

Strategy for Direct Access

Naima Saleh

United Arab Emirates





Dubai During 1950



Dubai 1960s-1970s



After Development



Healthcare System UAE

Ministry of Health (MOH)	Health Authority Abu Dhabi (HAAD)	Dubai Health Authority (DHA)	Dubai Healthcare City (DHCC)
<ul style="list-style-type: none"> •Federal Government of Health Care Constitution •Legislative laws for all Emirate •Licensure provider for Northern emirates and hospital under its jurisdiction in Abu Dhabi &Dubai •Health care providers as well 	<ul style="list-style-type: none"> •Licensure provider for emirate's of Abu Dhabi •Health care service providers as well •Equity & accessabilty for all 	<ul style="list-style-type: none"> •Licensure provider for emirate's of Dubai •Health care service providers as well •Equity and accissablity for all 	<ul style="list-style-type: none"> •Licensure provider forhealth care providers in health care city (Dubai) •Health care service providers as well •Free Zone
<p style="text-align: center; color: yellow; font-weight: bold;">All above need to comply with MOH Constitution and legislative law</p>			

Populatin

4.5 million of which 15 % nationals

First UAE PT 1989

Total No. Of UAE nationals PT > 40

Benchmark

Benchmark against renowned healthcare industries is followed

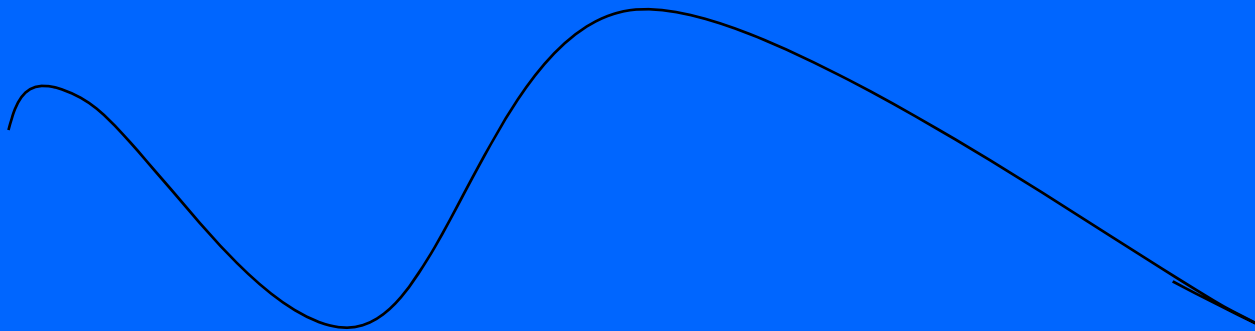
Made the PT in Up and DOWN Curve

PT Practice Model in UAE

- MOH & Other Governmental hospital: need Ref
- Head of PT dept: Physiatrists preferably
- Physiatrists: All patient to be seen by them in Gov. practice (out-patient) despite referral from GP, Specialist & prescribe PT intervention
- Majority PT dept in private hospitals managed by PT but requires Ref.

What is the Status of PT

- Baby steps (two steps forward) one step backward
- HAAD: pt from GP/specialist seen by PT directly and if other rehab such as OT, SPL required could do Ref
- HAAD PT did not take steps to prevent backward step
- HAAD merged with renowned hospital in US (Cleveland, John Hopkins lost autonomy)
- Below is the curve we are going through



The strategy to Direct Access should target the following:

- Private and Public Hospital Private Clinics
- Do not take the autonomy as granted
- Risk of policy change exist



Issuing License

- Committee member's for issuing license in MOH & DHA are physiatrists
- EPS continuously communicated with Licensure dept, as a result were able to have a PT members with PMR in licensure committee.

