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Response to the Draft Superintendent's CTI Guideline

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ABOUT THE ONTARIO REHAB ALLIANCE

Founded in 2009, the Ontario Rehab Alliance (ORA) is a non-profit association representing 140 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 *Draft Superintendent's CTI Guideline*. This submission follows our July 29, 2015 submission commenting on the *Final Report of the MITPP* and subsequent participation at the consultation following the release of the *Draft Superintendent's CTI Guideline* on August 19, 2015.

The Guideline and associated care pathways will have profound implications for insured individuals and the diverse health care professionals who treat them. We are therefore concerned by the disproportionate make-up of the professionals on the MITPP teams, and the MIG clients they consulted, that advised the Superintendent. These teams were heavily weighted with chiropractors and clinicians that specialize in insurer examinations. The sole occupational therapist on the team did not seem to influence the resulting recommendations. There was no representation by speech language pathology, social work or psychology, all of which have key roles in best practice treatment of many minor injuries. Further, there was no representation by clinicians that carry out treatment, nor was there representation by patients that had completed their approved sessions, and, of particular note, none that felt they had not fully recovered. In sum, we are concerned that the resulting blind spots compromise the acceptance and efficacy of the proposed care pathways.

The slides presented by the FSCO team at the August 19 consultation cited the priorities of availability, sufficient coverage, affordability and sustainability. They seem to miss some of the key features cited by Dr. Cote and his team. Specifically, the CTI Guidelines do not appear to be respectful of user needs, preferences and expectations; accessible within a reasonable time; appropriate; and safe. 'Appropriate'

does not include generally accepted best practice, as it should. There is no reference to safety. Furthermore, while we understand that the CTI guidelines are specifically meant to address minor injuries, there was a lack of clarity regarding how those with more than a minor injury will have access within a reasonable time. The FSCO benchmarks appear to focus exclusively on monetary parameters rather than a mix of monetary and quality of care parameters. We propose that the Alberta Quality Domains for Health be adopted; they are: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety.

The Draft Superintendent's CTI Guideline was presented as based on Evidence Based Practice. However, at the information session that we attended, there seemed to be a lack of clarity about the definition of this term. The Superintendent and the MITPP team seem to be taking the approach that only practices that are proven to be effective by quality research are worth implementing. While we support the need for quality research to sharpen the collective knowledge and skill base, by its very nature, research follows best practice. Bone and Joint Canada set out to address wait times for Hip and Knee Replacement Surgery. A thorough review of the literature demonstrated that there were few randomized controlled trials to support the various clinical practice guidelines and overall best practices. There was a high quality randomized controlled trial conducted in Alberta under the direction of Dr. Cy Frank that showed that the proposed model of care improved care measurements across the health domains of acceptability, accessibility, appropriateness, effectiveness, and efficiency; and that there was no negative impact on the final health domain of safety. Bone and Joint Canada convened key opinion leaders from across Canada to help define Best Practices, with the recommendation that future research be directed towards confirming these best practices. They did not advocate ceasing what were commonly accepted as best practices until they could be proven effective. But they did recommend that evaluating the efficacy of such practices be encouraged as research priorities.

The balance of this submission follows the structure of the Guideline.

Part B – Definition of Common Traffic Impairment

We believe that the clarity of several of the definitions can be improved, as follows:

- Adding the phrase "lasting no more than six months" to the end of the definitions of *Physical Impairments* and *Psychological Impairments*
- Renaming *Psychological Impairments* as *Psychosocial Impairments*
- Incorporating language to clearly exclude those 18 years or younger from the CTI/*Mental Impairments* in keeping with the Ontario Neuro trauma Foundation (ONF) Guideline.

Part D - Impairments That Do Not Come Within this Guideline

CTI by Default?

Our reading of the introductory paragraphs and subsection (a) in this section is that the language implies that all auto injuries fall within the CTI by default, and that the processes subsequently described are required in order to establish that injuries are not CTI. However, when this concern was raised at the consultation a FSCO representative confirmed that this was not in fact the intention. We therefore urge the development of alternate language to clarify this. Otherwise, we can certainly anticipate confusion,

delays in meeting the needs of the more seriously injured, and escalating disputes and litigation. The currently drafted "CTI-by-default" approach will create an almost insurmountable barrier for the most severely injured who must receive assistance to ensure attendant care services, safety equipment, etc. in a timely way, such as upon discharge from hospital. It is outrageous to automatically lump in Level 2 and 3 injuries (as defined in the MITPP report) under the heading of "Common Traffic Injury".

