



# From Search to Surface: Why you need a digital strategy

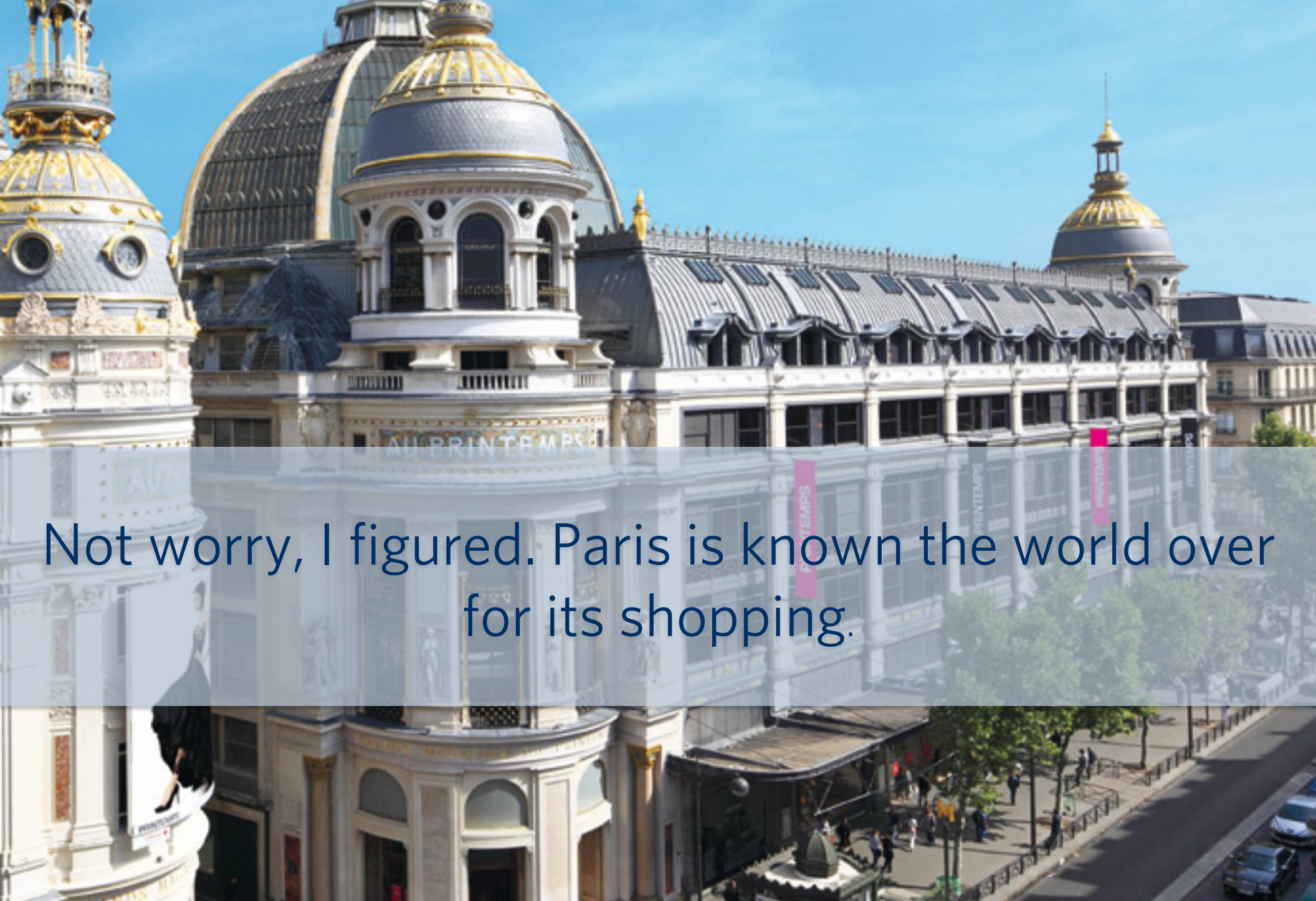
Michael Clarke  
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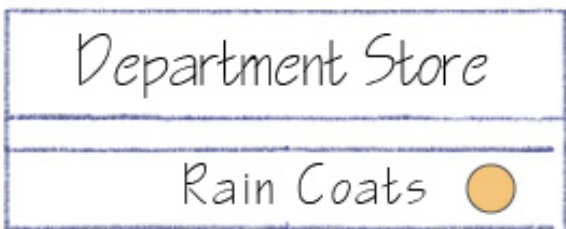
On a recent trip to Paris I discovered I had forgotten a raincoat. The forecast was for rain all week.

