Inclusion of physiotherapists in clinical practice guidelines: The Chilean experience

Inclusão de fisioterapeutas em diretrizes de prática clínica: a experiência chilena

Ruvistay Gutierrez-Arias [1-3*]
Roberto Vergara-Cabezas [1]
Karim Alul Araya [1,2]
Carlos Rázuri-Soto [1]
Francisco Salinas-Barahona [1,2,4]
Pamela Seron [5]
On behalf of INTRehab Research Group

[1] Instituto Nacional del Tórax, Santiago, Chile
[2] INTRehab Research Group, Instituto Nacional del Tórax, Santiago, Chile
[3] Universidad Andres Bello (UNAB), Santiago, Chile
[4] Universidad de las Américas, Santiago, Chile
[5] Universidad de La Frontera, Temuco, Chile

Date of first submission: April 15, 2024
Last received: July 9, 2024
Accepted: August 8, 2024
Associate editor: Ana Paula Cunha Loureiro

***Correspondence:** rgutierrez@torax.cl

Abstract

Introduction: Including physiotherapists is crucial for developing comprehensive clinical practice guidelines (CPGs) to manage health conditions related to impaired movement and functional capacity. The methodology used to develop these guidelines may influence the extent of their inclusion. **Objective:** To assess the association between the development methodology and the inclusion of physiotherapists in CPGs for the Explicit Health Guarantees (GES) program of the Chilean Ministry of Health (ChMH). Additionally, for CPGs developed using the Evidence to Decision (EtD) framework, we aimed to examine the association between the inclusion of physiotherapists on the expert panel and the generation of recommendations relevant to their clinical practice. **Methods:** A cross-sectional study was conducted to analyze 148 CPGs developed by the ChMH up to December 2022. The CPGs were retrieved from the official ChMH website, which hosts CPGs developed with the original ChMH and those produced using the EtD framework. **Results:** The use of the EtD framework-based methodology for CPG development was significantly associated with a higher likelihood of including physiotherapists in the expert panel (OR 3.62; CI 95% 1.76 to 7.43). Moreover, the inclusion of physiotherapists in CPGs developed with the EtD framework-based methodology was significantly associated with a higher likelihood of generating recommendations related to their clinical practice (OR 18.41; CI 95% 3.80 to 89.09). **Conclusion:** The EtD framework-based methodology for developing CPGs of the GES program designed by the ChMH likely contributed to the inclusion of physiotherapists on expert panels and facilitated the development of recommendations relevant to their interventions.

Keywords: Evidence-based practice. GRADE Approach. Physical therapy specialty. Practice guidelines as topic. Rehabilitation.

Resumo

Introdução: *A inclusão de fisioterapeutas é fundamental para o desenvolvimento de diretrizes de prática clínica (DPCs) abrangentes para o gerenciamento de condições de saúde relacionadas ao movimento prejudicado e à capacidade funcional. A metodologia usada para desenvolver essas diretrizes pode influenciar a extensão de sua inclusão.* ***Objetivo:*** *Avaliar a associação entre a metodologia de desenvolvimento e a inclusão de fisioterapeutas nas DPCs para o programa de Garantias Explícitas de Saúde (GES) do Ministério da Saúde do Chile (ChMH). Além disso, para as DPCs desenvolvidas usando a estrutura* Evidence to Decision *(EtD), objetivou-se examinar a associação entre a inclusão de fisioterapeutas no painel de especialistas e a geração de recomendações relevantes para sua prática clínica.* ***Métodos:*** *Realizou-se um estudo transversal para analisar 148 DPCs desenvolvidas pelo ChMH até dezembro de 2022. As DPCs foram recuperadas do site oficial do ChMH, que hospeda DPCs desenvolvidas com o ChMH original e aquelas produzidas usando a estrutura EtD.* ***Resultados:*** *O uso da metodologia baseada na estrutura de EtD para o desenvolvimento de DPCs foi significativamente associada a uma maior probabilidade de inclusão de fisioterapeutas no painel de especialistas (OR 3,62; IC 95% 1,76 a 7,43). Além disso, a inclusão de fisioterapeutas em DPCs desenvolvidas com a metodologia baseada na estrutura EtD foi significativamente associada a uma maior probabilidade de recomendações relacionadas à sua prática clínica (OR 18,41; IC 95% 3,80 a 89,09).* ***Conclusão:*** *A metodologia baseada na estrutura de EtD para o desenvolvimento de DPCs do programa GES projetadas pelo ChMH provavelmente contribuiu para a inclusão de fisioterapeutas nos painéis de especialistas e facilitou o desenvolvimento de recomendações relevantes para suas intervenções.*

Palavras-chave: *Prática baseada em evidências. Abordagem GRADE. Especialidade de fisioterapia. Diretrizes práticas como tópico. Reabilitação.*

