September 11th, 2015

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

Dear Sir/Madam;

Re: Superintendent's Draft Common Traffic Impairment Guideline

The Ontario Physiotherapy Association (OPA) is the Ontario Branch of the Canadian Physiotherapy Association and represents more than 5600 member physiotherapists, physiotherapy assistants and students working, learning and living in Ontario.

The OPA appreciates this opportunity to provide comments and input to the Superintendent's Implementation Proposal for the Common Traffic Impairment Guideline (CTI Guideline). The CTI Guideline is based on the Final Report of the Minor Injury Treatment Protocol Project (MITPP).

INTRODUCTION

OPA has previously submitted our recommendations regarding the MITPP and, as the MITPP has informed the draft proposed CTI Guideline, many of these concerns and recommendations continue to apply. In particular the following recommendations persist as they directly apply to the pathways integral to the CTI Guideline;

- Evidence-based care: Physiotherapists believe in and practise evidence-based care. By definition, evidence-based care occurs at the junction of the best available clinical evidence, individual clinical expertise and each patient's values and expectations[1]. Despite acknowledging the importance of clinical judgement and patient values and expectations in introductory sections of the MITPP, the pathways reflect solely the current available evidence. Policy and funding models should be based on all three pillars of evidence-based practice allowing for requisite flexibility to achieve the best possible, individual client outcomes.

  The Institute of Medicine defined Clinical practice guidelines as "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[2] The recommendations in the MITPP are made based on currently available evidence and should therefore in essence be interpreted with caution when used to create

policy and direct funding, given that the research evidence is constantly changing. A CPG is intended to be used as a guide for clinicians, but not as a recipe.

- Limitations of Protocols: As acknowledged by the authors, any guideline, pathway or protocol is time-limited in its relevance due to the ever-evolving body of evidence in health care and in particular in rehabilitation sciences. There are many risks to patients, providers, and the system as a whole, associated with protocols falling behind current best practices. We urge consideration be given to promoting the flexibility of protocols/pathways in adapting to new or evolved evidence in the years between the planned large-scale reviews.

- Limitations of Conditions Considered in the MITPP: The MITPP provides very specific care pathways for a limited number of conditions. During the August 19th meeting Dr Côté acknowledged that the specificity of the pathways preclude extrapolation to other conditions resulting from traffic accidents.

- Overly Prescriptive Pathways: 'Lack of evidence' is not the same as 'evidence against' and treating them as the same has resulted in an overly-restrictive guideline/protocol/pathway. Though there is a commitment to shared decision making and recognition of the individual nature of each patient in this report, we are concerned that the recommendations and pathways are too prescriptive to allow for the individualization of care (including as appropriate interventions not currently included in the pathway) and the achievement of patient-centered care principles if the expectation is that they be followed as rigidly as the language implies.

- Restrictions on Number of Visits: This is another case where the language chosen has become overly-prescriptive and limiting to the individual care needs of patients, e.g. 'max 6 sessions over 8 wks' as opposed to setting a minimum number of visits to be effective and allowing the individual response of the patient and the clinical judgement of the clinician, in a shared decision- making process to determine whether additional visits are needed.

- Referral to Physician/Nurse Practitioner: At many points within the pathways the decision matrix leads to 'referral to physician/nurse practitioner'. We feel strongly that, though referring to a physician or a nurse practitioner may be appropriate in some cases, it is not appropriate for all situations. Should a referral be required, it would be more reflective of the inter-professional nature of health care delivery in Ontario and the utilization of health professionals to their full scopes of practice and individual competencies to change this to read 'refer to a health professional with the appropriate scope of practice'.

In addition, in the protocols/pathways, should the patient not recover, there is a line 'refer to physician.' We question this as overly prescriptive and inappropriate in some cases. Should a patient not recover fully and there are no further therapeutic options that would be appropriate, no purpose would be achieved by referring the individual to a physician. It would be appropriate if there are signs that additional testing/assessment is required beyond the scope of the treating professional, but that is not always the case. In addition some individuals do not or cannot access physicians for their primary care needs. Referral to physicians as a final option also minimizes the benefit of an inter-disciplinary approach by which communication links and consultations among treating professionals should be encouraged and not limited to the end of a pathway.