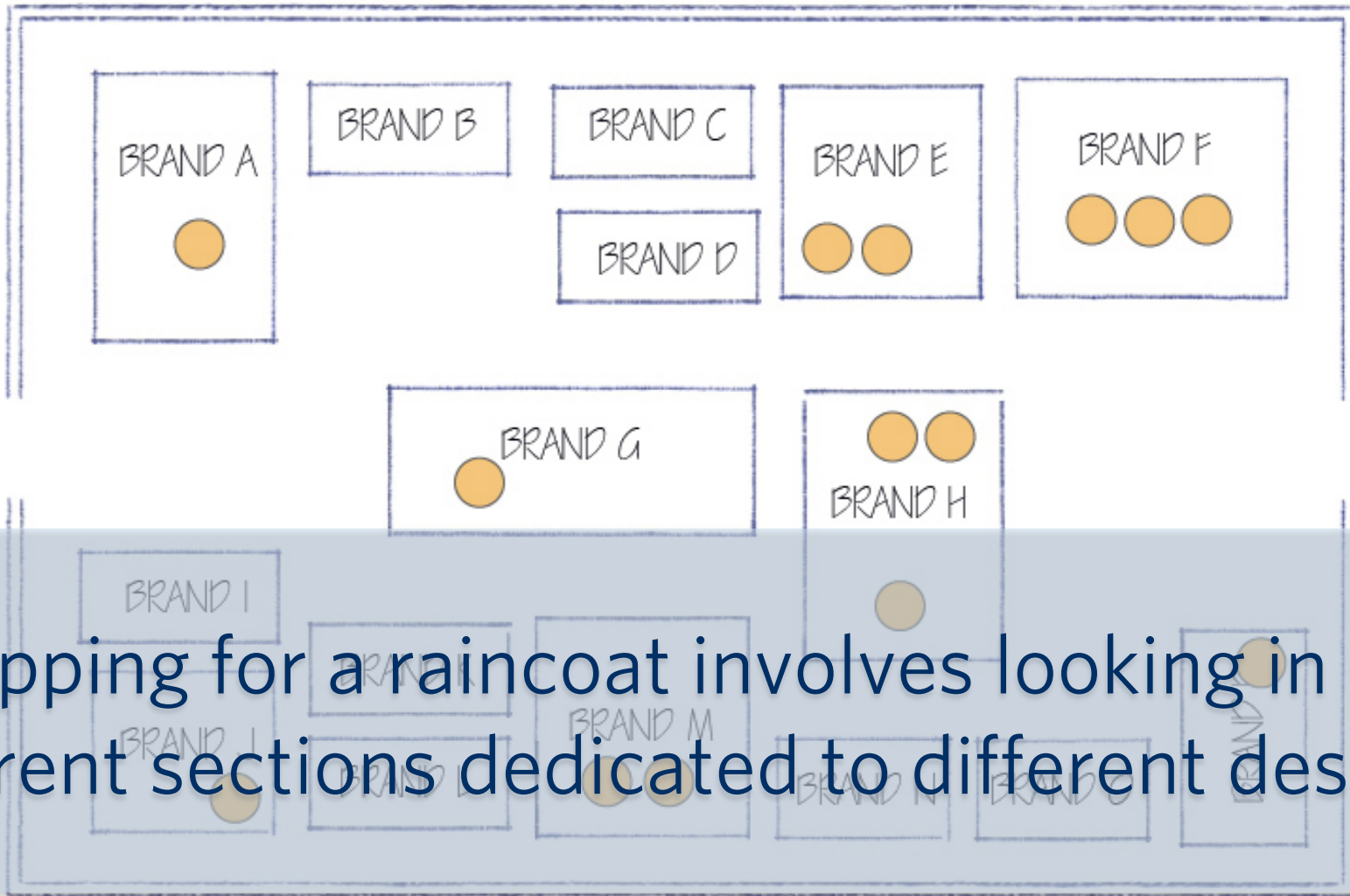


Not worry, I figured. Paris is known the world over for its shopping.



