ENABLING RECOVERY FROM COMMON TRAFFIC INJURIES: A FOCUS ON THE INJURED PERSON

Response of the Ontario Physiotherapy Association

INTRODUCTION

The Ontario Physiotherapy Association (OPA), a branch of the Canadian Physiotherapy Association, represents more than 5600 member physiotherapists, physiotherapist assistants and students working and living in Ontario. More than half of our members daily provide services to Ontarians recovering from an automobile accident and close to 100% of our members are purchasers of auto insurance in Ontario. We fully understand the need for an affordable and accessible auto insurance product while also having a unique perspective as health professionals about the importance of access to needed health services post-accident to facilitate a return to function, employment and activities of daily living.

Physiotherapists believe in and practice evidence-based care. By definition, evidence-based care occurs at the junction of the best available clinical evidence, individual clinical expertise and the patient's values and expectations[1]. The triad that makes up evidence-based care allows for the integration of formal research evidence, thoughtfully and reasonably applied using clinical expertise and respect for the needs, values and expectations of individual patients. It is not rigid, it is not black and white, but is grounded in the shades of grey that are inherent in the science and art of health care.

Physiotherapists and our colleague health professions apply all three elements of evidence-based care in making clinical decisions with patients. Treatment protocols that are overly prescriptive and limiting restrict the application of two of these three critical elements to the detriment of patient care.

We acknowledge the important work by Dr. Coté and his team and the contribution of this snapshot in time of the evidence that influences clinical decisions for these patient populations. However, evidence is continually evolving and the use of evidence to develop funding and/or health policy must be done carefully, allowing for change and developments in the short- and long-term.

The time limitations of this consultation prohibits a full review of the methodology of this review and whether it meets accepted standards. We do note however, a lack of substantial consultation of the broader clinical and academic communities in arriving at the final recommendations and pathways. As this project is not an academic one which would result in publication in a peer-reviewed journal, there has been little opportunity for open debate by the broader community as to the conclusions reached or their impact on potential health system or policy changes. In addition, the methodology and the criteria used for

determining the quality of studies that inform the recommendations is unclear and has not been subjected to expert review.

In the absence of an open forum there is an imperative for targeted and meaningful consultation of front-line clinicians who would be expected to implement the results of this report at the level of the individual patient. The methodology, and conclusions of this project would have been stronger had this critical step been integrated prior to the finalizing and submission of the report.

In addition, the OPA would like to register our significant concern about the process of this current consultation. The minor injury protocol project was announced and then reconfirmed in the 2012 Ontario Budget. After more than two years of work including an extension to the original timeline of the project, the report was delivered to the Financial Services Commission of Ontario in December 2014. Other than one update presentation to stakeholders in February 2014, no other engagement of stakeholders external to the project team occurred. An executive summary and a portion of the final report excluding all supporting references (available only upon request) were posted and a notification sent to stakeholders on July 6th, 2015. This extremely short consultation of less than a month during the summer when resources are more limited and a single general question indicates that there is little expectation that the resulting stakeholder input will have any significant contribution or impact to how the report is received or interpreted by FSCO and other decision makers.

Despite this, we will make every effort to provide constructive input into this process and to represent the concerns not only of our members but of Ontarians who depend on access to needed care post- accident.

We highly encourage that additional opportunities for meaningful consultation and feedback be considered. This will not only result in a stronger outcome to this significant investment but also improve the potential that this work will have a positive influence on outcomes at the level of the individual patient, the auto insurance system and the health system as a whole.

The consultation question posed by FSCO is:

"What are the potential impacts of the recommendations in the Final Report on you as a stakeholder?"

In this submission we will summarize the feedback we received from our members into themes. We believe that these themes highlight areas that impact on the integration of the protocol into clinical practice.

