GUIDELINE FOR GUIDELINES:

Guidance for VA/DOD Clinical Practice Guideline Development

Department of Veterans Affairs
Washington, DC 20420

Department of Defense
Falls Church, VA 22402

Signatory Authority:
Evidence-Based Practice Work Group

Effective Date:
January 27, 2026

Responsible Owner:
Evidence-Based Practice Work Group

Recertification Date:
January 27, 2031

1. PURPOSE AND AUTHORITY

A. The purpose of this document is to establish guiding principles for the development of joint Department of Veterans Affairs (VA)/ Department of Defense (DOD) Clinical Practice Guidelines (CPG).

B. The DOD Clinical Quality Improvement, Office of Evidence-Based Practice (DOD CQI/OEBP) and the VA Office of Quality and Patient Safety, Evidence-Based Practice Program (VA QPS/EBPP) work collaboratively to develop evidence-based practice guidelines to be used within the VA and DOD. VA/DOD guideline development work is done under the auspices of the VA/DOD Evidence-Based Practice Working Group (EBPWG), a working group chartered by the VA/DOD Health Executive Committee (HEC) since 1998.

(1) The EBPWG: The EBPWG will actively collaborate to advise the HEC on the use of clinical and epidemiological evidence to improve the health of the population across the Veterans Health Administration (VHA) and the Military Health System. The EBPWG reports to the HEC through the Clinical Care Business Line (BL). The EBPWG is co-chaired by a VA and a DOD leader appointed by their respective VA or DOD BL Co-Leads.

(2) Health Executive Committee (HEC): The HEC is supported by a structure of Business Lines and Work Groups to encourage, support, and oversee VA and DOD sharing and collaboration efforts. The HEC is co-chaired by the Under Secretary for Health, VHA and Assistant Secretary of Defense, Health Affairs, DoD and reports to the Joint Executive Committee (JEC).

(3) The JEC is a VA-DOD interagency committee established by 38 U.S.C. § 320 in 2004, and is co-chaired by the Secretary VA and the Secretary of Defense for Personnel and Readiness

(USD(P&R)) to oversee health care coordination and sharing activities between both Departments.

2. PROCEDURES

A. Guideline Development and Approval Process:

(1) New Guideline Request:

a. A clinician or other group may request the development of a new VA/DOD guideline utilizing the following process:

i. An application may be submitted to VA/DOD EBPWG through the submitter's respective Veterans Affairs Central Office (VACO) or DOD chain of command, to include respective VA and DOD EBPWG Co-Chairs.

ii. At a minimum, the application will include:

i. A description of the guideline.

ii. Intended end users of the guideline.

iii. Perceived gaps in care and/or identify changes in practice to be driven by the guideline.

iv. Data substantiating the need for the guideline.

v. Responsible program office.

vi. Brief review of the literature, including a summary of existing guidelines.

vii. See Appendix A: Application Form.

b. The EBPWG may also suggest topics/areas for guideline development, particularly as they relate to the frequency of occurrence and uniqueness of the military and veteran populations or as mandated by Congress or public law (e.g. Suicide Prevention, Opiate CPGs).

B. Application review and approval:

(1) The EBPWG will review complete applications, vote to approve or disapprove the development of a new CPG, and prioritize it for development if it is approved.

(2) The respective VA or DOD Evidence-Based Program Office will acknowledge receipt of each application within five business days.

(3) The EBPWG may consider the following issues:

a. High incidence or prevalence.

b. Risk and cost of the disease or condition in the general veteran/military population or sub-populations targeted by Special Emphasis Programs.

c. Potential for reduction of clinically significant variations in the prevention, diagnosis, treatment, or clinical management of a disease or condition.

(4) EBPWG will review applications for approval during regularly scheduled meetings.

(5) The EBPWG Co-Chairs will notify the applicant of the outcome within five business days.

C. Guideline Review and Updates:

(1) The EBPWG will review the VA/DOD CPGs for update or archive every five years.

(2) The EBPWG may extend the CPG update renewal period if it is identified that no new evidence will impact CPG recommendations.

(3) The EBPWG makes the final determination on when CPGs are archived.

(4) The immediate update of guidelines will be triggered if any recommendation contained in a guideline is identified as harmful to patients (e.g., pharmaceutical or device recall, etc.).

