Coalition

Coalition of Health Professional Associations in Ontario Automobile Insurance Services

July 31, 2015

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

Re: The Optima Report "Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person"

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

While the content of the Report has many possible policy implications, the content focusses exclusively on clinical evidence for treatment pathways, and so we will limit our comments primarily to this content rather than potential policy direction. Based on conversations with FSCO, we understand that there will be an opportunity to consult separately on any policy or Superintendent's Guidelines that may result from this clinical review.

REVIEW PROCESS

From the report, we note that the process for reviewing the scientific literature provides a methodology that can contribute to evidence-based policy development. We do note, however, the lack of substantial consultation of the broader clinical and academic communities in arriving at the final recommendations and pathways.

Consistent with current understanding of health care and rehabilitation, the language of the report conveys an appreciation of a "patient- centred" approach and the document is titled, a "focus on the injured person". However, the bulk of the research and the construction of the Care Pathways are diagnosis and stage-based. There is very little actual discussion or consideration of individual patient preferences or characteristics or of ways in which these individual characteristics determine the appropriate utilization/application of the various Care Pathways.

REPLACEMENT OF THE TERM "MINOR"

We are in agreement that the term "minor injury" is one that is of concern to many injured persons as it is unrepresentative of the actual experience associated with traffic-related injuries. Based on feedback from practitioners and patients, the Coalition would support a change in terminology that would see those injuries currently referred to as "minor" in the SABS being otherwise labelled. The use of the term "minor" to refer to a patient's injury does not reflect and often trivializes the patient's experience following a motor vehicle accident.

Section 3.1.8 highlights the recommendations proposed by injured persons with minor injuries sustained in a motor vehicle collision. In reviewing this, we are in agreement with the following:

a. Change the language used to label and categorize the injuries and to take out words such as "minor."
b. Promote the development of a partnership between injured persons and their healthcare providers for the purpose of shared decision-making.
c. Make available emotional and psychological support for those involved in the collision.
d. Insurers need to understand and be guided by claimants' health care preferences.
e. injured persons should have access to information that will help them navigate the insurance and healthcare systems

Patients also identified concerns regarding the use of extended health benefits prior to the auto insurer paying for a claim (the "first payer" rule). Although this is outside the mandate of this report, we would encourage FSCO to further explore this significant concern of both patients and health professionals.

INJURY TYPES

The report is recommending that we use terminology called Type 1, Type 2 and Type 3 injuries. To replace the minor injury definition, the recommendation is to use Type 1 injuries.

Type 1 is defined as those injuries which include musculoskeletal injuries, traumatic radiculopathies, which includes nerve root symptoms of pain, numbness and weakness in the muscles, post-traumatic psychological symptoms such as anxiety and stress. The features that have been identified include those that have no significant loss of anatomic alignment or no loss of structural integrity and improve within days to a few months of the collision leaving no permanent and serious impairment. Typically, the effect is modest and the treatment intervention is modest. The definition also indicates that it is not confined to physical injuries and that it does include psychological symptoms such as anxiety and distress. The report correctly distinguishes psychological and mental disorders as Type II disorders. The research identified that a small percentage of these Type 1 patients will experience residual problems. The clinical pathways include both an acute (zero to three months) and persistent (three to six months) phase of treatment.

Although the research has been done based on epidemiological studies, clinicians are not always aware of those conditions that all have favourable natural history. In our opinion, there would continue to be ambiguity in the definition of Type 1 injuries.

Traumatic radiculopathies in particular can have different courses of care. If, for example, the neurological signs outweigh the musculoskeletal symptoms, it is our opinion that this would not be considered a Type 1 injury.

Mild traumatic brain injuries also have numerous sequelae and can have significant psychological components. We also note that, while it is correct that most individuals with these injuries have a good recovery, a subset will be identified who require more specialized, intensive and longer-term interventions (the ONF Guideline states that up to 15% of patients diagnosed with MTBI will "continue to experience persistent disabling problems). The report also does not distinguish Concussion/ MTBI from Post-Concussive Syndrome after 3 months of persistent symptoms, which is addressed in the ONF Guideline. In addition, we do not agree that MTBI would meet all of the criteria for Type 1 Injuries identified by the report.

This, combined with the report's assertion that clinical management remains controversial, has contributed to the Coalition's recommendation that MTBI should not be included in Type 1 injury classification.

The research highlights that a small percentage of patients with Type 1 injuries would develop residual problems. In the model that has been designed, there are intervention recommendations for zero to three months and three to six months. It would be our view that any condition that is a Type 1 condition that prolongs after six months would no longer meet the definition of Type 1 and may be considered a Type 2 injury.

REFERRAL TO PHYSICIAN

There are several points in each clinical pathway that require the provider to refer back to the patient's physician to determine next steps. For instance, when symptoms persist for longer than 6 months, or if patients experience a worsening of symptoms or develop new symptoms. We can infer that the physician in this treatment model is therefore the primary clinician and decision-maker. In practice, this is often not the case, and the research committee did not present any evidence as to why this was the preferred method of care.

