## Template 2 : prioritaire initiatieven

1. ***U hoeft niet alle velden in te vullen.***
2. ***Zend het ingevulde formulier naar :*** [***taskforce.DZ-SE@riziv-inami.fgov.be***](mailto:taskforce.DZ-SE@riziv-inami.fgov.be)

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| Codering : ………. *(voorbehouden voor het RIZIV)* Datum *: 04 / 05 / 2021* | |
| Auteur : *(individuele zorgverlener / organisatie / AOC / overheid / andere )*  🡺 naam: AXXON Ptib (Physical Therapy in Belgium) | |
| Voorstel kadert in: (*aankruisen wat van toepassing is*)  0 quick-win in kader akkoord NCAZ 2021 (search 40 mio €)   x structurele en flankerende maatregelen om doelmatige zorg te faciliteren  x effectieve maatregelen doelmatige zorg  0 maatregelen voortvloeiend uit gezondheidszorgdoelstellingen | |
| Onderwerp | **Implementation of group physiotherapy/exercise sessions in the care of chronic diseases, mental health disorders and pregnant women in first-line physiotherapy practices in Belgium.**  Taking into account that patients or pregnant women with NCD’s or mental health disorders often suffer from co-morbidities and/or symptoms, a close medical attention and specific and individual prescription of exercise training programs are required in order to maximize the clinical benefits and medical safety of the exercises. |
| Definition of done | According to the current physiotherapy nomenclature, a physiotherapist is allowed to treat one patient with a NCD or mental health disorder every 30 minutes only, and such individual exercise session costs at least 19,75 euro to society (in case of M24). Therefore, physiotherapists working in first-line private practices are simply not able to contribute to limit significantly the NCD or mental health disease burden due to the low number of allowed patients/hour, and the implementation of exercise therapy in these patients is, at least in the short term, too expensive to society. Moreover, it has been observed frequently that the expertise of the physiotherapist in the rehabilitation of NCD’s is often underused, unknown and/or underappreciated by other healthcare providers, despite sufficient education and expertise. |
| Doelgroep | Patients or pregnant women with NCD’s or mental health disorders with important co-morbidities and/or symptoms. |
| Toelichting van de actie en motivering | The prevalence of non-communicable diseases (NCD: obesity, diabetes, renal, cardiovascular and pulmonary disease, neoplasia, chronic low back pain, chronic renal insufficiency/failure, systemic rheumatic diseases) and mental health disorders is increasing rapidly on global scale, but also in Belgium.  **A cornerstone in the treatment** of NCD’s and mental health disorders is exercise therapy. This is endorsed by many official international instances such as the American College of Sports Medicine, American Heart association, European Association for Cardiovascular Prevention and Rehabilitation, European Society of Cardiology, European Respiratory Society, International Obesity Task Force, European Association for the Study of Diabetes, World Health Organisation, etc.  The scientific literature clearly indicates that regular exercise training leads to significant improvements in cardiovascular disease risk factors, body composition, physical fitness, mental health, and reductions in morbidity and mortality. As a result, these instances warrant implementation of exercise training/increased physical activity in NCD’s and mental health disorders on community scale.  The Belgian’s current healthcare system is severely limited in its capability to prescribe exercise training programs for patients with NCD’s or mental health disorders in supervised exercise training interventions.  Belgian hospitals should ideally focus on rehabilitation of patients with NCD’s and/or mental health disorders with severe/significant co-morbidities, and patients with less severe co-morbidities can then be referred to peripheral first-line practices. This approach will lead to optimized therapy for every patient. However, first-line physiotherapy practices are currently severely restricted in the capacity to rehabilitate these patients (mainly due to restrictions in nomenclature).  Moreover, in some areas the distribution and density of hospitals and rehabilitation centers is too low and unequal to be able to prescribe rehabilitations programs for patients with NCD’s or mental health disorders.  Furthermore, some patients (especially the elderly and significantly disabled patients) are unable to transfer to rehabilitations centers and hospitals several times per week.  References   1. International recommendations for exercise intervention in NCD’s 2. 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 3. <https://www.ecorys.com/sites/default/files/2021-01/3049300%20eindrapport_substitutie%20van%20zorg_def.pdf> 4. https://www.zorginstituutnederland.nl/binaries/zinl/documenten/adviezen/2016/12/20/systeemadvies-fysiotherapie-en-oefentherapie/Systeemadvies+fysio-+en+oefentherapie.pdf |
