Learning Brief

Georgia's Journey to Integrating Rehabilitation Services into the Health System: Insights and Lessons

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Acronyms

CIF - Curatio International Foundation

DDI - Bureau for Development Democracy and Innovation

DRG - Diagnostic Related Groups

GBD - Global Burden of Disease

GEL - Georgian Lari (currency)

IAC - Independent Assessment Committee

ICD-10 - International Classification of Diseases, 10th Revision

LMIC - Low and Middle-Income Countries

MoIDPLHSA/MoH - Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health, and Social Affairs of Georgia

NCSP - Nordic Classification of Surgical Procedures

NHA - National Health Agency

OOP - Out-of-Pocket

PIR - Package of Interventions for Rehabilitation

SME - Subject Matter Expert

SPRING - Strengthening Physical Rehabilitation in Georgia

STARS - A Tool for the Systematic Assessment of Rehabilitation Situation

TSMU - Tbilisi State Medical University

UHCP - Universal Health Coverage Program

USAID - United States Agency for International Development

WHO - World Health Organization

Introduction

Background

The Inclusive Development Hub of the United States Agency for International Development (USAID) Bureau for Development, Democracy, and Innovation (DDI) has partnered with the Health Systems Strengthening Accelerator (Accelerator) to support countries in strengthening and integrating rehabilitation in health systems in post-conflict countries. Georgia was selected as one of several priority countries for program support. The Accelerator, through a subgrant to Curatio International Foundation (CIF), supported the program implementation in Georgia. This assistance included rendering technical expertise relevant to Georgia's health systems and its financing context, complemented by the Accelerator's global expertise and ability to translate existing global knowledge into locally feasible solutions. The program was implemented from January 2022 to June 2024 in collaboration with USAID's office in Georgia and the DDI Bureau in Washington.

The project's main goal was to improve the population's financial protection when accessing rehabilitation services. The project collaborated with the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health, and Social Affairs of Georgia (MoH) and other key stakeholders toward the following objectives:

1. Integration of rehabilitation in Georgian health systems and state-financed health programs.
2. Creating supportive systems for reform implementation under Objective 1.

Purpose and Objectives

This Learning Brief chronicles and summarizes Georgia's journey to integrate rehabilitation services into the health system. It aims to describe the strategies, approaches, and actions undertaken throughout this transformative process, revealing the 'WHAT' and 'HOW' aspects of integration. This resource intends to offer valuable, practical insights and lessons learned from a developing country context, potentially guiding program managers, technical assistance suppliers, and implementers of similar endeavors in other lower- and middle-income settings. Furthermore, we highlight the important changes to the health systems building blocks of governance and financing that facilitated integration of rehabilitation services in Georgia's health system, as supported by the project team. Finally, we briefly discuss workforce training initiatives and their significance in supporting integration.

Georgia's Health System Context

Overall organization and funding of the health system.

In 1995, Georgia transitioned to an output-based healthcare financing model, where payments are determined by service outputs, moving away from the common (for the Soviet Union) input-based and line-item funding model. Currently, Georgia has a mixed healthcare system, encompassing both public and private providers contracted by the public single purchaser – the National Health Agency, which uses general tax financing to reimburse providers. After waves of health provider privatization in Georgia, as of 2024, private providers dominate the service provision landscape. The MoH is central to the country's healthcare governance, which includes several subordinate entities. The National Health Agency (NHA) operates under the MoH and serves as the single purchaser for the Universal Healthcare Program (UHCP).

The UHCP was introduced in 2013 to expand the breadth and depth of population coverage. Under this program, approximately 91% of eligible individuals (Gotsadze & Gorgodze, 2024) can access a comprehensive set of preventive and curative healthcare services free of charge or with a co-payment, the amount of which depends on the beneficiary belonging to state-defined groups. The NHA reimburses providers according to established tariffs for specific conditions and/or procedures, and a big part of hospital services are reimbursed using Diagnostic Related Groups (DRG)[1], introduced in late 2022. Like in many countries, healthcare in Georgia is funded through a combination of government allocations, voluntary private insurance contributions, and out-of-pocket payments, the latter comprising 31.2% of current health expenditure as of the year 2020 (Gotsadze & CIF Research Team, 2024).

Funding and delivery of rehabilitation services before the Accelerator

A legacy from the Soviet era was that rehabilitation and assistive technologies were primarily designated for individuals with disabilities, funded through the social sector budget, and not seen as part of the healthcare system. Therefore, services that people without **a legal disability status** require when they face functional impairment were subject to out-of-pocket payments. This led to inadequate rehabilitation service provision in the health sector and, importantly, a lack of care coordination among the service providers (Zoidze & Tsuladze, 2022).