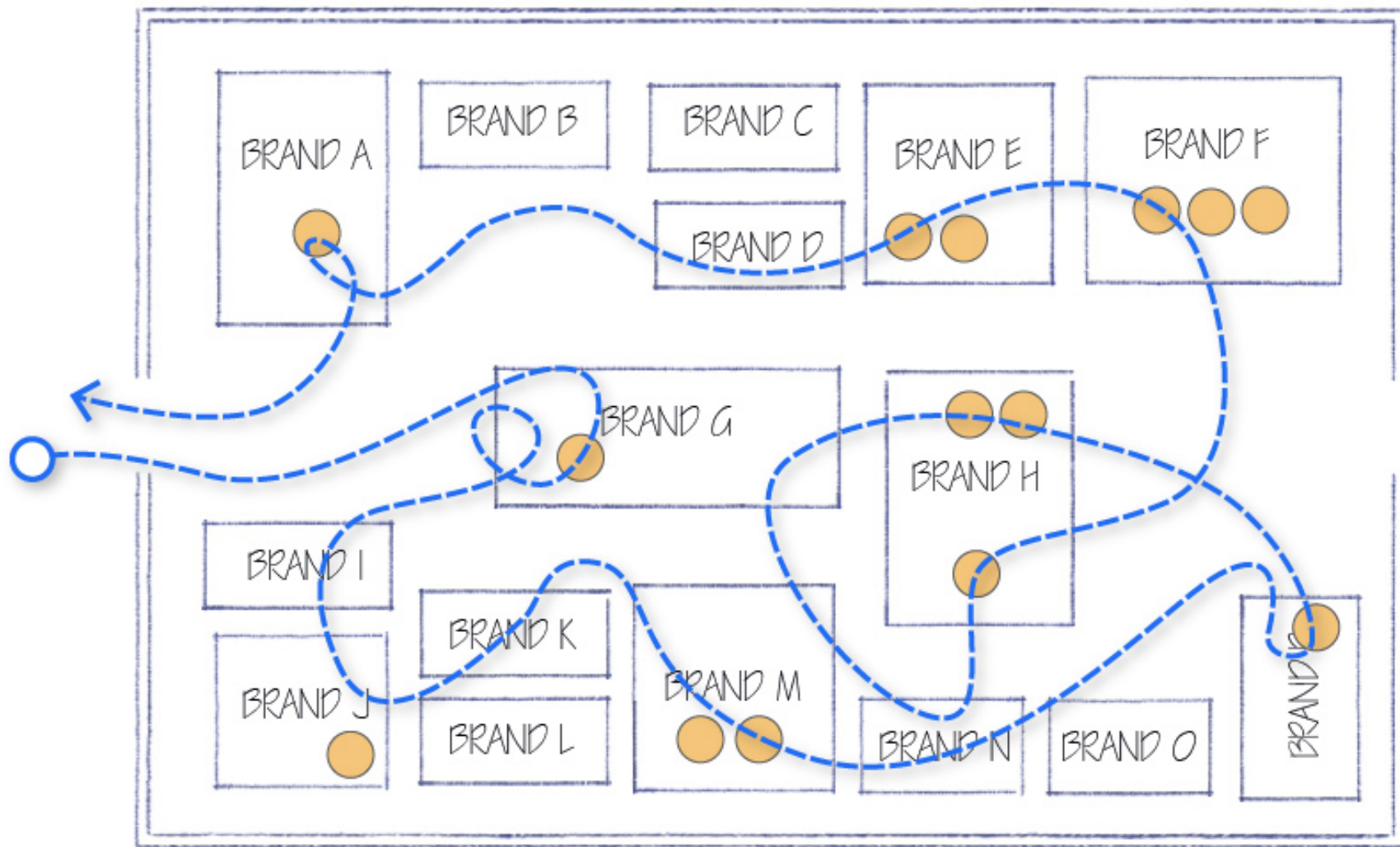
Parisian department stores, like most in Europe, are organized around brands.





Shopping for a raincoat involves looking in many different sections dedicated to different designers.





Department Store

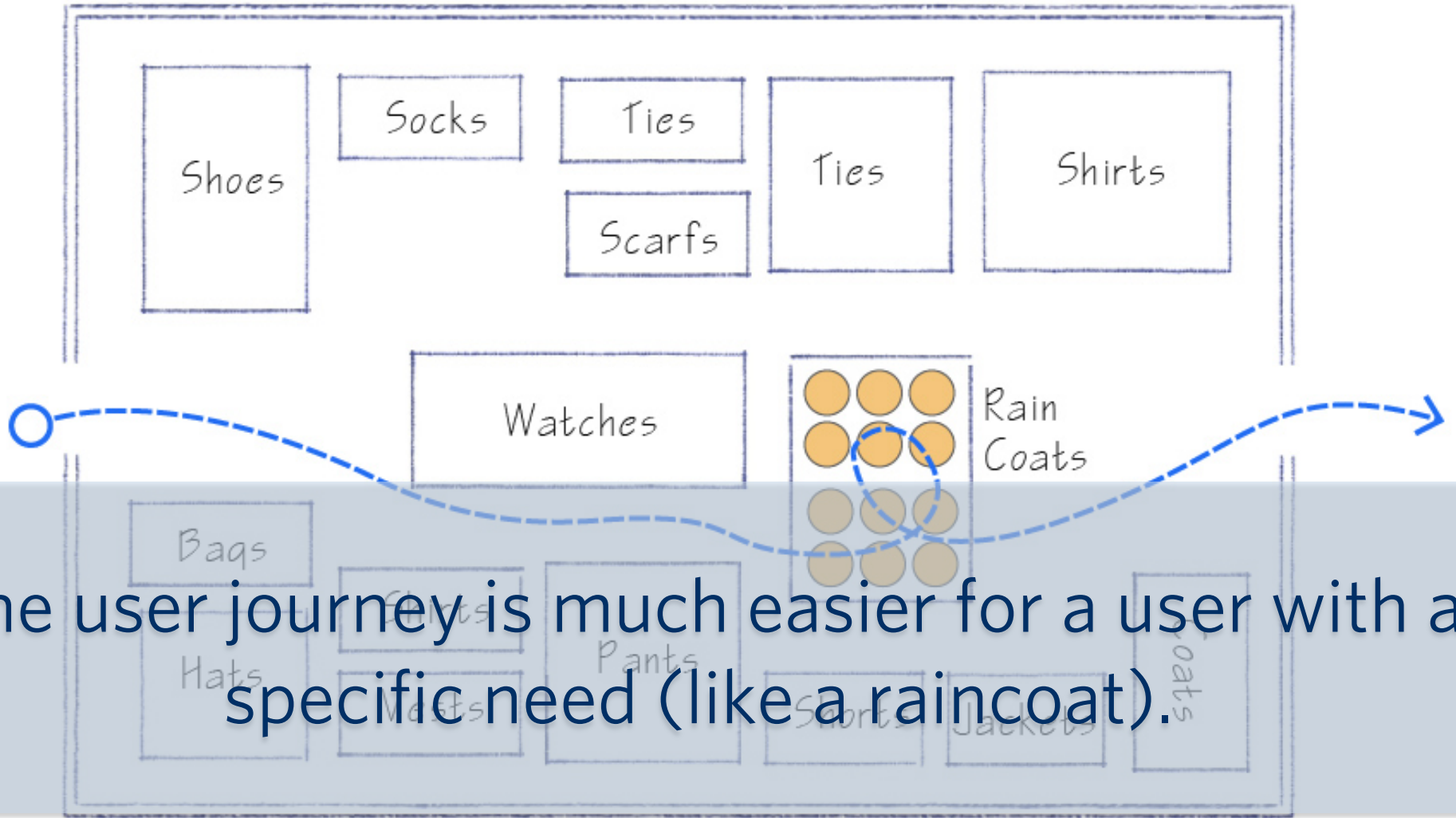
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Rain Coats ●