(5) It is recognized that there may be areas of significant evidence advancement in between update periods. Guideline champions may bring focused update requests forward to the EBPWG at any time for consideration.

a. EBPWG considers the request for a focused update.

b. If approved, then convene a small WG consisting of the champions and 1-2 subject matter experts.

c. Focused evidence reviews (typically limited to Medline, Cochrane Library).

d. Results and recommendations from the focused review will be presented to the EBPWG for approval.

e. Once approved by EBPWG, results will be posted to the electronic version of the CPG as an addendum.

D. Work Group Composition:

(1) Identification of WG Clinical Champions and Members: When a topic has been approved for guideline development or update, designees of the DOD CQI/OEBP and the VA QPS/EBPP, will identify Clinical Champions, and CPG WG Members Representatives. Specifically, the DOD CQI/OEBP and VA QPS/EBPP representatives:

a. Will convene a group of not more than 20 WG members; ideally, ten from the VA and ten from the DOD, to evaluate the evidence and develop the guideline.

i. Potential WG members can be recommended by various stakeholders, but the DOD CQI/OEBP and the VA QPS/EBPP retain the final decision-making authority regarding WG member selection to ensure the composition of the WGs aligns with organizational goals, priorities, and requirements.

b. Will identify WG Champions:

i. Champions will be subject matter experts and leaders in the clinical topic who do not have a financial conflict of interest.

ii. The VA and DOD will each provide two Clinical Champions for each CPG.

c. Will identify WG Members:

i. VA and DOD will each provide eight WG members for each CPG.

ii. All CPG WGs will be comprised of an interprofessional team, including primary care, specialty care, medicine, nursing, and pharmacy.

iii. Other professionals may be added to the WG as appropriate to the topic (e.g. behavioral/mental health, dietician, physical therapy, occupational therapy, social work, prosthetist, and others).

d. Representatives from DOD CQI/OEBP and the VA QPS/EBPP offices will monitor and support the CPG development processes.

E. Potential Conflicts of Interest: The VA/DOD has adopted a policy of transparency, disclosing potential conflicts and competing interests of all individuals who participate in the development and revision of the VA/DOD CPGs.

(1) Champions, WG members, and other key clinical advisor roles involved with this effort will be required to submit a conflict of interest disclosure form to reveal any areas of potential financial conflict of interest for the preceding 24 months.

(2) Conflict of Interest (COI) forms will be sent to DOD CQI/OEBP and the VA QPS/EBPP.

(3) Verbal disclosures of COI will be conducted at each meeting.

(4) A signed disclosure statement will be obtained prior to starting work and at the beginning of the Recommendation Development Meeting (RDM).

(5) Members may be subject to random web-based surveillance (e.g. CMMS open payments or ProPublica).

(6) WG members with an identified potential financial conflict of interest will be reviewed by the EBPWG, which will determine if the WG member will be dismissed from the CPG.

(7) DOD CQI/OEBP and the VA QPS/EBPP will review potential intellectual conflict of interest with the WG Champions.

a. If there is a positive (yes) intellectual conflict of interest response (actual or potential) then a determination is made by the WG champions based on level and extent of involvement to mitigate conflict of interest. Determination may range from restricting participation and/or voting on the area related to conflict, up to removal from the WG.

b. DOD CQI/OEBP and the VA QPS/EBPP will monitor the mitigation strategies.

F. CPG Development Management:

(1) The CPG development will follow The National Academies 'Clinical Guidelines We Can Trust' guidelines for CPG development (1).

(2) Consensus:

a. Decisions on CPG content will be made with WG consensus.

i. Unanimous consensus: consensus is reached when all WG members agree on topic decisions without formal objections.

ii. Majority support with minority input: consensus is achieved when the majority of the WG supports the decision and input from the minority is considered and integrated into the final decision to ensure broad alignment.

G. The Work Group Members Will:

(1) Attend regular weekly WG meetings.

a. Regular meetings will be conducted through a virtual platform.

b. Attend at least 80% of the weekly meetings in real time.

i. Alternative attendance may be approved and tracked by DOD CQI/OEBP and the VA QPS/EBPP leadership.

ii. Review recordings and minutes for meetings not attended in real time.

(2) Attend the RDM in person.

a. Alternative attendance may be approved on a case-by-case basis and tracked by DOD CQI/OEBP and the VA QPS/EBPP leadership.