Though it is our understanding from the Stakeholder Consultation Session held August 19th that our concerns and the concerns of other stakeholders on the above points were considered in the development of the proposed CTI Guideline, it appears that they have not been addressed. We believe strongly that these fundamental concerns must be addressed in order to develop good policy, a sustainable funding model and to ensure the best outcomes for individual patients and the system as a whole.

The presentation by Dr. Côté on August 19th very clearly outlined the mandate of the research team and the limitations of the project. Specifically, in his explanation of the methodology section of his presentation, he explained that the research team followed the OHTAC decision determinant framework. This framework is used by OHTAC in its process for reviewing the literature and making recommendations for health interventions delivered in Ontario. The first three elements of the framework were within the mandate of the MITPP. Nevertheless, as pointed out by Dr. Côté, the fourth element, feasibility of adoption in the auto insurance industry, was outside of the mandate of the MITPP project and it would be for FSCO to determine feasibility through the drafting of related policy.

We respectfully submit the following recommendations to assist in addressing the feasibility determinant.

REVIEW OF THE CTI GUIDELINE

1. Definition of Common Traffic Impairment

Inclusion of Radiculopathy: In no jurisdiction in Canada is radiculopathy as a result of trauma/injury included within the definition of minor injury. In Alberta it is specifically excluded and in programs to address persistent low back pain in Ontario (the Interprofessional Spine Assessment and Education program), radiculopathy is an indicator

that impacts on the assessment, treatment and outcomes. Radiculopathy is clearly defined as a neurological disorder which is excluded according to the MITPP.

> Recommendation: We recommend that disorders with cervical, thoracic and/or lumbar radiculopathy be excluded from the CTI Guideline.

Inclusion of MTBI: The inclusion of MTBI based on the application of the Ontario Neurotrauma Foundation Guidelines for Concussion/Mild Traumatic Brain Injury and Persistent Symptoms (ONF Guideline) is a significant concern as the CTI Guideline does not allow for the application of the ONF Guideline in significant areas including;

- Duration of treatment – the ONF recommends continuing treatment as long as there are functional impairments; this is counter to the CTI Guideline.
- The ONF Guideline recommends symptom-based multi-disciplinary treatment for those whose symptoms are not sufficiently resolved as early as 'within days' after injury; it is unclear how such an approach could be supported within a funding model applicable to 'minor injuries'.

In addition 'MTBI lasting no more than 3 months' are included but those with symptoms lasting longer are not included. There is no way to predict the duration of symptoms for MTBI and treating them within the CTI will limit patients' access to needed interventions within the acute phase.

> Recommendation: We recommend the exclusion of the diagnosis MTBI/concussion from the CTI Guideline.

2. Exclusions to the Guideline

Part C of the CTI Guideline expressly notes that all injuries other than the exclusions in Part D fall within the Guideline. This being the case, it is critical that the exclusions be appropriate and that the process to exit the CTI Guideline is appropriate. It is noted in (b) that if the CTI is the most serious injury but the following conditions exist and those conditions are likely to prevent the insured person from recovering if treated only under the care pathways (emphasis added). We have already stated above our recommendations for the exclusion of radiculopathies and MTBI from the CTI Guideline. We believe that both of these qualify as neurological disorders as per exclusion criteria (b) in the CTI Guideline for the very reason that those with these conditions are likely to experience poor outcomes if treated only under the care pathways noted.

> Recommendation: That radiculopathy and MTBI/Concussion be considered neurological disorders and therefore excluded from the CTI Guideline.

