
Response to the Final Report of the Minor Injury Treatment Protocol Project, titled "Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person"

July 29, 2015

ABOUT THE ONTARIO REHAB ALLIANCE

Founded in 2009, the Ontario Rehab Alliance (ORA) is a non-profit association representing 136 healthcare organizations with over 4500 healthcare professionals. It is these professionals who are the primary providers of healthcare and rehabilitation services to the 65,000 Ontarians who are injured each year in motor vehicle accidents (MVA). Our member companies operate in the auto insurance sector as well as a variety of non-institutional sectors.

We are the only association focussed solely on the interests and issues of healthcare providers in the auto sector. We advocate on behalf of our members to influence government policy and public opinion on behalf of our members and the accident victims they support.

Our association is an active and constructive participant on multiple forums including *FSCO's Service Providers Licensing Forum*, the *HCAI Antifraud Group* and the *HCAI Forms Committee*.

INTRODUCTION

The ORA welcomes this opportunity to respond to the Final Report of the MITPP. However, we emphatically note that it is not possible to provide feedback on the likely impact of this report on stakeholders in the absence of information about the regulatory policies (SABS changes) that will be implemented to support the report's recommended pathways.

Clinical pathways prescribed within a context of regulatory and funding parameters, such as these are, cannot be evaluated in a vacuum of knowledge of what those parameters will be. For example, a particular recommended pathway may make clinical sense, but not if those interventions have to be accomplished in two sessions or for a cost of \$50.

Further, the timelines provided for this consultation do not allow for a process that we believe should include consultation with the multiple professional Colleges whose members practice in the auto-insurance sector. These Colleges mandate standards of practice for assessment and treatment, and their members could find themselves in the untenable position of weighing the use of prescribed pathways (required if they are to be paid for their services) when these do not align with Colleges' standards.

In January 2015, knowing that the Ministry of Finance was expecting the MITPP's report in December 2014, we wrote to the Ministry requesting an opportunity for meaningful consultation on the report. In the same document: *Evidence Based Practice & Treatment Protocols* (Appendix A), we outlined our position on such protocols. Portions of this previous submission are incorporated into this response.

CARE PATHWAYS: GENERAL OBSERVATIONS

Evidence Based Practice is the conceptual foundation on which specific treatment, or care pathways, are based. Simply put, it means that clinical practice should be informed by the scientific evidence about what works (and what doesn't work) for the treatment of various conditions. Care pathways flow out of this conceptual framework and outline clinical interventions that have been developed in response to the evidence. Virtually all Regulated Health Professions have adopted various care pathways as best practice for some conditions and populations.

The Ontario Rehab Alliance fully appreciates the value-for-money pressures which give rise to interest and investment in exploring Treatment Protocols. Our keen interest in developments such as the MITPP stem from our concern that mandated treatment protocols such as those imposed by third parties (such as the MITPP) must be grounded in proper evidence and must be designed to respect the clinician's duty of appropriate care as mandated by their regulating College.

Multiple research studies, conducted within various injury populations, have demonstrated that while care pathways are useful for some injuries, all regulated health professions acknowledge that there are inherent clinical dangers in any 'one-size-fits-all' approach to assessment and treatment. Such treatment protocols are best applied to specific areas where populations or injuries and disorders are homogeneous, meaning that they have a great deal in common. The most respected and widely adopted protocols allow for alternate approaches and considerations to be factored into the analysis of each individual client's condition and circumstances. Care pathways cannot generally be applied properly to diverse populations.

We have examined the key research findings for care of post-accident injuries, including Orthopedic Injuries and Soft Tissue Injuries. Research reveals that the most successful care pathways and practice guidelines are those that incorporate clinician engagement and allow some degree of customization to meet specific patient needs, and that provide clear and well accepted methods to allow people who do not follow the typical recovery path (e.g. due to pre-existing conditions, or if the original diagnosis changes) to access more or different care.

We believe that the principles and trends arising from the research can most usefully be applied in the auto insurance sector to assist adjusters in appropriately approving assessment and treatment requests rather than requesting Insurer Examinations. This will both expedite service and reduce costs: a win/win scenario.

Care pathways should never be used to automatically deny or limit benefits when a patient's experience does not "fit" the expected outcomes. There are many clinically valid reasons why one patient may respond differently to treatment than another and poor patient engagement should not automatically be the presumed cause.

Well-designed care pathways should:

- a) Respect assessment and treatment guidelines and protocols established by the various Colleges of Regulated Health Professionals,
- b) Reflect current research knowledge and expected patient variability,
- c) Include 'red flags' for symptoms and conditions which may legitimately impact responsiveness to intervention,
- d) Include indicators for application of a different Treatment Care Plan vs the generic Care Protocol,
- e) Exclude rigid application of standard one-size-fits-all procedures and timelines,
- f) Require clear documentation of outcome,
- g) Refer to College guidelines for guidance on clinical decisions for temporary or permanent discontinuation of service when outcomes are not being achieved. Such guidelines routinely include expectations for clinician consideration of client/patient engagement in treatment and follow-through.