H. Overview of CPG Development Workflow:

(1) The DOD CQI/OEBP and the VA QPS/EBPP team will monitor the CPG development and assist as needed to ensure fidelity to the process. See CPG Process Flow Appendix B.

(2) CPG Scope:

a. The WG will determine the scope of the CPG including:

i. The target population.

ii. The disease process to be addressed.

iii. Care setting (e.g., Primary care, specialty care, inpatient, outpatient).

iv. The intended users for the CPG.

(3) Patient Focus Group

a. The purpose of the focus group is to inform Key Question (KQ) development and provide patient preferences and values for the development of the recommendations.

b. The Patient Focus Group will be a convenience sample of nine participants in accordance with OMB (Office of Management and Budget) Paperwork Reduction Act.

c. The WG will identify appropriate Veterans and Service members as potential Patient Focus Group participants.

d. The DOD CQI/OEBP and the VA Office of QPS/EBPP will contact the Service members and Veterans to confirm their willingness to participate in the Patient Focus Group and assist with accessing the virtual platform.

e. The WG will review and modify the Patient Focus Group questions to ensure they address the areas of interest for CPG development.

f. Representatives of the DOD CQI/OEBP and the VA QPS/EBPP will attend the Patient Focus Group as observers.

g. WG members will not attend the Patient Focus Group.

h. The WG will be provided with an anonymized report of the Patient Focus Group.

(4) Key Question (KQ) Development:

a. VA and DOD Champions and WG members will use a standardized process to identify Key Questions (KQs) formulated in the PICOTS framework:

   i. Population: Characteristics of the target patient population.

   ii. Intervention: Exposure, diagnostic, or prognosis.

   iii. Comparison: Intervention, exposure, or control used for comparison.

   iv. Outcome: Outcomes of interest to be answered by the evidence.

   v. Time (if applicable): Describes the duration of time that is of interest.

   vi. Setting (if applicable): Describes the setting or context of interest.

b. The WG will identify and prioritize outcomes of interest for each KQ.

c. New CPGs have 20 KQs.

d. Updates of previous CPGs have 12 KQs.

e. The WG will review the KQs to ensure that they will lead to a comprehensive, systematic review of the literature.

I. Literature Search and Systematic Review:

(1) Systematic literature searches and reviews will be conducted by a disinterested third-party using inclusion and exclusion criteria set by the WG.

(2) Systematic reviews will use explicit, reproducible methods to:

a. Identify relevant, eligible studies.

b. Assess the quality of each study and the body of evidence.

c. Critically appraise key studies,

d. Synthesize results.

(3) To grade the quality of individual studies, the reviews will apply the USPSTF criteria for quality as outlined in the USPSTF Procedure Manual 4 (2).

(4) Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) will be used to assess overall strength of evidence and clinical recommendations (3-8).

(5) Evidence tables will be formatted per the USPSTF guidelines.

J. CPG Background Development:

(1) Concurrent with the evidence search and evaluation, the WG members will develop the Background section of the CPG.

(2) For revisions of existing CPGs, the WG members will review and revise the background from the previous CPG.

(3) For new CPGs the WG members will utilize a template to develop the background materials.

(4) Background information may include evidence not included in making the recommendations but must clearly state that the evidence is outside of the evidence evaluation for the CPG.

K. Recommendation Development Meeting (RDM): The goal of the RDM is to review the evidence and make recommendations with the input of all WG members.

(1) Prior to the RDM:

a. Evidence Synthesis Report will be sent to the WG for review.

b. Breakout groups will be assigned to review the evidence for specified KQs.

c. The evidence review workload will be distributed as evenly as possible.

d. Breakout group members will be assigned to KQs that most closely align with their expertise.

e. WG members will review the evidence for the KQs to which they are assigned and make draft recommendations to be presented during the RDM.

(2) RDM attendance:

a. RDM meetings will be held in person at a location determined by the DOD CQI/OEBP and the VA QPS/EBPP.

b. The RDM will be scheduled so that the meeting and all travel take place Monday through Friday and not on Federal holidays. Typically, travel will occur on Monday and Friday afternoons, and the meeting will be held all day on Tuesday, Wednesday, Thursday, and for half a day on Friday.

c. WG members and facilitators are expected to attend the RDM in person. Exceptions may be made at the discretion of the DOD CQI/OEBP and the VA QPS/EBPP leadership. WG members who are unable to attend in person will be expected to attend virtually.

    i. Virtual attendees are expected to obtain release time from clinical duties and a space to work that is free from interruption to allow full participation in the RDM.

d. The DOD CQI/OEBP and the VA QPS/EBPP will have in-person staff present at the RDM to monitor the process and assist as necessary.