Introduction

Physiotherapy aims to develop, restore, and maintain optimal movement and functional capacity throughout life.[1] It is provided when factors such as aging, injuries, pain, diseases, disorders, conditions, or environmental influences threaten movement and function.[1]

This complex discipline[2] relies on the best available evidence, integrating the physiotherapist's experience and the patient's values and preferences[3] to achieve the best possible outcomes. To do this, physiotherapists must continually update their knowledge, a challenging process given the numerous primary and secondary studies published daily.[4] In this context, clinical practice guidelines (CPGs) are considered a viable solution because they can offer recommendations related to the diagnosis, treatment, and other areas of clinical practice,[5] thus bridging the gap between evidence and practice.

In 2004, the Chilean Ministry of Health (ChMH) implemented the Explicit Guarantees in Health (known as GES program in Chile). This strategy incorporates 85 health conditions for which one or more CPGs have been created to guide the interventions. Three studies have assessed the methodological quality of these CPGs,[6-8] concluding that they need improvement in several evaluated domains, including methodological rigor, applicability, and stakeholder involvement. These assessments were conducted using the Appraisal of Guidelines for Research & Evaluation (AGREE) tool[9] and its second version (AGREE II).[10] Stakeholder involvement (Domain 2 on the AGREE II instrument) considers the points of view of the patients or target population if the potential users of the guide are clearly defined, and the inclusion of all the relevant groups of professionals for the health condition.[10] In the case of the Chilean CPGs, this domain received a score of 4.8 (SD = 1.36) out of a maximum of 7 points.[8] Additionally, evaluating the methodological quality of CPGs focused on rehabilitating different health conditions has also revealed shortcomings in stakeholder involvement.[11,12] This could affect the overall assessment of the other CPGs,[13] and, ultimately, the quality-of-care patients receive.

The ChMH has been updating and improving the methodology of the CPGs included in the GES program. This includes the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach to assess the quality of the evidence,[14] as well as other aspects considered in the Evidence to Decision (EtD) framework.[15,16] This approach could enhance the inclusion of all the stakeholders in the different health conditions, including physiotherapists. This study aimed to determine the association between the development methodology and the inclusion of physiotherapists in developing CPGs under GES program of the ChMH. Additionally, for CPGs developed under the EtD

framework, the study examined the association between the inclusion of physiotherapists in the panel of experts and the generation of recommendations related to their clinical practice.

Methods

A cross-sectional study was conducted, analyzing the CPGs developed by the ChMH to manage the 85 health problems included in the GES program up to December 2022. The CPGs were obtained in their most up-to-date version from the official ChMH website.[17] When the CPGs were published with an updated methodology based on the EtD framework, their previous versions developed without the GRADE approach were also obtained. Two evaluators independently extracted the information from the CPGs, and a third reviewer resolved any discrepancies.

A standard form in Google Forms® was used to collect the information about the CPGs, including publication year, methodology used to develop the CPG, the total number of professionals and physiotherapists included on the panel of clinical experts, number and type of recommendations given by the CPG (diagnosis, treatment, and follow-up), and recommendations related to physiotherapy practice. If a physiotherapist had a role in the methodology or organizing team of the CPGs, these roles were not counted if they differed from participation on the panel of clinical experts.

For this study, health problems and recommendations were considered relevant to physiotherapy practice when associated with physical dysfunction leading to activity limitation[18] due to aging, injuries, pain, diseases, disorders, conditions, or environmental factors. Physiotherapy interventions in the assessment, diagnosis, prognosis, and treatment phases must address these issues.[1]

Data processing and synthesis

Categorical variables were described using absolute and relative frequency, while quantitative variables were described using the median and interquartile range (IQR). Univariate logistic regression was performed to determine the association between the inclusion of physiotherapists and the methodology used to develop the CPGs. The same analysis was conducted for CPGs developed with the EtD framework-based methodology to determine the association between the inclusion of physiotherapists on the panel of clinical experts and the presence of recommendations related to their clinical practice. All the analyses were performed with the STATA 15.1® statistics package, with a significance level set at 0.05.

Results

A total of 148 CPGs were analyzed (Figure 1). These guidelines were published between 2005 and 2021 (Table 1). The health problems addressed by the CPGs were predominantly related to oncological (20.14%) and cardiorespiratory diseases (14.58%) (Table 2; Supplementary Table 1). Sixty-nine CPGs (47.92%) were developed with the EtD framework-based methodology, and 88 CPGs (61.11%) were related to physiotherapy practice (Table 2). Additionally, 52 CPGs (36.36%) included physiotherapists on the panel of clinical experts.