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.

CARE PATHWAYS

Overly Directive Language

Although Care Pathways are described as the sequence and "options," the options within some of the Pathways are very limited. The language used in the protocols seems far more restrictive or directive than that seen in the guidelines. For example:

- **"one of the following"** – in the protocols, the use of this phrase was viewed to be over-prescriptive, requiring providers to choose a single intervention approach from the list provided. When clinically indicated, for individual patients, doing more than one of the recommended interventions would be appropriate but not 'allowed' based on the language of the protocols.
- **"do not offer"** - we believe the intent of the inclusion of some of the interventions under 'do not offer' (such as application of heat) is meant to address the concern of cases where these would be the primary or only intervention offered in the clinic setting. We fully agree that this is not in the best interest of the patient. However the use of clinic-based heat to relieve some symptoms in order to facilitate participation in exercises, mobilizations or to assist with pain relief at the end of a treatment session is very appropriate. This is an example of how 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 document 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 guideline/protocol/pathway.

Specific Guidelines

Under Section 6.2, soft tissue disorders of the shoulder have been noted to be grade 1 and 2 sprains and strains, tendonitis, bursitis and impingement syndrome affecting the glenohumeral and the acromioclavicular joint. It is important to clarify, therefore, that complete rotator cuff tears, as well as injuries to the labrum, would not be part of these Type 1 injuries.

Section 7.0. Guidelines for Clinical Management of Lower Extremity Soft Tissue Disorder. In reviewing the care pathways for lower extremity pain, not all conditions have been highlighted here. We need to clarify how those that are not highlighted would be classified (for instance, a meniscal or internal derangement of the knee).

In the care pathway for patellofemoral pain, there is indication that there is no treatment recommended for less than three months. Many cases of patellofemoral pain have associated quadriceps injury, which would be a sprain and strain-type injury. There are also factors that affect a differential diagnosis where the condition may be patellofemoral in nature or may have other pathologies. It is unclear in this case and may not be consistent with normal clinical practice to have no intervention for the first three months of patellofemoral pain. Similarly, with achilles tendinopathy, the recommended care pathways are no intervention for the first three months. This is inconsistent with normal clinical practice where pain management and range of motion would be something that would be considered.

While we agree with the decision to adopt the Ontario Neurotrauma Foundation Guidelines for Concussion/ Mild Traumatic Brain Injury & Persistent Symptoms (Second Edition) within the Report, we do not support the inclusion of MTBI in Type 1 Injury classification.

Section 11.0 identifies intervention without evidence or inconclusive evidence. In our opinion, those interventions that have been identified as having inclusive evidence should not be completely ruled out and there should be a scope for the clinical practitioner to utilize these services with patient consent where it is appropriate. Patient expectations need to be considered.

Additionally, each care pathway outlines potential risk factors that could indicate delayed recovery times. While the flowchart for each pathway requires that the provider “address modifiable prognostic factors”, there are no recommended strategies or best practices for doing so.

MANAGING MULTIPLE INJURIES

As the data from the IBC Health Claims Database shows, very few people injured in motor vehicle accidents present with individual and distinct injuries. Overall, the care pathways identify that when more than one condition has been involved, multiple pathways can be utilized. 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.

USE OF MASSAGE THERAPY

There is concern regarding the separation of massage therapy into "clinical massage" and "relaxation massage." The study referenced in the report, "Development of a taxonomy to describe massage treatments for musculoskeletal pain" by Sherman et al, is based on a taxonomy derived exclusively from the United States. The terminology presented in the international studies cited, and included in this report, is not appropriate for the regulatory environment in Canada, particularly in Ontario. Registered massage therapists are health care professionals governed under the Regulated Health Professions Act, 1991 and The Massage Therapy Act, 1991.

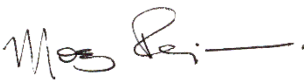
The College of Massage Therapists of Ontario (CMTO), the regulatory body for the profession of massage therapy in Ontario, does not recognize separate classifications for massage therapy in this manner. All registered massage therapists in Ontario are proven to be competent to provide therapeutic massage appropriate to the clinical setting. The term "massage therapy" would therefore be more appropriate to describe the treatments currently described in the report as "clinical massage" and "relaxation massage" as they relate to the treatments provided by registered massage therapists in Ontario.

CONCLUSION

The full potential impact of this report on stakeholders will not be realized in this time-limited review but will be very dependent on how this impacts policy and any corresponding system changes. Overall, it is our opinion that this care pathway model that has been designed is evidence-informed, however it should allow for more flexibility in care based on patient expectations, what has worked for the patient in the past, and clinical experience of the health care provider.

We thank you for the opportunity to respond to this phase of the Minor Injury Treatment Protocol revision. We look forward to additional opportunities to help translate this complex information into effective policy that will benefit those injured in motor vehicle accidents.

Respectfully Submitted,



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