September 11, 2015

Financial Services Commission of Ontario (FSCO)
5160 Yonge Street, P.O. Box 85
Toronto, Ontario, M2N 6L9

Re: Superintendent's Draft Common Traffic Impairment Guideline

The Coalition of Health Professional Associations in Automobile Insurance Services represents over 10,000 front line health professionals from over ten professions involved in the assessment and treatment of Ontarians after an auto accident.

We would like to thank FSCO and the Ministry of Finance for the opportunity to review the Superintendent's Draft Common Traffic Impairment Guideline. The Coalition was able to send representatives to the in-person stakeholder consultations on August 17th and 19th but was compelled to submit a written response as well. We understand that feedback from the stakeholder meetings, written submissions, as well as written feedback in response to the Final Report of the Minor Injury Treatment Protocol Project will all be included in any future deliberations by government around possible implementation.

We appreciate the need for fulsome debate and consideration of these changes to the auto insurance system, as this expansion of treatment protocols beyond sprains, strains and Whiplash Associated Disorders would be the first of its kind in Canada.

As we have already responded to the MITPP Final Report, we will limit our comments to the Draft Guideline, and to those areas where we have concerns or that still require clarification following the stakeholder meetings.

SUMMARY OF ISSUES AND RECOMMENDATIONS

Definition of CTI

- The Coalition recommends that neurological disorders, including cervical and lumbar radiculopathy, be excluded from the CTI Guideline.
- The term Psychological Impairments is too suggestive of psychological conditions and disorders which are – appropriately – not included in the Guideline. The Coalition recommends use of ICD 10 language "Symptoms and signs involving cognition, perception, emotional state and behaviour (R40-R46)", or adoption of the term "psychosocial issues".
- We also suggest that it would be helpful to replace the term "anxiety" with "worry and nervousness" and the term "depressed mood" with "unhappiness, sadness", to illustrate early psychological signs and symptoms.
- We do not support the inclusion in the CTI Guideline of Mild Traumatic Brain Injury. Although we agree that the Ontario Neurotrauma Foundation Guidelines for Concussion/ Mild Traumatic Brain Injury & Persistent Symptoms (Second Edition) is a comprehensive guideline it is not without limitations.
- Requiring only a physician or nurse practitioner to determine whether a patient can exit the CTI Guideline once treatment has commenced is not feasible. The Coalition strongly recommends the removal of the proposed policy that only a physician or nurse practitioner can provide the

confirmation and compelling evidence in an OCF 24 to allow for exit of the patient from the CTI Guideline. We recommend that the Initiating Practitioner be empowered to complete the OCF 24. Should a referral to another professional be required the treating practitioner would refer to a health practitioner with the appropriate scope of practice not limited to only to physician or nurse practitioner.

Evidence-based Care

- With respect to limiting providers under "Delivering Goods and Services through the Care Pathways", the Coalition recommends applying the language from the current Minor Injury Guideline "any health practitioner, as defined by the SABS, who are authorized by law to treat the injury and have the ability to deliver the interventions referred to in this Guideline".
- Health care professionals must be able to use their professional judgement and expertise to offer discretionary interventions that the provider and insured person agree could benefit the person's recovery.
- The Guideline should incorporate a process for ongoing review and inclusion of new evidence into the Care Pathways. This process should involve multi-stakeholder representation, including treating clinicians.
- Better consideration needs to be given to implementing multiple Care Pathways for insured persons diagnosed with multiple injuries. This must include the application of best practices to compounding factors of multiple injuries as well as allowance for time and funding considerations of the treatment approach.
- Iyengar yoga and Qigong should not be singled out as particular forms of guided exercise that are eligible for funding.

Funding Framework

- As funding formula are determined, the impacts of time required to accommodate multiple Care Pathways must be built into the fee structures applied to treatment of claimants with multiple injuries.
- The Coalition recommends development of a funding or referral model for those insured persons who have not recovered from a CTI after 6 months.
- If the Care Pathway recommends multimodal care as an option, then funding for multimodal care should not be excluded from the Guideline. If there are issues of overuse, entry criteria should be developed.
- Prior to finalizing fees for this Guideline, the Coalition recommends the establishment of a CTI Fees Working Group to collaborate on a consensus proposal for the final fees and funding model. The working group should include insurers as well as treating health professionals.