We suggest this alternate wording, which is consistent with the language of the current Minor Injury Guideline Part 3:

"An insured person's impairment comes within this guideline if the impairment is predominantly a CTI"

This suggested wording should replace the second paragraph under Part D and the following subsection "a". The above **should be followed by the word "*OR*".**

Inconsistency with College Standards

While we recommend a re-drafting of the second paragraph in Part D we would also like to highlight additional drafting issues in this paragraph for future reference.

As this paragraph is currently drafted the word "impartially" implies a presumption of bias or self-serving interest on the part of the provider. The word "impartially" should be replaced with the word "reasonably". Our proposed wording better reflects the standards of the Professional Colleges which expect the treating professional to advocate on behalf of their client and conduct themselves from a client centred orientation. Further, several Colleges prohibit and/or discourage their members from identifying themselves as "experts" or claiming "expertise". As such, the word "expertise" should be replaced with the phrase "scope of practice".

Physicians and Nurse Practitioners as Gatekeepers

The final paragraph of this section positions physicians and nurse practitioners as gatekeepers:

> *Where an insured person has already received any treatment under this Guideline, the confirmation and compelling evidence referred to above must be provided only by a physician or nurse practitioner in a completed….*

We echo here our position opposing physicians as MVA-funding gatekeepers, first articulated in our submission of November 2012.

Once again, we are tasked with pointing out the inconsistency of this recommendation with the Government's own health policy which, in recognition of the ongoing shortage of general practice physicians, the Ministry of Health has launched multiple initiatives to reduce and distil the workload of physicians, thereby enhancing patient access. These initiatives include expanding the scope of practice of other professions and encouraging physicians to work with and refer to allied health care professionals in Family Health Teams and Community Health Centres. Furthermore, both the provincial and federal governments have supported the development and implementation of the *Bone and Joint Canada Model of Care for Hip and Knee Replacement Surgery*, which introduced the use of Advanced

Practice Physiotherapists to help address wait times for orthopaedic surgery. The model includes the use of Central Intake, which reduces the load on both primary care physicians and orthopaedic surgeons. This model has since been expanded to hip replacement surgery. In rheumatology, advanced practice physiotherapists and occupational therapists act as physician extenders to help address medical shortages and improve overall patient care. While we support ongoing involvement and consultation with physicians in client care, we find the recommendation to appoint them de-facto "gatekeepers" to be shocking in light of the Ministry of Health's contrary strategy.

Further, the vast majority of general practice physicians do not possess thorough knowledge of rehabilitation and/or the auto insurance system. Most importantly, the majority of physicians that our members connect with through the care of their injured patients do not want and would not welcome greater involvement – let alone a key role - in what they see as a fraught and complex system.

We question why this Guideline, which claims to be rooted in evidence, should propose such a mechanism when there is no supporting evidence that the proposed positioning of physicians and nurse practitioners will improve either clinical or administrative efficacy. As mentioned, we strongly support the ongoing involvement of physicians and/or nurse practitioners in patient care. However, we strongly oppose introducing a potential bottleneck to the system by requiring that they act as gatekeepers. We feel that this recommendation attempts to turn physicians and nurse practitioners, being a key publicly funded resource, into the insurance industry's clerks. This strategy will not only result in huge bottlenecks for MVA victims but, more importantly, less access to primary healthcare for all other Ontarians as precious physician time is diverted away from meeting the usual mix of patients' needs to serving the administrative and financial interests of insurers.

We have long been concerned about the ongoing vilification of healthcare providers by the IBC which paints all as self-interested and biased profiteers. We suspect this lies at the root of this recommendation. If this is the case, FSCO must know that Regulated providers are bound by their College standards, including scope of practice limitations. If any given provider is in violation of such standards their College should investigate such misconduct rather than appointing physicians to that role. Anyone with concerns can register a complaint with the professional colleges.