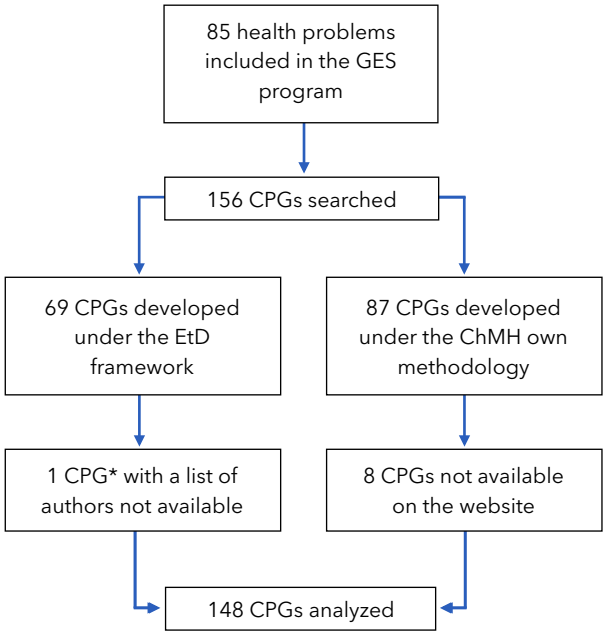

Figure 1 - Flow chart of the number of clinical practice guidelines (CPGs) analyzed

Note: ChMH = Chilean Ministry of Health; EtD: Evidence to Decision; GES = Explicit Guarantees in Health. *CPG that did not have a list of authors was still included in the analyses, with data related to authors being considered missing data.

Table 1 - Clinical practice guidelines publication frequency

Year of publication	n (%)
2005	1 (0.69)
2006	0 (0.00)
2007	2 (1.39)
2008	0 (0.00)
2009	2 (1.30)
2010	21 (14.58)
2011	8 (5.56)
2012	1 (0.69)
2013	28 (19.44)
2014	5 (3.47)
2015	5 (3.47)
2016	2 (1.39)
2017	26 (18.06)
2018	22 (15.28)
2019	11 (7.64)
2020	5 (3.47)
2021	5 (3.47)

Table 2 - Types of health problems addressed by the clinical practice guidelines

Types of health problems	n (%)	EtD framework*	Related to the CP of the PT*
Chronic noncommunicable	13 (9.03)	7 (53.85)	5 (38.46)
Cardiorespiratory	21 (14.58)	8 (38.10)	21 (100)
Oncological	29 (20.14)	16 (55.17)	29 (100)
Neurological	19 (13.19)	9 (47.37)	17 (89.47)
Musculoskeletal	12 (8.33)	5 (41.67)	12 (100)
Ophthalmological	12 (8.33)	7 (58.33)	0 (0.00)
Dental	9 (6.25)	5 (55.56)	0 (0.00)
Behavioral	5 (3.47)	2 (40.00)	0 (0.00)
Infectious	7 (4.86)	3 (42.86)	1 (14.29)
Auditory	5 (3.47)	2 (40.00)	3 (25.00)
Other	12 (8.33)	5 (41.67)	0 (0.00)

Note: EtD = Evidence to Decision; CP = clinical practice; PT = physiotherapists. *Percentage calculated on the number of clinical practice guidelines by health condition.

When the EtD framework-based methodology was used to formulate recommendations, the likelihood of including physiotherapists in the expert panel increased significantly, with an odds ratio (OR) of 3.62 (CI 95% 1.76 to 7.43). Furthermore, in CPGs related to the physiotherapists' clinical practice, the EtD framework-based methodology in developing CPGs further increased this association, with an OR of 7.10 (CI 95% 2.77 to 18.20). Of the CPGs developed using the EtD framework-based methodology (n = 69), 40 (57.97%) were related to the physiotherapists' clinical practice (Table 3), and 35 (51.47%) included physiotherapists on the panel of experts. The expert panels comprised a median of 14.5 (IRQ 12 - 16) health professionals, with a median of 1 (IRQ 0 - 1) physiotherapist. This distribution is consistent even considering only CPGs related to the physiotherapists' clinical practice, with a median of 1 (IRQ 0 - 2) physiotherapist.

Table 3 - Clinical practice guidelines developed with the Evidence to Decision framework-based methodology according to the health problem addressed

Types of health problems	n (%)	Related to the CP of the PT*
Chronic noncommunicable	7 (10.14)	2 (28.57)
Cardiorespiratory	8 (11.59)	8 (100)
Oncological	16 (23.19)	16 (100)
Neurological	9 (13.04)	8 (88.89)
Musculoskeletal	5 (7.25)	5 (100)
Ophthalmological	7 (10.14)	0 (0.00)
Dental	5 (7.25)	0 (0.00)
Behavioral	2 (2.90)	0 (0.00)
Infectious	3 (4.35)	0 (0.00)
Auditory	2 (2.90)	0 (0.00)
Other	5 (7.25)	1 (20.00)

Note: CP = clinical practice; PT = physiotherapist. *Percentage calculated on the number of clinical practice guidelines by health condition.