The Government of Georgia's State Program for Social Rehabilitation and Childcare (funded out of the social budget) aims to enhance the physical and social well-being of individuals with disabilities, encompassing children and the elderly beneficiary groups. The program also targets homeless individuals and those facing social vulnerability, striving to facilitate their social integration (World Health Organization, Regional Office for Europe, 2021). The primary budgetary allocations for this program encompass early childhood development and a habilitation/rehabilitation subprogram focused only on children, with a total budgeted amount of GEL 19 million (approximately US$ 7 million) (Government of Georgia, 2023a). The population faces financial access barriers in accessing all other rehabilitation services not covered by this program, as these services are primarily funded through out-of-pocket (OOP) payments (World Health Organization. Regional Office for Europe, 2021).

Data and information systems for rehabilitation

As in many LMICs, a critical barrier to planning and improving rehabilitation services in Georgia is limited data availability for comprehensive policy formulation and program planning. Georgia's health information system that collects information about rehabilitation needs and services is largely paper-based, not comprehensive, siloed, and impeding data pulling across the providers and having limited comparability. Also, there is a lack of national standards/classification for rehabilitative interventions and professionals/specialists, which limits data comparability across providers. Consequently, consolidated data is unavailable to estimate the population's needs or use of services, intervention outcomes, and their quality and effectiveness (Government of Georgia, 2023b).

[1] Under DRG payment models, providers are paid a fixed amount according to the patient's standardized diagnosis-related group. Cost adjustments depend on the severity of an individual's case, primary and secondary diagnosis, comorbidities, and complications, etc.

Human resources and infrastructure

Practitioners in Georgia acquire specialization in rehabilitation through residency or postgraduate training programs. The field is subject to state regulation, mandating practitioners to obtain a license, specifically the Certificate of Independent Medical Practice, as a physician specialist in Physical Medicine, Rehabilitation, and Resortology. However, other specialties such as occupational therapy, physical therapy, or speech and language therapy are not regulated (there are no licensing requirements/registration mechanisms for continuing medical education and/or professional development) (Government of Georgia, 2023b), and therefore, statistics about these professionals are not being collected, imposing limitations on assessing existing human resource capacity for service delivery.

Furthermore, accredited training programs for physical, occupational, and speech therapy are limited in number and available at the bachelor's and, in some cases, master's levels. Rehabilitation infrastructure (equipment and treatment space) varies across the limited number of providers in the marketplace. Finally, Georgia lacks state requirements setting minimum standards for rehabilitation infrastructure and equipment, which further limits the state's ability to evaluate the adequacy of providers and their ability to render safe, quality, and effective services (World Health Organization. Regional Office for Europe, 2021).

Global and National Efforts Preceding Reforms

Several events preceded rehabilitation service integration into the health system of Georgia, which played an important role in creating the window of opportunity for policy change and facilitated the project's efforts. The global Rehabilitation 2030 initiative (WHO, 2020) was an important milestone that prompted the WHO country office to engage and assess the state of Georgia's rehabilitation sector, identify key challenges and opportunities, and produce recommendations for future reforms. Before this, and for some years, USAID supported the training of providers through collaborative efforts with Tbilisi State Medical University (TSMU) (USAID, 2021). Furthermore, investments were made to establish the Ken Walker Clinic as a model clinic for rehabilitation services.

Rehabilitation 2030

In 2017, recognizing the global rehabilitation needs, the underdevelopment of rehabilitation services, and the significant potential for these unmet needs to increase, the WHO, Member States, development partners, and civil society united and launched the Rehabilitation 2030 initiative (WHO, 2020). This initiative introduced a "call for action" in February of the same year and motivated stakeholders towards a unified and strategic international endeavor to enhance rehabilitation services (WHO, 2020).

WHO assessment

In February 2020, the WHO, in partnership with MoH, assessed the current situation in the field of rehabilitation to determine gaps and identify future interventions and priority directions in the mentioned field. Standard tools developed by WHO (STARS - A Tool for the Systematic Assessment of Rehabilitation Situation) (Kleinitz et al., 2022) were used for this assessment, and more than 100 stakeholders participated in the process. The assessment identified significant issues in Georgia's rehabilitation sector, including insufficient and poorly integrated services, an underdeveloped workforce, and a lack of data, underscoring the urgent need for comprehensive reforms. Another challenge reported in the assessment included the lack of a national rehabilitation strategy, leading to fragmented activities without a unified guiding document for all relevant departments, ministries, and stakeholders.

National Strategy Development

The global initiative, WHO's assessment outcomes, and advocacy of international organizations and national stakeholders helped shape the country's political will to develop rehabilitation services. The Government of Georgia recognized the unmet need for these services and considered reforms for the field. This acknowledgment culminated in the MoH, with support from WHO and USAID, developing a National Strategy for the Development of Rehabilitation Services 2023-2027, which was approved by the government on 1 February 2023 (Government of Georgia, 2023b).