Part E – Delivering Goods and Services through the Care Pathways

Inadequate List of Permitted Initiating and Coordinating Health Professionals

This section begins with a list of the permitted initiating and coordinating health professionals. The absence of Occupational Therapists (OTs) from this list is very troubling. OTs are frequently involved in the initial and subsequent stages of treatment of CTIs, most notably with respect to psychosocial and mental impairments (MTBI) and also with respect to injuries to the upper extremities. The ONF guidelines, cited as a standard of practice in the appended *Recommendation for the Clinical Management of MTBI*, makes multiple references to the recommended role of OTs in treatment of

MTBI. OTs and kinesiologists are often involved in assessing and facilitating a return to work for those that would be included in the CTI group.

Current evidence supports assessment, education, and in some cases, treatment of individuals with cognitive and communication difficulties after a mild brain injury and there is most certainly a role for OT and SLPs here. For example, regardless of the diagnosis, the speech-language pathologist can provide helpful practical strategies to assist the person with daily communications. Often it is the case that a focus on functional re-integration is more helpful than multiple assessments and diagnostic deliberation.

We urge the inclusion of Occupational Therapists and Speech-Language Pathologists into this list. We suggest that this list should in fact replicate the list of health professionals able to sign OCF-18s.

Clarification Needed re Multiple Impairments & Fees Payable

On page four, paragraph five, the draft guideline states:

> *An injured person with multiple impairments that come within this Guideline should be treated using all appropriate care pathways….*

However, *Part G – Fees Payable Under This Guideline*, does not make clear how treatment using multiple care pathways will be compensated nor how such compensation will be structured.

Confusing Language

The final paragraph of Part E lists the circumstances under which the initiating and coordinating health professional must complete an OCF-24. The final bullet point is extraordinarily difficult to understand:

- The insured person is being referred to a physician or nurse practitioner to determine whether an insured person has an impairment that comes within this Guideline.

Is this meant to describe the intention and language found in the current OCF-24? If so, the existing bullet points of the OCF-24 should be used here or those found in Part D should be replicated. If not, this should be revised to better reflect the intention.

Part F – Maximum 6 Month Timeframe for the Treatment

The final paragraph in this section requires clarification with respect to how approved treatment at various stages of entry into the CTI intersects with fees payable. It reads that an insured person who arrives 'late' into the pathway at 2 months can access all the treatment set out in the recent onset phase but that an insured person who begins treatment between 4 and 6 months may only access treatment set out in the persistent phase. Does this mean that 'late' access at 4-6 months will reduce the available funding for treatment or is it intended only to direct the clinical aspects of care, eg. the type of treatment provided by the relevant care pathways?

Any reduction of available treatment funds due to 'late access' is unacceptable. It is very often the case that injured individuals do not access treatment immediately following an accident. There are many reasons for this. Most commonly, delays result from a lack of information and/or a delay in receiving information provided by the insurer.

Part G – Fees Payable Under this Guideline

The second paragraph of this section is confusing. It states that the insurer shall pay for goods and services submitted on an OCF-23 without approval, but the current OCF-23 requires insurer approval.

As stated earlier in this submission, this section should be revised to **clarify the fees payable in the case of multiple care pathways** and **at the various stages of entry into the CTI.**

Payment Process Workability

Further, to ensure that treatment and payment processes in the CTI are workable, and do not impose unnecessary and additional administration burdens on health care providers we urge policy makers (as recommended at the August 19 consultation) to consult with providers on the development of these mechanisms so that they will reflect the administrative realities of providers who must navigate already complicated payment processes. The ORA would like to be included in this consultation as the only association whose members **all** deal with these processes on a daily basis we are able to offer practical and constructive suggestions.

Iyengar Yoga and Qigong

We question the special status accorded to these two interventions. (See *Appendix - General Comments* section later in this submission).

We vigorously oppose the Guideline's requirement that:

> *…the initiating and coordinating health professional must advise [emphasis is ours] him or her of these treatment options and, where the insured person elects either Iyengar Yoga or Qigong, must advise the insurer of this choice on the OCF-23.*

We have several objections to this:

- The prescriptive ("must") approach compromises the professional's ability and responsibility to make his or her own assessment of the applicability of any intervention; it is possible that not all CTI clients will benefit from either one or both of these practices;
- Iyengar Yoga and Qigong are not available in many parts of the province. How are the health professionals expected to navigate this reality?
- Why is this made the responsibility of the health professional and not the adjuster?

Part H – Other Fees Payable

Are this section's outlined fees payable to be applied against the (still unknown) CTI funding caps or are they to be distinct?