(3) Making recommendations:

a. Recommendations may only be made based on the evidence included in the systematic evidence review.

b. Breakout Groups:

    i. Breakout groups will include a champion.

    ii. Breakout groups will utilize the GRADE worksheets (Appendix C) to evaluate the evidence for each KQ assigned to the breakout group.

    iii. Upon completion of the GRADE worksheets, the breakout group will make draft recommendations.

    iv. Recommendation language will follow the GRADE format (3-8).

c. Plenary sessions:

    i. Parts of the plenary sessions may be utilized for instruction on the GRADE process.

ii. During plenary sessions, the entire WG will review the recommendations from the breakout groups.

iii. The WG will clarify the evidence utilized for recommendations and may ask the breakout group to modify recommendations.

(4) Algorithms and sidebars:

a. Are used to guide clinicians in clinical decision making.

b. May include evidence outside of the systematic evidence review, standard of care, expert opinion, but must not conflict with the evidence included in the recommendation and must clearly state that the evidence is outside of the evidence evaluation for the CPG.

L. Draft One:

(1) The background, recommendations algorithms and sidebars will be compiled into one document and sent to the WG members and DOD CQI/OEBP and the VA QPS/EBPP within 10 business days of the RDM.

(2) WG members will use the narrative sections to further explain the recommendation with key nuances and clinical considerations.

a. May include evidence not included in making the recommendations but must clearly state that the evidence is outside of the evidence evaluation for the CPG and was not used for the recommendation.

(1) WG members are expected to review and comment on all sections of the CPG draft one within 15 business days of receiving the document.

(2) Draft one may not be shared with anyone outside of the WG or the DOD CQI/OEBP and the VA QPS/EBPP.

M. Draft two:

(1) Draft two will be compiled and sent to the WG members, the DOD CQI/OEBP, and the VA QPS/EBPP for review no later than five business days after the completion of draft one.

(2) WG members are expected to review and comment on all sections of the CPG draft two within ten business days of receiving the document.

(3) Draft two may not be shared with anyone outside of the WG or DOD CQI/OEBP and the VA QPS/EBPP.

N. Draft three:

(1) Draft three will be compiled and sent to the WG members, the DOD CQI/OEBP, VA QPS/EBPP, and external reviewers for review no later than five business days after completion.

(2) Draft three will be sent to community experts external to the WG by representatives from the DOD CQI/OEBP and the VA QPS/EBPP.

a. WG members will identify external reviewers. External reviewers may also be recommended by program offices.

b. External reviewers are experts in their field and can be DOD, VA, or non-DOD, non-VA.

c. DOD CQI/OEBP and the VA QPS/EBPP will contact external reviewers to ask for their input.

d. The independent review is an evaluation of the content of the guideline.

(3) WG members are expected to review and comment on all sections of the CPG draft three within 15 business days of receiving the document.

(4) Responses to external reviewer comments and recommendations regarding proposed changes to the content of the guideline must be supported by evidence.

(5) The WG will adjudicate comments and suggestions from external reviewers into the guideline as appropriate.

(6) The EBPWG will receive a copy of the CPG draft with reviewers' comments and how they were adjudicated.

(7) The final draft will be compiled and sent to the WG members and DOD CQI/OEBP and the VA QPS/EBPP for review no later than five business days after the completion of the final draft.

O. Presentation of Guideline to full VA/DOD EBPWG for Approval:

(1) An electronic copy of the guideline, along with a summary of the comments from the external reviewers, will be provided to the entire VA/DOD EBPWG at least 10 business days in advance of the meeting.

(2) The VA/DOD EBPWG will review comments from independent reviewers and validate that all appropriate comments have been adjudicated.

(3) The CPG Champions and representatives of the guideline contractor will present the guideline to the EBPWG.

(4) Following the presentation, EBPWG members will have the opportunity to ask questions of the Champions and provide feedback that will be entered into the meeting minutes.

(5) The Guideline will be approved or returned for edits.

a. The WG will address requested modifications from the EBPWG.

b. Edits will be resubmitted to the EBPWG.