Ken Walker Clinic.

The Ken Walker Medical Rehabilitation University Clinic, which opened in 2019 and became fully operational in 2020, was a major advancement in Georgia's healthcare system. It is the first rehabilitation clinic in the country built to international standards, capable of serving up to 500 patients daily. The clinic's development was supported by a USAID grant to strengthen physical rehabilitation services in Georgia. This funding allowed the construction of a clinic and, more importantly, the development of professional staff with specialized training from Emory University experts. In collaboration with Georgia's MoH, Emory University's School of Medicine played a crucial role. Named after Dr. Ken Walker, a key figure in the US-supported efforts to develop medical education and professions in Georgia (including physical rehabilitation), the clinic reflects its vision for advancing rehabilitation services. This initiative addressed a critical gap in Georgia's healthcare system, enhancing rehabilitation services and increasing access to quality care.

Investing in Education

During 2017-2022, Tbilisi State Medical University partnered with the Emory University School of Medicine and, with USAID funding, carried out the SPRING project—Strengthening Physical Rehabilitation in Georgia. This partnership was crucial in sharing Western experience in rehabilitation services, advancing approaches in medical education and clinical skills, and contributing to workforce development for rehabilitation service delivery. The partnership has played an important role in advocacy for the field (Tbilisi State Medical University, 2018).

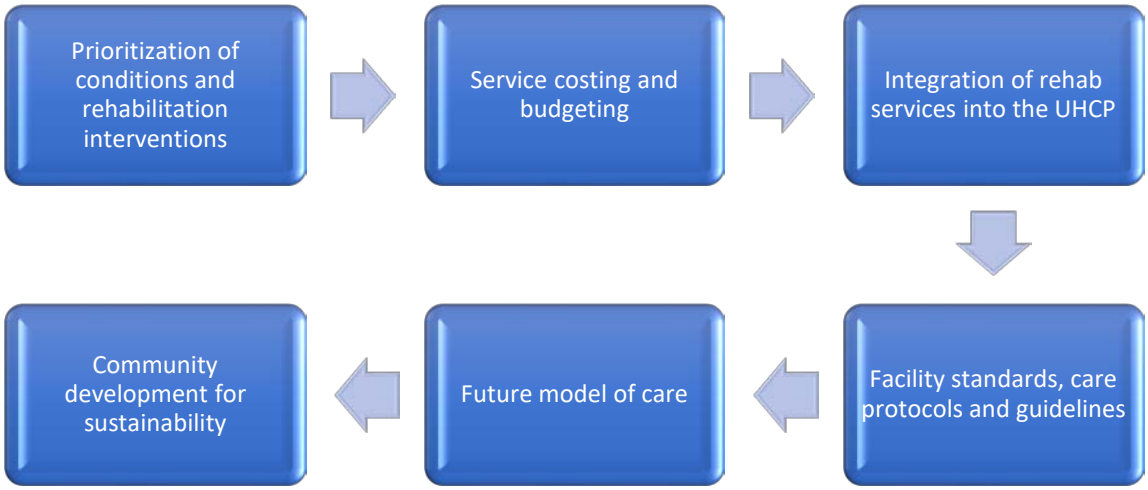
Methods

The lessons presented in this Learning Brief were drawn through a two-way approach using a combination of semi-structured interviews and document reviews. An extensive review of project documentation provided an understanding of the project's scope, objectives, and outcomes. These documents included progress reports and updates, meeting minutes, and workshop summaries, capturing the discussions, decisions, and stakeholder engagements that shaped the project's direction and implementation. Document review was complemented by semi-structured interviews with various stakeholders, including representatives from the CIF, MoH, rehabilitation service providers, and subject matter experts (SME) involved in the project implementation. A total of six individuals informed this document. These interviews aimed at gathering personal insights and reflections on the project's implementation processes, technical and operational challenges, and successes. The questions were designed to elicit detailed responses on specific project activities/processes such as stakeholder engagement, development of tools and guidelines, analytical products, workshops, and the overall effectiveness of the project's strategies in achieving its goals.

Reform Implementation Steps

This section describes sequentially the steps depicted in Figure 1. First, it provides information on how health conditions and rehabilitation interventions were prioritized for inclusion in state funding. Next, it elaborates on how costing and budgeting for priority services were carried out. After that, we proceed to describe the actions taken to include adult rehab services in the state budget. Then, we describe the development of facility standards, care protocols, and guidelines. Two sections covering the future model of care for rehabilitation services and professional community development conclude the description of the reform implementation steps.

Figure 1 Important activities on this journey: Key Programmatic Steps.



