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Report on prioritization of rehabilitation services in Georgia

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Abbreviations

CIF – Curatio International Foundation

COPD - Chronic obstructive pulmonary disease

CUA - Cost-Utility Analysis

GBD – Global Burden of Disease

LBP – Low Back Pain

LMICs _ Low- and Middle- Income Countries

MoIDPLHSA – The Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia

OT - occupational therapy (therapist)

PIR - Package of Interventions for Rehabilitation

PT - physical therapy (therapist)

QALY - The quality-adjusted life-year

R4D – Results for Development

RCT -Randomized Controlled Trial

RCT - Randomized Controlled Trials

SLT - speech and language therapy (therapist)

SME -Subject Matter Expert

SR- Systematic Review

UHC – Universal Health Coverage

USAID – United States Agency for International Development

WHO – World Health Organization

YLD - Years of healthy life lost due to disability/ Years lived with disability

Introduction

Rehabilitation in Georgia has often been seen as a disability-specific service needed by only a few of the population and has previously received little attention from governments. This has contributed to poor service availability and a lack of coordination between services. However, this perception is false, as anybody may need rehabilitation at some point in their lives, following an injury, surgery, disease or illness, or because their functioning has declined with age. Rehabilitation ensures that people remain independent with chronic health problems as they age and can continue to participate in education, work and other meaningful life activities. Thus, the WHO considers rehabilitation to be accessible for all people, forming part of the continuum of health care and part of health systems. Affordable and high-quality services should be available to all those in need, as rehabilitation should become an essential part of Universal Health Coverage (UHC) along with the promotion of good health, prevention of disease, treatment and palliative care.¹ UHC is recognized as a key target in Goal 3 of the Sustainable Development Goals (Ensure healthy lives and promote well-being for all at all ages),² and so access to rehabilitation is essential in order to reach the SDG goals and targets. Access to rehabilitation for people with disabilities is also a human right, as stated in Article 26 of the United Nations Convention for the Rights on People with Disabilities.

The WHO estimates that 2.4 billion, or one in three people globally, have a health condition over the course of their life that would benefit from rehabilitation.³ The need for rehabilitation services is largely unmet, particularly in the Low- and Middle-Income Countries (LMICs), to which Georgia is not an exception. On the one hand, according to the 2014 census, the number of people with self-reported difficulty functioning in the country is over 1,3 million, or over one-third of the population, who may have benefited or still benefit from rehabilitation.⁴ This is consistent with 2018 Multiple Indicator Cluster Survey results that identify 28% of children and adults (aged 2–49 years) as having difficulty functioning in at least one domain.⁵ On the other hand, according to the 2021 WHO Situation Assessment of Rehabilitation in Georgia, only a limited spectrum of rehabilitation and habilitation services are physically available (mostly in Tbilisi and Batumi). Moreover, almost no rehabilitation services are publicly financed, except for a narrow package of rehabilitation and habilitation services for children, making rehabilitation unaffordable for most of the Georgia population.⁶ The current demographic and health transitions globally and in Georgia are contributing to a rapid increase in the number of people experiencing disability or declines in functioning for substantially larger periods of their lives.

The growing and unmet need for rehabilitation in Georgia is acknowledged by the Government of Georgia, as the Ministry of Internally Displaced Persons, Labour, Health and Social Affairs (MoIDPLHSA) is completing the elaboration of the multiyear national strategy for rehabilitation.

¹ [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)) accessed 1 July 2022

² United Nations Sustainable Development Goals. Available online: <https://sustainabledevelopment.un.org/?menu=1300> accessed 1 July 2022

³ Cieza, Alarcos et al. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, Volume 396, Issue 10267, 2006 - 2017

⁴ 2014 general population census. Tbilisi: National Statistics Office of Georgia; 2014 (<http://census.ge/en/results/census1/health> accessed 1 July 2022)

⁵ Georgia multiple indicator cluster survey 2018, survey findings report. Tbilisi: National Statistics Office of Georgia; 2019 (https://www.unicef.org/georgia/media/3501/file/Georgia_MICS_2018_en.pdf, accessed 2 July 2022).

⁶ Situation assessment of rehabilitation in Georgia: February 2020. Copenhagen: WHO Regional Office for Europe; 2021. Licence: CC BY-NC-SA 3.0 IGO

The Inclusive Development Hub of USAID's Bureau for Development, Democracy, and Innovation has partnered with the Accelerator to support countries in strengthening and integrating rehabilitation in health systems in post-conflict countries. Georgia was selected as a priority country for program support, which will entail direct technical assistance in addition to regional and global level activities to catalyze country-level work. The program will be implemented during July 2021-September 2023 in close collaboration with USAID in Georgia and the DDI Bureau in Washington.

The Accelerator issued a subgrant to Curatio International Foundation (CIF), to support the program's implementation of activities to achieve program objectives on the ground. This includes operational support and technical expertise on Georgia's health systems and financing context to complement the Accelerator's global expertise and translation of existing knowledge into locally feasible solutions.

The main goal of the project is to improve population financial protection for rehabilitation according to need. The project collaborates with the MoDPLHSA and other key stakeholders toward the following objectives:

1. Integration of rehabilitation in Georgian health systems and health financing programs.
2. Creating support systems for implementing programs from Objective 1.

Identifying the priority health conditions amenable to rehabilitation and establishing priority rehabilitation interventions and eligibility criteria for publicly financed State Health Programs is the first step in achieving these objectives. This report describes how this task has been accomplished.

Prioritization methodology and process

Concepts and definitions used

Rehabilitation - A set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment.⁷

Rehabilitation interventions - Targeted actions to build muscle strength and improve balance, cognitive ability or communication skills.⁸

Package of Interventions for Rehabilitation (PIR) - A WHO resource containing information on evidence-based interventions for rehabilitation relevant to the most prevalent health conditions associated with limitations in functioning and that are amenable to rehabilitation. The PIR is intended to facilitate the integration of rehabilitation interventions in all health service delivery platforms.⁹

Health condition - A disease (acute or chronic), disorder, injury or trauma. A health condition may also refer to other circumstances, such as pregnancy, aging, stress, congenital anomaly or genetic predisposition.¹⁰

Medical rehabilitation - Improving functioning through the diagnosis and treatment of a health condition, reducing impairments and preventing or treating complications.

Therapy - Restoring or compensating for the loss of functioning and preventing deterioration in functioning, which may include physiotherapy (physical therapy - PT), occupational therapy (OT), and speech and language therapy (SLT).

⁷ [Rehabilitation \(who.int\)](https://www.who.int/rehabilitation) accessed 1 July 2022

⁸ Western Pacific Regional framework on rehabilitation. Manila: World Health Organization Regional Office for the Western Pacific; 2019 (<https://iris.wpro.who.int/handle/10665.1/14344>, accessed 2 July 2022). Licence: CC BY-NC-SA 3.0 IGO.

⁹ [Package of Interventions for Rehabilitation \(who.int\)](https://www.who.int/publications/m/item/package-of-interventions-for-rehabilitation)

¹⁰ Ibid

Assistive devices - Any equipment that is used to increase or maintain functional capabilities. These do not include primarily curative interventions such as the provision of spectacles, cataract surgery, hip replacement surgery, and similar treatments.¹¹

Years Lived with Disability (YLD) - A measure of the burden of non-fatal disease and injury and is calculated by multiplying the prevalence of each sequela (the disabling consequences of diseases and injuries) by the estimated level of health loss in the form of a disability weight.

Methodology

A stepwise process was used for the prioritization of rehabilitation services to be considered for public financing in Georgia. The process entailed three key steps:

1. Identification of **priority health conditions** that are associated with limitations in functioning and are amenable to rehabilitation, and
2. Identification and grouping of *evidence-based* interventions for rehabilitation available in the country for these *priority health conditions* to be considered for inclusion in the state health programs.
3. Validation of the selected priority health conditions and the evidence-based intervention groups with key national stakeholders through the consensus-building workshop.