Private practice in Northern Emirates

- Patient can self refer, but without insurance reimbursement
- Physical medicine/ physiatrist resist such practice and are presently in MOH, HAAD & DHA licensure committee for PT license

Factors Negatively Influencing Direct Access

- PT education & Years of education questioned by policy makers through PMR influence
- Inconsistent eligibility criteria for DA/ no criteria is adopted in MOH
- Absence of objective assessment
- PT title: classified as technicians
- Internal Drive of PT: payment scale, recognition of higher degree etc
- Influence of renowned health care such as Mayo Clinic, Johns Hopkins, Cleveland

PT Education Policy

- WCPT need to unified the degree for PT graduates
- Is that level of entry to profession is sufficient for direct access without prior experience
- Is internship/residency/experience required post graduation needed (e.g. such as Tennessee Board of PT Position statement for direct Access to PT 2007)
- Who should have DA?

DHA Reform

- One goal of reform is:
 - To review the scope of all health care providers in the Emirate's of Dubai

Developed Committees for healthcare work force in DHA:

- Physicians
- Nursing
- Radiology
- PT
- Pharmacy

Strategy followed for Committees

- Have representative from MOH, private practice, DHCC
- Fortunately PT committee all members were PT (because of having an employee in that dept who was PT background)
- Lobbying: is important strategy

Draft for Licensure Requirements
for Physiotherapy is Developed

Draft of PT Scope of Practice
develop and reflected autonomy

Autonomy: objective assessment is required which is challenge

one option is to request PT pass

Australian exam which is

conducted in Australian Embassy

The draft for licensure and scope of practice were made available for public feedback and had the following feedback:

Feedback on the Draft of PT scope

The following was the feedback from PMR

- **The model presented in UK and Australia is not applicable in Dubai for the following reasons:**
- **Physiotherapists aspiring to work in Dubai are coming from different countries (most of them from India, Pakistan, Philippines), and based on our own, long experience in evaluation and licensing process for physiotherapists in Dubai we recognized that their educational background and practical training does not match the criteria for complete independent work proposed in the Scope of Practice for Physiotherapists.**
- **We suggest that clinical practice needs to be supervised by medical doctor, with experience in diseases affecting the locomotor system - to avoid malpractice and to assure patient safety.**

Cont.

- Standard model for **rehabilitation team** that is recognized in international rehabilitation organizations and institutions includes the following members:

Attending Rehabilitation Physician (Physiatrist)

- Rehabilitation Nurse
- Occupational Therapist
- Physical Therapist
- Recreation Therapist
- Speech-Language Pathologist
- Social Worker
- Psychologist/Neuropsychologist
- Rehab Nurse Liaison
- Respiratory Therapist
- Please don't hesitate to contact us if need more details and explanations

Rehabilitation leaders

- Who should lead the patient rehab process in hospital setting when pt is coming with Ref?
- Is it Physiatrists/PMR for further Dx/prescription/cordination?
- Is it PT?
- Is it OT?
- Is it SLP?

Or the one who have most leadership skills or based on the pt progress and patient need of each specialty (which reflect patient center approach)

i.e. IT SHOULD EVOLVE AROUND PATIENT

- Do PT need to Challenge PMR to achieve DA & Promote themselves among other specialities?
- Do PT need to promote there scope of practice, competencies, skills, etc among stakeholders to achieve DA/Autonomy?
- Or Do both method shall be used?

Both Models need to be used

Having PMR leaders of Rehab

- What are the **added value** to patient in hospital setting especially when they act as a co-coordinator
- Need to use risk assessment matrix for objective evaluation
- Use of cost and evidence base from different studies

Promoting PT skills, competencies

- Important to change view of policy makers
- Trust the PT decision
- Understand the capabilities of PT

Value Added Service

- Umiker (1995): “Employees who’s Hands on work are often in better position to visualize how things can be improved in clinical practice”
 - The above statement re-enforce that PT,OT, SPL, etc are in position of:
- **Shared Leadership: driven by Patient Centre Approach**

Why promoting PT among other Physician

- Annals of Internal Medicine (2007) presented Non Pharmacological Mx of LBP and PT intervention as Elector physical Agent only.
- Such article in a prestige journal does not reflect actual role of PT → technician