Prioritization of Health Conditions and Interventions

In the initial stages of the project, one of the foremost important tasks was to prioritize conditions amenable to rehabilitation. The WHO provides a comprehensive list of these conditions, comprising 20 health conditions (Rauch et al., 2019). The development of the National Strategy for the Development of Rehabilitation Services in Georgia for 2023-2027, which preceded the project's initiation, highlighted the MoH's willingness to incorporate rehabilitation services into the UHCP. However, it became evident that it was not feasible to incorporate all 25 conditions into the priority list to be funded out of state budget during the pilot phase or the program's first year. This realization set the stage for strategic prioritization regarding which conditions should be prioritized and initially integrated within the UHCP.

Assessment of population rehabilitation needs:

Initiating this first step came with challenges. The project team soon confronted a significant hurdle - the absence of comprehensive data on the prevalence rates for diseases and conditions in question. This led to a decision to use and base judgment on global estimates in the WHO's Global Burden of Disease (GBD) Study 2019 (Institute for Health Metrics and Evaluation, 2019). Leveraging the GBD estimates helped bridge the existing data gap about the priority health and rehabilitation needs.

Assessment of rehabilitation intervention availability: The goal was to understand which rehabilitation interventions were readily available in Georgia and accessible to the population. This step was critical for identifying gaps in the current rehabilitation offerings and determining which conditions and interventions could be initially included in the state program so that existing providers in the country could deliver. This process involved consultations with local rehabilitation experts and service providers. At this phase of the project, consultations were still limited to engagements with a small group of experts. Individual and group discussions with SMEs in the field provided an in-depth understanding of the range of interventions available in Georgia. These deliberations were instrumental in gaining a nuanced perspective on the current landscape for rehabilitation interventions, highlighting existing supply-side obstacles and the diversity of options and their feasibility within the local context.

Selection of rehabilitation interventions: A critical step in prioritization and intervention package development was incorporating the WHO's Package of Interventions for Rehabilitation (PIR) (WHO, 2023)**.** This document, provided by WHO in its advanced draft form, was instrumental in prioritizing conditions, selecting rehabilitative interventions already available in Georgia, and aligning them with those recognized internationally. Thus, the PIR played a pivotal role in prioritizing health conditions for inclusion in UHCP and choosing and/or amending interventions based on global standards and evidence described in the PIR. Specifically, the PIR facilitated the learning process of the project team and local experts, enabling systematic organization, prioritization, and selection of interventions suitable for the local context. This involved identifying interventions that could be effectively delivered by existing service providers and met the evidence-based, effective, and economically viable criteria. WHO's guidance was crucial to ensure that the selected interventions fit well with the local healthcare system and budget limitations, thus upholding the project's dedication to sustainable solutions.

Prioritization of conditions and interventions: The final and most crucial step relied heavily on the opinions of SMEs regarding the prioritization of health conditions. Through their insights and understanding of the local health landscape, these experts played a pivotal role in the prioritization process. Their opinions were weighted heavily (in the prioritization tool created by the team) (Zoidze & Tsuladze, 2022), and, most importantly, their final recommendations were closely aligned with the outputs from the previous analyses (disease burden, PIR assessment, and availability of interventions).

Semi-structured interviews with involved experts revealed the importance of SME consultations conducted during March-May 2022. These consultations helped (a) finalize the list of priority health conditions recommended for inclusion in the publicly financed program and (b) elaborate the condition-specific rehabilitative intervention packages from the interventions available in Georgia. The SME panel consisted of two neurologic and three orthopedic/musculoskeletal rehabilitation specialists and also included one occupational therapist. Initially, SMEs were individually consulted, and the project's objectives were introduced to secure their commitment and engagement in the proposed process by the Project team. Then, initial findings on the national disease burden distribution and a potential list of priority conditions for consideration were shared and discussed with SMEs. Several working meetings were conducted in a collaborative and trust-based environment, which was also inclusive and participatory, and these meetings proved instrumental in condition prioritization.

The next objective was to select the rehabilitative interventions for the chosen conditions and ensure that interventions were aligned with the PIR and tailored to each condition's severity. For these purposes, SMEs held several discussion sessions to select individual interventions and their recommended number for a

given health condition before reaching a final agreement[2]. Thus, integrating empirical evidence and expert insights ensured a comprehensive and robust approach to prioritizing health conditions and rehabilitation interventions. The culmination of this process was a comprehensive consensus-building workshop that engaged a diverse range of stakeholders representing service providers, civil society organizations, and key officials from the MoH. We fostered a collaborative environment through facilitated discussions where all voices were heard. This resulted in a successful consensus on the selected conditions and the rehabilitation intervention packages for inclusion in the UHCP. There was unanimous agreement among all parties present to continue this collaborative approach moving forward. This spirit of partnership across the stakeholder groups was crucial as we navigated the next steps, which involved further consultations to refine the implementation details and ensure a smooth integration of rehabilitative services in UHCP.