(6) Once approved, the CPG and associated tools will be assembled into the final format.

P. Clinical Support Tools (CSTs):

(1) Clinical Support Tools (CSTs) are resources that complement the CPGs. These resources may be a condensed part of the CPG that providers utilize, highlight critical information, and support implementation. CSTs are not intended to replace or supersede CPGs; rather, they address a particular aspect of a CPG or help to disseminate knowledge about the evidence-based treatments to patients, families, and clinicians.

(2) CSTs may be updated from current CSTs or created new by CPG workgroup members.

(3) See Appendix D for the process for Approved Final Drafts of Clinical Support Tools (CSTs) to be Placed on DOD and VA Websites.

Q. Dissemination:

(1) All guidelines and webinars will conform to the requirements described in Section 508 of the Rehabilitation Act of 1973, as amended (9).

(2) The DOD CQI/OEBP and the VA QPS/EBPP will post the CPG Materials on VA/DOD internal platforms and publicly accessible platforms including:

a. Guideline Links.

b. Full Guideline.

c. Provider Summary.

d. Pocket Card.

e. Patient Provider tools.

f. Webinars.

g. Related Guidelines.

(3) Webinar presentations:

a. DOD CQI/OEBP and the VA QPS/EBPP will solicit presenters from the Champions from the WG and WG group members as appropriate.

b. DOD CQI/OEBP and VA QPS/EBPP will work with their accrediting bodies for CE accreditation and distribution of the webinar on appropriate platforms.

c. Will be presented as soon as possible after the publication of the CPG.

d. Recorded presentations will be transferred to enduring material with CE for DOD and VA platforms.

(4) Publications:

a. The DOD CQI/OEBP and the VA QPS/EBPP staff encourage publications in peer-reviewed journals summarizing the CPG.

b. The WG members should refer to the International Committee of Medical Journal Editors (ICMJE) (10) for

details on the Roles and Responsibilities of Authorship and Contributors.

3. DEFINITIONS

A. Clinical Practice Guideline: A document that synthesizes best practices for patient care based on current evidence. Guidelines address patient cohorts, serve to reduce errors, and provide consistent quality of care and utilization of resources throughout and between the VA and DOD health care systems. Guidelines are also cornerstones for accountability and facilitate learning and implications of future research. Guidelines must always be implemented in the context of a healthcare provider's clinical judgment in the care of a particular patient, taking into consideration the patient's preferences.

B. Clinical Support Tools: Resources that complement the CPGs and support use of the guideline.

C. Key Questions: The questions that guide the literature search and review.

D. Patient Focus Group: A group of Veterans and service members who have experienced the condition of interest and who volunteer to share their preferences and values to be used in the development of the CPG.

E. Recommendation Development Meeting: A face-to-face meeting where evidence is reviewed and recommendations are drafted

F. Recommendations: Specific guidance to clinicians for the care of patients with the CPG issue of focus. Recommendations are based solely on the evidence included in the evidence evaluation for the CPG.

G. Work Group Champion: An appointed healthcare professional with clinical content expertise, who leads the development, review, and updating of a CPG focusing on a specific clinical topic. The WG Champion is a voting member of the CPG WG.

H. Work Group Member: An appointed healthcare professional with clinical content expertise, who contributes to the development, review, and updating of a CPG focusing on a specific clinical topic. The WG Member is a voting member of the CPG WG.

REFERENCES

1. Institute of Medicine of the National Academies 2011; https://nap.nationalacademies.org/catalog/13058/clinical-practice-guidelines-we-can-trust.

