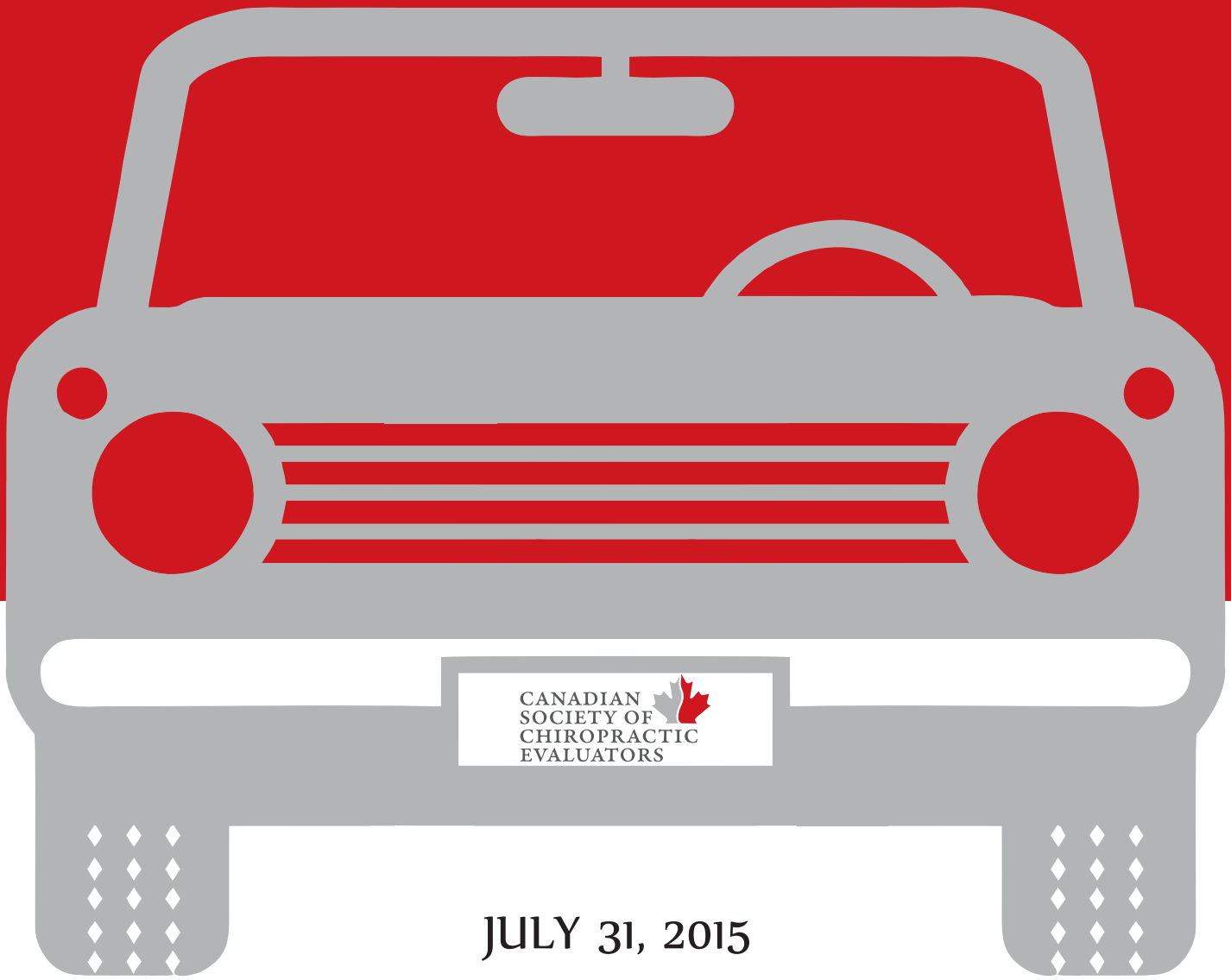
The OPTIMA REPORT

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

A response
by the
Canadian Society of Chiropractic Evaluators



JULY 31, 2015

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July 31, 2015

CANADIAN SOCIETY OF CHIROPRACTIC EVALUATORS

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

Dear Sirs,

Preface
The Canadian Society of Chiropractic Evaluators (CSCE) is a national chiropractic organization representing advanced-practice chiropractors involved in performing independent third party assessments. In particular its mission is:

- To roster and promote a list of highly qualified advanced-practice chiropractic practitioners who regularly perform independent chiropractic assessments and network with third party representatives,
- To advance the quality of independent advanced-practice chiropractic evaluations through post-graduate education and the promotion of related research,
- To promote standardization of independent advanced-practice chiropractic evaluation and documentation amongst its members,
- To liaise with the public, government bodies, third party payers, chiropractors and other health care professionals on all matters concerning chiropractic evaluations, and
- To promote the importance of using advanced-practice chiropractic evaluations for peer review of chiropractic case management.