Before moving to the next step, the costing and budgeting exercise, the team shared the recommendation for selected conditions and respective intervention packages with the MoH. This allowed for an initial review and ensured that plans aligned with the Ministry's priorities and expectations. Thus, involving the MoH early on made the process more collaborative and set the conducive preconditions for the costing exercise conducted after selecting conditions and condition-specific intervention packages (Zoidze & Tsuladze, 2022).

Lessons learned

1. **Navigating Data Limitations:** Project/program planners should consider the availability of the national data (about the health needs of the population and existing provider capacity to deliver rehabilitation services) early in the planning process and be prepared to seek out and adopt alternative approaches if data is not available. In Georgia's case, using GBD data, supplemented by provider network assessment and expert inputs, helped resolve this challenge. However, as Georgia moves forward, strengthening health information systems will be critical to ensure that comprehensive and quality data (to collect a nationally agreed set of rehabilitation indicators[3]) is available and informs decision-making on further integration of rehabilitation services in the national system.
2. **Translating Global Guidance to Local Context:** While the WHO's PIR offered a valuable framework for organizing and prioritizing evidence-based rehabilitation interventions for public financing, its application underscored the necessity of tailoring global tools to local contexts. The PIR's effectiveness was significantly enhanced by adjusting intervention packages to fit the specifics of Georgia's health system landscape, including the availability of interventions, necessary human

[2] The number of interventions to be delivered to a patient with a given health condition was necessary pre-condition for costing purposes. As noted earlier, Georgia moved away from input-based financing to output-based payment and decision/agreement was made by MoH to reimburse providers for a set of rehabilitative interventions, instead of reimbursing each intervention separately. These decisions created requirements for costing and budgeting discussed later in the document.

[3] Using WHO guidance Georgia is in the process of agreeing on the national set of indicators required for monitoring the rehabilitation field of the country and its development.

resources, and institutional capacities. Projects in other settings should anticipate the need for such adaptations to ensure global methodologies align with local needs, resources, and capacities.

3. **Engaging Local Experts:** The insights and recommendations from SMEs were invaluable, particularly in the absence of robust national data on the prevalence of conditions amenable to rehabilitation and the availability and accessibility of different interventions nationwide. Their knowledge of the local health landscape informed the prioritization of health conditions and the customization of intervention packages. This emphasizes the critical need for engaging local experts throughout the project to inform the prioritization process and ensure that the selected interventions are feasible and relevant to the local environment.

Intervention Costing and Budgeting

Navigating the Data Drought

After finalizing the intervention packages for selected priority conditions, the team advanced to the phase of determining the costs associated with providing these interventions. To facilitate this process, the team initially attempted to utilize a costing tool developed by Johns Hopkins University[4], which proved to be data-thirsty relative to Georgia's context and demanded comprehensive and substantial statistical data with a level of detail and specificity not routinely available in the country. Due to budgetary limitations, collecting these data through surveys was not feasible. Furthermore, the tool is better-suited for healthcare systems that use input-based payments rather than output-based financing, as in Georgia. Therefore, given Georgia's transition to an output-based payment system for health services, it was necessary to (a) define a service unit as a subject of payment and (b) estimate its costs to determine reimbursement amounts appropriately.

Confronted with these challenges, the Project team searched for alternatives. Comprehensive information from the USA was accessible in the public domain, but its complexity proved inadequate for a Georgian context. Next, the team engaged with the WHO Regional Office for Europe and consulted colleagues, who helped establish a peer connection with counterparts in Estonia (Estonia's Health Insurance Fund https://www.tervisekassa.ee/en). Estonia's experience with output-based financing presented an opportunity to gain insights into the amounts and cost structure for similar rehabilitative interventions selected by Georgia.

This collaboration marked a pivotal moment in our methodological approach to the costing exercise. It became clear that leveraging international experiences, particularly the cost estimation data from Estonia,

[4] The tool was developed for Ukraine within the initiative ReLAB-HS (Learning, Acting, and Building for Rehabilitation in Health Systems), which is a global initiative led by the Johns Hopkins International Injury Research Unit at the Johns Hopkins Bloomberg School of Public Health, funded by the USAID. The project aims to develop responsive health systems to meet the growing needs for rehabilitation services in low-income and conflict-affected countries. In Ukraine, ReLAB-HS has been actively involved in strengthening rehabilitation services amid the ongoing conflict. Their efforts include providing technical assistance and resources to support the rehabilitation workforce, ensuring the availability and accessibility of necessary rehabilitation interventions, and integrating these services into the broader health system to improve care for those affected by the conflict.

would be the most effective strategy. Adopting and adapting cost structures provided a practical solution to our immediate challenges and underscored the importance of international collaboration in addressing complex health financing issues. Informed by Estonia's experience refining the costing methodology for the chosen intervention packages, we proceeded with the data collection required for cost estimates. This phase involved conducting interviews and group discussions with SMEs and other specialists to gather information about the duration of each intervention and necessary inputs (staff, equipment, etc.), time spent on administrative tasks such as documentation production, and transition time from one patient. Through this meticulous process, we collected data comparable to what Estonia used in its costing. We made several macroeconomic adjustments to replace Estonian salaries with Georgian ones and to account for non-salary inputs, such as electricity and other utility payments data unavailable in Georgia. After extensive work and refinements, we finalized the service costing and produced reimbursement rates for each selected health condition, accounting for disease/condition severity.