Contrast this with most American department stores which are organized around clothing *types*.





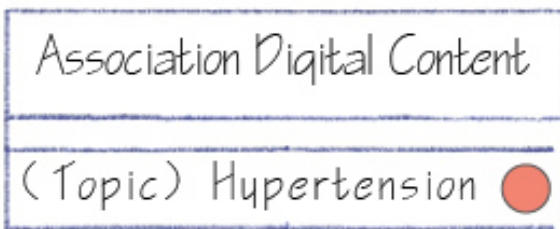
The user journey is much easier for a user with a specific need (like a raincoat).

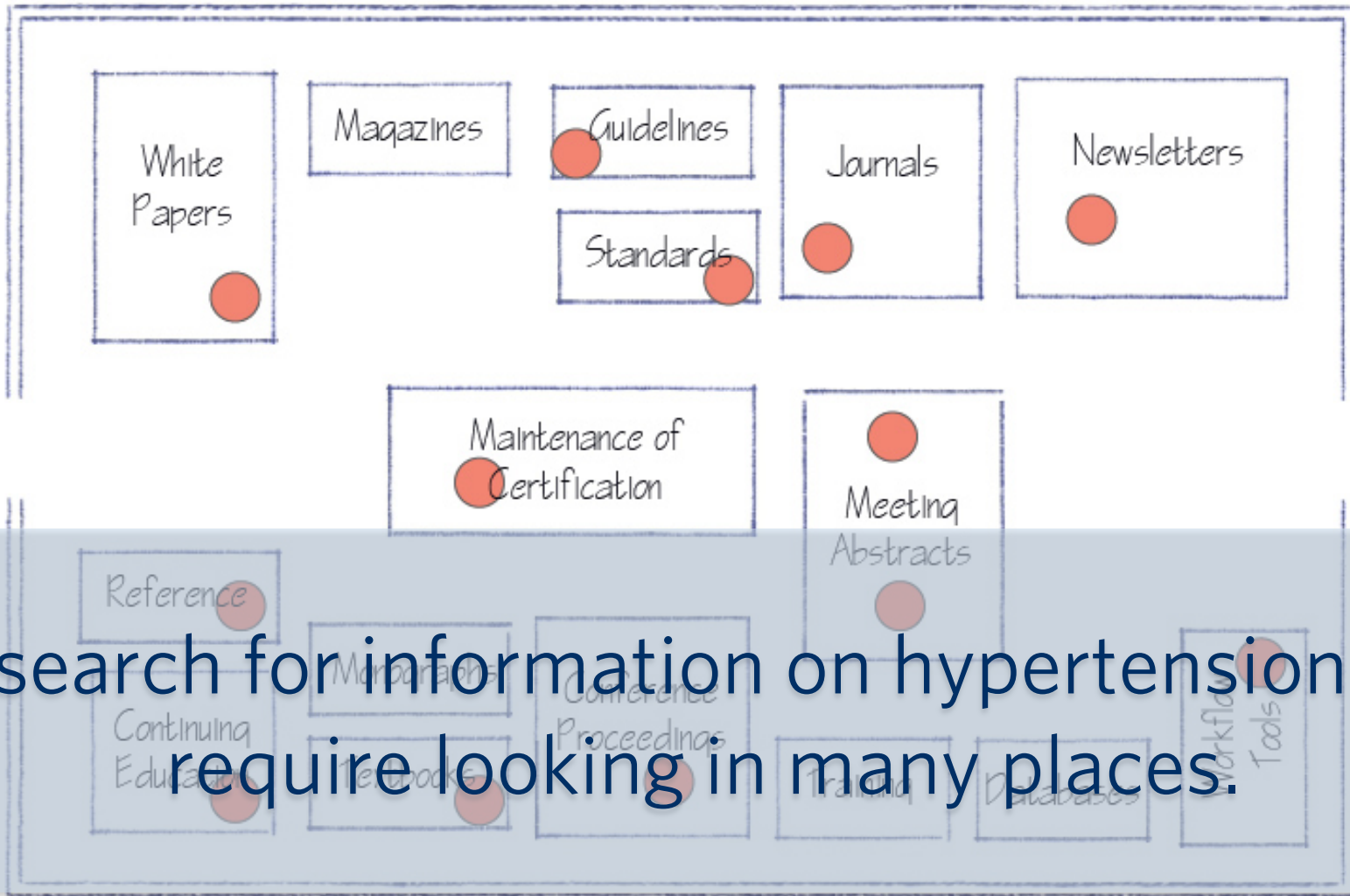






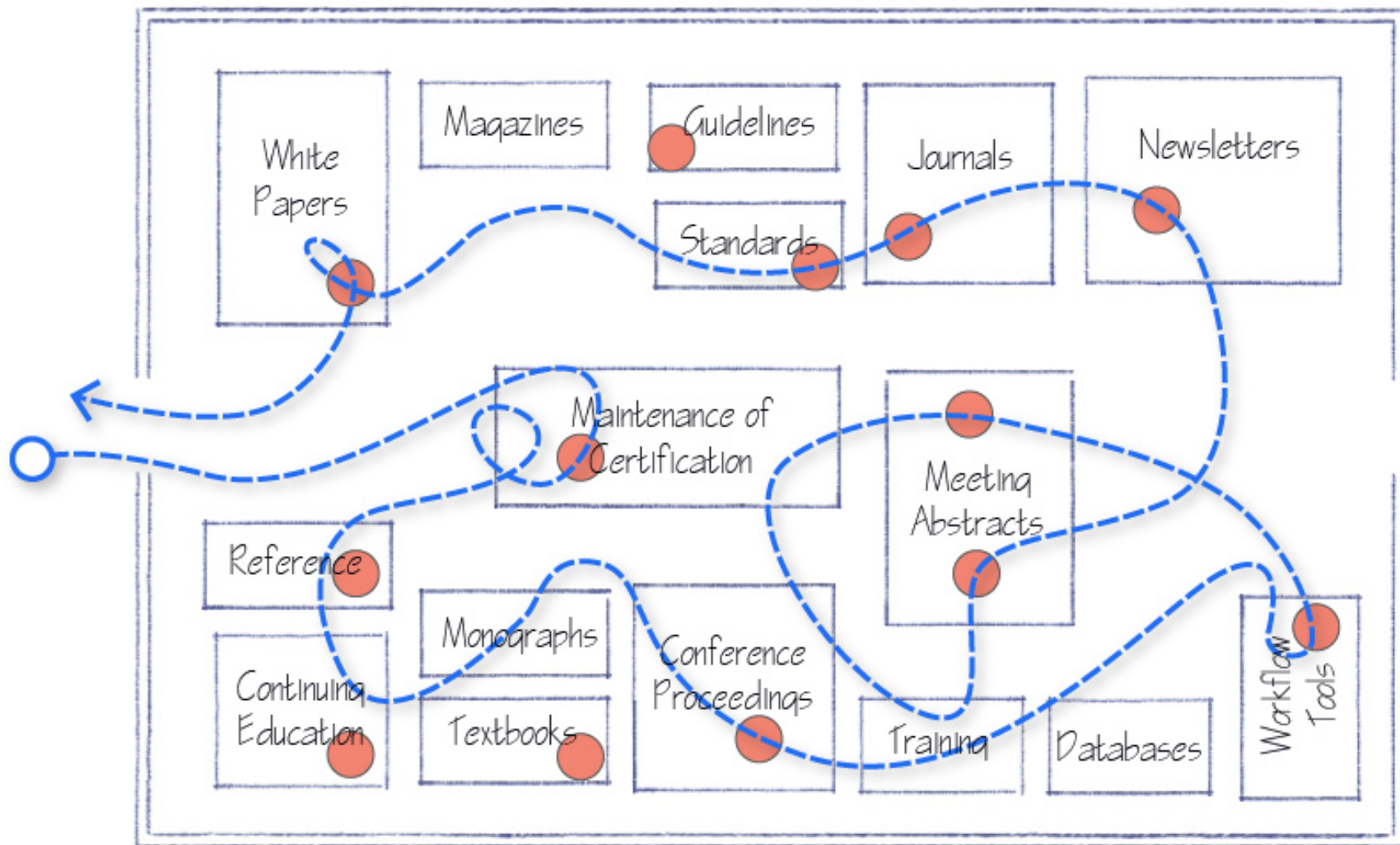
Association websites are often like Paris department stores in that they are organized around the wrong silos.