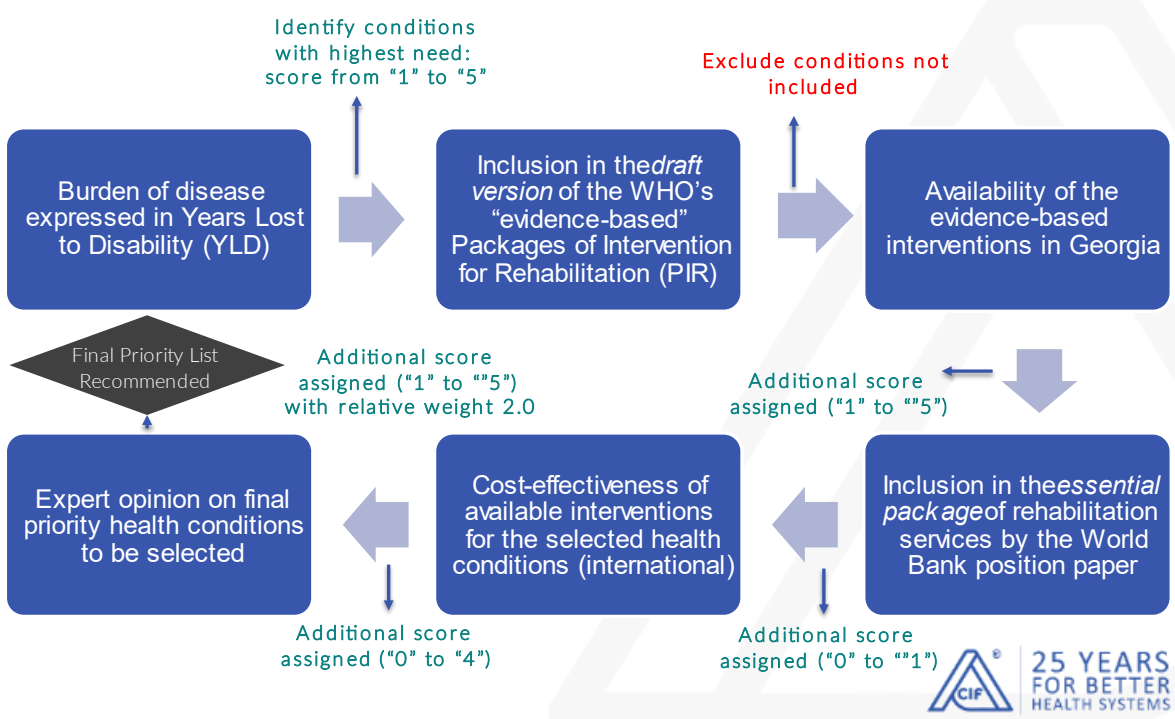
The CIF team accomplished the first step by progressively applying predefined criteria and commensurate qualitative scores to derive a priority list of health conditions that (a) generate the highest need for rehabilitation in the country; (b) are amenable to evidence-based rehabilitation interventions; (c) these evidence-based rehabilitation interventions are currently available and provided in Georgia and (d) the same interventions are recommended for the inclusion in an “essential package of services” proposed by the World Bank position paper;¹² (e) in expert opinion is of highest priority considering the existing demand for the respective rehabilitation services and their public health importance (see Figure 1).

The second step was completed by “matching” interventions included in the WHO PIRs with respective rehabilitation interventions provided in Georgia and by grouping them in larger intervention groups (by type of intervention) to be used for reimbursement of the rehabilitation services under the considered state program. The third step involved consensus building on the selected priority health conditions and interventions through a one-day workshop with key national stakeholders. More details for each step follow in the respective subsections of the Results section.

¹¹ Bright T, Wallace S, Kuper H. A Systematic Review of Access to Rehabilitation for People with Disabilities in Low- and Middle-Income Countries. *Int J Environ Res Public Health*. 2018 Oct 2;15(10):2165. doi: 10.3390/ijerph15102165. PMID: 30279358; PMCID: PMC6210163.

¹² [Table 15.1, Essential Package of Rehabilitation Interventions - Disease Control Priorities: Improving Health and Reducing Poverty - NCBI Bookshelf \(nih.gov\)](#) accessed 3 July 2022.

Figure 1: Process and criteria used for prioritization of health conditions amenable to rehabilitation for public financing in Georgia



STEP 1.

1. Assessing the need for rehabilitation

The CIF team assessed the rehabilitation needs for Georgia using the data from the Global Burden of Diseases (GBD), Injuries, and Risk Factors Study 2019.¹³ The estimates for Georgia were produced on prevalence and YLD of 25 diseases, impairments, or adapted aggregations of sequelae that were selected by WHO as most amenable to rehabilitation.¹⁴ Institute for Health Metrics and Evaluation’s WHO Rehabilitation Need Estimator tool¹⁵ and GBD results tool¹⁶ were used for extracting the YLD estimates for the country. Estimates were collected for each condition, sex and age group, which allowed us to prioritize and score health conditions by different groups. The rehabilitation hierarchy used in the GBD 2019 and IHME studies was applied (see Figure 2). Qualitative scores from 0 to 5 were assigned to the health conditions based on the following scoring system:

- “5” - Very High = For adults > 20,000 and for Children >600 YLD per 100,000 population;
- “4” - High = for adults from 10,000 to 20,000 and for children 400-600 YLD per 100,000 population
- “3” - Moderate = for adults from 5,000 to 10,000 and for children 200-400 YLD per 100,000 population
- “2” - Low = for adults from 2,500 to 5,000 and for children 100-200 YLD per 100,000 population

¹³ The GBD study produces the most comprehensive assessment of prevalence, incidence, and years of life lived with disability for 354 diseases and injuries, and 3484 sequelae for all countries from 1990 to 2019.

¹⁴ Cieza, Alarcos et al. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019. The Lancet, Volume 396, Issue 10267, 2006 – 2017.

¹⁵ [WHO Rehabilitation Need Estimator | IHME Viz Hub \(healthdata.org\)](https://vizhub.healthdata.org/who-rehabilitation-need-estimator/) accessed on 2 July 2022

¹⁶ [VizHub - GBD Results \(healthdata.org\)](https://vizhub.healthdata.org/gbd-results/) accessed on 2 July 2022

“1”- Low = for adults <2,500 and for children <100 YLD per 100,000 population.

Figure 2: Rehabilitation hierarchy: Health conditions grouped in the disorder groups

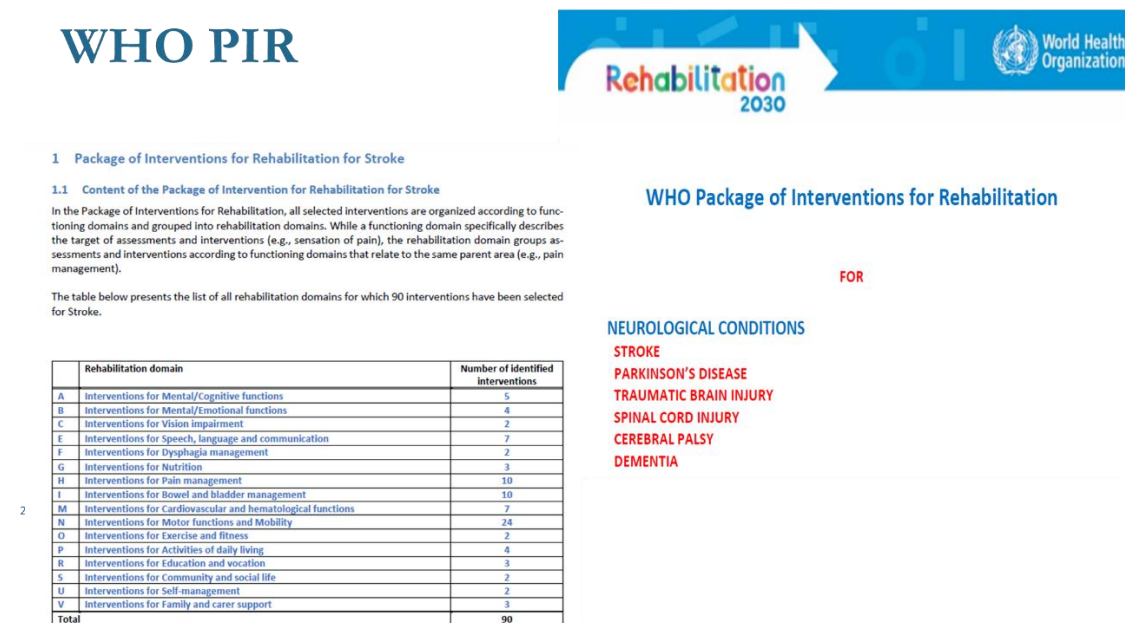
- **Musculoskeletal disorders**
 - Low back pain, neck pain
 - Osteoarthritis
 - Rheumatoid arthritis
 - Fractures
 - Amputation
 - Other injuries
- **Cardiovascular diseases**
 - Acute myocardial infarction
 - Heart failure
- **Chronic respiratory disease: COPD**
- **Neoplasms**
- **Sensory impairments**
 - Hearing loss
 - Vision loss
- **Neurological Disorders**
 - Stroke
 - Alzheimer's disease and dementia
 - Parkinson's disease
 - Traumatic brain injury
 - Cerebral palsy
 - Spinal cord injury
 - Multiple sclerosis
 - Motor-neuron disease
 - Guillain-Barré syndrome
- **Mental disorders**
 - Schizophrenia
 - Developmental intellectual disability
 - Autism spectrum disorders

Source: IHME 2020

2. Inclusion in WHO PIRs

The CIF team used the WHO PIR to narrow down the priority health conditions for rehabilitation with the premise that only the health conditions for which the WHO PIRs were developed are amenable to evidence-based rehabilitation interventions. For this purpose, the draft versions of the WHO PIRs were obtained with kind support from R4D and the WHO Regional Office for European Region and WHO Geneva (see example in Figure 3). As a result, the health conditions not included in the WHO PIRs were excluded from the priority list of health conditions in Georgia.

