Social justice lens	(Moderate Importance)

Consistent with CFPC social justice lens ☐ Social justice concerns ☐

9) Financial conflicts of interest (COI)	(High Importance)

None ☐ Low (< 20% committee) and managed* ☐

Moderate (20%-49% committee) and managed* ☐ Serious COI (≥ 50% committee and/or chair) ☐

* Managed must be explained

10) Are any employees of the health care/ pharmaceutical industry on the guideline committee/membership	

No ☐ Yes, but non-voting ☐ Yes and voting ☐

11) Reputational risk of CFPC	(High Importance)

No risks or concerns for CFPC ☐ Possible concerns ☐ Clear risks or concerns ☐

Patient Engagement and Decision-Making

12) Presentation of information	(High Importance)

Benefits/harms in absolute values ☐ Benefits or harms in relative values ☐ None/surrogates ☐

13) Shared-informed decision-making content	(High Importance)

Content for shared decision making and graphics ☐ Minimal content ☐ None ☐

14) Consideration of financial costs to the system	(High Importance)

Consideration of financial costs to the system ☐ None ☐

15) Consideration of costs to patients	(High Importance)

Consideration of financial costs and inconvenience to patients ☐ None ☐

Scientific/Rigor

16) Development of clinical questions	(Moderate Importance)

Described multiple contributors, iterative process ☐ Not described or minimal process ☐

17) Evidence assessment	(High Importance)

Independent and full systematic review ☐ Independent or systematic review ☐ Neither ☐

18) GRADE or similar function	(Moderate Importance)

GRADE evaluation and recommendations match evidence ☐ Inconsistent ☐
No grade and recommendations don't match ☐

19) External peer review	(Moderate Importance)

Large and broad user-base external peer review ☐ None ☐

20) Issues not noted above	

Guide to Interpret Criteria

Overview: The following provides instructions on issues to consider when evaluating guidelines for endorsement by the CFPC. While it can't capture every potential concern for each guideline, it offers key elements that are relevant for consideration in family medicine.

Definitions: Health care/pharmaceutical industry includes but is not limited to pharmaceutical manufacturers, vaccine manufacturers, medical device manufacturers, imaging device or lab testing manufacturers, or manufacturers of tools/products used in the provision of health care.

Primary care family physicians for the purposes of this document, this refers to comprehensive primary care family physicians.

Section 1

1. Who funded the Guideline? Simply provide details of funding sources related to the guideline.
2. Explain clearly if there was funding from the health care pharmaceutical industry? The CFPC and the Guideline and KT Expert Working Group feel that industry funding is particularly important but not necessarily prohibitive. It requires clarity of how that funding was used. As it is not always clear, we request that indirect funding be explained as well.
3. Was funding of the guideline clearly reported in the guideline document? This is required because even if the guideline is endorsed, it is essential that any guideline reader/user be able to easily identify funding and judge for themselves the relevance of that funding.
4. Was there at least one family physician on the guideline committee? It is essential that at least one family physician had a role on the primary guideline committee. If not, the guideline will not be endorsed by the CFPC. As detailed later, guidelines that are highly relevant to family physicians, which family physicians provide the majority of the care, more family physicians are expected, including potential leadership role (see Section 2).
5. Will the guideline, or at minimum a summary, knowledge translation or decision aid, be in both official languages? CFPC is a national and bilingual organization. It is expected that at least key portions of the guideline will be available in both official languages.
6. Are there recommendations in this guideline that conflict with other national guidelines? If so, which recommendations and which other guidelines? It will help to be aware of potential conflicting recommendations. This may be particularly relevant

when recommendations conflict with key partners like the PEER (who create CFPC guidelines) or the Canadian Task Force on Preventive Health Care.

7. Which other organizations have already endorsed this guideline? Just helpful information for reviewers.

Section 2

Can Single Factors Disqualify a Guideline: It is possible but highly unlikely that any single factor would disqualify a guideline. Nor would one well done component obligate endorsement or support. The factors should be taken into consideration as a collection of important variables, contributing to an overall assessment.

1. **Topic Relevant to Family Physicians**: Primarily family physicians in primary care. Highly relevant are things we see every day or almost every day. Topics not relevant would be things not seen by most family physicians (example specific occupational medicine guides or in-hospital management of specific conditions).
2. **Family Physicians on Guideline Committee**: The average proportion of family physicians on guidelines is about 15%. However, they deliver about 65% of Canada's health care. We are looking for better family physician representation. For this section, we are after any family physicians (those with CFPC designation), including those who are comprehensive primary care clinicians and those with a focused practice (with or without added competency designation)
3. **Guideline committee members who are primarily primary care family physicians (FP)**: We appreciate the inclusion of family physicians with differing practice focuses on guidelines. However, to have relevance to the largest number of family physicians, we are hoping that guideline committees will include primary care family physicians. As stated above, they provide the majority of care in Canada and should be well represented to promote application to their practice and their patients.
4. **Consideration of practical applicability in primary care**: Primary care has many competing demands so a guideline recommending a great deal of screening, monitoring, follow-up, treatment discussions, and other care for one condition will inevitably detract from other care. Does the guideline recognize this and attempt to balance the benefit to patients with the opportunity costs? There should be indication that the guideline committee considered time demands and tried to find efficiencies/compromises where possible. Ideally, it might also include tools or EMR plug-ins/downloads for easier adoption.
5. **Guideline document size & primary care summary**: Family physicians are faced with an impossible task of keeping up with all published literature that is relevant to the care they provide. Research suggests that even in 2004 it was estimated family physicians would need 21 hours of reading a day to keep up but other research suggests they spend only two minutes to look up answers. Guideline writers should be