A search for information on hypertension can require looking in many places.

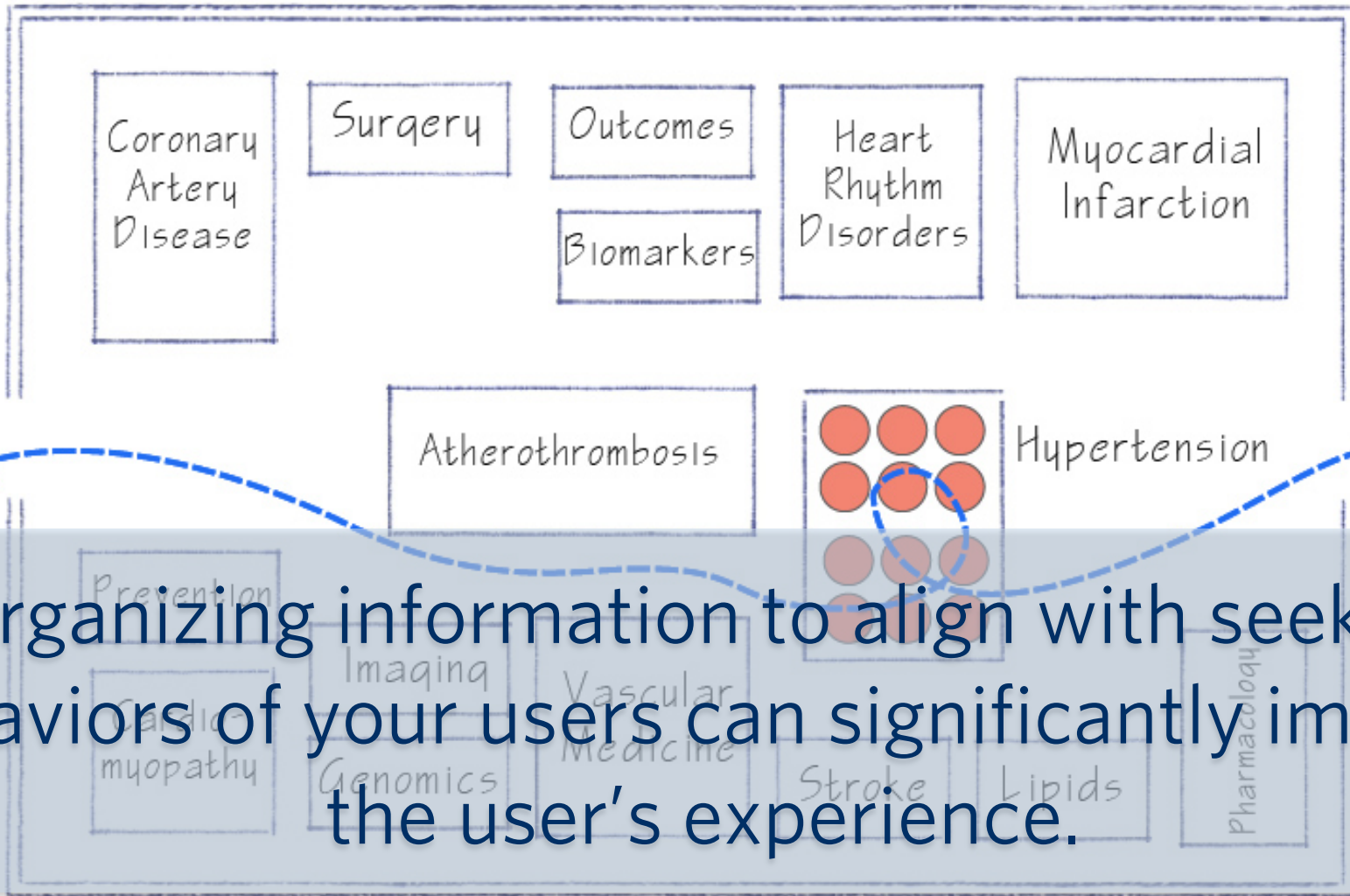
Association Digital Content
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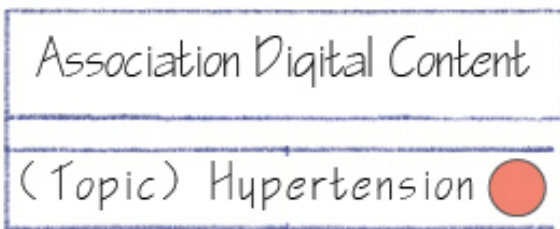
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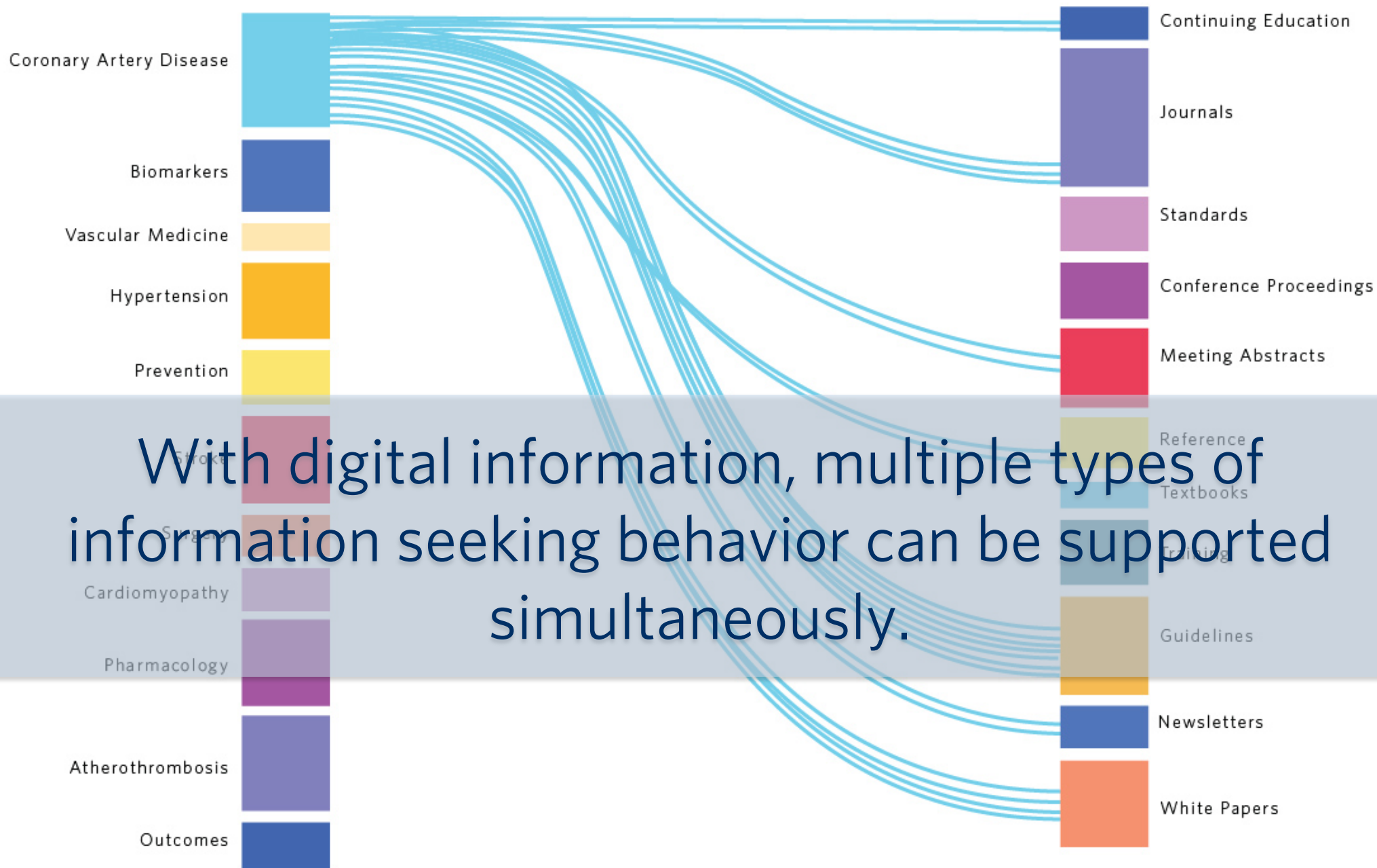
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(Topic) Hypertension ●



Organizing information to align with seeking behaviors of your users can significantly improve the user's experience.





With digital information, multiple types of information seeking behavior can be supported simultaneously.