The PIR proved invaluable again for this process, offering us a framework to efficiently plan the necessary human resources and time allocation for each intervention. This tool was instrumental in enhancing the precision of our costing exercise. However, the most significant impact of the PIR was that it facilitated consistent terminology and understanding among SMEs from various backgrounds (medical, financial, managerial, etc.).

Validating Estimated Reimbursement Rates

Upon completing the data collection and production of cost estimates/reimbursement rates, the next critical step involved sharing the used methodology and its outputs with a broader stakeholder group to solicit their feedback and secure consensus around the produced estimates for reimbursement. This wider group included service providers (notably representatives from financial departments) and the MoH. Given the depth and rigor of the presented approach, the MoH and other stakeholders heavily relied on the work conducted by the CIF experts, recognizing the robustness of the methods used and steps taken during the costing exercise. Again, this collaborative and inclusive approach underscored the project's commitment to transparency, inclusivity, methodological rigor, and stakeholder engagement in developing a robust and reliable estimate for proposed reimbursement rates for the selected rehabilitation services.

Next, the team was expected to provide estimates for financing over the medium-term period to inform the financial needs of the rehabilitation service expansion. Using the national condition-specific service utilization data for 2016 - 2021 from the anonymized claims dataset of the NHA, the team, with inputs from SMEs, forecasted the need for rehabilitation services across selected health conditions. A technical working group was integral to this process, selecting specific ICDs and NCSPs (Nordic Classification of Surgical Procedures) codes related to prioritized conditions. Quantitative analysis of utilization data and inputs from SMEs underpinned the projections for annual patient numbers in 2023 and thereafter. Estimated cases, along with agreed reimbursement rates, based on clinical assumptions supplied by SMEs, informed future budgetary requirements. The final costing and budget forecasts (Goguadze & Gotsadze, 2022) were presented to the MoH for review and approval. We received valuable feedback on these documents, and after addressing any outstanding questions with further clarifications, the MoH provided their final acceptance.

Lessons Learned

1. **The Need for More Universal and Flexible Global Costing Tool (s) for Rehabilitation Services**: the use of available costing tools/methods for rehabilitation services could present significant challenges in environments where required data may not be readily available or if these tools do not account for the specificity of health systems, especially the way health purchasing functions are organized and the way providers are paid. While countries will still be expected to use more tailored approaches to rehabilitation services costing that fit their unique health system and available information, the refinement of the existing costing tools or the development of more universal and flexible tools (e.g., using the WHO PIRs) may help the countries to lay a solid foundation for costing rehabilitation services at the national level.
2. **Collaborative Success with PIR**: Despite the valuable guidance, tools, and insights received from our Estonian colleagues, the success of our efforts would not have been possible without an inclusive and consultative process engaging all relevant stakeholders, including those managing rehabilitation provider financing. The PIR enhanced this approach, which provided Georgian stakeholders with a framework for discussions, structuring conversations, and deliberating on various services/interventions and their resource requirements. The PIR was an excellent guide in shaping our understanding and approach to discussing different rehabilitation services and their cost implications.
3. **Enhanced by Participatory Approach:** Our team's expertise and methodological robustness of the approach used were important. However, numerous consultative meetings with stakeholders proved critical for producing the final outcomes. These consultations offered a platform for receiving valuable inputs that significantly enriched our project outputs and their quality.

Integration of Rehab Services into the UHCP

After completing the pivotal activities—prioritization, intervention selection, costing, and budgeting—it was time to progress to the project's primary goal: integrating rehabilitation services into the UHCP. For this crucial phase, a dedicated working group composed of SMEs held repeated iterative meetings. These meetings aimed to achieve consensus on the eligibility criteria for patients to access the state-funded services. These criteria included age, specific ICD-10 codes, i.e., disease conditions, functional improvement criteria for admission to a repeated course of treatment, treatment adherence, etc. The document outlining the proposed criteria was shared with the MoH for review and feedback, which has led to active discussions and refinement of the eligibility criteria with the MoH officials. Eventually, the consensus was reached, and the MoH accepted the recommendations made by the team. Later in the year (November 2022), MoH added rehabilitation services to the UHCP benefits, which included a limited set of conditions (stroke, traumatic brain injuries, and spinal cord injuries) with a plan for future expansion in 2024. By June 2024, the state program had reached 1,146 patients, with 169 of them benefiting from the services multiple times.