Terminology

- With the removal of MTBI/concussion from the scope of this Guideline, we would recommend "Soft Tissue Injury Guideline" over "Common Traffic Impairment Guideline".
- If MTBI continues to be included in the scope of the Guideline, we would recommend maintaining the current terminology of Minor Injury Guideline.

DEFINITION OF COMMON TRAFFIC IMPAIRMENT

Radiculopathy

Within the definition of CTI, we continue to question whether nerve root injury should be included. Traumatic radiculopathies in particular can have different courses of care; the Inter-professional Spine Assessment and Education Clinics identify radiculopathy as a differentiator in the assessment, prognosis and treatment for patients with low back pain. Radiculopathy has never been defined as a "minor injury" in any other jurisdiction including Alberta, and it is clearly defined as a "neurological disorder" which is explicitly excluded from the CTI Guideline.

> ***The Coalition recommends that neurological disorders, <u>including</u> cervical and lumbar radiculopathy, be excluded from the CTI.***

Psychological Impairments

We also have concerns around the use of the term "psychological impairments" for impairments that come within the Guideline. We agree with the inclusion of "early psychological signs and symptoms, including: depressed mood, anxiety, fear, anger, frustration and poor expectation of recovery" as stated in the Guideline. However these early signs and symptoms should be called, "Symptoms and signs involving cognition, perception, emotional state and behaviour (R40-R46)" using ICD 10 language. The term "psychological impairments" is too suggestive of psychological conditions and disorders which should not be included in the Guideline. The terms depressed mood and anxiety also are too easily confused with diagnosed disorders. We suggest that they be replaced with terms that are not also used as labels of disorders. The use of the term "mental impairment" is also problematic; we would prefer that the term be removed entirely (preferable) or be specified simply as MTBI/concussion.

> ***The term Psychological Impairments is too suggestive of psychological conditions and disorders which are – appropriately – not included in the Guideline. The Coalition recommends use of ICD 10 language "Symptoms and signs involving cognition, perception, emotional state and behaviour (R40-R46)" or adoption of the term "psychosocial issues".***
>
> ***We also suggest that it would be helpful to replace the term "anxiety" with "worry and nervousness" and the term "depressed mood" with "unhappiness, sadness", to illustrate early psychological signs and symptoms.***

Mild Traumatic Brain Injury and Concussion

In relation to mTBI/concussion, the "Final Report of the Minor Injury Treatment Protocol Project" states:

1. The subcommittee recommends that the updated guidelines be used for the management of mTBI following traffic collisions in Ontario, Canada.
2. mTBI/concussion be classified as a mental impairment.
3. The Ontario Neurotrauma Foundation Guidelines for Concussion/ Mild Traumatic Brain Injury & Persistent Symptoms (Second Edition) (ONF Guideline) be adopted.
4. Part D – Impairments That Do Not Come Within this Guideline if a health practitioner confirms in writing and provides compelling evidence that conditions which may pre-date the accident or develop during the course of treatment under this Guideline such as a Neurological disorder.

The paradigm proposed by the CTI Guideline does not align with the ONF Guideline for the following reasons:

The CTI Guideline's dependence on best evidence of care based on a literature review:

- The ONF acknowledges that research on some interventions delivered post-mTBI is scant, and that any treatment guideline needs to be rigorously reviewed and updated. The ONF guideline indicates that any treatment evidence based on published literature needs to be given equal weight to the judgment of the treating professionals and patient preference hence consent.

A CTI's expected improvement with prescribed treatment modalities based on a literature review:

- Although the ONF guideline recommends specific treatment they are reticent to **prescribe** treatment acknowledging that research on some interventions delivered post-mTBI is scant
    - "The recommendations provided in these guidelines are informed by best available evidence at the time of publication, and relevant evidence published after these guidelines could influence the recommendations made within. **Clinicians should also consider their own clinical judgement, patient preferences and contextual factors such as resource availability in clinical decision-making processes."**
    - "The recommendations and resources found within the *Guidelines for Concussion/Mild Traumatic Brain Injury & Persistent Symptoms* are intended to inform and instruct care providers and other stakeholders who deliver services to adults".
    - They do not recommend intervention by one profession over the other.