2. U. S. Preventive Services Task Force 2023;Pageshttps://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/methods-and-processes/procedure-manual.
3. Andrews J, Guyatt G, Oxman AD, Alderson P, Dahm P, Falck-Ytter Y, et al. GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations. J Clin Epidemiol. 2013;66(7):719-25.
4. Andrews JC, Schunemann HJ, Oxman AD, Pottie K, Meerpohl JJ, Coello PA, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. J Clin Epidemiol. 2013;66(7):726-35.
5. Brunetti M, Shemilt I, Pregno S, Vale L, Oxman AD, Lord J, et al. GRADE guidelines: 10. Considering resource use and rating the quality of economic evidence. J Clin Epidemiol. 2013;66(2):140-50.
6. Guyatt G, Oxman AD, Sultan S, Brozek J, Glasziou P, Alonso-Coello P, et al. GRADE guidelines: 11. Making an overall rating of confidence in effect estimates for a single outcome and for all outcomes. J Clin Epidemiol. 2013;66(2):151-7.
7. Guyatt GH, Oxman AD, Santesso N, Helfand M, Vist G, Kunz R, et al. GRADE guidelines: 12. Preparing summary of findings tables-binary outcomes. J Clin Epidemiol. 2013;66(2):158-72.
8. Guyatt GH, Thorlund K, Oxman AD, Walter SD, Patrick D, Furukawa TA, et al. GRADE guidelines: 13. Preparing summary of findings tables and evidence profiles-continuous outcomes. J Clin Epidemiol. 2013;66(2):173-83.
9. U. S. Access Board 2024;Pages https://www.access-board.gov/ict.html.
10. International Committee of Medical Journal Editors 2025;Pages https://www.icmje.org/recommendations/browse/roles-and-responsibilities/.

SIGNATORY AUTHORITY

JAMES SALL Digitally signed by JAMES SALL
Date: 2026.02.05 17:13:31 -05'00'

James Sall PhD, FNP-BC, FAANP
Director Evidence Based Practice Practice (17QM5)
Office of Quality and Patient Safety (17)
Department of Veterans Affairs

MENO.JENIFER.ANN.1025470580 Digitally signed by MENO.JENIFER.ANN.1025470580
Date: 2026.02.17 11:16:25 -05'00'

Jenifer A. Meno, DNP, FNP-BC, AMB-BC, NEA-BC, FAANP
Acting Chief, Clinical Quality Improvement Program
Medical Affairs/Clinical Support Division
Assistant Director for Healthcare Administration
Defense Health Agency

Date Approved: January 27, 2026

NOTE: *The signature remains valid until rescinded by an appropriate administrative action.*

DISTRIBUTION: Policy is available at: https://www.healthquality.va.gov/

Appendix A: Application Form

VA/DoD Evidence-Based Clinical Practice Guidelines
Guideline Project Submission Form

Project Name			
Project Description			
Project Champion			
Last Name	**First Name**		**Title**
Service/Organization/Command			
Address			
City		**State**	**Zip Code**
Phone	**Fax**	**E-mail**	

MAKING A CASE FOR CHANGE – Provide narrative to support guideline development.

Perceived gap in health status:
[Is there new information from the medical literature? What about current outcomes (e.g., prevalent conditions, diagnosis)? Are there clinical areas for improvement suggested by clinicians? Are there benchmarks available that suggest a need to change practice? Are there existing evidence-based guidelines on this subject? What is the impact of this guideline on patient outcomes?]

Perceived gap in patient satisfaction:
[Is there survey information available addressing patient satisfaction that indicates an opportunity for improvement? Are there benchmarks available that suggest a need to change practice?]