Figure 3: Example of the draft WHO PIR: Neurological Conditions



3. Availability of the rehabilitation interventions in Georgia

The list of health conditions with the highest need for rehabilitation in Georgia amenable to the evidence-based rehabilitation interventions (e.g., the health conditions included in the WHO PIRs) were further reviewed to establish a physical availability of the evidence-based rehabilitation interventions for these health conditions in Georgia. CIF team used the findings of the rehabilitation situation assessment conducted by the WHO team in 2020 (see Annex 1) and consultations with Subject Matter (rehabilitation) Experts SMEs (see Annex 2), rehabilitation services utilization data from three rehabilitation providers (Ken Walker University Clinic for Medical Rehabilitation, the New Hospital’s Inpatient Rehabilitation Department and Aversi Rehabilitation Clinic) and additional interviews with other providers of rehabilitation services, both included and not included in the WHO situation assessment report, to establish the current availability of rehabilitation interventions and services for the selected conditions in the country. Qualitative scores from “1” to “5” were assigned to the health conditions based on the following scoring system:

- “5” - Key interventions are currently provided by more than one provider, including those located outside Tbilisi
- “4” - Key interventions are currently provided by more than one provider; however, only in Tbilisi
- “3” - Key interventions are provided by only one provider
- “2” - Limited range of interventions is provided by one or two providers
- “1” - No interventions are currently provided

4. Inclusion in the “essential package of services.”

The health conditions and the respective rehabilitation interventions were further assessed on the subject of whether these conditions and rehabilitation interventions were included in an “essential package of

rehabilitation services” proposed by the World Bank position paper.¹⁷ An additional score or “1” was assigned if included or zero otherwise.

5. Evidence on Cost-effectiveness

The Cost-effectiveness of the available “evidence-based” rehabilitation interventions for the selected health conditions was the next criterion used by the CIF team for prioritization of the selected health conditions. The evidence on cost-effectiveness from the international practice with the emphasis on Low and Middle-Income Countries was gathered through the literature review. As in the case of other criteria, scores were applied based on the following custom-designed system:

“4” - Strong evidence

“3” - Strong, but single study evidence

“2” - Evidence of moderate strength

“1” - Inconclusive

“0” - No evidence

6. Expert opinion

The CIF team consulted five national SMEs and their “expert opinion” on the unmet need for and the public health priority of the needed rehabilitation services for the selected health conditions as a final criterion, assigning to it the double relative weight. The following custom-tailored qualitative scoring system was applied to assign the relative scores based to the health conditions based on the expert opinion:

“5” - High individual and public health priority

“4” - High individual but moderate public health priority

“3” - High public health but moderate individual health priority

“2” - Moderate individual and public health priority

“1” - Low individual and public health priority

The final priority list of health conditions for rehabilitation services was derived based on the summary scores across the above criteria.

Step 2

The CIF team engaged again with five SMEs to complete the second step: “matching” interventions included in the WHO PIRs with respective rehabilitation interventions provided in Georgia for the selected priority health conditions and grouping them in larger intervention groups (by type of intervention) to be considered for reimbursement under the proposed state program. During the matching process, the intervention groupings used for the reimbursement by the Estonian Health Insurance Fund were also considered. Information on the rehabilitation services publicly financed in Estonia, specifically available interventions and ceiling tariffs for rehabilitation procedures, was extracted from the “List of health care services of the Estonian Health Insurance Fund” (available on the Riigi Teataja website that is hosted and responsible for the technical operation of the Center of Registers and Information Systems of the Ministry of Justice of Estonia). The engagement details with SMEs are presented in Annex 1 of the Report.

¹⁷ [Table 15.1, Essential Package of Rehabilitation Interventions - Disease Control Priorities: Improving Health and Reducing Poverty - NCBI Bookshelf \(nih.gov\)](#)

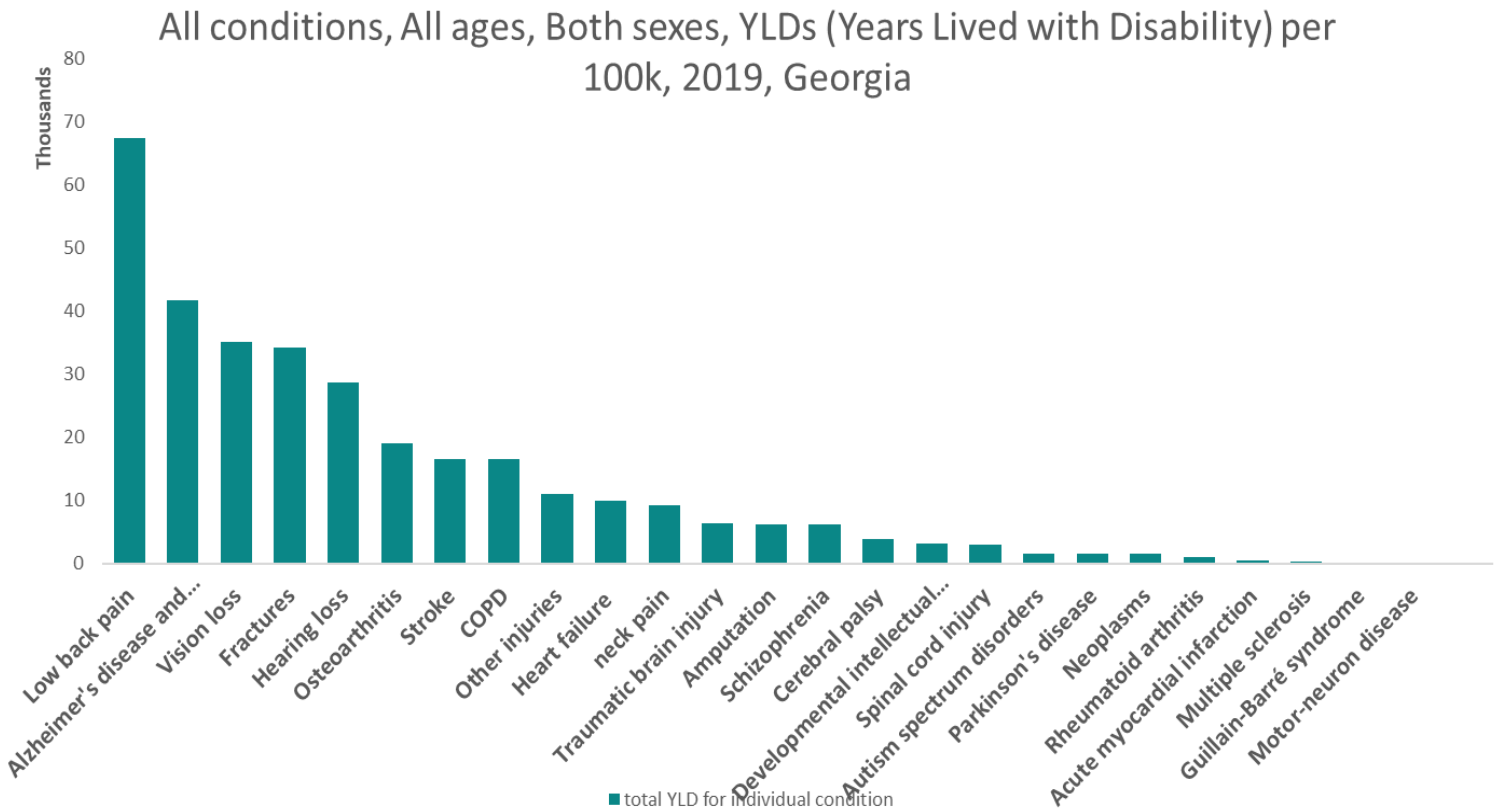
Step 3

The CIF team presented the selected priority health conditions and the intervention groups for validation at a Stakeholder Consensus Workshop.

Prioritization Results

Diseases Burden. The health conditions and groups with the highest burden of YLD for all ages in Georgia are presented in Figure 4 and Figure 5, respectively.