PT competencies & Skills Challenged

- Pezzin et al (2005): questioned eligibility of non physician (PT & podiatry) on conducting EMG and why should be eliminated from such privilege
- Fellechner et al (1995): PT malpractice reduced after the emerge of PMR in 1948
- Presently there website asks questions the Medicare decision for passing DA

Influence of renowned Healthcare organization of US on DA policy

- Cleveland & John Hopkins merged with two of HAAD Hospitals
- The head of PT and Rehab Changed to PMR
- Policy Changed: all pt referred to PT from any specialty to be seen by PMR for RX Plan

PT Attrition

- The emerge of these new policy resulted in attrition of nationals PT (5% to 10%)

Question to be Answered

- What Approach to follow?
- What is the role of PT societies in promoting the profession & their role as **rehab expert**
- Is PT title need to be changed to reflect their actual domain of practice

Most of the universities the PT speciality comes under the rehabilitation Science faculty however this is not reflected in their scope of practice in the hospitals website versus the PMR who promote themselves on our behalf

Cleveland Clinic Physical Medicine & Rehab Team

- **Physiatrists** (physicians who specialize in physical medicine and rehabilitation) are responsible for the patient's overall medical care, and for the coordination of therapies and services provided by the rehabilitation team.
- **Physical Therapists** assess, evaluate and treat patients' physical abilities. They develop treatment programs to help patients maximize their mobility and minimize pain through exercise and training.
- **Occupational Therapists** assist patients in developing the skills necessary for activities of daily living such as getting dressed, taking a shower, or eating. They evaluate patients' ability and develop treatment programs to help patients achieve a maximum level of independence.
- **Rehabilitation Nurses** work with other team members to help patients achieve the very best outcomes in terms of health, independence and function.
- **Orthotists** assess the needs of patients who require support for their spine, an arm or leg. Often, an orthosis (brace) is custom fabricated at Cleveland Clinic to specifically meet the needs of the patient.
- **Prosthetists** design prostheses (artificial limbs) for patients who have undergone an amputation or present with a congenital anomaly. The prosthesis is custom designed for each patient to fulfill individualized needs.
- **Vocational Rehabilitation Counselors** evaluate patients with disabilities and make recommendations to ensure they have the resources and knowledge to live successfully, be meaningfully employed, and enjoy being productive members of the community.

Cleveland Clinic Physical Medicine & Rehab

Co-ordinate the following Services

- Aquatic rehab
- Amputee rehab
- Bariatric rehab
- Breast cancer rehab
- Chronic pain rehab
- Comprehensive neurological rehab
- Drivers equivalent rehab
- Fitness & wellness performance
- Golf performance
- Orthopedic (musculoskeletal) rehab
- Orthotic&prosthetic
- Low vision services
-
- Osteoporosis rehab
- Rehab for head
- Pelvic floor rehab
- Performance medicine
- Rehab technology
- Return to work service
- Spine injury or pain rehab
- Vestibular rehab
- Vocational rehab
- Wound care

Annual Representative Conference 2009 -CSP

- Motion 1

Career ladders

Conference calls on the CSP and members to campaign against the increasing disappearance of the career ladders, -----which enable the future allied health professional managers to gain experience of leadership and management. resulting in a 'glass ceiling',

Rehab Service Co-ordination

- Do we need someone to co-ordinate the services on our behalf
- Are We Lacking communication skill
- Why others should take the credit of our work

Taking the leadership of our core business should improve the opportunities in career ladder

Suggested Policies

- PT manager should reflect in their scope their role as rehab professional in website of their healthcare organization and to be articulated and written clearly
- Identify the eligibility criteria for direct access
- Adopt the recommended years of APTA for education
- WCPT should promote the APTA concept of DPT/ or minimally the MSc
- WCPT should communicate with policy makers with policy makers in countries where PT are not autonomous to promote their role
- DA should be reflected in both hospital setting and private clinic
- Rehab physicians should take the charge of medical problems not to prescribe and co-ordinate our management.

Thank You