respectful of these challenges, ideally keep their guidelines brief and focused and/or providing a focused summary for improved access.

6. **Recommendation language**: Some guideline recommendations are dogmatic (e.g., All Family physicians should,…) or highly prescriptive. This language invites performance measures or can be too restrictive to accommodate the individual and variable nature of patient care (or the competing demands). Flexible, more respectful language like "we recommend" or "we suggest" is generally preferred (similar to that proposed by GRADE). One possible exception is the use of stronger language specifically to encourage high valued behaviour like shared decision-making, attaining consent of procedures, etc.
7. **Broad representation on guideline committee**: Health care is team-based, including the medical home. Guidelines should be representative of health care providers involved.
8. **Social justice lens**: Guidance that could negatively impact social justice (eroding the social determinants of health, disrespectful of diversity, etc) could disqualify endorsement. The following is link to CFPC Social Justice Lens statement (https://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/SJ_Lens_Final_Print.pdf)
9. **Conflicts of Interest (COI)**: Ideally, no guideline members would have COI with the Health Care Pharmaceutical or Medical Device Industry (HPI). If present, COI should be in only a few and mitigation should be described. If COI is present in more than a few members, mitigation is likely of limit impact. **Note, if ≥50% of the guideline committee members and/or the chair have financial COI with the health care pharmaceutical industry, CFPC endorsement is very much in jeopardy**. Also note of direct COI: When guideline recommendations could directly benefit employment or income of guideline authors this should also be considered here. (e.g., *J Clin Epidemiol*. 2012 Jul;65(7):725-33.).
10. **Are any employees of the health care pharmaceutical industry on the guideline committee/membership**: It is important to know if employees from the health care pharmaceutical industry were on the guideline and if so, how were potential conflicts of interest managed.
11. **Reputational risk of CFPC**: This may not be readily apparent within the guideline or its context but we would like you to reflect on any potential risk if the CFPC was to endorse the guideline (or not endorse it). It may require broad reflection and consideration of potential risks (including controversial topics/recommendations, polarized/opinionated groups, etc).
12. **Presentation of information**: Clinically important benefits/harms of interventions should be presented in absolute numbers (percent with the clinical outcome if we do something and percent if we do nothing). A secondary option is the presentation of relative numbers. Reporting changes in surrogates alone and/or the absence of numerical description of benefits/harms is inadequate.

13. **Shared-informed decision-making content**: Does the guideline promote shared informed decision-making, beyond token words? Preferably it would offer numbers and graphics for discussion with patients and provide patient education. For direction around evidence-based decision tool consider the reference: *Ann Intern Med*. 2014;161(4):270-280.

    (https://www.acpjournals.org/doi/10.7326/M14-0295?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed).
14. **Consideration of financial costs to the system**: A cost effective analysis is not required but recognition of costs to the public funded system is important. For example, advocacy for more testing, high-cost testing, more interventions and/or high-cost interventions needs to be considered.
15. **Consideration of costs to the patient**: Consideration to the costs of the patients is equally (or more important). Consider here at a minimum the financial costs of pharmaceuticals and non-covered services. Ideally, also consider secondary costs like parking, time-off work for medical visits, travel costs (particularly for rural patients), etc. This might also be seen as "inconvenience." Recognition of full cost/risks would even include consideration of risks of outside of the traditional harms (like screening harms and medication adverse event) like risk of driving to appointments.
16. **Development of clinical questions**: Ideally, questions should be developed and then selected through an iterative and blinded process to identify key questions relevant to practice. Otherwise, questions could come from single individuals, have academic bias, or other biases.
17. **Evidence assessment**: This should be done separately from the guideline (by different individuals) and as a systematic review.
18. **GRADE (Grading of Recommendations, Assessment, Development and Evaluation) or similar function**: GRADE evaluation (or similar) of the evidence and the guideline recommendations is a standard now. Ideally they should include a GRADE decision table to outline how GRADE was performed and the recommendations should be linked to (match) the GRADE evaluation and statements. For further details on GRADE see: https://www.gradeworkinggroup.org/
19. **External peer-review**: Guidelines should perform peer review from groups of potential users, subject matter experts and patients. That should be explained and ideally available for review.
20. **Issues not noted above**: Please indicate any issues you feel important but not noted already.