The 69 CPGs developed using the EtD framework-based methodology included a total of 574 recommendations: 72 about diagnosis (12.54%), 474 about treat-ment (82.58%), and 28 about follow-up (4.88%). Each CPG had a median of eight recommendations (IRQ 6 – 10). Of all the recommendations, 43 (7.49%) were related to the physiotherapists' clinical practice (Supplementary Table 2). Including physiotherapists in the expert panel of the CPGs developed using the EtD framework-based methodology significantly increased the likelihood of including recommendations related to physiotherapists' clinical practice, with an OR of 18.41 (CI 95% 3.80 to 89.09).

Discussion

The use of the EtD framework-based methodology in developing and updating Chilean CPGs was associated with including physiotherapists on the panel of clinical experts. This association was stronger when these CPGs were related to the physiotherapists' clinical practice. Additionally, including physiotherapists on the panel of experts on the CPGs developed with the EtD framework-based methodology was associated with an increased likelihood of recommendations related to their clinical practice.

This is the first study to evaluate the association between the methodology used in developing CPGs and the inclusion of physiotherapists on their panels of experts. Most health problems in the analyzed CPGs were related to oncological and cardiorespiratory diseases. Specific CPGs for physical activity and exercise have been designed for these health conditions. However, these CPGs have shown low to moderate methodological quality when assessed with the AGREE II instrument,[10] with an average score of 64% in terms of stakeholder involvement for those guiding the management of oncological diseases,[19] as well as 60% and 52% in cardiovascular diseases[11] and respiratory diseases,[20] respectively.

According to our definition, 88 (61.11%) CPGs were related to the physiotherapists' clinical practice. However, none of the five CPGs related to behavioral problems or mental health were associated with the physiotherapists' practice, likely due to the limited knowledge of their possible impact on these conditions.[21,22] Additionally, the definition and role of physiotherapists vary according to each country's context and legislation. In Chile, physiotherapists not only use human movement, physical agents, and new techniques to treat patients,[2] but also apply respiratory care interventions like airway permeabilization and ventilatory support.[23] However, only three of the 43 recommendations related to the physiotherapists' clinical practice addressed noninvasive mechanical ventilation in chronic obstructive pulmonary disease and preterm patients.

Rehabilitation-related health professionals, such as physiotherapists, must keep their knowledge up-to-date to base their practice on the best available evidence.[3] For this, CPGs are essential in synthesizing and assessing the evidence to provide recommendations for daily clinical practice.[24] However, for CPGs to fulfill this function, their adaptation, construction, and updating[25] must be based on systematic and transparent methods.[15,16] These methods should incorporate the preferences of the end-users of these CPGs,[26] and include all the professionals involved in the prevention, diagnosis, treatment, and rehabilitation of specific health problems.

This study has limitations. The analysis shows an association, not a causal relationship, between the use of the EtD framework-based methodology and the inclusion of physiotherapists, as well as the generation of recommendations related to their clinical practice. Many factors may contribute to an increase in the inclusion of physiotherapists in the development of CPGs, such as the possible learning curve effect. Additionally, one of the CPGs lacked a correct listing of professionals on the panel of experts, and eight CPGs developed with the ChMH methodology were not available on the website. Nevertheless, the analysis included 95% of the CPGs, a proportion considered representative. Furthermore, data extraction and the determination of whether the health problems included in the CPGs were related to the physiotherapists' clinical practice were performed by clinicians experienced in cardiorespiratory and oncological diseases. However, two physiotherapists independently extracted and analyzed the data about the included CPGs.

Future studies could explore the inclusion of other rehabilitation professionals to assess the possible underrepresentation of these disciplines in the development of CPGs related to their clinical practice. This could help identify issues that may lead to incomplete management of various health problems, potentially affecting the functionality and quality of life of the end users of the CPGs. Additionally, qualitative research should investigate the perspectives and meaning of rehabilitation professionals regarding their participation in CPG development and their views on the possible underrepresentation of certain health problems in their field.

Conclusion

The use of the EtD framework-based methodology in developing CPGs for the GES program designed by the ChMH appears to have facilitated the inclusion of physiotherapists on expert clinical panels. This inclusion was more pronounced when these CPGs were related to the physiotherapists' clinical practice.

Moreover, the inclusion of physiotherapists on panels for CPGs developed using the EtD framework-based methodology was associated with the generation of recommendations pertinent to their clinical practice.