The classification of mTBI /concussion as a mental impairment in the CTI Guideline

- The ONF document states: "In this document, the terms mTBI and concussion are used interchangeably and denote the acute neurophysiological effects of blunt impact or other mechanical energy applied to the head, such as from sudden acceleration, deceleration or rotational forces. Mild TBI is among the most common neurological conditions with an estimated annual incidence of 500/100,000 in the United States".
- *mTBI/ concussion is not a mental impairment but rather a neurological condition therefore should not be in the guideline as stated by the CTI*.

The care pathways incorporated in the CTI Guideline recommend treatment up to a maximum of 3 months from the date of accident in the acute phase. These time frames and phases are not applicable to the ONF guideline.

- The ONF Guideline indicates that early interventions include monitoring as well as education and support using suggested tools during the first three months post injury as soon as these needs are identified.
- The ONF Guideline recommends that individuals whose symptoms are not sufficiently resolved, as early as "within days" after the injury, should be referred for symptom-based multi-disciplinary treatment.
- The ONF suggests continuing treatment for as long as there are functional impairments.
- The ONF Guideline states that clients 18 years or older with a mild traumatic brain injury/concussion (which the ONF indicates are used interchangeably) can have numerous physical, behavioural/emotional, and cognitive sequelae. Their Guideline indicates that up to 15% of patients diagnosed with mTBI will "continue to experience persistent disabling problems beyond 3 months."

Although funding formula for the care pathways has not been finalized, it appears that most CTIs will be funded based on the client having only one injury/symptom/impairment

- A client with a mTBI/concussion can have multiple symptoms/impairments requiring intervention by several disciplines. When these affect functioning and/or persist they require referral for specific evaluation(s) and treatment(s).
- The ONF has developed algorithms reflecting care that **suggest** the need for more than one professional to work with a client dependent upon the specific impairments, as soon as these needs are identified (during and beyond 3 months post injury).
- Diagnostic evaluations and treatments are required by those with more severe and/or persistent functional symptoms that are not included in the Pathways.
- Interventions that do not appear to be in the CTI can also include goods and services such as family education, worksite assessments, and assistive devices such as memory aides, or equipment such as a brace.

We do not support the inclusion in the CTI Guideline of Mild Traumatic Brain Injury. Although we agree that the Ontario Neurotrauma Foundation Guidelines for Concussion/ Mild Traumatic Brain Injury & Persistent Symptoms (Second Edition) is a comprehensive guideline it is not without limitations.

Role of Physician and Nurse Practitioner

Especially troubling in a Guideline that purports to be evidence-based is the inclusion of an enhanced mandated physician/nurse practitioner role to act in essence as a gatekeeper to medical rehabilitation benefits.

It was clear in the presentation by Dr. Coté on August 19th that they envisioned the role of the physician (and nurse practitioner as written in the guideline) to be needed only in cases where the treating practitioner assesses the patient to have signs and symptoms indicating a condition whose assessment and treatment would be beyond the current treating practitioner's legislative scope of practice.
The policy decision to propose that the only route to exit the CTI Guideline once treatment under the Guideline commences is an OCF 24 completed and signed by a physician or nurse practitioner is not feasible. It is not supported by evidence, is a misuse of health system human resources (HHR) and will promote increase use of diagnostic testing as patient expectations will drive practice.

Lack of evidence
The professionals listed as able to initiate and coordinate assessment and treatment under this guideline (chiropractors, dentists, nurse practitioners, physicians and physiotherapists) are all direct access professionals under the RHPA. They have the knowledge and the legislative scope of practice to identify what assessments and treatments are outside of their scope of practice and require referral to the appropriate professional. In some cases the appropriate professional would be a physician but not in all cases. It is an integral part of the education and training of these professions to be able to identify those who need referral and which professional is needed to address concerns. Direct access has been implemented in payment models in Ontario including auto insurance specifically because evidence shows us that this improved access to needed care at the right time by the right professional.