The CSCE would like to thank the Financial Services Commission of Ontario (FSCO) and the Ontario Ministry of Finance for the opportunity to respond to the Final Report of the Minor Injury Treatment Protocol Project, titled "Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person" (Final Report) which was delivered to FSCO at the end of December 2014 but only to stakeholders on July 6, 2015. The Final Report recommends treatment purportedly based on extensive research by medical and scientific experts which complied with rigorous scientific methodologies and research protocols. In particular, stakeholders are being asked to answer the question:

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

Comments and Potential Impact on Medical and Rehabilitation Service Providers

1. Ontario's auto insurance program has undergone numerous changes since the introduction of a mixed no-fault/tort insurance system in 1990, with legislative reforms enacted in 1994, 1996, 2003, 2006, 2010, 2014 and 2015. These legislative changes have also been complemented by a plethora of regulatory and Superintendent of Insurance Guideline changes further compounding the problem. The majority of these changes were purportedly made largely to address both the growth in the cost of Statutory Accident Benefits Schedule (SABS) payouts and the resulting increase in insurance premiums. In each case, however, insurers claim that the legislative reforms enacted have only provided temporary relief from higher premiums and continue to request from the government further concessions.

2. The CSCE notes that the Superintendent of Insurance's 2009 Five Year Review indicates that it was the CSCE that recommended that the authors of the Neck Pain Taskforce, in partnership with key stakeholders, be contacted to examine the feasibility of expanding the PAF Guidelines to provide a more extensive continuum of care and to include the treatment and assessment of other soft tissue injuries. The Government's 2015 Budget under Section F, A Fair Society states: "The government will also continue to ensure, where possible, **that insurance coverages reflect the most relevant scientific and medical knowledge on identifying and treating injuries from automobile accidents. This approach will provide clarity to help minimize disputes in the auto insurance system and ensure that people get the treatment they need after an automobile accident**."

   While, the CSCE applauds the Government's initiative in this direction, we have significant concerns that there was a lack of transparency by the Government as to the OPTIMa Collaboration's complete mandate and that there was little to no consultation with healthcare services providers in the development of the various Care Pathways. This issue amongst other concerns expressed further in this response raises a significant measure of scepticism amongst stakeholders.

3. The CSCE is also deeply concerned and distressed that given the two plus years in preparing this Collaboration Report, the magnitude of the report (279 pages), and the potential long-term impact on the delivery of auto insurance medical and rehabilitation benefits by stakeholders that the Liberal Government and FSCO has only seen fit to allow an **extremely** narrow three-week window of opportunity to comment on the Report's findings and that this narrow window would come at the start of the summer holidays when many individuals are not available to provide comment. The only information presented to stakeholders prior to the release of this Report was a partial discussion on the methodology in January 2015. **Given the inappropriate timeframe for providing comments, the CSCE is forced to restrict it remarks to higher level issues and not the specifics of individual care pathways.**

4. The Financial Services Commission of Ontario current website states that "scientists and other experts have contributed to the development of an evidence-based Minor Injury Treatment Protocol (MITP) that will form the basis of a new Minor Injury Guideline, subject to government approval. If approved, the MITP will be used by insurers and health care providers when treating minor injuries resulting from automobile accidents, and ensure that there is an extensive continuum of care based on current scientific and medical evidence. The MITP includes clinical prediction rules to screen for patients who may be at higher risk for developing chronic pain and disability. In addition, it focuses on treatment outcomes, and provides health care providers with numerous milestones to measure progress."

   The CSCE finds that these comments on the FSCO's website to be contradictory given the fact that the Collaboration Report clearly states that there is no scientific merit or rationale in continuing to utilize the term "minor injury." The CSCE would suggest that the FSCO website be appropriately altered to reflect this.