THEMES OF FEEDBACK

The Patient Perspective

ONTARIO PHYSIOTHERAPY ASSOCIATION

We applaud the inclusion of the perspective of patients that have experienced the minor injury guideline. Though some have expressed concerns regarding the low number of patients interviewed, the results of the interviews do represent what we hear from our patients regularly. OPA supports the recommendations under this section (3.1.8.1 to 3.1.8.5) as consistent with our long-standing principles of supporting the patient's right to choose their provider, patient-centred care and informed shared- decision making.

We agree, based on the results of the patient interviews and other evidence discussed in the document, that consideration be made of changing the nomenclature of the categorization of injuries from 'minor' to one that does not minimize the patient's experience of their injuries.

We believe that the emphasis on shared decision making throughout the document is important and must be a respected component to any guideline or pathway for this to truly be an evidence-based care approach.

Patients also noted concerns regarding the use of extended health benefits as first payer in the system. Though this is perhaps outside the mandate of this report, the OPA would highly encourage FSCO to further explore this significant concern of patients and health care professionals.

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. Our experience in other payment systems that have based programs of care on a body of evidence shows us that it is difficult to maintain a commitment to ensuring that the evidence is updated. There are many risks to patients, providers, and the system as a whole, associated with protocols falling behind current best practices. We urge consideration of the flexibility of protocols/pathways in adapting to new or evolved evidence in the years between the planned large-scale reviews. A process for this is lacking in the current report.

There is a continuum of language from informative/recommendations seen in guidelines to a more prescriptive/directive tone seen in protocols. Members expressed significant concerns in the wording of the protocols/pathways and in particular:

- 'one of the following' – In the protocols the use of this phrase was viewed to be overly- prescriptive and unsupported based on the clinical experience of our members. 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 heat (clinic-based) is meant to address the concern of cases where these would be the predominant or single intervention offered in the clinic setting. We fully agree that this is not a desirable situation in the best interest of the patient or outcomes. However, the use of heat (clinic-based) to relieve some symptoms in order to facilitate participation in exercises, mobilizations or to assist with pain relief at the end of a session is very appropriate. Other examples that could be elaborated include the use of TENs for pain management or supervised progressive exercise programs. In both examples, the intervention could be appropriate for individual patients in combination with other interventions.

It is important to note that in section 2.5.2.4 the report defines 'do not offer' as interventions that "do not offer *sufficient* benefit to *most* patients" [emphasis added] whereas by the time we arrive at the recommendations the meaning has changed in section 2.5.2.4.2 and all other parts of the document to the following: "the Guideline Expert Panel is confident that the treatment will not benefit the patient". Again language used becomes a barrier to care rather than an enabler of evidence-based care and the individual need of the patient and the clinical judgement of the health professional are removed from the equation.

The statement "interventions not described in this guideline are not recommended …because of lack of evidence about their effectiveness…" is repeated many times in the document. It is important to state that 'lack of evidence' is not synonymous with 'evidence against'. This statement is overly-restrictive and limiting to evolving evidence-based practice to the detriment of the patient and the health system.

In some circumstances evidence appears to trump common sense, in others the recommendations extend beyond the available evidence. For example, there is a recommendation for shock-wave therapy for Achilles tendonitis and calcific tendonitis of the rotator cuff however that recommendation doesn't seem to be present for other superficial tendinopathies. In other instances there are strong recommendations for interventions that go beyond the quality of evidence available to support the recommendation e.g. 'offer a program of qigong exercise supervised by a certified qigong instructor'.

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 and the achievement of patient-centred care principles if the expectation is that they be followed as rigidly as the language implies.

Restrictions on the Number of Visits

This is another case where the language chosen becomes over-prescriptive and limiting to the individual care needs of patients. For example, the use of "max 6 sessions over 8 wks" as opposed to setting a minimum number of visits shown 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. The objective clinical research that supports setting a maximum number of sessions in any of the recommendations is not evident and the conclusions seem to be based on opinion, not evidence.

We are pleased to note that for most, if not all, conditions covered in this report it is acknowledged that evidence supports treatment beyond the initial 12 weeks which is currently included in the minor injury guideline.