Misuse of HHR

It is estimated that between 75% and 80% of those who need to access medical rehabilitation services post-MVA would be served under the current Minor Injury Guideline. This represents a large number of claimants. It is not estimated how many of these potentially might need to exit the CTI after treatment is commenced. Physicians and nurse practitioners practice almost exclusively within the publicly funded health system. Should the policy to require a physician/nurse practitioner assessment and completion of an OCF 24 be implemented, needed resources within the public health system will be diverted to meet this requirement. As not all cases require the interventions of a physician or nurse practitioner, this step is a further waste of resources as the physician/nurse practitioner will have no option but to refer to the actual appropriate professional or send back to the treating professional for further interventions outside the guideline; a cyclical referral system that has been demonstrated internationally to be a waste of limited health professional resources and a barrier to timely access to needed care.

Increased use of diagnostic testing

Referral to a physician/nurse practitioner builds an expectation of the patient that further testing is required. One of the primary drivers for increased use of diagnostic testing is the expectations of the patients. Today in Ontario we are holding professions with the legislative scope of practice to order diagnostic testing to a higher level of accountability regarding appropriate testing. It is contradictory therefore to implement policies that directly counter best practices and places these practitioners in an untenable position in meeting their patient expectations.

While the Coalition supports a multidisciplinary model of care that includes the primary physician, we would prefer to see that the resulting guidelines allow for referral to the "appropriate healthcare professional" that has the necessary education and training.

> ***For these reasons the Coalition strongly recommends the removal of the proposed policy that only a physician or nurse practitioner can provide the confirmation and compelling evidence in an OCF 24 to allow for exit of the patient from the CTI Guideline. We recommend that the Initiating Practitioner be empowered to complete the OCF 24. Should a referral to another professional be required the treating practitioner would refer to a health practitioner with the appropriate scope of practice not limited to only to physician or nurse practitioner.***

EVIDENCE-BASED CARE

List of Initiating Practitioners

The Coalition questions the decision to limit providers who are able to initiate care under the CTI Guideline. The current Minor Injury Guideline allows "any health practitioners, as defined by the SABS, who are authorized by law to treat the injury and who have the ability to deliver the interventions referred to in this Guideline." Patient choice, a pillar of the research that drove the development of this guideline, should extend to their choice of provider.

> ***With respect to limiting providers under "Delivering Goods and Services through the Care Pathways", the Coalition recommends applying the language from the current Minor Injury Guideline "any health practitioner, as defined by the SABS, who are authorized by law to treat the injury and have the ability to deliver the interventions referred to in this Guideline".***

Restrictive Care Pathways

While the Care Pathways are backed by best available evidence, and quite clearly identify those interventions that would most benefit a particular patient population, the wording of these pathways as they apply to treatment protocols remain overly restrictive. We remain very concerned that choice of language used becomes a barrier to care rather than an enabler of evidence-based care.

The statement "if an intervention is not described in the guideline it should not be offered due to lack of evidence." is repeated many times in the MITPP Final Report and seems to indicate some confusion between a *lack* of evidence and evidence *against*. These are not synonymous as implied in this statement and results in an overly restrictive Care Pathway. If health care practitioners are prohibited from providing care that does not fit within the Care Pathways, it will limit the clinician's ability to employ their clinical judgement, based on their experience and expertise, and will not allow for patient's choice outside of the interventions required.

This type of prescriptive approach was not the case with the Pre-Approved Framework Guideline, nor with the Minor Injury Guideline. Each of these guidelines allowed for both recommended and discretionary interventions. In the Minor Injury Guideline, it states:

> *"Recommended interventions refers to interventions that are ideally provided each time the insured person attends the health practitioner's clinic.*
> *Discretionary interventions refers to interventions that are provided at the discretion of the health practitioner based upon the specific needs of the insured person. These interventions should not be interpreted to be less important in the treatment of the insured person."*

In the CTI Guideline and appendices there is, in many cases, reference to a single course of recommended treatment that can be offered for a specific injury. We would recommend that, instead of the patient being offered a choice of only one intervention, the language of the Care Pathways adopt a similar approach to the previous guidelines in terms of a list of recommended and discretionary interventions. Discretionary interventions would include those interventions where there is no evidence of harm, but that the provider and insured person agree could benefit the person's recovery (an example might be use of acupuncture in the Care Pathway for Ankle Sprain). Those interventions that evidence shows have no benefit, or where there is evidence of harm, should continue to be listed as "do not offer". This enables integration of patient choice - a critical aspect of care identified by the CTI researchers - and provider clinical experience into an evidence-based Care Pathway.