5. The OPTIMa Collaboration indicates that:
   a. They critically reviewed the contents and evidentiary basis of published clinical practice guidelines for the management of traffic injuries,
   b. They carried out an exhaustive search followed by a rigorous methodological evaluation of the current scientific literature concerning the management of traffic injuries published in peer-reviewed journals which were summarized in 43 new systematic reviews of the literature,
   c. They conducted a new study in which they gathered and carefully considered the narratives of Ontarians who have sustained injuries in traffic collisions and received health care, and
   d. They used a modified framework which considered the overall clinical benefit; value for money; societal and ethical considerations; and the economic and organizational feasibility of proposed interventions in the new Care Pathways.

   The CSCE recognizes that the Ontario Protocol for Traffic Injury Management (OPTIMa) Collaboration included a multidisciplinary team of regulated and non-regulated health professionals. However, the CSCE would like to note that the vast majority of the OPTIMa Core Team are not actively engaged in clinical practice or involved in the day-to-day delivery of the services outlined in the suggested *Care Pathways* and that these *Care Pathways* are not completely representative of current evidenced-based care.

FSCO indicates on its website that the research material referenced in the Final Report is currently available, in English, by contacting FSCO. To date, our effort in obtaining this material has not been fruitful and again brings into serious question, in its absence, the timeframe provided for comment and the recommendations provided in the Report.

The Collaboration indicates that it conducted a new study where they gathered and considered the narratives of Ontarians who had been involved in motor vehicle accidents. However, it is our opinion that utilizing only 11 narratives out of a pool of the thousands of Ontarians injured, during the period of time that the Report was being formalized, fails to meet the test of a rigorous methodological evaluation. The selection criteria for this process are not well delineated and, at best, the comments provide only anecdotal observations.

The Collaboration makes note of David Sackett's 1996 definition of Evidence-Based Health Care. However, what the Collaboration fails to emphasize is Sackett also clearly states that: *without clinical expertise, practice becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Evidence based medicine is not "cookbook" medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. Similarly, any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied. Clinicians who fear top down cookbooks will find the advocates of evidence based medicine joining them at the barricades".*

However, Sackett further states that "*Evidence based medicine is not restricted to randomised trials and meta-analyses. Some questions about therapy do not require randomised trials or cannot wait for the trials to be conducted. If no randomised trial has been carried out for our patient's predicament, we must follow the trail to the next best external evidence and work from there".*

Sackett also goes on to say that *"there is fear that evidence based medicine will be hijacked by purchasers and managers to cut the costs of health care. This would not only be a misuse of evidence based medicine but suggests a fundamental misunderstanding of its financial consequences. Doctors practising evidence based medicine will identify and apply the most efficacious interventions to maximise the quality and quantity of life for individual patients; this may raise rather than lower the cost of their care".*

Given the fact that the Collaboration Committees also included non-regulated health professionals and also focused ultimately on issues as value for money; societal and ethical considerations; and the economic and organizational feasibility of proposed interventions in the new Care Pathways, the CSCE would suggest that a more appropriate term for **the Care Pathways is that they are evidence-informed rather than evidence-based.**

6. The Collaboration clearly states in their Report that there is no scientific merit or rationale in continuing to utilize the term "minor injury" as was delineated in the Minor Injury Guideline (MIG). The CSCE would strongly concur with this statement and that it represents a position which we have strongly endorsed since the development of the original Pre-approved Framework of Care (PAF), which was a concept developed by some of our members, and further reinforces our longstanding position that the MIG has significant deficiencies for the provision of reasonable and necessary medical and rehabilitation benefits.

7. The Collaboration proposes a new classification system that categorizes automobile collision injuries as Type I, Type II, or Type III injuries. Further, given the important temporal considerations outlined above, the Collaboration gave merit in further characterizing the injury, in order to optimize the approaches and interventions, by phase: Recent (0-3 months post-collision), or Persistent (4-6 months post-collision). The Collaboration emphasizes that the focus of its Report and the Care Pathways was on Type I injuries and their management within the first 6 months post-collision.

   For the most part, the CSCE supports this newer classification system with the two sub-category phases of Recent and Persistent. However, we do not support the inclusion of traumatic radiculopathies, mild traumatic brain injuries or WAD III neck pain and associated disorders as part of the Type I classification. It is our opinion that these three scenarios are best handled from a rehabilitative perspective as part of a Type II classification.