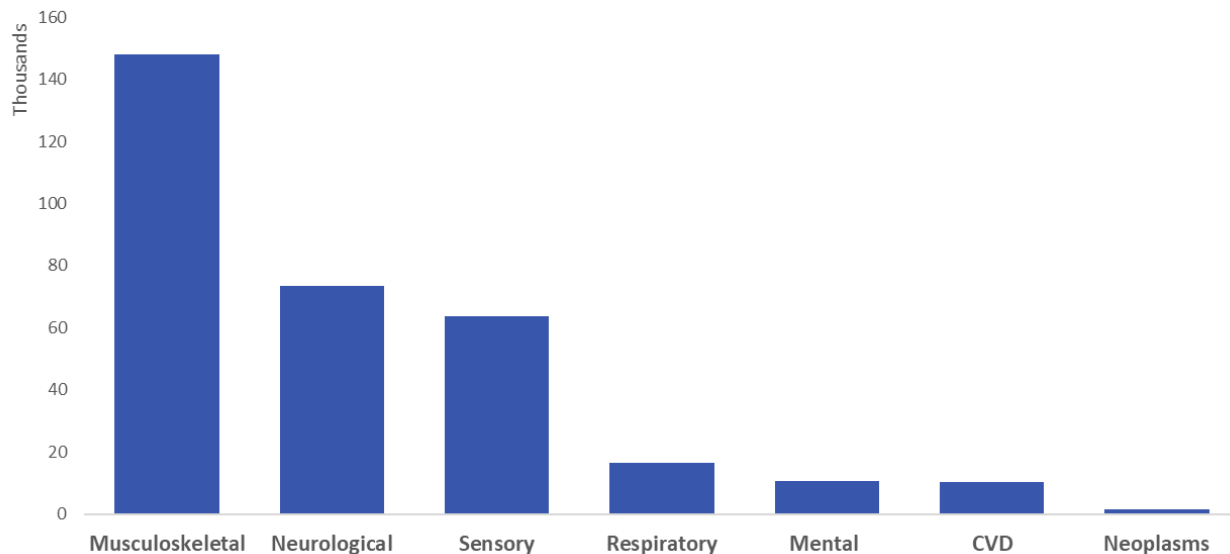
Figure 4: Health conditions and related YLDs per 100,000 population, all ages, both sexes



Source: Authors estimates based on GBD 2019 and Institute of Health Metrics and Evaluation

Figure 5: Health conditions' groups and related YLDs per 100,000 population, all ages, both sexes

All categories, All ages, Both sexes, YLDs (Years Lived with Disability) per 100k, 2019, Georgia



Source: Authors estimates based on GBD 2019 and Institute of Health Metrics and Evaluation

Inclusion in the WHO PIR. Twenty-two health conditions with the highest YLD burden for all ages and sexes and hence with the highest need for rehabilitation were reduced to nineteen health conditions once the three conditions not included in the WHO PIR (neck pain, multiple sclerosis and moto-neuron diseases) were excluded.

The availability of rehabilitation interventions in Georgia. Along with consultations with SMEs described in Annex 2, five additional interviews were conducted with representatives of rehabilitation service providers: Dr. Dimitri Jorbenadze, General Director of Avery Hospital and Dr. Maia Kurtanidze, Director of Avery Rehabilitation Center, Dr. Ekaterine Sanikidze, Rehabilitation Lead, Balneological Resort, Tea Adamia, Chief of the Rehabilitation at David Tatishvili Medical Center and Dr. Pavle Kasradze, the Head of the Republican Hospital. The interviews did not reveal any major developments in the availability and scope of the rehabilitation services compared to the situation assessment results presented in the WHO situation assessment conducted in 2020. Apart from this, the interviews and analysis of the provider data on utilization of rehabilitation services (both outpatient and inpatient) showed that:

- Most rehabilitation providers in the country currently supply outpatient rehabilitation services with a limited scope
- Neurologic and orthopedic conditions and developmental disorders are predominant health conditions for which rehabilitation is demanded and supplied
- Pandemic has negatively affected the utilization of rehabilitation services and the number of patients served for 2020-2021

The final scores for the availability of rehabilitation interventions per health condition are presented in the respective column of the table in Annex 3.

Inclusion in the “essential package of services”. Rehabilitation services for 13 health conditions (see table in Annex 3) identified for Georgia matched with the services proposed by the World Bank position paper for defining the essential package of rehabilitation services as part of the essential package of health services in the LMICs.

Evidence on cost-effectiveness. The results of the literature review on cost-effectiveness of rehabilitation interventions for various health conditions and diseases are presented in Annex 4. The qualitative scores assigned by the CIF Team are shown in the relevant column in Annex 3.

Expert opinion. The summary of the SME interviews and working meetings with the SME panel is presented in Annex 2. The scores assigned to the respective criteria based on the SME consultations are given in Annex 3.

After applying all the criteria, ten health conditions were derived with summary prioritization scores above 20 (see Table 1 and Annex 3 for details). Certain rehabilitation services for five health conditions (vision and hearing impairments, cerebral palsy, developmental and autism spectrum disorders) are already included in the publicly funded state programs for (a) Children Rehabilitation and Habilitation and (b) Program for Prosthetics and Assistive Devices. The remaining five (Amputation, fractures and post-orthopedic surgery, stroke, traumatic brain and spinal injuries) priority health conditions were further considered and presented at the Stakeholder Consensus Workshop as recommended for the initial list of health conditions eligible for public financing of rehabilitation services.

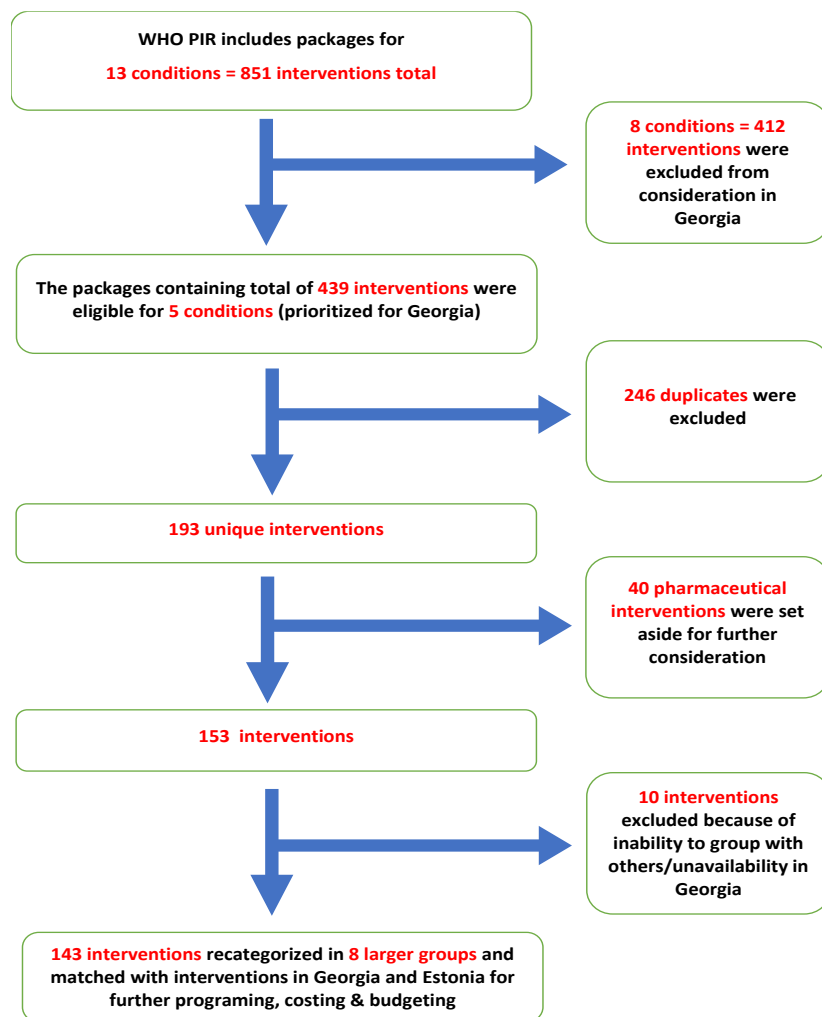
Table 1: Priority health conditions for rehabilitation with criteria summary scores and the recommended final selection of the conditions.