THE MITPP'S REPORT

Objectivity

Portions of the report include inflammatory suggestions and raise questions about the objectivity of the authors. For example, on p.33 (4th bullet point from the bottom) there is a reference to total AB costs of \$4.5 billion. GISA shows this figure at \$3.8 billion. Further, the authors have selected the highest number in the last five years, presumably to make the situation seem worse than it is in actuality. The second highest number in this five year period is \$2.4 billion – almost half the amount selected for reference in this report. This suggests a significant concern of bias impacting analysis and recommendations throughout the report.

Terminology

We support the report's suggestion to move away from "Minor Injury" and replace this with "Type I". We applaud the MITPP team's inclusion of claimants' observations. Though the cohort was very small, we feel the authors have done a good job of accurately and sensitively reflecting the cohort's collective experience and believe it to be quite representative of auto-insurance claimants generally.

Rigid Application & Potential Insufficiency of Pathways

We have concerns that a number of the pathways are overly restrictive of both some of the treatments "allowed" and the recommended number of visits.

What happens to those patients who could fall outside standard norms and respond to treatment differently than others? If the client does not improve, then the problem could well be the pathway and not the client or clinician. For example, not every client is going to improve with 6 visits in 8 weeks, particularly if they are in pain. If clients are in sufficient pain to be off work this type of limitation seems counter-productive to helping them return to activity. What happens in such cases? The recommended pathways do not appear to take into account changes in health status and new diagnostic findings during treatment. If a referral to physician is made in the algorithm there appears to be no next step: the pathway ends. We understand that these pathways are designed to restrict many 'passive' forms of treatment, (ie. moist hot packs should not be administered in the clinic). While we support not having these be the sole mode of treatment, there are instances where such a modality might support 'active' treatment. For example, application of a hot pack when a client is sore after an exercise or mobilization session will settle these symptoms down, so that the client is more likely to participate in the next session, knowing they can manage their post-treatment soreness.

There is much similarity between these care pathways and those prescribed for use with WSIB claimants. These often leave people requiring further care. This leads to ongoing loss of employability and delayed or discontinued schooling and other activities. Numerous studies indicate clearly that soft tissue healing and continued dysfunction occur long into the recuperating process. Additionally, other recent studies are showing that injuries to the hip, knee and ankle have a 50 per cent chance of developing osteoarthritis within 15 years. The management of these injury sequelae (eg. neck fusions, joint replacements) over the long term will put an additional burden on OHIP. We suspect these studies have not been incorporated here in order to support an expedited, reduced-cost treatment agenda that is politically, rather than clinically, inspired.

It is vital to the integrity of the care pathways approach that consideration be made for patients who simply do not respond to a proposed treatment protocol/pathway. We urge that a 'safety net' be put in place for any/all patients who do not respond to the proposed protocols.

Respecting Professional Standards and Expertise

We are unsure of the pathways' implications for the health professional's ability to self-regulate and base treatment on scientifically supported treatment approaches, as expected by their Colleges. What happens when their professional judgment does not align with the prescribed approach?

One example of such a possible conflict occurs in the case of supervised exercise. Many of the recommended pathways identify supervised exercise as "not recommended" and suggest that patient self-directed exercise take place when a pathway ends. This suggests that the goal of the pathway is to reduce pain and basic symptom management (a 'band aid' approach), not proper rehabilitation, symptom resolution and preventing recurrence. Most reputable clinicians agree that supervised exercise should form part of broader treatment plan, and not be the sole treatment mode. There are many instances when properly supervised exercise is essential to achieving goals and avoiding re-injury. Placing full responsibility for exercise on the patient post-discharge negates a key aspect of the clinician's (eg. Physiotherapy, Chiropractic) professional role and expertise. This essentially downloads responsibility onto the patient once their

pathway ends, even in those situations where the clinician feels that some supervised exercise will support ongoing patient engagement and meaningful rehab gains. Exercise programs are not static. In situations where such gains are continuing to be made, exercise programs are dynamic and adjusted by the treating professional to maximize recovery.

We wonder if the report's recommended avoidance of supervised exercise programs reflects a misguided effort to limit "supervised exercise" programs where the therapist is not directly supervising the exercise and inappropriately or inadequately trained staff are not following a therapeutic program. The care pathways should allow for appropriately supervised exercise programs, whether supervised directly by the therapist (eg. physiotherapist) or by an appropriately trained assistant (eg. Physiotherapy Assistant) following the professional's treatment program and tracking outcomes.