   Clinically, all three of these conditions tend to be more serious impairments with significantly more variable outcomes. Each requires a different diagnostic work-up, plan of management and often has a protracted recovery timeframe often with less than favourable prognosis. Some of these cases (i.e. WAD III and radiculopathies) may even require surgery. It does not make clinical sense to trivialize these types of conditions and no responsible treating clinician would lump them in the same category of a WAD I impairment. This is especially important if it is the government's intent to consider fee caps and limits to these categories. This is grossly unfair and will only precipitate further benefit entitlement disputes with all their associated additional costs.

Given the lack of time to review and provide comment, it is the CSCE's general opinion that there will be other Care Pathway conditions which have been inappropriately assigned to a Type 1 classification. Further, it is the CSCE's opinion that there needs to be a Chronic sub category phase for those impairments that persist for more than 6 months post-collision.

As part of the Neck Pain and Associated Disorders Care Pathway, the Collaboration uses the acronym NAD. The CSCE would strongly recommended that the use of the NAD classification system not be used on a go forward basis due to the confusion that it will generate with the new Type classification and the prior Whiplash Associate Disorder (WAD) classification systems. It is the CSCE's strong position that ambiguities with the prior classifications systems and phases coupled with ongoing changes to the regulations has led to a lack of clarity in stakeholder knowledge which has been a significant contributing factor to ongoing disputes.

The Collaboration Report identifies that only 50% of individuals, with accident-collision impairments, achieve either complete or almost complete cessation of pain and disability within a six month timeframe. The Collaboration Report, while it cites a twelve month period of recovery, does not ascribe what percentage of individuals achieve either complete or almost complete recovery. This percentage of recovery identified by the Collaboration clearly illustrates how inappropriate the MIG was as a mechanism in the management of accident–collision impairments and disabilities and the MIG's associated financial caps has undoubtedly led to the significant rise in mediation, arbitration and tort costs.

The Collaboration Report does attempt to provide some discussion on the determinants or influences on recovery. The Report divides these determinants and factors into five categories. Notwithstanding this, the CSCE would note that these five categories are for the most part limited by a lack of good clinical studies and thus should only form a consideration but not the basis for either approving or denying services. The CSCE notes that there currently are not sufficient studies dealing with the histopathology of tissue healing, the presence of comorbidities such as but not limited to pre-collision smoking habits, alcohol intake, age, nutritional status and general health status. Further, the determinant or influences on recovery do not take into consideration multiple impairments – i.e. does a single Type I injury recover in the same time frame as a constellation of Type I injuries?

8. As part of the Neck Pain and Associated Disorders Care Pathway, the Collaboration attempted to develop a Clinical Prediction Model (Rule) CPR for self-reported recovery and insurance claim closure utilizing a Cox regression model and C-statistics. Their prediction model included prior traffic-related neck injury claims, expectation of recovery, age, percentage of body in pain, disability, neck pain intensity and headache intensity which resulted in a C-statistic of 0.64. The prediction model for claim closure included prior traffic-related neck injury claims, expectation of recovery, age,

percentage of body in pain, disability, neck pain intensity, headache intensity and depressive symptoms which resulted in a C-statistic of 0.64.

The CSCE notes that the use of a C-statistic that the probability of a Clinical Prediction Rule accurately predicts the outcome is better than chance results in figures ranging from 0.5 to 1.0. A value of 0.5 indicates that the model is no better than chance at making a prediction and a value of 1.0 indicates that the model perfectly identifies those within a group and those not. Models are typically considered reasonable when the C-statistic is higher than 0.7 and strong when C exceeds 0.8.

There is still much debate with regards to the validity and clinical applicability of Clinical Prediction Rules and clinicians are cautioned about relying on them exclusively. There is little evidence that CPRs can be used to accurately predict effects of treatment for musculoskeletal conditions. The principal problem is that most studies use designs that cannot differentiate between predictors of response to treatment and general predictors of outcome.

Last, but not least, the use of CPRs by a clinician tends to classify patients into just one group, where it is highly unlikely that one would treat patients with multiple impairments with just one single intervention. It is more likely that patients will benefit from multimodal therapy incorporating a combination of interventions. So perhaps using a CPR as “hindsight”, to underpin the hypothesis derived after a sound clinical reasoning process, is a better clinical way forward.