<i>Health Conditions</i>	<i>Group of Disorders (WHO PIR grouping)</i>	<i>Final Criteria Score</i>	<i>Include in Priority List</i>	<i>comments</i>
Fractures	Musculoskeletal	35	Yes	
Vision loss	Sensory Impairments	35	Yes	Provision of assistive devices and related services
Hearing loss	Sensory Impairments	35	Yes	Provision of assistive devices and related services
Stroke	Neurological	29	Yes	
Low back pain, including lumbar spinal stenosis	Musculoskeletal	26	Yes?	While YLD burden is high and certain cost-effective interventions are available, the priority is very low according to the expert opinion
Cerebral Palsy	Neurological	26	Yes	
Developmental intellectual disability	Mental	25	Yes	Already included in publicly financed programs with fair geographical access
Amputation	Musculoskeletal	22	Yes	
Traumatic brain injury	Neurological	22	Yes	
Autism spectrum disorders	Mental	21	Yes	Already included in publicly financed programs with fair geographical access
Spinal cord injury	Neurological	20	Yes	
Chronic obstructive pulmonary disease	Cardiopulmonary	20	Yes?	Specific evidence-based and cost-effective interventions may be considered
Alzheimer disease and dementia	Neurological	19	No	Limited rehabilitation services are available currently
Ischemic heart disease, including myocardial infarction and heart failure	Cardiopulmonary	18	No	
Osteoarthritis	Musculoskeletal	16	No	
Schizophrenia	Mental	14	No	Limited rehabilitation services are available currently
Cancer	Neoplasms	10	No	
Parkinson disease and other neurodegenerative disorders	Neurological	9	No	
Neck pain, including the cervical spinal stenosis	Musculoskeletal	0	No	
Rheumatoid arthritis	Musculoskeletal	0	No	
Motor-Neuron disease /Peripheral Neuropathies, inc. Guillain-Barre syndrome	Neurological	0	No	
Multiple sclerosis	Neurological	0	No	

The draft version of the WHO PIR provided to the CIF team included 13 health conditions with total of 851 recommended evidence-based rehabilitation interventions. Out of this number, the SME consultations on “matching” and grouping rehabilitation services allowed first to identify 143 “unique” rehabilitation interventions available in Georgia, categorize them by type, match them with practiced rehabilitation

interventions in Georgia and Estonia and group them accordingly in 8 larger groups (see Figure 6) to be used for further programming, costing and budgeting of the proposed state health program (subprogram) on rehabilitation

Figure 6: The process for “matching” and grouping WHO PIR rehabilitation interventions for the proposed priority health conditions



The outstanding interventions that we could not assign to a group were listed separately and will be reviewed in the future capacity development plan. The issue of whether to include pharmaceutical interventions in the intervention groups eligible for reimbursement has been discussed at the Stakeholder Consensus Workshop.

The final step of the prioritization process – a Stakeholder Consensus Workshop, was conducted on 30 June 2022 with the participation of all key national stakeholders. The agenda and the list of the workshop participants are attached in Annex 5. A separate digital file with a record of presentations and facilitated discussions is also available. Most stakeholders, including the representatives of the MoIDPLHSA, supported the final selection of the priority health conditions for rehabilitation and the intervention groupings to be considered for programming, costing and budgeting to elaborate the state health program (sub-program) for rehabilitation for 2023. The final list of the priority health conditions supported by the

stakeholders for the inclusion in the 2023 program include: amputation, fractures and post-orthopedic surgery, stroke, traumatic brain and spinal injuries.

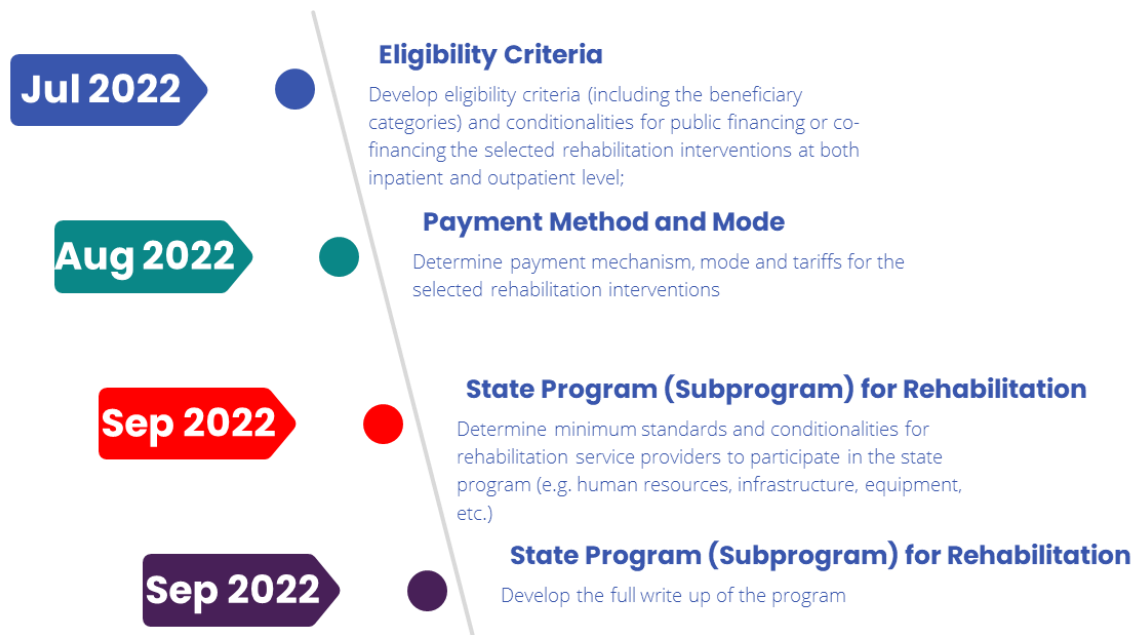
It was agreed that the participatory approach with the involvement of presented stakeholders, will also be used to accomplish the planned next steps (see next section) for integrating the rehabilitation services in the health system of Georgia.

The MoIDPLHSA has also requested the recommendations for criteria on admission to and continuation of rehabilitation for the eligible patients for the pilot outpatient rehabilitation sub-program that MoIDPLHSA plans to launch in September 2022. The First Deputy Minister has requested that, ideally, such criteria be linked with rehabilitation outcomes and consistent with the requirements that will be eventually proposed by the CIF/R4D for the 2023 rehabilitation (sub) program. To meet the request, the CIF team used a similar process in building consensus among the SMEs for defining the priority health conditions and the rehabilitation intervention groups and recommended the criteria and the criteria verification process for admission to rehabilitation services for the neurologic disorders selected for the pilot and outcome-based criteria for continuation of the rehabilitation courses, in case if the repeated course will be demanded by the eligible patients and providers for the same conditions (see Annex 6).

Next Steps

Key next steps for finalization of programming, costing, and budgeting of the rehabilitation services for the selected priority health conditions are presented in

Figure 7: Key next steps for finalization of rehabilitation state sub (program) proposal



Annex 1: List of rehabilitation service providers identified in WHO Rehabilitation Situation Assessment 2020

No.	Name	Location	Public/ private	Beds	Rehabilitation staff				
					MD	PT	OT	ST	Psy
1.	Lung Diseases Rehabilitation Centre	Abastumani	Public (MoDPLHSA)	100*	2	1	0	0	0
2.	The National Hero of Georgia Mariam (Maro) Makashvili Military Rehabilitation Centre	Tserovani	Public (MoD)	17**	1	4	2	0	3
3.	David Tatishvili Medical Centre (Health Palace) Rehabilitation Department	Tbilisi	Private	0	2	26	0	1	?
4.	PSP-New Hospitals Inpatient Rehabilitation Department	Tbilisi	Private	5***	1	6	0	0	0
5.	Ken Walker University Clinic for Medical Rehabilitation LLC	Batumi	Private	0	3	3	0	1	2
6.	Ken Walker University Clinic for Medical Rehabilitation LLC	Tbilisi	Private	12****	8	35	7	7	3
7.	Aversi Rehabilitation Centre	Tbilisi	Private	0	2	6	0	0	0
8.	Chakvi Neurorehabilitation Centre (Evex)	Batumi	Private	0	2	9	0	5	15
9.	Neurodevelopment Centre	Tbilisi	Private	0	4	15	2	8	?

Source: Situation assessment of rehabilitation in Georgia: February 2020. Copenhagen: WHO Regional Office for Europe. 2021.

Annex 2. Report on expert consultations conducted to finalize the list of priority health conditions and matching and grouping of the rehabilitation interventions

- Semi-structured interviews and consultations with a selected panel of Subject Matter Experts (SMEs) were conducted in March-May 2022 to (a) finalize the list of priority health conditions for rehabilitation to be recommended for inclusion in the publicly financed programs and (b) to elaborate the rehabilitation service packages with the available interventions in Georgia.
- The panel of consulted SMEs consisted of two neurologic rehabilitation, three orthopedic/musculoskeletal rehabilitation specialists and one occupational therapist.
- The SMEs were initially interviewed separately to introduce the project objectives, agree upon their involvement in the process, and share preliminary results of disease burden distribution and a potential list of priority conditions. Then, final working meetings for the priority health conditions and the grouping of rehabilitation interventions were conducted to maximize the common understanding among SMEs.
- The following part presents each expert and a brief summary of discussions that impacted the “expert opinion” criteria of the prioritization process.