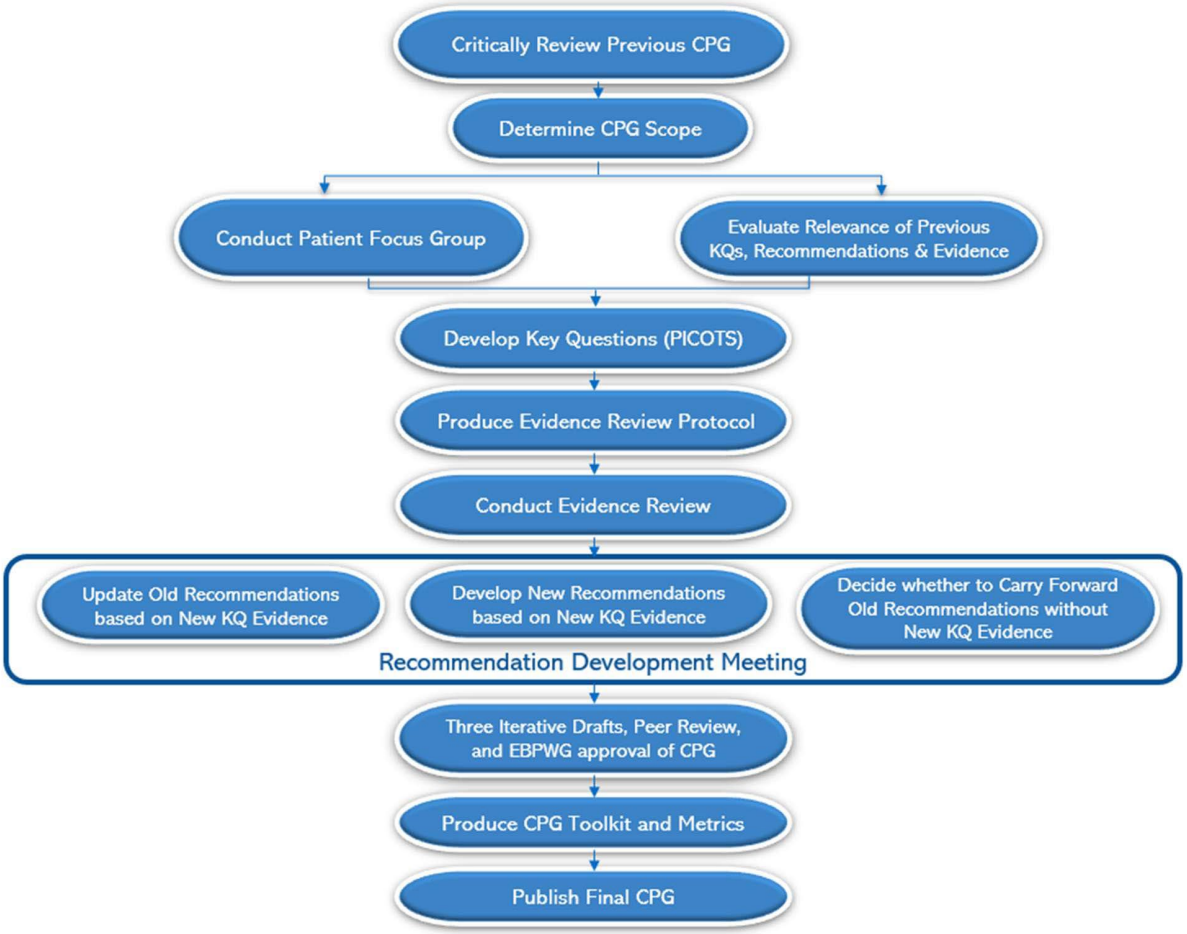
Perceived gap in provider satisfaction:
[Are there surveys or suggestions addressing provider satisfaction that indicate an opportunity for improvement? Are there benchmarks available that suggest a need to change practice?]

Perceived gap in cost/utilization:
[Are there areas of care with high utilization? Is there significant variation or an opportunity for improvement in utilization patterns (e.g. drug utilization, lab utilization, referral rates, or local variation)? Are there benchmarks available that suggest a need to change practice? Rational and supporting evidence of relevance/importance of topic to the VA and/or DoD population?]

Perceived organizational issues:

[Are there political or organizational reasons why a change in practice might be warranted? Are there benchmarks available that suggest a need to change practice? Is the implementation of this project feasible? Is there evidence available to support evidence-based guideline development?]

Appendix B – CPG Process Flow



Appendix C – GRADE Worksheet

Recommendation Development Worksheet

Key Question XX: [insert KQ wording]?

Tracking Info	***KQ XX; BG X; Primary author: [insert WG member]***			
2024 Recommendation Text			**2024 Strength (+2 to -2)**	**2024 Category**
			Choose an item.	Choose an item.
If *Reviewed* (other than *New-added*)				
2019 Rec #	**2019 Recommendation Text**		**2019 Strength**	**2019 Category**
XX	[insert rec text]		[insert strength]	[insert category]
XX	[insert rec text]		[insert strength]	[insert category]
GRADE Domains	**Confidence in the Quality of Evidence (4 – 1)**	**Balance of Desirable and Undesirable Outcomes (+2 to -2)**	**Patient Values and Preferences (+2 to -2)**	**Other Implications (+2 to -2 for each)**
Judgment	Choose an item.	Choose an item.	Choose an item.	Choose an item. Choose an item. Choose an item.