Given the 0.64 C-statistics, the CSCE would opine that the Clinical Prediction Model developed by the Collaboration has marginal predictive value at best and would concur with the Collaboration that further work is required in this area. Further, in light of the absence of strong Clinical Prediction Rules for all Type I, II, or III injuries, it is the CSCE’s opinion that the allocation of individuals into low, medium, or high resource Care Pathways would be inappropriate and the historical FSCO practice of arbitrarily putting auto collision individuals into a low resource, underfunded pathway places them “at risk” of not receiving timely access to reasonable and necessary medical and rehabilitation goods and services.

The Collaboration notes that this inability to predict recovery has important implications including: 1) impacting clinician-patient interactions regarding education and prognosis; and 2) limiting the capability of insurers to estimate and allocate funds to manage common traffic injury claims. While, the CSCE acknowledges that these implications exist, they also serve to further reinforce the need for a robust, independent, peer-review, dispute resolution process when there is uncertainty over benefit delivery or entitlement.

9. It is noted that in each of the Care Pathways that when a patient fails to respond to care or develops risk factors that he or she is automatically referred to a physician. It is uncertain whether this means an initial contact family physician or any physician including medical specialists.

   The CSCE does not dispute that there are scenarios where there is a need to refer an accident collision individual to a medical specialist if the treating healthcare practitioner suspects the presence of serious pathology as delineated by one of the red flags identified in the healthcare literature. However, as a matter of routine practice, the CSCE cannot support this recommendation. There are many Advanced Practice Clinicians (i.e. Chiropractic Specialists, Advanced Practice Physiotherapists, Neuropsychologists, Psychologists) who have the requisite skills via their advanced education and training coupled with their clinical experience to appropriate triage patients when they fail to respond to care or develop risk factors.

   This recommendation also runs counter to programs which are being developed in such initiatives as the WSIB's Programs of Care, the Ministry of Health and Long-Term Care's ISAEC and Low Back Pain Initiative programs, Carlington Community Health Centre's Spine Care Program, the Champlain and Mississauga Halton LHINs' eConsultation program, the Trillium Health Centre's Spine Care program, the Mount Sinai Hospital's Spinal Stenosis program, Sunnybrook Health Science Centre and the Queensway Carleton Hospital's knee and hip programs which all place a higher emphasis on the use of non-physician Advanced Practice Clinicians. We also see in many communities across the Province the development of Regional Pain programs which again places a heavy emphasis on these Advance Practice Clinicians. It further runs counter to the extensive recommendations made by stakeholders in this Government's prior Expert Assessor Network consultation process.

   Clinical experience by stakeholders demonstrates that physicians (especially family physicians) often do not have the time, clinical acumen or desire to deal with the plethora of issues exhibited by auto collision individuals nor for that matter have sufficient familiarity with appropriate clinical practice guidelines or regulatory frameworks. Further, it needs to be clearly recognized that the portal of entry to the delivery of medical and rehabilitation benefits often does not start with the family physician and that many auto collision individuals do not have a family physician in the first place.

   We additionally note that wait times to access medical specialists for elective services is often in excess of one year and up to two years for many of the conditions detailed in the various Care Pathways by the Collaboration. The CSCE would again stress that many of these conditions are currently being appropriately addressed in a timely fashion in other healthcare models by Advanced Practice Clinicians who demonstrate that they have the requisite education, training and experience to appropriately address the issue.

10. The CSCE has significant concerns about the implementation of the OPTIMa Collaboration's Care Pathways and the development of any associated regulatory changes. Our concerns are compounded by the belief that any regulatory changes are likely to be in place for a protracted period of time. These concerns are exacerbated by the inappropriate timeframes for stakeholders to provide meaningful responses and the absence of all the data upon which the Collaboration Report is based. The CSCE's concerns are further confounded by such intangible factors of the Government's failure to deliver a 15 percent reduction in auto insurance premiums, the insurance industry's continued allegations of rampant fraud and the Ontario Trial Lawyers of Ontario study which asserts that Ontario consumers may have overpaid for auto insurance by as much as $4 billion between 2001 and 2013, with excess fees amounting to $840 million in 2013 alone. In 2011, The Ontario Auditor General estimated that about half of all claims are arbitrarily turned down by insurers which reinforces that legitimate access to medical and rehabilitation benefits is already difficult.