Care pathways should not only address the patient's current symptoms but should reflect the clinician's professional responsibility to assist the client in achieving meaningful rehab outcomes and prevent recurrence. Arbitrary discharge in such cases may conflict with College expectations.

Expanded Role of Physicians

The approach seemingly suggested by the design of these care pathways presumes and insists upon the involvement of family physicians at key junctions in rehabilitation treatment. This creates a 'gatekeeper' role for physicians in the auto-insurance rehab system that will be as unwieldy as it is unwise. Unwieldy, because most physicians are not familiar with the complex administration of MVA cases. Requiring physicians to operate a gateway that they are not familiar with will lead to more delays and confusion and therefore disputes and prolonged recovery times. Further, most are simply too busy and not as familiar with the rehabilitation of Type I injuries as are treating professionals such as physiotherapists, chiropractors, occupational therapists, etc. whose sole practice is rehab. And finally, too many Ontarians still do not have appropriate levels of access to a family doctor. The Ministry of Health continues to struggle with policies and strategies to address this and to manage the escalating acute care (hospital ER use) costs that result.

Keeping physicians informed about a patient's injury and treatment will remain a cornerstone of good healthcare. Making them responsible as gatekeepers would be a disservice to them and fly in the face of current Ministry of Health policy that aims to relieve physicians of responsibilities that may be better performed by other regulated health care providers. As a matter of fact, MOH has been expanding scope of practice for other professionals in efforts to relieve unnecessary pressure placed on physicians. If the intent of this report is not just to keep family physicians in the loop about claimant progress, but indeed to appoint family physicians as gatekeepers, then the financial implication to our publicly funded healthcare system will be unimaginable. It is inconceivable that tax-payers, many of whom don't drive a car, will foot the insurers' bill.

Instead, we recommend that the exit strategy from the pathway should be that the treating provider either refer on for additional diagnostic consultation to the appropriate professional(s) or make their own client-centred treatment plan recommendations.

Reflecting Current Research

The 'lack of evidence' or 'good' evidence should not summarily lead to a modality being restricted in a care pathway.

For example, exercise studies are generally non-specific and varied leading to 'apples to oranges' comparisons when doing comparative studies. "Exercise" is a vague research category and it is therefore unlikely that it would reveal anything meaningful. But this does not mean it is not effective: it means it's hard (or expensive) to research. In such cases it is an error to remove clinician experience from the assessment of the modalities' application to the condition.

It is curious that the pathways support Qigong and Iyengar Yoga as appropriate interventions, but not Astanga or Hatha Yoga. We find it difficult to believe that there is strong evidence to support these relatively fine distinctions. That the report does so strikes us as unnecessary, possibly misguided, micromanagement of clinicians' practices.

Co-Morbidities

There appears to be no mechanism to take into account multiple injuries from the same accident. Each pathway is an isolated “island in the stream” which does not factor in complicating injuries from the same accident. Rarely, if ever, do patients present with one specified injury only. How do these pathways change if a shoulder and a neck injury are sustained together? Is treatment time doubled?

Mild Traumatic Brain Injury (mTBI) & Emotional/Cognitive Treatment

We are shocked to see mTBI classified as a Type 1 injury. While it is true that mTBI's have a “favourable natural history with recoveries ranging from a few days to months” this is where the overlap ends. In fact, mTBI's (especially those with persistent symptoms) have much more in common with the Type II injury classification. We are concerned that Emotional/Cognitive Treatment isn't included in Type 1. Emotional/mental health issues associated with Type 1 injuries do occur. In such cases addressing these is often essential to physical rehab success.

A Plethora of Pathways

The great number of distinct care pathways recommended by the report will likely prove to be too difficult to navigate for clinicians to conveniently apply them, especially given that most patients will present with injuries spanning more than one pathway.

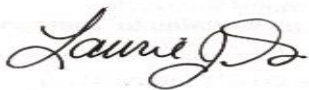
CONCLUSION

As mentioned previously in this report we cannot comment purposefully on the report, viability of the recommended pathways, the impact on stakeholders nor whether or not these are workable in the context of caring for auto-insurance claimants without the following information:

- Funding for each pathway and for Level I in its entirety
- Completion of pathways/flowcharts that are shown to end at the point of referral to a physician in the instances where the application of care pathway has not achieved patient recovery/rehab

With respect to the above we recommend that if the government chooses to adopt these pathways, the Minor Injury Guideline should be done away with; it will no longer be necessary to keep a MIG cap of \$3500 or any other amount so that we can return to the pre-2010 two-category state of Accident Benefits. The reason for this is self-evident: the protocol in the event of a Type I injury will be to administer the pathway. In the event that after application of the care pathway the claimant does not recover then their injury should be classified as a Type II injury.