3. Physician/Nurse Practitioner Role

Under Part D of the CTI Guideline, the only exit from the CTI Guideline once treatment is commenced is an OCF 24 completed and signed by a physician or nurse practitioner. This policy is a de facto introduction of a gatekeeper role for physicians and nurse practitioners, which is not supported by evidence and would have a detrimental impact on access to care and the effective use of limited health system resources. Furthermore, this position is contrary to that presented by the advisors of the MITPP report on which the CTI Guidelines are based; in his presentation on August 19th, Dr. Côté defined the role of the physician (and nurse practitioner as included in the guideline) as one acting only in cases where the treating practitioner assesses the patient to have a condition whose assessment and treatment would be beyond the treating practitioner's legislated scope of practice.

This gate-keeper role for physicians and nurse practitioners will have consequences for access and the health care system beyond the care of those in motor vehicle accidents. As not all cases will require the interventions of a physician or nurse practitioner, many will require a re-referral to the appropriate professional or send the patient back to the treating professional for further interventions outside the guideline – this cyclical referral system that has been conclusively demonstrated to be a waste of limited health professional resources and a barrier to timely access to needed care.

Additionally, referral to a physician or nurse practitioner creates patient expectations that further diagnostic testing is required and that further testing and treatment may be effective. With increasing accountability measures aimed at decreasing the instances of inappropriate use of diagnostic testing it would be contradictory to implement policies that could counter best practices.

All professionals authorized to initiate and coordinate assessment and treatment under the CTI Guideline (chiropractors, dentists, nurse practitioners, physicians and physiotherapists) are direct access professionals under the RHPA. They have the knowledge and the legislated scopes of practice to identify assessments and treatments that are outside of their scope of practice and when a referral to an appropriate health care professional is indicated.

> Recommendation: We recommend that the process remain as it is currently with the treating practitioner completing 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 physicians or nurse practitioners.

4. Discharge Criteria

In reviewing the MITPP Report the OPA noted that the discharge criteria of 'discharged as soon as they report significant improvement or recovery' based on a self-rated recovery question was overly subjective and open to a level of interpretation that makes it difficult to apply in practice. We are therefore very concerned to see this scale applied here in policy.

> Recommendation: We recommend that the discharge criteria for any care pathway reflect an evidenced-based, objective measure chosen by the treating health professional and occur when the treating health professional based on evidence, professional judgement and in consultation with the patient assesses that a) no additional treatment is required and improvements can continue to occur via home program or activities or b) the patient is non-compliant or chooses to end treatment or c) patient requires assessment/treatment outside of the Guideline.

5. Maximum Six Month Timeframe

In Dr. Côté's presentation he specifically noted that one of the decision criteria for inclusion in the guideline was 'evidence of favourable recovery (50% recover within six months)'. This means specifically that 50% of patients with this condition recover within six months of the injury, but it also means that 50% of patients with this condition do not recover within six months of the injury. The maximum timeframe of this guideline does not take into consideration the latter. If this is an evidence-based process and the evidence chosen is based on a 50% recovery rate within the time limit then there must be a process to access treatment and funds beyond the six months for the 50% who do not recover within six months.

> Recommendation: The Guideline should reflect a process to access funding and treatment beyond 6 months.

6. The Funding Model

Multimodal Care: There seems to be no reason if, as stated in the Guideline, insurers are responsible for funding services as set out in the pathways why they would not be required to pay for multimodal care for an insured individual with persistent non-specific low back pain as included in care pathway for this condition.

> Recommendation: OPA seeks clarification for the reasoning behind this exclusion for funding under the CTI Guideline.

Iyengar Yoga and Qigong: The CTI Guideline references the practices of Iyengar Yoga and Qigong. It states that "the initiating and coordinating health professional must advise the insured person of these treatment options" for persistent neck pain and associated disorders. This obligation is contrary to the treating professionals' standards of practice.

Regulated health professionals must make individual treatment decisions based on the assessment of the individual patient.

The evidence that supports these interventions is insufficient to meet the inclusion criteria noted by Dr. Côté in his presentation. The three studies do not indicate that Iyengar Yoga or Qigong are conclusively effective in treating chronic neck pain. In addition, all studies conclude that further investigation is required to determine the long-term effects of this type of practice.

In addition, these two interventions have been identified as requiring a separate payment scheme within the CTI Fee Guideline, but are applied to the monetary limit established for the persistent phase.