> ***The Coalition recommends that health care professionals must be able to use their professional judgement and expertise to offer discretionary interventions that the provider and insured person agree could benefit the person's recovery.***

While all treatment is expected to follow the Care Pathways, we have questions about goods and services outside of the "treatment" sphere – worksite assessments or equipment for example – that are not referred to in the CTI Guideline.

Managing Multiple Care Pathways

The CTI Guideline notes that an insured person with multiple impairments that come within this Guideline should be treated using all appropriate Care Pathways found in the Appendix. However, we would benefit from a structured and appropriate process in which this can occur so that the patient gets maximum value of the different interventions in each unique Pathway. The research examined for the purposes of this document did not take into account the cumulative effects of multiple versus single injuries in terms of recovery time, response to treatment, or associated risk factors and what effect this might have on the recommended Care Pathway. Given that more practice time is required to help a patient manage several injuries versus just one, it is recommended that funding is in line with this time commitment.

> ***Better consideration needs to be given to implementing multiple Care Pathways for insured persons diagnosed with multiple injuries. This must include the application of best practices to compounding factors of multiple injuries as well as allowance for time and funding considerations of the treatment approach.***

Evolution of Evidence

The Coalition notes that the effectiveness of any evidence-based treatment guideline relies on ongoing review and evaluation of new and emerging clinical evidence. While it may not have been part of the scope of the MITPP, we believe that it is crucial to develop a process and schedule for reviewing and updating CTI Care Pathways as necessary.

> ***The Guideline should incorporate a process for ongoing review and inclusion of new evidence into the Care Pathways. This process should involve multi-stakeholder representation, including treating clinicians.***

Iyengar Yoga and Qigong

The CTI Guideline contains specific references to the practices of Iyengar Yoga and Qigong. It is stated in the draft guideline that "the initiating and coordinating health professional must advise [the insured person] of these treatment options" for persistent neck pain and associated disorders (NAD) grades 1 and 2. In addition, these two treatment options have been identified as requiring a separate payment scheme within the CTI Fee Guideline.

There are three studies cited to support the inclusion of the two fitness/energy practices. These three studies do not provide sufficient evidence that Iyengar Yoga or Qigong are conclusively effective in treating chronic neck pain. In addition, all studies determine that further investigation is required to determine the long-term effects of this type of practice.

Neither Iyengar Yoga nor Qigong are regulated and thus there are no competence criteria for these treatment options. Without transparent competency criteria, or an associated regulatory body, the referral to these treatment options is left solely to the opinion of the initiating and coordinating health professional, who would be accountable to their respective regulatory body. Without a regulatory body to ensure the interest of the public, these two professions lack accountability.

It was determined that Iyengar Yoga or Qigong practitioners would not be registered with FSCO. The payment for these two practices would be the responsibility of the patient, who would then be refunded the treatment fees directly by the insurer. There is however no satisfactory explanation of how the insurer is to confirm that the practitioner the patient is consulting is of sufficient competence to warrant the reimbursement. There is also no information on how disputes regarding repayment would be arbitrated where the competence of the practitioner is in question.

Iyengar Yoga and Qigong practitioners are greatly concentrated in southern Ontario, specifically in the Greater Toronto Area, but it is difficult to access this treatment in the central and northern areas of the province. Patients wishing to access this type of care, under the required notification of their health professional, may not have equitable access for this portion of a care pathway for their injury.

> ***For these many reasons, the Coalition recommends that Iyengar yoga and Qigong should not be singled out as particular forms of guided exercise that are eligible for funding.***

FUNDING FRAMEWORK

As previously noted, the CTI Guideline requires that an insured person with multiple injuries follow all appropriate Care Pathways. However, it remains unclear whether multiple Care Pathways have an impact on available funding. Given that substantially more time is required to help manage several injuries compared to a single injury, it will be important from both professional and patient care perspectives that funding allows for this significant time commitment.