The anticipation surrounding the new program's introduction came with the expectation that only a few providers would offer it, and the initial public funding would not be enough to cover all who would demand the rehabilitation services. This raised concerns about a potential imbalance between supply and demand. To address this issue and help to allocate the limited public funding to those who will benefit most, CIF

proposed a strategic solution to the MoH: creating a committee to manage demand through a preauthorization process based on patient eligibility criteria and intervention selection for authorized cases. This recommendation established the Independent Assessment Committee (IAC) within the NHA. However, the assigned responsibilities, the composition of the IAC, and its operational modalities did not fully align with the initial intentions (preauthorization and intervention selection for eligible patients). Implementation Research[5] conducted by the CIF team (Tsuladze et al., 2023) showed that providers believed this structure lacked the necessary expertise for informed decisions, the IAC often prescribed interventions not included in the state program, indicating insufficient knowledge of the relevant state regulations and, finally, the IAC's lack of direct contact with patients raised further concerns about its ability to understand specific patient needs to design the individual rehabilitation plans. Consequently, the Project provided training in rehabilitation planning and outcomes assessment for the IAC members and rehabilitation providers. It generated further recommendations and possible solutions to improve the committee's performance: to improve the rehabilitation patient's pathways and to limit the responsibilities of the IAC to administrative review of the patient documentation and determining patient eligibility (particularly for repeated rehabilitation courses), and program monitoring.

Lessons Learned

Not only technical aspects of condition prioritization, costing and budgeting were important, but also eligibility aspects to achieve service integration into UHCP. The latter required specifying legal provisions in the Government of Georgia Resolution regulating UCHP as well as establishing the body to implement established eligibility provisions through pre-authorization. All of this was possible by maintaining continuous communication and active involvement with the MoH and the NHA during the establishment of the IAC and in defining its function and responsibilities. Finally, not all initial designs deliver on the expectation and therefore, the value of implementation research to inform necessary adjustments could not be underestimated.

Facility standards and guidelines

The project's original intent was to support the MoH in integrating rehabilitation services into UHCP and gradually expand the geographic coverage of these services. However, during project implementation and consultative meetings with stakeholders, two challenges consistently emerged, underscoring areas requiring immediate attention and action. The two challenges included a lack of facility standards for outpatient rehabilitation services provision and guidelines for delivering evidence-based, quality-assured, and effective rehabilitative interventions.

Minimum standards for outpatient service providers

As noted above, the first challenge centered on the absence of established standards for outpatient rehabilitation facilities. This lack of state-approved standards has been a significant barrier, precluding established outpatient facilities from participating in the state's rehabilitation program. While the WHO was developing global guidance for establishing standards for outpatient rehabilitation service providers, this guidance was not anticipated until the end of 2024. This situation slowed down the geographic expansion of the provider network and delayed patient enrollment in the treatment, especially in remote

[5] The researchers employed qualitative research methods and conducted semi-structured interviews and focus group discussions with purposively sampled respondents, including patients, providers, and policymakers, to explore the implementation of a state rehabilitation program in Georgia.

areas. It also emerged as a barrier for providers interested and motivated in offering outpatient rehabilitative services to patients.

CIF, exposed to the demands of patient groups and adhering to its commitment to advancing rehabilitation services geographically, was required to proactively convene an expert working group for outpatient facility standard development. The aim was to develop **minimum requirements** (standards) for outpatient rehabilitation facilities. The diverse group of experts met almost bi-weekly and exchanged ideas and knowledge. This consistent engagement and the broad spectrum of knowledge base brought to the discussion table were instrumental in developing the necessary requirements. Within just a few months, these concerted efforts culminated in creating a set of minimum requirements for outpatient rehabilitation facilities submitted to the MoH for review and approval in August 2023. The CIF team also participated in the lengthy consultation process with providers and other stakeholders organized by the MoH to develop the change to the Governmental Resolution No 359 from 2010 that mandates technical regulations for providers of health services using the minimum requirements' recommendations developed by the Project. The work was completed in 2024, and adopting the changes to the Government Resolution is anticipated in July 2024.

Clinical Guidelines For Selected Conditions

The second challenge identified was the lack of national guidelines covering rehabilitation for only one prioritized condition. This narrow coverage left other prioritized conditions without quality rehabilitation guidelines, thereby limiting the comprehensiveness and effectiveness of rehabilitative interventions and also allowing substandard or ineffective rehabilitation interventions (largely inherited from the Soviet Union) to be provided by the existing providers.