Acknowledgments

The INTRehab Research Group is made up of the following members: Teresita Cortés, Pablo Gómez, Rocío Salazar-Invernizzi, Macarena Cerda, Paulina Wilson, Karim Alul, Carmen Echeverría-Valdebenito, Victoria González-Berrios, Mauricio Contador, Mathías Olivares, Ignacio Cortéz, Stephanie Rodríguez, Sofía Keppeler, Sebastián Calderón, Marjorie Valdés, Ariela Moreno, Natalia Guajardo-Latorre, Iván Ramírez, Valeria Rivas-Gálvez, Geraldine Castañeda-Ayala, Adriana Lastra, Osvaldo Cabrera, Johanna Salinas, Francisco Salinas-Barahona, Cristián Olave, Paula Herrera, Diego Ibacache-Huerta, Annette Fellay-Pernigotti, Gabriel Salgado-Maldonado, Paola Letelier, Sthefany Quezada, María Paz Riquelme, Francisco Valdés, and Ruvistay Gutierrez-Arias. Roberto Vergara-Cabezas, Carlos Rázuri-Soto, and Pamela Seron are external collaborators.

Authors´contributions

RGA was responsible for the conceptualization, data curation, formal analysis, project administration, supervision, visualization, and writing of the original draft. RGA, RVC, KA, CRS, and FSB were responsible for the investigation; RGA and PS, for the methodology. RVC, KA, CRS, FSB and PS were responsible for the writing, review and editing. All authors approved the final version.

References

1. World Confederation for Physical Therapy. Policy statements. London: WCPT; 2011. Link

2. What types of interventions do physiotherapists provide? Phys Ther.1997;77(11):1213-26. Link

3. Dijkers MP, Murphy SL, Krellman J. Evidence-based practice for rehabilitation professionals: concepts and controversies. Arch Phys Med Rehabil. 2012;93(8 Suppl):S164-76. DOI

4. Hoffmann T, Erueti C, Thorning S, Glasziou P. The scatter of research: cross sectional comparison of randomised trials and systematic reviews across specialties. BMJ. 2012;344:e3223. DOI

5. Woolf SH, Grol R, Hutchinson A, Eccles M, Grimshaw J. Clinical guidelines: potential benefits, limitations, and harms of clinical guidelines. BMJ. 1999;318(7182):527-30. DOI

6. Pantoja T, Valenzuela L, Léniz J, Castañón C. Clinical practice guidelines in the Chilean health sector reform: A critical assessment of their quality. Rev Med Chil. 2012;140(11):1391-400. DOI

7. Rodríguez MF, Pineda I, Rozas MF. Quality assessment of clinical practice guidelines of the Chilean explicit guarantees in healthcare program. Rev Med Chil. 2016;144(7):862-9. DOI

8. Loezar C, Pérez-Bracchiglione J, Arancibia M, Meza N, Vargas M, Papuzinski C, et al. Guidelines in low and middle income countries Paper 2: Quality assessment of Chilean guidelines: need for improvement in rigor, applicability, updating, and patients' inclusion. J Clin Epidemiol. 2020;127:177-83. DOI

9. AGREE Collaboration. Development and validation of an international appraisal instrument for assessing the quality of clinical practice guidelines: the AGREE project. Qual Saf Health Care. 2003;12(1):18-23. DOI

10. Brouwers MC, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G, et al. AGREE II: advancing guideline development, reporting and evaluation in health care. Can Med Assoc J. 2010;182(18):E839-42. DOI

11. Serón P, Lanas F, Ríos E, Bonfill X, Alonso-Coello P. Evaluation of the quality of clinical guidelines for cardiac rehabilitation: a critical review. J Cardiopulm Rehabil Prev. 2015;35(1):1-12. DOI

12. Dijkers MP, Ward I, Annaswamy T, Dedrick D, Feldpausch J, Moul A, et al. Quality of rehabilitation clinical practice guidelines: an overview study of AGREE II appraisals. Arch Phys Med Rehabil. 2020;101(9):1643-55. DOI

13. Dijkers MP, Ward I, Annaswamy T, Dedrick D, Hoffecker L, Millis SR. What determines the quality of rehabilitation clinical practice guidelines? An overview study. Am J Phys Med Rehabil. 2021;100(8):790-7. DOI

14. Guyatt GH, Oxman AD, Vist GE, Kunz R, Falck-Ytter Y, Alonso-Coello P, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ. 2008; 336(7650):924-6. DOI

15. Alonso-Coello P, Schünemann HJ, Moberg J, Brignardello-Petersen R, Akl EA, Davoli M, et al. GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 1: Introduction. BMJ. 2016;353:i2016. DOI

16. Alonso-Coello P, Oxman AD, Moberg J, Brignardello-Petersen R, Akl EA, Davoli M, et al. GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 2: Clinical practice guidelines. BMJ. 2016;353:i2089. DOI

17. Guías Clínicas GES [cited 25 Apr 2024]. Chile: Ministerio de Salud. Available from: https://diprece.minsal.cl/le-informamos/auge/acceso-guias-clinicas/guias-clinicas-auge/