    Clinically, with the ever increasing downward spiral in accident benefits, health professionals are increasingly seeing auto collision individuals being downloaded to fully or partially funded OHIP, Ontario Works (OW), Ontario Disability Support Program (ODSP) and CPP disability public programs. These programs are already overburdened and, more often than not, don't offer the specialized treatments that many legitimate claimants require leaving them to fend for themselves or seek legal representation.

    All of these factors are taking place against a backdrop of the recent Toronto Star's Editorial demanding that the Auditor General is called in to determine whether or not Ontarians are getting a fair deal and the Government's new proposed legislative change that would see the test for some benefits go from "reasonable and necessary" to "essential" and proposed changes to the catastrophic impairment benefits. The CSCE would note that many of the recommendations from the Auditor General's 2011 Report have not been addressed and those that have are disproportionately aimed at service providers and accident benefit reductions. Additionally, there is a Statistics Canada report that 61,063 civil cases on issues of accident benefits that are still awaiting hearings in the province's Superior Court.

    Continued unilateral changes to auto insurance regulations that negatively impact auto collision individuals, without the benefit of an appropriate consultation process with major stakeholders, will only increase disputes especially when they have been unjustly terminated. This will undoubtedly put pressure on system costs by making the auto insurance more adversarial, with limited avenues for dispute resolution, short of mediation/arbitration and the courts.

All of the aforementioned issues and expressed concerns only highlight the need for greater collaboration between stakeholders in the development of a balanced system, and the introduction of an independent, expert, peer-reviewed assessment process to reduce disputes and help achieve targeted cost savings. Given the plethora of Legislative, Regulatory and Guideline changes into the auto insurance system since 1994, the CSCE would also support a no-holds barred Auditor General Review of the entire system prior to any further major changes.

Recommendations

The CSCE acknowledges that the goal of any proposed changes to the auto insurance scheme is to balance premium affordability, stakeholder and insurer viability and an auto collision individual's access to timely and appropriate benefits to resolve impairments and disabilities. With this in mind, the CSCE would like to make the following recommendations:

1. **That given the complexity of the Care Pathways and the inappropriate timeframe for stakeholders to provide comment that prior to the implementation of any Care Pathways or Regulatory changes that a more reasonable timeframe be provided for additional Stakeholder written and verbal consultation and submissions.**

2. That all Care Pathways be modified to replace the use of physicians with Advanced Practice Clinicians who have the requisite education, training and experience to address issues when an auto-collision individual fails to respond to care or develops risk factors.

3. That an **independent,** evidenced-based, **peer-review** process that makes use of Advanced Practice Clinicians to address any disputes over medical/rehabilitation, disability and catastrophic impairment benefits be implemented.

4. That these dispute or treatment clarification reviews could be requested and completed at three month intervals starting at week twelve post injury.

5. That any regulated health professional in an Advanced Practice Clinician role be required to have complete familiarity with any implemented Care Pathways or Regulatory changes.

6. That the inclusion of traumatic radiculopathies, WAD III neck pain and associated disorders, and mild traumatic brain injuries not be included as part of the Type I classification but rather as part of the Type II classification.

7. That the phases of recovery be further divided into Recent (0-3 months post-collision), Persistent (4-6 months post-collision) and Chronic (more than 6 months post-collision).

8. That the implementation of Care Pathways serve as clinical practice guidelines and not as rigid protocols which do not allow regulated health professionals to exercise a measure of clinical decision making and patient choice.

9. That the Neck Pain and Associated Disorders (NAD) classification system not be used in conjunction with the new Type I, II, III or established WAD classification systems.

10. That the government introduce a no-holds barred Auditor General Review of the auto insurance system prior to any further major changes.

In conclusion, on behalf of the CSCE, I would like to thank the Financial Services Commission of Ontario (FSCO) and the Ontario Ministry of Finance for the opportunity to respond to the OPTIMa Collaboration's Final Report on "Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person." The CSCE looks forward to further opportunities to provide additional comments prior to any Care Pathway implementation or Regulatory changes. Should the reader have any questions about this submission, the CSCE requests that they be directed to my attention.

Sincerely,

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