Neurology expert #1:

Dr. Temur Margania, neurologist and rehabilitation doctor, was contracted as CIF consultant to support the project in every aspect of the process; he is also a service provider at an inpatient hospital, providing adult rehabilitation for neurology patients (cerebrovascular conditions, TBI, spinal cord injuries, polyneuropathies, meningoencephalitis, Parkinsonism, etc.). Dr. Margania was actively involved in the prioritization process.

Neurology (and orthopedic) expert #2:

Dr. Irakli Natroshvili is a neurologist, rehabilitation doctor and director of the Ken Walker Clinic, which provides rehabilitation services for adults and children. The services include neurological disorders (such as stroke, cerebral palsy for 18+ y/o, spinal cord injuries, Parkinson) as well as orthopedic: post-surgery - Endo prosthetic replacement, post-surgery hernia, discopathies, etc. Also, services for children are available that are currently under the state program.

The CIF Team Conducted: 2 f2f interviews, 1 working group meeting, email communication, phone calls.

Orthopedic expert #1:

Dr. Besik Kortava is a rehabilitation doctor, the head of the physical rehabilitation department at the Ministry of Defense of Georgia, Wounded Warrior Rehabilitation Center. The center does not provide services for civilians, but Dr. Kortava provided useful guidance on how to approach the issues in rehabilitation, and technical assistance on the intervention selection for amputation – as this has been his primary field of expertise.

Conducted: 1 f2f interview, one working group meeting, email communication, and phone calls.

Orthopedic expert #2:

Dr. Mikheil Gorshkov is a physical therapist who works in several private facilities providing mostly physical therapy to patients. His input mostly provided technical expertise and opinions on the work done, including advice on structuring chosen conditions (fractures) into several groups depending on the region, severity, etc. This approach was later used for all of the conditions.

Conducted: 2 f2f interviews, one working group meeting, email communication, and phone calls.

Orthopedic expert #3:

Dr. Teimuraz Khvedelidze is a physical therapist at the Sportsmed&Biology medical center that mostly services a healthy population (sportsmen with trauma). He provided information regarding the services that his facility provided and suggested that would be the optimal interventions for the chosen conditions.

Conducted: 2 f2f interviews, email communication, and phone calls.

Occupational Therapist:

Dr. Lasha Metreveli is an occupational therapist at the Wounded Warrior Rehabilitation Center, together with Dr. Kortava. He attended a working group meeting on intervention selection for rehab packages and provided his expertise on the topics of occupational therapy and in general rehabilitation issues, including the lack of experts in the field.

Summary of the interviews and working meeting discussions

The majority of SMEs supported the exclusion of low back pain and neck pain from the priority list due to little clinical effectiveness and cost-effectiveness of the available interventions in Georgia. However, it was decided to discuss still the inclusion of this health condition in the final priority list at the consensus-building meeting to avoid any provider-related bias. The neurologic rehabilitation experts also suggested removing Motor-neuron disease from prioritized conditions, which was taken into account, considering the WHO package of rehabilitation interventions¹⁸ did not include the given condition either. Dr. Margania suggested including the Guillain-Barré syndrome, or peripheral neuropathies, which was also absent from the WHO package, but the final decision was to abstain from the inclusion for the first year of the program due to its rarity and the relatively low burden of the disease.

Dr. Natroshvili was actively involved in the prioritization process, mostly supporting the CIF team with standards, interventions and technical expertise on different topics, including suitable interventions for chosen conditions. Considering the fact that the Ken Walker clinic is considered to have high-quality rehab services and the majority of them are evidence-based, the interventions which were later matched with the WHO PIR, were based on the list provided by the clinic.

Limitation: the CIF team acknowledges that the SMEs recruited are also providers of rehabilitation services and thus may be biased in their recommendations on the inclusion of certain interventions in the rehabilitation packages. To control this bias for intervention selection – beyond

¹⁸ Rauch, A., Negrini, S., & Cieza, A. (2019). Toward Strengthening Rehabilitation in Health Systems: Methods Used to Develop a WHO Package of Rehabilitation Interventions. *Archives of physical medicine and rehabilitation*, 100(11), 2205–2211. <https://doi.org/10.1016/j.apmr.2019.06.002>

the individual consultations and group consultations - working group meetings were conducted with the participation of several SMEs, followed by a consensus-building meeting with the majority of the national rehabilitation stakeholders - to agree on the final list of the priority health conditions and intervention groups to be proposed for the public financing.

Annex 3: Priority health conditions for rehabilitation with criteria scores and the recommended final selection of the conditions.

Health condition/disease (GBD)	Group of Disorders (WHO PIR grouping)	Criteria									Final Criteria Score	Include in Priority List of Health Conditions	comments
		Burden of Disease (YLD) by Age Groups, Georgia				Included in WHO Priority Interventions for Rehabilitation (PIR)	Availability of evidence-based (WHO PIR) interventions in Georgia	Included in essential package of Rehabilitation Services recommended by the WB	Cost Effectiveness of available interventions (international)	Expert Opinion on Prioritization			
		All ages	Children (0-18)	Working age (18-60 for females and 18-65 for males)	Retirement age (>60 for females and >65 for males)								
1 Low back pain, lumbar spinal stenosis	Musculoskeletal	5	5	5	5	+	2	0	2	1	26	Yes?	the priority is very low according to the expert opinion
2 Neck pain, cervical spinal stenosis	Musculoskeletal	2	1	2	2	-	-	-	-	-	-	No	
3 Osteoarthritis	Musculoskeletal	4	1	2	4	+	1	0	2	1	16	No	
4 Rheumatoid arthritis	Musculoskeletal	1	1	1	1	+	-	-	-	-	-	No	
5 Amputation	Musculoskeletal	3	2	1	2	+	3	1	2	4	22	Yes	
6 Fractures	Musculoskeletal	5	5	5	4	+	4	1	1	5	35	Yes	
7 Stroke	Neurological	4	1	2	4	+	4	1	3	5	29	Yes	
8 Traumatic brain injury	Neurological	2	2	2	2	+	3	1	2	4	22	Yes	
9 Spinal cord injury	Neurological	1	2	1	1	+	3	1	3	4	20	Yes	
10 Cerebral Palsy	Neurological	2	5	1	1	+	4	1	2	5	26	Yes	
11 Alzheimer disease and dementia	Neurological	5	1	1	5	+	2	1	2	1	19	No	
12 Motor-Neuron disease /Peripheral Neuropathy	Neurological	1	1	1	1	-	-	-	-	-	-	No	
13 Multiple sclerosis	Neurological	1	1	1	1	-	-	-	-	-	-	No	
14 Parkinson disease and other	Neurological	1	1	1	1	+	2	0	1	1	9	No	
15 Ischemic heart disease, myocardial infarction and heart failure	Cardiopulmonary	3	1	2	3	+	1	1	3	2	18	No	
16 Chronic obstructive pulmonary disease	Cardiopulmonary	4	1	2	4	+	2	1	2	2	20	Yes?	Specific evidence-based and cost-effective interventions may be considered
17 Cancer	Neoplasms	1	1	1	1	+	1	0	1	2	10	No	
18 Vision loss	Sensory Impairment	5	4	2	5	+	4	1	4	5	35	Yes	Provision of assistive devices and related services
19 Hearing loss	Sensory Impairment	5	4	2	5	+	4	1	4	5	35	Yes	Provision of assistive devices and related services
20 Schizophrenia	Mental	2	1	2	1	+	1	0	1	3	14	No	Limited rehabilitation services are available currently
21 Developmental intellectual disability	Mental	1	5	1	1	+	4	1	4	4	25	Yes	Already included in publicly financed programs, fair geographical access
22 Autism spectrum disorders	Mental	1	3	1	1	+	4	1	2	4	21	Yes	Already included in publicly financed programs, fair geographical access

*** Burden of Diseases Scale**
 >600 YLD per 100,000 pop;
 children 400-600 YLD per 100,000
 for children 200-400 YLD per 100,000
 children 100-200 YLD per 100,000 pop.
 per 100,000 pop.