18. World Health Organization. International Classification of Functioning, Disability and Health. Geneva: WHO; 2018. Link

19. Shallwani SM, King J, Thomas R, Thevenot O, De Angelis G, Aburub AS, et al. Methodological quality of clinical practice guidelines with physical activity recommendations for people diagnosed with cancer: A systematic critical appraisal using the AGREE II tool. PLoS One. 2019;14(4):e0214846. DOI

20. Uzeloto JS, Moseley AM, Elkins MR, Franco MR, Pinto RZ, Freire APCF, et al. The quality of clinical practice guidelines for chronic respiratory diseases and the reliability of the AGREE II: an observational study. Physiotherapy. 2017;103(4):439-45. DOI

21. Lee S, Waters F, Briffa K, Fary RE. Limited interface between physiotherapy primary care and people with severe mental illness: a qualitative study. J Physiother. 2017;63(3):168-74. DOI

22. Andrew E, Briffa K, Waters F, Lee S, Fary R. Physiotherapists' views about providing physiotherapy services to people with severe and persistent mental illness: a mixed methods study. J Physiother. 2019;65(4):222-9. DOI

23. Bello G, De Pascale G, Antonelli M. Noninvasive ventilation. Clin Chest Med. 2016;37(4):711-21. DOI

24. Heiwe S, Kajermo KN, Tyni-Lenné R, Guidetti S, Samuelsson M, Andersson IL, et al. Evidence-based practice: attitudes, knowledge, and behavior among allied health care professionals. Int J Qual Health Care. 2011;23(2):198-209. DOI

25. Kredo T, Bernhardsson S, Machingaidze S, Young T, Louw Q, Ochodo E, et al. Guide to clinical practice guidelines: the current state of play. Int J Qual Health Care. 2016;28(1):122-8. DOI

26. Blackwood J, Armstrong MJ, Schaefer C, Graham ID, Knaapen L, Straus SE, et al. How do guideline developers identify, incorporate and report patient preferences? An international cross-sectional survey. BMC Health Serv Res. 2020;20(1):458. DOI

Supplementary Table 1 - Health problems covered by clinical practice guidelines (CPGs)

Types of health problems	Health problems included in the CPGs	Number of CPGs	Methodology
Chronic non-communicable diseases	Chronic kidney disease	2	One old and one new
	Peritoneal dialysis and hemodialysis	3	One old and two new
	Diabetes mellitus	2	One old and one new
	Gestational diabetes	1	Old
	Primary or essential hypertension	2	One old and one new
	Hypothyroidism	2	One old and one new
	Renal transplantation	1	New
Cardiorespiratory	Operable congenital heart diseases	2	One old and one new
	Acute myocardial infarction	2	One old and one new
	Lower respiratory infection	1	Old
	Community-acquired pneumonia	2	One old and one new
	Cardiac impulse generation and conduction disorders	1	Old
	Chronic obstructive pulmonary disease	2	One old and one new
	Asthma	3	Two old and one new
	Respiratory distress syndrome in newborns	2	One old and one new
	Cystic fibrosis	2	One old and one new
	Bronchopulmonary dysplasia of prematurity	2	One old and one new
	Surgical treatment of chronic valvular lesions	2	Two old
Oncology	Cervical cancer	1	Old
	Advanced cancer pain and palliative care	2	One old and one new
	Breast cancer	2	One old and one new
	Testicular cancer	2	One old and one new
	Hodgkin's and non-Hodgkin's lymphoma	3	One old and two new
	Lymphoma and solid tumors in children	1	Old
	Epithelial ovarian cancer	2	One old and one new
	Preventive cholecystectomy	1	Old
	Gastric cancer	1	New
	Prostate cancer	2	One old and one new
	Leukemia	4	Two old and two new
	Colorectal cancer	2	One old and one new
	Bladder cancer	2	One old and one new
	Osteosarcoma	1	Old
	Lung cancer	1	New
	Kidney cancer	1	New
	Multiple myeloma	1	New
Neurological	Spinal dysraphism	2	One old and one new
	Epilepsy	2	One old and one new
	Ischemic stroke	2	One old and one new
	Subarachnoid hemorrhage secondary to ruptured brain aneurysms	2	One old and one new
	Primary central nervous system tumors	2	One old and one new

Note: *The new methodology includes an Evidence to Decision framework-based methodology for developing recommendations.