In either case, we anticipate that compensation to physicians and nurse practitioners for completing an OCF-24 will exceed the $85 available to the other health providers, as that/those fees are not given in the draft Guideline. We consider this inequitable as well as fiscally irresponsible, likely resulting in escalating costs for gatekeepers ill equipped for the role.

Part J – Changing Initiating and Coordinating Health Professional Within This Guideline

The Guideline states: "*In a month when more than one initiating and coordinating health professional has provided or coordinated services, amounts payable will be calculated on a pro-rated basis*."

We propose that a provision be inserted to stipulate that it **will be the responsibility of the insurer to advise the new health professional as to the balance of funds remaining**.

Part K – Amounts Payable under Other Insurance and Health Care Coverage

We find the last paragraph in this section unclear. While we understand that the intent is to ensure that the insurer does not pay for any treatment that can be covered by other insurance it is not clear how provision of other goods and services that may be required and are approved within the care pathways, but are not covered by other insurance, will be treated.

The present system poses many administrative challenges for providers who must ensure that they have first exhausted EHCBs. The insurers covering extended benefits often respond with great delays. The CTI Guideline proposes time-limited caps with deductions for benefits covered under extended care plans. It would be onerous if not impossible to revise database systems to capture and process this information with the proposed restraints (of time and dollars). Claimants could wait the entire time during which they would be eligible for SABS funded services before getting a response from the extended health carrier. This would mean that they would potentially have reduced access to SABS services due to delays in EHCB responsiveness. This would be both inequitable and unworkable.

APPENDIX TO THE CTI – (Care Pathways)

General Comments

<u>Exclusion of Modalities</u>

We are concerned by this Guideline's exclusion of a number of modalities on the basis that the MITPP found no evidence of efficacy in the studies reviewed. Research into the efficacy of rehabilitation interventions is, generally, in short supply. Unlike other some other aspects of health care, such as pharmaceuticals, there are few funding sources for such research. Nevertheless there is an evolving and dynamic exploration of best practice that rehabilitation professionals rely upon to guide and inform treatment.

Best practice standards are in place for many of the disciplines impacted by the care pathways, and a number of excluded modalities have a well-earned place in these standards. To exclude these modalities is to limit and compromise the treating professional's capacity to deliver the best standard of care for their clients' condition.

<u>Resulting Double Standard of Care</u>

Imagine a clinic providing physiotherapy to three clients with NAD. One is paying out of pocket for their care, one is using their Extended Health Benefits to cover costs while the third is being treated within

the proposed CTI. In this hypothetical example all three clients have similar conditions, are at the same stage in treatment and are receiving similar care. Following treatment the physiotherapist determines that application of a hot pack will mitigate some of the pain resulting from the intervention and thereby enable the individuals to continue the regime at home, between sessions, and lead to a speedier recovery. Only two of the three have hot packs applied, leaving the CTI patient to manage without – and leaving it up to the physiotherapist to explain why this is so.

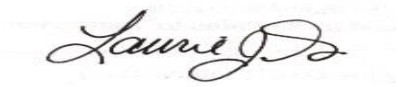
'Shelf Life' of Research & Evidence

We are concerned that these care pathways, the evidence embraced (Iyengar Yoga and Qigong), and the interventions excluded may soon be outdated. Research is ongoing. Yesterday's approved remedy all-too-often becomes today's discredited one. How will these care pathways avoid such a fate?

If these are to be adopted in this form, there must be mechanism in place to update and revise as new information and evidence emerges.

The field of research is highly competitive with very limited resources. Industry supported research is typically linked to medications and expensive medical devices. Government funded research funds are very limited. Recognizing the disadvantages that researchers working in the area of musculoskeletal conditions face with respect to successfully competing for limited research funds in Canada and the USA, Bone and Joint Canada joined forces with the US Bone and Joint Decade to offer the Young Investigator Workshops. Within that group, non-physician researchers were recognized as additionally disadvantaged in research competitions, so a certain number of positions were protected for non-physicians. FSCO must acknowledge how difficult it is to train and develop high quality researchers in the field of rehabilitation, which typically lacks industry funding. To rule out services because the research has not yet caught up, is to throw the baby out with the bath water. FSCO could show leadership by contributing unrestricted funds to research in the areas addressed by CTI.

Respectfully submitted,



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