Managing Multiple Conditions

> *"Patients with multiple injuries should be managed using all appropriate care pathways. For example, a patient who suffers from cervicogenic headaches and low back pain should be managed according to the recommendations included in both the cervicogenic headache and low back pain care pathways." Page 121*

The authors indicate in multiple places (the above quote is one example) that a patient with multiple injuries should have access to the recommendations in multiple pathways. However, there doesn't seem to be any guidance as to how this would be applied or what the impact could be of multiple injuries on the expected response to treatment.

The use of multiple single-condition pathways to treat a patient with multiple conditions is insufficient to address the global impact of injuries on patient functioning and recovery. Without assessment of limitations and synergies of varied combinations of injuries, the sum of individual protocols is unlikely to comprehensively address complex patient needs.

Choice of Conditions and What is Grouped Under 'Category 1'

The choice of conditions of the upper and lower extremity for which a care pathway was described seems arbitrary and inconsistent with the accident-related conditions that are seen in clinic.

Type 1 injuries addressed in this model include previously called WAD I/II as well as radiculopathies and mild traumatic brain injury (MTBI) - these are beyond what was previously covered in the Minor Injury Guideline. This will have significant impact on the development of policies and funding systems associated with a 'category' approach rather than a 'minor injury' approach.

MTBI/concussions seem to be included in under Type 1 injuries. Many expressed concerns that the recovery of those with concussion might be limited if they are restricted to receiving care only within a
'minor injury protocol' and not have access to care beyond this. The majority will recover in 3 months; however, some will go on to develop Post-Concussion Syndrome which can have a prolonged impact on the person's life and function (the ONF Guideline states that

up to 15% of patients with MTBI fall into this category). We do not agree that MTBI should be included in Type 1 injuries.

Physician Referral

In most of the situations in the protocols/pathways, should the patient not recover, there is a line stating '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, it is unclear what could be achieved by referring the individual to a physician. It would be appropriate if there are signs that additional testing/assessment that are beyond the treating professional's scope of practice are indicated but that is not always the case. In addition, some individuals do not access physicians for their primary care needs (e.g. they have a nurse practitioner as their primary care provider) or they do not have a primary care provider.

Referral to physician as a final option also minimizes the benefit of an inter-disciplinary approach by which communication links and consultations between treating professionals should be encouraged throughout but is presently limited to the end of a pathway.

Discharge Criteria

> *"Patients should be discharged as soon as they report significant improvement or recovery. It is recommended that health care professionals use the self-rated recovery question to measure patient recovery: "How well do you feel you are recovering from your injuries?" The response options include: 1) completely better, 2) much improved, 3) slightly improved, 4) no change, 5) slightly worse, 6) much worse, 7) worse than ever. Patients reporting to be 'completely better' or much improved' should be considered recovered. Patients who have not recovered should follow the care pathway outlined in the guideline." Page 175*

It is unclear how the scale was determined, whether it has been tested and whether its application is appropriate for these patient populations. The introduction of this scale is counter to the concept of evidence-based decision making. In addition, to indicate that discharge after a 'significant improvement or recovery' is subjective and open to a level of interpretation that makes this a potential source of conflict within the auto insurance system.

CONCLUSION

The full potential impact of this report on stakeholders will not be realized in this time-limited review but will be dependent on how this impacts policy and any corresponding system changes. We have identified significant themes that require further investigation to resolve outstanding questions. Addressing these issues will be critical in increasing

evidenced-based care by all and minimizing discord and conflict within the auto insurance sector.

We do think that the release of this report presents an excellent opportunity to engage in a dialogue that can lead to knowledge transfer activities to improve practice for the benefit of the patient and the system as a whole.

The OPA looks forward to engaging with FSCO and other stakeholders in meaningful and substantial consultation as we move forward with next steps in this process.

Sincerely,

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CEO, Ontario Physiotherapy Association

[1] http://community.cochrane.org/about-us/evidence-based-health-care. Accessed on 31/07/15.