****** Included in the World Bank PES**
 1 - Yes
 0 - No

**** Included in WHO PIR**
 "+" - Yes
 "-" - No
Key criteria: if "-", the condition is excluded

******* Cost Effectiveness interventions**
 4 - Strong evidence
 3 - Strong, but single study evidence
 2 - Evidence of moderate strength
 1 - Inconclusive
 0 - No evidence, or

***** Availability of Interventions**
 5 - Key interventions are currently provided by more than one provider, including those located outside Tbilisi
 4 - Key interventions are currently provided by more than one provider, however, only in Tbilisi
 3 - Key interventions are provided by only one provider
 2 - Limited range of interventions is provided by one or two providers
 1 - No interventions are currently provided

******* Expert Opinion on Prioritization**
 5 - High individual and public health priority
 4 - High individual, but moderate public health priority
 3 - High public health, but moderate individual health priority
 2 - Moderate individual and public health priority
 1 - Low individual and public health priority
key criteria with relative weight 2.0

Annex 4: Summary of economic evidence for health-related rehabilitation interventions from systematic reviews ¹

Condition: Rehabilitation intervention	Available SRs	Design and no. of included studies	Main conclusions
Pain and other musculoskeletal conditions Spinal/back pain: Non-operative and operative interventions	Indrakanti et al (2012)	27 studies (25 RCTs): Strong single study evidence	<ul style="list-style-type: none"> • <u>Consistent evidence indicated that operative interventions were cost-effective for treating spinal disorders involving nerve compression and instability.</u> • For non-operative interventions, strong single-study evidence indicated that: <ul style="list-style-type: none"> ○ The graded activity was more cost-effective than physical therapy and pain management ○ Cognitive-behavioral and physiotherapy were more cost-effective than advice only ○ Acupuncture, exercise, and neuroreflexotherapy were more cost-effective than usual care ○ Spinal manipulation was more cost-effective than exercise.
Low back pain: Various guideline-endorsed treatments	Lin et al (2011)	26 RCTs with economic evaluations	<ul style="list-style-type: none"> • <u>There was evidence supporting the cost-effectiveness</u> of the guideline-endorsed treatments of interdisciplinary rehabilitation, exercise, acupuncture, spinal manipulation, and cognitive behavioral therapy for sub-acute or chronic LBP. • <u>There was little evidence for other treatments,</u> advice, medication, spinal manipulation for acute LBP, and massage, yoga or relaxation for chronic LBP.
Spinal pain: Spinal manipulation	Michaleff et al (2012)	6 RCTs with full economic evaluations	<ul style="list-style-type: none"> • <u>Inconclusive, mostly single-study, evidence</u> indicated that spinal manipulation was cost-effective to manage back or neck pain.
Neck pain: Various conservative treatments	Driessen et al (2012)	5 RCTs with economic evaluations	<ul style="list-style-type: none"> • <u>Limited and heterogeneous evidence was insufficient to decide the cost-effectiveness of conservative treatments for non-specific neck pain.</u>
Chronic pain-geriatric: Self-management support	Boyers et al (2013)	10 RCTs with economic evaluations (6 Cost-Utility Analysis (CUAs))	<ul style="list-style-type: none"> • <u>Inconclusive evidence indicated that self-management may be cost-effective for older people with chronic pain conditions</u>
Ankylosing spondylitis: Therapeutic interventions	Gaujoux-Viala & Fautrel (2012)	13 RCTs or modeling studies	<ul style="list-style-type: none"> • <u>The cost-effectiveness ratio of interventions for ankylosing spondylitis (including spa exercise, and group physical</u>

Condition: Rehabilitation intervention	Available SRs	Design and no. of included studies	Main conclusions
			<u>therapy</u>) remains within an acceptable range (e.g., 1£30,000/QALY).
Arthritis: Self-management education	Brady (2012)	11 studies (8 cost analysis, 3 full cost-effectiveness analysis)	<ul style="list-style-type: none"> • <u>Self-management education programs may improve health outcomes at a relatively low cost to deliver</u> • <u>Full economic evaluations from a societal perspective (including patient out-of-pocket costs and lost productivity) provided more encouraging evidence on the cost-effectiveness of the program.</u>
Osteoarthritis (hip/knee): Nonpharmacologic, non-surgical interventions	Pinto et al (2012)	11 RCTs or quasi-RCTs with economic evaluations	<ul style="list-style-type: none"> • <u>Exercise programs were cost-effective when QALYs were the clinical outcome.</u> • <u>There was very limited economic evidence on</u> patient education and conservative interventions for hip or knee osteoarthritis
Stroke survivors: Integrated care: Early supported discharge, home-based rehabilitation, stroke unit, and stroke service	Tummers et al (2012)	12 RCTs and 3 non-randomized studies with economic evaluations	<ul style="list-style-type: none"> • <u>Consistent evidence indicated that early supported discharge was 4-30% less costly compared with usual care, at similar clinical outcomes.</u> • Home-based rehabilitation was unlikely to be cost-saving, but may improve health outcomes, compared with center-based rehabilitation. • Stroke unit care was more expensive but associated with improved clinical outcomes, compared with conventional inpatient stroke care. • Integrated stroke services (e.g., extended stroke unit service, stroke unit linked to continued care in geriatric units) may reduce health care costs
Stroke survivors: Inpatient rehabilitation	Brusco et al (2014)	RCTs with economic evaluations	<ul style="list-style-type: none"> • High quality evidence (from 4 RCTs with 732 patients) indicated that <u>inpatient rehabilitation was more costly than rehabilitation in the home</u>, for patients with moderate to severe stroke and with an appropriate home environment and adequate social support. The health outcomes were similar or in favor of rehabilitation in the home. • Moderate quality evidence (from 3 RCTs with 463 patients) indicated that stroke unit care was less costly compared with general acute care, with improved patient outcomes.

Condition: Rehabilitation intervention	Available SRs	Design and no. of included studies	Main conclusions
Cardiac rehabilitation-Heart diseases: Exercise training based cardiac rehabilitation	Wong et al (2012)	16 economic evaluations alongside trials or modeling studies	<ul style="list-style-type: none"> • There was evidence that supervised or home-based cardiac rehabilitation interventions were more cost-effective than no cardiac rehabilitation, for patients with myocardial infarction and heart failure. • There were no significant differences in clinical outcomes and costs between center-based and home-based cardiac rehabilitation interventions.
Dementia and Alzheimer disease Dementia: Various interventions	Knapp et al (2013)	59 reviews and 29 primary studies	<ul style="list-style-type: none"> • <u>Cognitive stimulation therapy, tailored activity programmes and occupational therapy were cost-effective compared with usual care.</u> • According to data from some of the included studies, the following interventions may also be cost-effective: Respite care in day settings, psychosocial interventions for carers, coordinated care management, and personal budgets held by carers
Geriatric rehabilitation: older people living at home: Falls prevention strategies	Davis et al (2010)	9 trials with economic evaluations	<ul style="list-style-type: none"> • Targeting falls prevention strategies at high-risk groups was associated with best value for money, e.g.: <ul style="list-style-type: none"> ○ An individually customized multifactorial programme in those with more than 4 out of 8 targeted fall risk factors ○ Home-based safety or exercise programmes in people ≥80 years, or in those with a previous fall
Pulmonary rehabilitation Adults with COPD: Multicomponent chronic care programs	Steuten et al (2009)	17 studies (14 RCTs), only 3 provided data on costs	<ul style="list-style-type: none"> • Programs containing at least 3 components reduced hospitalization, compared with usual care. • <u>It was unlikely that multi-component COPD programmes could be cost-saving</u>
Injury: Lateral ankle sprains: Diagnosis, treatment, and prevention interventions	Lin et al (2013)	10 economic evaluations alongside RCTs or modeling studies	<ul style="list-style-type: none"> • The available evidence indicated that the following interventions may be cost-effective: <ul style="list-style-type: none"> ○ Implementation of the Ottawa ankle rules (OAR) in the emergency setting ○ Use of anti-inflammatory medication and the plaster cast in the acute phase ○ Prescription of neuromuscular exercises to prevent re-injury
Mental disorders	Hamberg-van Reenen & Proper (2012)	10 studies (6 RCTs)	<ul style="list-style-type: none"> • Worksite interventions to prevent or treat mental health problems might be cost-effective in terms of health outcomes