Supplementary Table 1 - Health problems covered by clinical practice guidelines (continued)

Types of health problems	Health problems included in the CPGs	Number of CPGs	Methodology
Neurological	Lumbar nucleus pulposus herniation	1	Old
	Trauma brain injury moderate to severe	1	Old
	Parkinson's disease	3	Two old and one new
	Multiple sclerosis	2	One old and one new
	Spinal cord injury	1	New
	Alzheimer's Dementia	1	New
Musculoskeletal	Scoliosis	2	One old and one new
	Endoprosthesis in hip osteoarthritis	2	One old and one new
	Medical treatment of hip or knee osteoarthritis	2	One old and one new
	Polytrauma	1	Old
	Rheumatoid arthritis	1	Old
	Juvenile idiopathic arthritis	2	One old and one new
	Hip dysplasia	2	One old and one new
Ophthalmology	Congenital and acquired cataracts	2	One old and one new
	Refraction defects	2	One old and one new
	Strabismus	2	One old and one new
	Diabetic retinopathy	1	New
	Non-rhegmatogenous retinal detachment	2	One old and one new
	Ocular trauma	1	New
	Retinopathy of prematurity	2	One old and one new
Dental	Labiopalatine cleft	1	Old
	Comprehensive oral health	6	Two old and four new
	Outpatient dental emergencies	2	One old and one new
Behavioral or mental health	Schizophrenia	1	Old
	Depression	1	Old
	Alcohol and other drug dependence	1	New
	Bipolar disorder	2	One old and one new
Infectious	HIV and AIDS	3	One old and two new
	Hepatitis B virus infection	1	Old
	Chronic hepatitis C virus infection	2	One old and one new
	Helicobacter pylori	1	Old
Auditory	Hearing loss	5	Three old and two new
Other	Preventing preterm birth	2	One old and one new
	Hemophilia	2	One old and one new
	Benign prostatic enlargement	2	One old and one new
	Technical aids	2	One old and one new
	Childbirth analgesia	2	One old and one new
	Large burn patient	1	Old
	Systemic lupus erythematosus	1	Old

Note: *The new methodology includes an Evidence to Decision framework-based methodology for developing recommendations. CPGs = clinical practice guidelines; HIV = Human Immunodeficiency Virus; AIDS = Acquired Immunodeficiency Syndrome.

Supplementary Table 2 - Recommendations related to the clinical practice of the physiotherapist

Types of health problems	Recommendation
Cardiorespiratory (Acute myocardial infarction)	In people with recent ST-segment elevation myocardial infarction in post-treatment who are receiving routine secondary prevention, the Ministry of Health suggests cardiac rehabilitation over no rehabilitation.
	In people post-treatment of acute myocardial infarction with ST-segment elevation in stage II, in whom cardiac rehabilitation is to be performed, the Ministry of Health suggests that it should be of moderate duration (< 20 sessions) rather than of prolonged duration (≥ 20 sessions).
Oncology (Breast cancer)	The Ministry of Health suggests physiotherapists use a prospective surveillance model over non-surveillance in people at high risk of developing lymphoedema.
Neurological (Spinal dysraphism)	The Ministry of Health suggests an annual multidisciplinary team check-up rather than a routine check-up for newborns with myelomeningocele.
	In newborns with operated myelomeningocele, the Ministry of Health suggests assessment and rehabilitation by a trained multidisciplinary team over non-rehabilitation.
Cardiorespiratory (Community-acquired pneumonia)	In adults aged 65 years and older with community-acquired pneumonia, the Ministry of Health advises against routine functional kinesiological rehabilitation.
Other (Technical aids)	For people with limited mobility who require a cane, the Ministry of Health suggests using one point of support over a cane with more points of support.
	For people with limited mobility who require a cane, the Ministry of Health suggests using a hand cane with one point of support or a Canadian cane, depending on the person's characteristics and preferences.
	The Ministry of Health suggests the use of an ipsilateral or contralateral single-point cane, depending on the clinical condition, in people 65 years of age and older with limited mobility.
	The Ministry of Health suggests using a four-wheeled walker over a stationary walker for people with limited mobility.
Cardiorespiratory (Chronic obstructive pulmonary disease)	The Ministry of Health suggests that health teams prescribe physical activity and pharmacological treatment for people with chronic obstructive pulmonary disease.
	In people with hypersecretory chronic obstructive pulmonary disease with frequent exacerbations, the Ministry of Health advises performing manual and non-manual breathing techniques (instrumental and non-instrumental) on the chest compared to not performing them.
	In people with exacerbated chronic obstructive pulmonary disease, the Ministry of Health suggests pulmonary rehabilitation over no rehabilitation.
	In people with exacerbated chronic obstructive pulmonary disease and acute hypercapnic failure, the Ministry of Health recommends the use of noninvasive mechanical ventilation over only medical treatment without ventilation.
Cardiorespiratory (Asthma)	In asthmatics under 15 years of age, the Ministry of Health recommends performing spirometry over not performing spirometry.
Cardiorespiratory (Respiratory distress syndrome in newborns)	The Ministry of Health recommends using prophylactic continuous positive airway pressure in newborns under 28 weeks rather than continuous positive airway pressure when symptoms of respiratory distress appear.
	The Ministry of Health suggests intubation for surfactant administration over noninvasive treatment in newborns under 28 weeks with respiratory distress syndrome on continuous positive airway pressure who achieve an oxygen fraction more significant than 40%.
Musculoskeletal	In people over 55 years of age with a clinical diagnosis of mild or moderate osteoarthritis of the hip or knee and who are also overweight or obese (excess malnutrition), the Ministry of Health suggests a structured physical exercise and dietary management plan over dietary management alone.
	In people over 55 years of age with a clinical diagnosis of mild or moderate hip osteoarthritis, the Ministry of Health suggests adding monitored and programmed physical exercise to the usual pharmacological treatment.
	In people over 55 years of age with a clinical diagnosis of mild or moderate knee osteoarthritis, the Ministry of Health suggests that monitored and programmed physical exercise associated with regular pharmacological treatment should be performed rather than regular pharmacological treatment alone.
	In people over 55 years of age with a clinical diagnosis of mild to moderate hip or knee osteoarthritis, the Ministry of Health suggests physiotherapy (transcutaneous analgesia) over no physiotherapy.