| Financiële situering | Number of treated patients/hour could be increased significantly so the costs of training sessions/patient for society could be significantly reduced.  With the same budget greater clinical benefits will be achieved and more patients can be treated. |
| Procedure | To be able to limit/lower NCD and mental health disorder burden on our current healthcare system and economy, patients with these diseases should be referred massively to physiotherapists in first-line private practices.  In this regard, the nomenclature should be adapted to make it possible to propose **group training sessions** for these patients.  Furthermore, the benefits of group sessions for exercise training programs (increased therapy adherence) have been widely recognized. In the long term, this will lead to greater reduction of morbidity and economic costs that normally would result from NCD’s and mental health disorders. These effects will be of significant benefit to society and patients. |
| Planning | The above-mentioned approach requires a significant adaptation in the physiotherapy nomenclature. |
| Werklast | 3 to 6 months ? |
| Beoogde financiële impact | Currently, patients with NCD’s or mental health disorders are allowed to visit the physiotherapist 2 x 9 times on a yearly basis (which are too less sessions to achieve any clinical benefit or long-term changes in lifestyle).  The first 9 sessions cost 26 euro (M24), the next nine sessions cost 25 euro; therefore the total cost equals to 432 M-values (18 sessions x 24M).  It is costly to community (at least 19,25 euro/session must be supported by society) although the 30 minutes/session might be too short to achieve optimal clinical benefits. If we assume that on average 4 patients will attend a group session (equals to M-value of 1728 from current nomenclature), then these 1728 M-values could be divided by 144 (36 sessions x 4 patients), which equals an M-value of € 12/session/patient.  With this approach, it would be possible to exercise up to 5 patients (=**cost effective and cheaper for the patient**) together in group for 1 hour (**clinical benefits will be twice as high**).  It thus follows that there is no request for a higher budget, but with the same budget greater clinical benefits will be achieved and more patients can be treated. |
| Benodigde middelen en samenwerking | We propose to adapt the nomenclature so that these patients could benefit from 36 one-hour (shorter durations are much less effective) supervised exercise sessions, on a regular basis (2 or 3 days/week) within a six-month period.  In the first month of intervention, it is recommended to install 3 supervised sessions/week. After this timeframe the number of supervised sessions/week should be decreased (1 or 2), patients should be encouraged to execute home-based exercise programs. Therefore, the program will last between 3 and 6 months (period often considered as the minimal program duration to observe clinical improvements).  The limit in time to attend the sessions will force people to respect the recommended participation rate. These exercise sessions should be a combination of endurance exercises (walking, cycling, rowing, stepping, …) and strength exercises, depending on the symptoms and limitations of the patient.  The opportunity to benefit from these 36 exercise sessions for each separate disease would be offered only once/year  Such group sessions would have to be proposed to homogenous groups (patients suffering from similar pathologies or altered health states) and in a fully equipped private practice adapted to handle groups of patients.  We recommend 3-5 patients/session. When exercises are prescribed in which the physiotherapist needs to monitor/assist on individual basis, the traditional nomenclature would be used. |
| Bijkomende opmerkingen | Outcome indicators provide insight into the effects of exercise programs by means of measuring instruments **(Patient Reported Outcome Measures**). There are various validated measuring instruments (questionnaires, function tests and performance tests) for measuring a person's active lifestyle, fitness, self-management, functional recovery, vital and / or cognitive limitations and maintenance of functions. These instruments are described on www.meetinstrumentzorg.nl. |