Condition: Rehabilitation intervention	Available SRs	Design and no. of included studies	Main conclusions
Workers with mental health problems: Worksite based interventions			(such as turnover, burnout and mood, hospitalization), productivity, and work performance. <ul style="list-style-type: none"> Return to work interventions that included a full economic evaluation aimed at depressed employees were not cost beneficial.
Cancer rehabilitation: Adult cancer survivors: Multidimensional cancer survivor rehabilitation	Mewes et al (2012)	6 economic evaluations alongside RCTs, quasi-trials, and modeling studies	<ul style="list-style-type: none"> There was no additional benefit in clinical outcomes when a multidimensional program was compared with the mono-dimensional interventions. Available economic evaluations assessed different rehabilitation interventions, and all showed favorable cost-effectiveness ratios.
Speech and language rehabilitation Children with speech, language, and communication needs: Various interventions	Law et al (2012)	5 RCTs with economic evaluations	<ul style="list-style-type: none"> The inclusion of parental time increased costs considerably The home-based intervention was less expensive than the clinic-based intervention even adding in the cost of parents
Hearing impairment: Adults with severe to profound hearing impairment: Cochlear implants	Turchetti et al (2011)	4 economic evaluations (2 retrospective and 2 prospective cohort studies)	<ul style="list-style-type: none"> Monolateral cochlear implantation is generally a cost-effective intervention The mean direct medical costs of monolateral cochlear implantation: 31,942 (2011 Euro) in prelingually deafened patients, and ranged from 30,026 Euro to 45,770 Euro in postlingually deafened patients. Cochlear implantation is not cost-effective for patients with a period of over 30 years profound deafness in the ear receiving the implant, who have benefited from the use of hearing aids. Monolateral cochlear implantation was more cost-effective than bilateral cochlear implantation in postlingually deafened patients.
Children with severe-profound: hearing impairment: Cochlear implants	Turchetti et al (2011)	9 economic evaluation studies (3 prospective, 3 retrospective, and 3 cross-sectional studies)	<ul style="list-style-type: none"> The direct cost of cochlear implants ranged between 39,507 and 68,235 (2011 Euro). The health care costs are high, but savings in terms of indirect and quality of life costs are also significant. Cochlear implantation in children is cost-effective.

Condition: Rehabilitation intervention	Available SRs	Design and no. of included studies	Main conclusions
Multiple disability conditions: Various conditions: Complementary and integrative care (CIM)	Herman et al (2012)	31 high quality full economic evaluation studies in English, between 2001 and 2010	<ul style="list-style-type: none"> • Study quality of the cost-utility analyses (CUAs) of CIM was generally comparable to that seen in CUAs across all medicine • Of the 56 comparisons made in the higher-quality studies, 16 (29%) show a health improvement with cost savings for the CIM therapy vs. usual care.
Lower limb prosthesis: Adult amputees: Different lower limb prosthesis	Samuelsson et al (2012)	1 RCT and 1 case-control study	<ul style="list-style-type: none"> • RCT e Total surface-bearing socket (TSB) vs. conventional patellar tendon bearing socket (PTB): Cost of materials was significantly higher, manufacturing time was significantly shorter, and number of visits was significantly less in the TSB group than in the PTB group.

CUA: Cost-Utility Analysis

RCT: Randomized Controlled Trials

SR: Systematic Review

Annex 5. Stakeholder Consensus Building Workshop. The list of participants and the agenda

Stakeholder Meeting Participants List		
30 June, 2022		
#	Name/Surname	Position/Organization
1	Tamar Gabunia	MoH First Deputy Minister
2	Eka Adamia	MoH
3	Mzia Jokhidze	MoH
4	Ia Kamarauli	MoH
5	Nino Jinjolava	MoH
6	Irakli Kirtadze	Georgian Medical Holding
7	Tamara Chikhradze	R4D
8	Emma Brainerd	R4D
9	George Gotsadze	CIF
10	Akaki Zoidze	CIF
11	Alisa Tsuladze	CIF
12	Keti Gogvadze	CIF
13	Temur Margania	CIF
14	Ano Akhvlediani	CIF
15	Salomea Guchmazashvili	WHO Georgia
16	Tamila (Tea) Eristavi	Social Rehabilitation Center for Persons with Limited Ability
17	Lela Maskhulia	TSMU, Dean of Physical Medicine and Rehabilitation Faculty
18	Ekaterine Tortladze	Foundatino Aures
19	Irakli Natroshvili	Ken Walker Clinic, TSMU Rehab Department
20	Guna Bibileshvili	Studio ADC
21	Ana Tsitsagi	Coalition for Independent Living
22	Giorgi Dzneladze	Disability Mobility Center
23	Pavle Kasradze	Republican Hospital; Rehab dept. head
24	Ekaterine Japharidze	Balneology center
25	Valeri Akhalkatsi	TSMU Rehab center, Georgian Sports Medicine Association
26	Sergo Maghradze	GEFPOR
27	Irakli Sharangia	Geomed
28	Tea Adamia	D. Tatishvili National Center CIU NPO Georgia
29	Rusudan Lortkipanidze	Georgian Occupational Therapists' Association
30	Nino Rukhadze	Ken Walker Clinic, Children rehabilitation department
31	Tamar Tskitishvili	New Hospitals, Neurologist
32	Nana Gulua	Balneology center
33	Eka Sanikidze	Balneology center
34	Maia Kurtanidze	Aversi clinic, rehabilitation dept. manager

Duration	Item
13:00 –13:20	Opening remarks (MoIDPLHSA, USAID, R4D, George Gotsadze)
40 minutes	Presentation: Rehab Service prioritization process and results: Presenting preliminary list of prioritized health conditions using predefined criteria Presenter : Akaki Zoidze Alice Tsuladze
1 hour	Facilitated Discussion: Suggested Topics: <ol style="list-style-type: none"> 1. Does the methodology used for the prioritization appear to be adequate and acceptable, if not what needs to be changed? 2. Is the assessment of availability of rehabilitation services presented accurate? 3. Is a preliminary list of the priority health conditions for rehabilitation interventions suggested for the 1st phase of integration in the state programs acceptable? 4. Are the priorities for 2023 appropriate and the plans for 2024-2026 acceptable?
15 minutes	Coffee Break
15 minutes	Presentation: Next Steps Planned in the Project: costing of rehabilitation services and rehabilitation capacity development plan Presenter : Akaki Zoidze George Gotsadze? Keti Gogvadze
30 minutes	Discussion: future steps and stakeholder engagement

Annex 6. The proposed criteria for admission and continuation of the rehabilitation for eligible patients and the suggested verification process

Proposed criteria and conditions for beneficiaries of the 2022 rehabilitation pilot sub-program (Working version)

1. Program beneficiaries must meet the following criteria:
 - 18 years or older;
 - With diagnosis: stroke (ischemic ICD10: I69.3, hemorrhagic I69.1, traumatic brain injury T90.5, traumatic spinal cord injury (without respiratory failure or ASIA C, D¹⁹) T91.1, T91.3 and non-traumatic injuries, time after being diagnosed should not exceed 24 months;
 - The patient must be sufficiently medically stable (participation in rehabilitation is safe and beneficial), which means that the patient does not require 24-hour medical care, does not have a tracheostomy or nasogastric feeding tube, does not require artificial lung ventilation, does not require intravenous or intrathecal pain medication, do not require intravenous medications to control blood pressure. Apart from rehabilitation specialists, they do not require any other type of medical assistance;
 - The patient can actively participate in intensive rehabilitation therapy for at least 3 hours a day, 2-6 days a week;
 - The patient is able to perform/follow at least one-step instructions, with communication support if necessary;
 - the injury does not progress during the rehabilitation process;
 - mental state/actions do not represent a risk, both for the patient himself (self-harm) and for the people around him;
 - has sufficient attention and ability to follow simple rehabilitation instructions for involvement in the rehabilitation process;
 - The patient has the desire to participate in the rehabilitation program, herself/himself declares his/her consent to be involved in the rehabilitation process or his/her legal representative (decision maker) declares this consent;
 - The patient can travel (from the place of residence to the rehabilitation clinic and back) or the patient's travel is provided on his/her own, through a family member and/or legal representative.

¹⁹ American Spinal Injury Association Impairment Scale. The scale items range from A (complete damage, below the level of damage there is no longer either motor or sensory functions) to E (motor and sensory functions are preserved). Source: National Institutes of Health.

2. The patient must have a certificate of health status - a diagnosis of an acute condition developed as a result of an injury recorded in form No. IV-100/a, no more than 24 months old (primary case) and a stable condition with varying degrees of expressed disabilities, which is not related to the pre-injury period disabilities.
3. The beneficiary of the program receives services in the scope and terms determined by the rehabilitation plan. The number of therapy sessions is determined by age and the total score obtained by the Functional Independence Measure (FIM). For the patient, after the completion of the first rehabilitation course, the completion of each subsequent course depends on the clinical-functional dynamics after the completion of the rehabilitation course, namely:
 - A. The second course, according to the category, will be funded to the person who, as a result of the rehabilitation course and clinical-functional reassessment, showed a 25% increase in the total score of age and functional independence measure (FIM);
 - B. in the event that the increase in the total FIM score obtained as a result of the clinical-functional reassessment of the person amounts to 10%-24%, the second course will be financed, for the relevant category, with 50% co-financing of the amount of financing determined by the state;
 - C. If the increase in the total FIM score after the first course is less than 10%, the second course of rehabilitation will not be financed within the framework of the state program.