				Choose an item.
Justification (for Value or Valence)	▪ ▪ ▪	▪ Benefits ○ ○ ▪ Harms ○ ○	▪ ▪ ▪	▪ ○ (-/+): ▪ ○ (-/+): ▪ ○ (-/+):

Future Research Priorities

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▪
▪

Other Notes for Author

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▪

Relevant Studies *(Including all studies for comparison unless otherwise stated)*	**Intervention & Comparator from Evidence Report**	**Outcome & GRADE Rating: (lowest for outcome if multiple)** *(Including all outcomes and studies for comparison unless otherwise stated)*			**Notes on Evidence Base** *(Capture results/effect direction)*
		Outcome	**Critical / Important**	**SoE Rating**	

Additional Notes on Individual Studies

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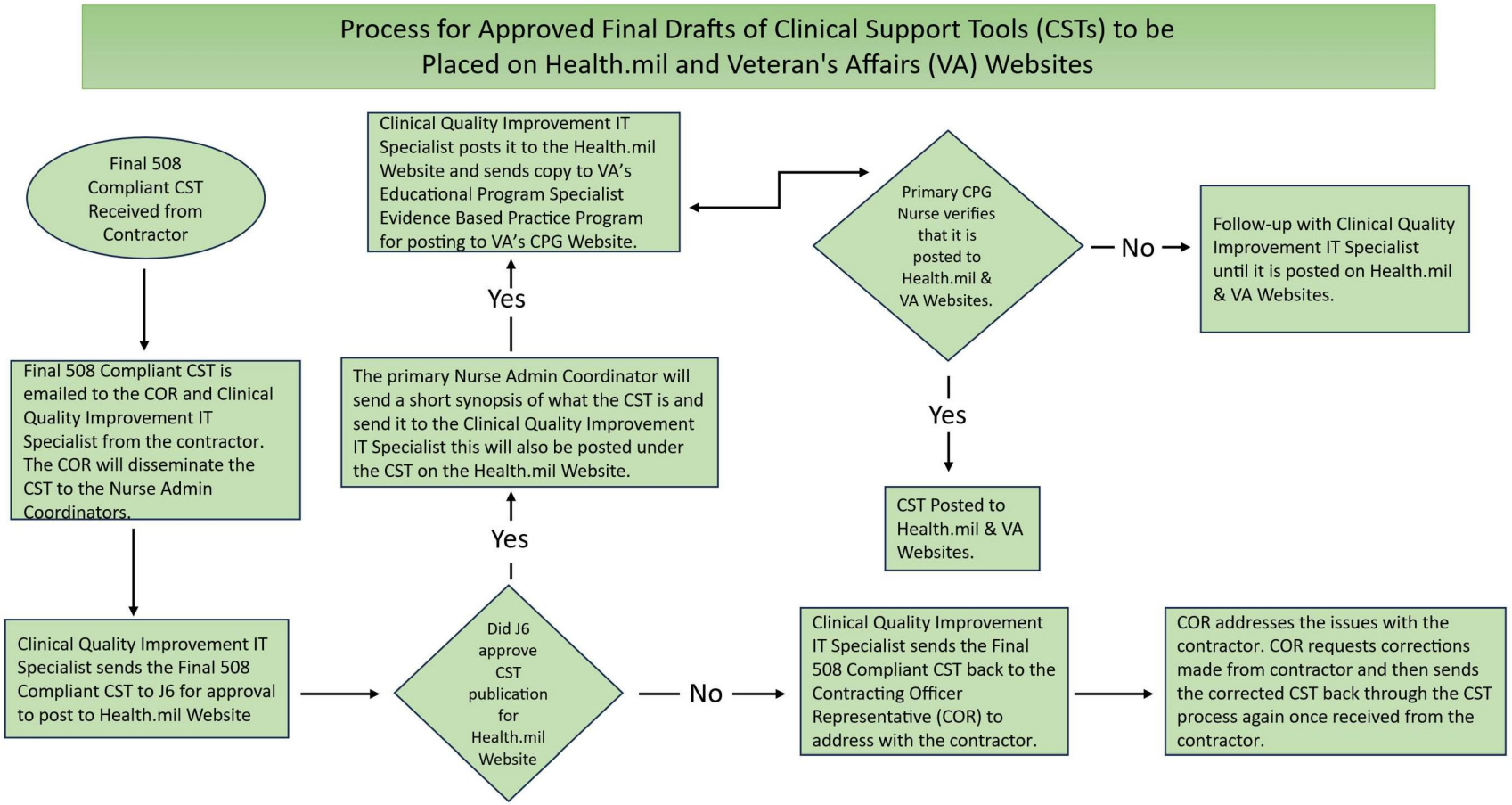

Appendix D – Process for CSTs to be published to websites