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Special Communication | February 5, 2014

# 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults

## Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8) **FREE**

Paul A. James, MD<sup>1</sup>; Suzanne Oparil, MD<sup>2</sup>; Barry L. Carter, PharmD<sup>1</sup>; William C. Cushman, MD<sup>3</sup>; Cheryl Dennison-Himmelfarb, RN, ANP, PhD<sup>4</sup>; Joel Handler, MD<sup>5</sup>; Daniel T. Lackland, DrPH<sup>6</sup>; Michael L. LeFevre, MD, MSPH<sup>7</sup>; Thomas D. MacKenzie, MD, MSPH<sup>8</sup>; Olugbenga Ogedegbe, MD, MPH, MS<sup>9</sup>; Sidney C. Smith Jr, MD<sup>10</sup>; Laura P. Svetkey, MD, MHS<sup>11</sup>; Sandra J. Taler, MD<sup>12</sup>; Raymond R. Townsend, MD<sup>13</sup>; Jackson T. Wright Jr, MD, PhD<sup>14</sup>; Andrew S. Narva, MD<sup>15</sup>; Eduardo Ortiz, MD, MPH<sup>16,17</sup>

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JAMA. 2014;311(5):507-520. doi:10.1001/jama.2013.284427.

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Editorial

Recommendations for Treating

This JAMA article highlights additional resources available from the AMA on the topic of high blood pressure.

Hypertension is the most common condition seen in primary care and leads to myocardial infarction, stroke, renal failure, and death if not detected early and treated appropriately. Patients want to be assured





should meet the clinical needs of most patients, these recommendations are not a substitute for clinical judgment, and decisions about care must carefully consider and incorporate the clinical characteristics and circumstances of each individual patient.

Hypertension remains one of the most important preventable contributors to disease and death. Abundant evidence from randomized controlled trials (RCTs) has shown benefit of antihypertensive drug treatment in reducing important health outcomes in persons with hypertension.<sup>1-3</sup> Clinical guidelines are at the intersection between research evidence and clinical actions that can improve patient outcomes. The Institute of Medicine Report *Clinical Practice Guidelines We Can Trust* outlined a pathway to guideline development and is the approach that this panel aspired to in the creation of this report.<sup>4</sup>

The panel members appointed to the Eighth Joint National Committee (JNC 8) used rigorous evidence-based methods, developing Evidence Statements and recommendations for blood pressure (BP) treatment based on a systematic review of the literature to meet user needs, especially the needs of the primary care clinician. This report is an executive summary of the evidence and is designed to provide clear recommendations for all clinicians. Major differences from the previous JNC report are summarized in [Table 1](#). The complete evidence summary and detailed description of the evidence review and methods are provided online (see [Supplement](#)).

**Table 1.** Comparison of Current Recommendations With JNC 7 Guidelines

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## THE PROCESS

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The panel members appointed to JNC 8 were selected from more than 400 nominees based on expertise in hypertension (n = 14), primary care (n = 6), including geriatrics (n = 2), cardiology (n = 2), nephrology (n = 3), nursing (n = 1), pharmacology (n = 2), clinical trials (n = 6), evidence-based medicine (n = 3), epidemiology (n = 1), informatics (n = 4), and the development and implementation of clinical guidelines in systems of care (n = 4).

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The panel also included a senior scientist from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), a senior medical officer from the National Heart, Lung, and Blood Institute (NHLBI), and a senior scientist from NHLBI who withdrew from authorship prior to publication. Two members left the panel early in the process before the evidence review because of new job commitments that prevented them from continuing to serve. Panel members disclosed any potential conflicts of interest including studies evaluated in this report and relationships with industry. Those with conflicts were allowed to participate in discussions as long as they declared their relationships, but they recused themselves from voting on evidence statements and recommendations relevant to their relationships or conflicts. Four panel members (24%) had relationships with industry or potential conflicts to disclose at the outset of the process.

In January 2013, the guideline was submitted for external peer review by NHLBI to 20 reviewers, all of whom had expertise in hypertension, and to 16 federal agencies. Reviewers also had expertise in cardiology, nephrology, primary care, pharmacology, research (including clinical trials), biostatistics, and other important related fields. Sixteen individual reviewers and 5 federal agencies responded. Reviewers' comments were collected, collated, and anonymized. Comments were reviewed and discussed by the panel from March through June 2013 and incorporated into a revised document. (Reviewers' comments and suggestions, and responses and disposition by the panel are available on request from the authors.)

## QUESTIONS GUIDING THE EVIDENCE REVIEW

ABSTRACT | THE PROCESS | **QUESTIONS GUIDING THE EVIDENCE REVIEW** | THE EVIDENCE REVIEW | RESULTS (RECOMMENDATIONS) | LIMITATIONS | DISCUSSION | CONCLUSIONS | ARTICLE INFORMATION | REFERENCES



This evidence-based hypertension guideline focuses on the panel's 3 highest-ranked questions related to high BP management identified through a modified Delphi technique.<sup>5</sup> Nine recommendations are made reflecting these questions. These questions address thresholds and goals for pharmacologic treatment of hypertension and whether particular antihypertensive drugs or drug classes improve important health outcomes compared with other drug classes.

1. In adults with hypertension, does initiating antihypertensive pharmacologic therapy at specific BP

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- 3 **Increase revenues** by upselling content and services
- 4 Provide a platform for the development of **new products & services**
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