Supplementary Table 2 - Recommendations related to the clinical practice of the physiotherapist (continued)

Types of health problems	Recommendation
Neurological (Subarachnoid hemorrhage)	In patients with aneurysmal subarachnoid hemorrhage, the Ministry of Health suggests early neurorehabilitation (within 15 days post-diagnosis) rather than no rehabilitation.
Neurological (Primary central nervous system tumors)	In patients with primary tumors of the central nervous system requiring radiotherapy, the Ministry of Health suggests performing neurorehabilitation over not performing neurorehabilitation.
Neurological (Spinal cord injury)	In people with spinal cord trauma in the critical care unit, the Ministry of Health suggests cough assistance over no cough assistance.
	In people with spinal cord trauma in the critical patient unit, the Ministry of Health suggests early mobilization, including standing, rather than no mobilization.
	In people with spinal cord trauma in a critical patient unit, the Ministry of Health suggests performing respiratory muscle training rather than not doing it.
	In people with spinal cord trauma in a tracheostomized critical patient unit, the Ministry of Health suggests the early use of a speaking valve over not using one.
Cardiorespiratory (Cystic fibrosis)	In patients with cystic fibrosis, the Ministry of Health suggests pulmonary rehabilitation as opposed to not doing it.
	In patients with cystic fibrosis, the Ministry of Health recommends physical exercise instead of not exercising.
Oncology (Lung cancer)	In patients with operable lung cancer, the Ministry of Health suggests prehabilitation (preoperative) and pulmonary rehabilitation (postoperative) over postoperative physiotherapy.
Neurological (Ischemic stroke)	In people aged 15 years and older with ischemic stroke, the Ministry of Health suggests initiating motor therapy within 24 hours of the event rather than after 24 hours.
	In people aged 15 years and older with ischemic stroke, the Ministry of Health suggests a high rehabilitation session load over a low rehabilitation session load.
Musculoskeletal (Scoliosis)	The Ministry of Health suggests performing motor physiotherapy rather than not performing it in people who maintain scoliosis after surgery.
Musculoskeletal (Hip osteoarthritis)	The Ministry of Health suggests pre-surgical rehabilitation rather than no rehabilitation for people who will undergo total hip arthroplasty with total hip endoprosthesis.
	The Ministry of Health suggests functional exercises (gait, transitions, and transfers in the in-hospital setting) over bed-based exercises for people undergoing total hip arthroplasty with endoprosthesis.
	The Ministry of Health suggests an individualized rehabilitation program for people undergoing total hip arthroplasty with endoprosthesis in the immediate postoperative period, followed by group therapy when they reach a level of function that allows them to exercise with less supervision.
Other (Pain relief during labor)	In women in labor who request pain relief, the Ministry of Health suggests using local thermotherapy over not using it.
	In women in labor who request pain relief, the Ministry of Health suggests using a kinesiology balloon over not using one.
	For women in labor who request pain relief, the Ministry of Health suggests using massage therapy over not using it.
Musculoskeletal (Arthritis)	The Ministry of Health suggests exercise or physical activity over no exercise or physical activity for people with juvenile idiopathic arthritis.
Oncology (Multiple myeloma)	In people with multiple myeloma who are candidates for autologous transplantation, the Ministry of Health suggests prehabilitation as opposed to education and counseling alone.
	In people with multiple myeloma, the Ministry of Health suggests rehabilitation versus education and counseling.
Neurological (Alzheimer)	In people with Alzheimer's dementia, the Ministry of Health suggests structured physical exercise over no exercise.