Respectfully submitted,



Laurie Davis
Executive Director

January 2015

POSITION STATEMENT: EVIDENCE BASED PRACTICE & TREATMENT PROTOCOLS

In anticipation of the report from the Minor Injury Treatment Protocol's Project (MITPP), the Ontario Rehab Alliance is taking this opportunity to share our perspective on Evidence Based Practice and Treatment Protocols. **We ask that the Ministry of Finance engage in meaningful consultation with our Association following receipt of the MITPP report in order to ensure the Protocol's efficacy and the initiative's success.**

Evidence Based Practice is the conceptual foundation on which specific treatment, or care, Protocols are based. Simply put, it means that clinical practice should be informed by the scientific evidence about what works, (and what doesn't work), for the treatment of various conditions. Treatment Protocols flow out of this conceptual framework and outline clinical interventions that have been developed in response to the evidence. Virtually all Regulated Health Professions have adopted various Treatment Protocols as best practice for some conditions and populations.

The Ontario Rehab Alliance represents approximately 4500 healthcare professionals from diverse Regulated Health Professions that assess and treat motor vehicle accident injuries. Many of our members also provide services in other healthcare sectors. We fully appreciate the value-for-money pressures which give rise to interest and investment in exploring Treatment Protocols. Our keen interest in developments such as the MITPP stem from our concern that mandated treatment protocols such as those imposed by third parties (such as the MITPP) must be grounded in proper evidence and must be designed to respect the clinician's duty of appropriate care as mandated by their regulating College.

Multiple research studies, conducted within various injury populations, have demonstrated that while Treatment Protocols are useful for some injuries, all regulated health professions acknowledge that there are inherent clinical dangers in any 'one-size-fits-all' approach to assessment and treatment. Such Protocols are best applied to specific areas where populations or injuries and disorders that are homogeneous, meaning that they have a great deal in common. The most respected and widely adopted Protocols allow for alternate approaches and considerations to be factored into the analysis of each individual client's condition and circumstances. Treatment Protocols cannot generally be applied properly to diverse populations.

We have examined the key research findings for care of post-accident injuries, including Orthopedic Injuries and Soft Tissue Injuries. Research reveals that the most successful Treatment Protocols and practice guidelines are those that incorporate clinician engagement and allow some degree of customization to meet specific patient needs, and that provide clear and well accepted methods to allow people who do not follow the typical recovery path (e.g. due to pre-existing conditions, or if the original diagnosis changes) to access more or different care.

How can the research best be applied in the auto sector?

We believe that the principles and trends arising from the research can most usefully be applied in the auto insurance sector to assist adjusters in appropriately approving assessment and treatment requests rather than requesting Insurer Examinations. This will both expedite service and reduce costs: a win/win scenario.

What do the best Treatment Protocols look like?

Treatment Protocols should never be used to automatically deny or limit benefits when a patient's experience does not "fit" the expected outcomes. There are many clinically valid reasons why one patient may respond differently to treatment than another and poor patient engagement should not automatically be the presumed cause.

Well-designed Treatment Protocols should:

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Examples of Problems with Overly Rigid Protocols:

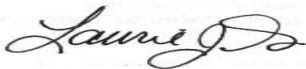
A 10 year old child is hit by a car while riding his bicycle. His injuries at first appear to be minor and he is placed in the MIG. He recovers quite nicely from his neck injury, but his family doctor notes that since the accident he has had problems with sleep, attention, memory, headaches and dizziness, and he diagnoses him with also having sustained a concussion in the accident. Treatment plans for further assessment related to the concussion are denied, on the basis that he is in the MIG. The client does not get the help he needs in a timely fashion while this is under dispute, and he ends up failing his school year.

An 8-month pregnant woman is injured in a car accident. Her injuries are determined minor immediately following the accident. However, her late stage pregnancy prevents her from receiving a full course of treatment as prescribed by the current Minor Injury Guideline. Following delivery she returns to treatment and is denied a full course of MIG benefits because of the interruption in treatment. As a result, her condition deteriorates, the impact of her injuries intensifies and she is unable to regain the level of function that treatment would have made possible.

A sixty-five year old man with Parkinson's sustains minor injuries in a car accident. The treating clinician's treatment plan reflects a longer course of treatment than that provided by the MIG because the client's neurological impairment complicates treatment of the minor injuries. The plan is denied because the adjuster, without any medical background and the Independent Examiner, who has no expertise in this field, do not agree with the clinician's assessment that the Parkinson's is a pre-existing condition that complicates treatment under the MIG.

We look forward to discussing this perspective and to participating in a formal consultation process.

Sincerely,



Laurie Davis
Executive Director