To address this challenge, CIF organized three separate working groups, each tasked with developing guidelines, using the existing global evidence base (WHO, 2023) but adjusting to the local setting. This approach followed the same steps as the earlier Project work on minimal facility standards, demonstrating CIF's consistent and tested method for tackling challenges through inclusive, participatory, and evidence-informed processes. Over the course of six months, this structured process facilitated the creation of three comprehensive guidelines for traumatic brain and spinal cord injury, hip and knee arthroplasty, and post-operative rehabilitation after amputation. One of these newly developed guidelines has already been endorsed through the relevant national process, while the other two are in the process of final approval.

Lessons Learned

The ultimate objective of interventions in healthcare is to ensure the population's access to quality services that lead to better health outcomes. Therefore, if the objective of the project is to integrate rehabilitation services into the health system– not only on a pilot basis but in a sustainable and scaled-up manner – the governance aspects needed for such integration cannot be ignored. Our experience showed what was needed on a governance level and as a regulatory framework for service expansion and for service quality. We think that the support provided by the Project for the development of the national guidelines and minimum requirements for rehabilitation providers was important for advancing rehabilitative service integration in Georgia and ensuring the quality of delivered rehabilitation services.

Development of a Rehabilitation Practice Community for Sustainability

Working Groups

In 2023, three working groups were established with the Project's facilitation to focus on different areas: a) national guidelines for three specific conditions, b) standards for outpatient rehabilitation facilities, and c) a human resources competency framework. In mid-2023, the MoH approved an order outlining the responsibilities of these working groups. While the working groups have made progress on the guidelines and standards, the development of the national competencies for the rehabilitation of human resources is still in the process.

The future vision suggested by us for the working group is to consolidate the rehabilitation experts, representatives of providers, and other rehabilitation stakeholders into the rehabilitation practice community that will continue working in partnership with the MoH, NHA, and other stakeholders to ensure the intersectoral approach to improvement of rehabilitation services and provide actionable recommendations on an annual basis for the program expansion and adaptation.

Capacity Building

To facilitate the Commission's capacity building and operation, the Accelerator recruited an international consultant, Professor Gwynnyth Llewellyn, from The University of Sydney. The consultant worked closely with the MoH, Accelerator, CIF, and other partners to develop a training program and facilitate the training of the Commission members to develop and implement the pre-authorization and rehabilitation interventions outcome assessment framework. For this purpose, a training seminar was organized in Tbilisi, Georgia, from 18 to 21 July 2023, which was preceded by online (May-June 2023) and live (17 July) consultations with key stakeholders on the training topics and framework.

The following key objectives of the seminar were successfully achieved:

- Review of the Commission's activities in establishing processes, tools, criteria and efficient protocols for making decisions about patient eligibility for rehabilitation financing under the UHCP.
- Training of the Commission members and rehabilitation providers to build capacities on the topics of (a) determining patient eligibility and appropriateness of prescribed rehabilitation interventions and (b) interdisciplinary approaches for evaluating rehabilitation interventions and patient outcomes.

In November 2023, the "Train the Trainer for Rehabilitation Health Care Providers" short course was conducted under the auspices of R4D, presented by the same consultant with support from the CIF. The objective of the course was to train academic counterparts and rehabilitation providers to develop a cadre of master trainers on rehabilitation planning and outcomes assessments and to draft a curriculum for a proposed certification course to be delivered by Master Trainers who successfully completed the program.

Conclusion: A Collaborative Journey Towards Integrated Rehabilitation Services

Georgia's journey towards integrating rehabilitation services into its health system offers valuable lessons for developing countries facing similar challenges. This project, supported by the USAID-funded Accelerator and implemented by CIF, exemplifies the power of collaboration and a participatory approach.

- ✓ **Data Limitations and Solutions:** For countries, tailoring activities and selecting tools based on available data in domains like prioritization and costing is essential. Data availability dictates the methods and tools used, ensuring that strategies are both relevant and effective. This approach guarantees interventions are data-driven and customized to meet each country's specific healthcare needs and resources efficiently. The project effectively addressed data scarcity by utilizing global estimates and collaborating with countries with relevant experience (Estonia).
- ✓ **Power of Participatory Approach:** Inclusive stakeholder engagement was crucial for the success of the Georgia rehabilitation program. Frequent engagement, including consultations with subject matter experts and service providers, ensured inclusivity, transparency, and the development of contextually relevant solutions.
- ✓ **Importance of Local Context:** Global tools like the WHO's PIR proved valuable frameworks but required adaptation to Georgia's specific health system and resource limitations

This project demonstrates a successful approach for donor-funded health system strengthening initiatives. By actively involving local stakeholders beyond just donors and the implementing organization, the project ensured significant local input into key activities. This collaborative approach led to positive changes within the rehabilitation service landscape.

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