> ***As funding formula are determined, the impacts of time required to accommodate multiple Care Pathways must be built into the fee structures applied to treatment of claimants with multiple injuries.***

While we are very pleased to see that the CTI Guideline expands the current available treatment and funding from 3 months to 6 months, the research acknowledges that there are a significant number of patients who will require more than the allocated six months of care to recover. The regulation does not state what benefits will be available to these insured persons who are slower to recover, but whose diagnosis remains within the framework of the CTI Guideline.

> ***The Coalition recommends development of a funding or referral model for those insured persons who have not recovered from a CTI after 6 months.***

If the clinical Care Pathways are to be used appropriately, there should not be any exceptions to the funding formula. In part G of the CTI Guideline, it is noted that:

"Insurers are not required under this Guideline to pay for multimodal care for an insured person with persistent non-specific low back pain outlined in the care pathway titled Guideline for the Clinical Management of Low Back Pain With And Without Radiculopathy (at 10.1.4.7)."

> ***It is our recommendation that if the Care Pathway recommends multimodal care as an option, then funding for multimodal care should not be excluded from the guideline. If there are issues of overuse, entry criteria should be developed.***

The Coalition is seeking clarification regarding maximum limits of months and phases. Based on our review of the guideline, we would assume that an insured person would have access to the phase maximum no matter at what month they enter the phase, but that the insured person would not have access to the maximum phase amount to use entirely in a single month.

It has been particularly difficult to respond to the funding framework for the CTI Guideline without any actual numbers to review. That said, we believe that the CTI Guideline funding formula should achieve the following goals:

- ensure timely access to needed services for insured persons
- prevent the establishment of perverse incentives, and
- allow for minimal transactions with the insurer in order to decrease their administrative burden.

Prior to finalizing fees for this Guideline, the Coalition recommends the establishment of a CTI Fees Working Group to collaborate on a consensus proposal for the final fees and funding model. The working group should include insurers as well as treating health professionals.

TERMINOLOGY

The Coalition previously supported the MITPPs recommendation that the term "minor injury", which was found to be of concern to both patients and providers, be replaced with "Type 1 Injury". The term has now been replaced by "Common Traffic Impairment" in the draft Guideline. It is our position that the term "Common Traffic Impairment" is not an improvement. A "traffic impairment" seems to refer to a deficiency in traffic rather than an insured person.

We well understand the challenge of finding an appropriate term that would be clear, accurate and reflective of the breadth of care provided in the Guideline, and we are further certain that you will receive several suggestions from other stakeholders regarding the terminology. The Coalition would like to suggest one of two options:

With the removal of MTBI/concussion from the scope of this Guideline, we would recommend "Soft Tissue Injury Guideline" over "Common Traffic Impairment Guideline".
If MTBI continues to be included in the scope of the guideline, we would recommend maintaining the current terminology of Minor Injury Guideline.

Soft Tissue Injury is more consistent with clinical descriptive language and understandable to patients and health professionals while avoiding negative associations with the term "minor" that were reflected in the MITPP patient survey.

CONCLUSION

The Coalition believes that there is merit in the MITPP Final Report and the CTI Guideline. We would encourage less prescriptive application of the current evidence, better incorporation of provider clinical expertise and patient choice, and a clear funding framework that acknowledges the complexities of multiple injuries. We look forward to ongoing meaningful discussions that can move us closer to adopting a treatment framework that benefits insured persons, health care providers and the insurance industry.

Given the expanded scope of this guideline over previously implemented treatment protocols, and previous experience implementing new and complex processes in Ontario's auto insurance system, we would strongly encourage FSCO and the Ministry of Finance to strike a multi-stakeholder working group to develop a strategy for implementation as well as to monitor, collect, report on and collectively resolve ongoing issues surrounding implementation of the CTI Guideline. The Coalition would be eager to participate in such a working group.

Respectfully Submitted,

Dr. Moez Rajwani
Co-Chair

Dorianne Sauvé
Co-Chair