There is limited access to Iyengar Yoga and Qigong practitioners in Ontario and those who do practise are not regulated as health professionals in this province. There is no equitable access for patients and no mechanism to address public safety in the delivery of care by these providers.

> Recommendation: OPA strongly recommends that Iyengar yoga and Qigong not be singled out as specific, required interventions eligible for funding under this guideline.

Managing Multiple Conditions: We believe that the use of multiple single-condition pathways to treat patients with multiple injuries is insufficient and that without assessment of limitations and synergies of varied combinations of injuries, the sum of individual protocols is unlikely to comprehensively address complex patient needs.

Regardless, Part E of 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'. In addition to the concern noted above, this would mean that someone with multiple applicable pathways would receive multiple treatments i.e. more care and require more health professional time to address all the interventions. However the funding model that follows in Part G does not seem to take this into account.

> Recommendation: We recommend that the funding model take into consideration situations where multiple minor injuries are incurred to allow for resources to provide all appropriate treatment interventions to achieve treatment goals.

Maximum limits of months and phases: Based on the presentation by FSCO on August 19th, we understood 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 except for the last month of that phase should the patient only access the care in that month. However without the amounts associated with the phases it is very difficult to see this within the draft as presented.

The OPA applies the following principles when evaluating funding models. Funding models should;

- Ensure timely access to the right care by the right practitioner in the most appropriate setting
- Incent quality care and positive outcomes at the patient and system level
- Reduce complexity to ease unnecessary administrative processes and costs to both the provider and payor.

At this time there is insufficient information to fully evaluate the funding model as presented though we do perceive there to be more transactional costs and the potential for perverse incentives that may impact negatively on practice and outcomes and create unnecessary administrative burden for the system. In addition, as previously mentioned there is no mechanism to address multiple conditions/pathways within this funding model.

> Recommendation: OPA strongly supports the initiation of a fees/funding model working group with representatives from both the insurer and health professional stakeholder groups to develop a funding model and fee schedule that reflect the principles noted above.

OCF 24 Fee for Physician or Nurse Practitioner: There is no reason noted as to why the completion of an OCF 24 (and the needed assessment therein) would be compensated for differently for physicians and nurse practitioners than for any other health practitioner able to complete the OCF 24 under this Guideline.

> Recommendation: The fee for the completion of the OCF 24 should be the same for all professions eligible to complete the form.

Amounts Payable under Other Insurance and Health Care Coverage: There is a significant lack of clarity, increased by the presence of '$XX (TBD)', in interpreting how 'reasonably available under other insurance or health care coverage' will be applied in the model as proposed. The impact of the 2 phase approach and the monthly limits is also unclear. This was noted in the MITPP Report as a significant concern not only to health professionals, but also to the patients we treat.

> Recommendation: The OPA recommends clarification of the application of the 'reasonably available under other insurance' provision in Subsection 47(2) to this funding model and further re- iterates the need to reduce complexity and administrative burden in the application of this portion of the funding model.

CONCLUSION

ONTARIO PHYSIOTHERAPY ASSOCIATION

We truly appreciate this opportunity to participate in this project to bring evidence-based practice into health policy and funding models. However, as noted by the recommendations above, this is not a simple translation of evidence into policy. The exercise must reflect the fact that evidence-based practice incorporates the total of the best available evidence, professional judgement and expertise and patient's values and expectations.

The OPA strongly urges FSCO to engage all stakeholders in further consultation and a process that will build on the extensive work completed to date and result in a program and funding model that achieves the best outcomes for both the patient and the system. OPA would be very pleased to participate and dedicate resources to achieve these important objectives.

Sincerely,

Dorianne Sauvé
Chief Executive Officer

[1] http://community.cochrane.org/about-us/evidence-based-health-care
[2] http://iom.nationalacademies.org/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust/Report Brief.aspx

416 322 6866 1 800 672 9668 opa.on.ca
55 EGLINTON AVE EAST, SUITE 210 TORONTO, ON, M4P 1G8