Ontario Rehab Alliance

Response to:

Stakeholder Round Table on Catastrophic Impairment
Summary of Proceedings
July 2013

Submitted by:

The Ontario Rehab Alliance
(formerly the Alliance of
Community Medical & Rehabilitation Providers)

September 6, 2013

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The Ontario Rehab Alliance appreciated the opportunity to participate in the Stakeholder Round Table on Catastrophic Impairment on March 15, 2013.

Dr. Doug Salmon, Psychologist and Patricia Howell, Occupational Therapist, who represented the Alliance at the Round Table, have reviewed the Stakeholder Roundtable on Catastrophic Impairment, Summary of Proceedings, dated July 2013. We feel some major points were not captured in this summary, and appreciate this opportunity to have these points included in the appended summary.

PROCESS ISSUES

We note that in section 2.0 the summary states that "Not all groups were able to address all issues and questions in the allotted time. There were limited areas of consensus within and between the tables".

In section 3.0 focusing on participant feedback the summary states: "Most participants reported that they learned something new". It goes on to say that "The negative feedback received was in regards to the amount of time allocated to each segment of the agenda. Groups found it challenging to address all of the issues and specific questions within the available time. Some indicated that they could have spent all day discussing the first two sets of questions. Further, it was reported that it was difficult to find areas of common ground and achieve consensus given the limited time and the broad range of participants and perspectives."

When asked what aspects of this meeting were most productive and/or informative and why, one comment noted that "Persons like Dr. Tator, who has spent 30+ years treating these folks provides for very practical experience & adds to this discussion".

When asked what aspects of this meeting were least productive and/or informative and why, one comment was "Non-medical people weighing in on medical/clinical issues".

Our comments:

We feel the summary should conclude that the goals of the round table were not met (that is, to help clarify major issues related to the definition of catastrophic impairment and promote exploration of potential areas for consensus) because of the following.

<u>Lack of time:</u>

We feel that it is important to note that this round table should be considered as only the first step towards reaching the stated objectives. **We believe that the summary should conclude in regards to the process comments excerpted above that much more time and stakeholder input/discussion should be sought before any changes to the definition are implemented.**

Underrepresentation of appropriately qualified participants to speak to specific clinical issues:

Should it be decided that changes to the CAT definition are indeed required, it is noted that this time of round table is not the forum to develop a consensus regarding what those changes should be, given the professional background of the participants invited to attend. Indeed, the issues being discussed were highly clinical in nature and yet only 10 of the 28 participants were clinicians with the appropriate kinds of credentials and experience required. Four of the 10 were chiropractors with no experience working with seriously injured individuals. Therefore, there were only six participants (one medical doctor, three psychologists and two occupational therapists) of the 28 present who could comment effectively speak to how the proposed changes in the definition would impact those with serious injuries from a clinical perspective.

As a result, the round table was not able to provide clarity regarding such key issues as:

- Whether the new tools are valid, reliable and practical;
- Whether the cut off points or thresholds proposed are too high; and,
- Whether the proposed changes would be fair across all injury groups (e.g. if a person with a spinal cord injury who can live independently and work would qualify while a person with a psychiatric condition or brain injury who is unable to live on their own or work does not).

With regards to the Combination, only three psychologists were present who actually do CAT assessments and could comments on whether or not the methodology exists.

Indeed, this should not have been a forum to educate people. One cannot develop an expert consensus when participants do not have the expertise required in the topics discussed.

We feel that it is important to note that the only way to properly clarify the major issues related to the definition is to bring together medical and rehab professionals with expertise in each of the diagnostic areas (e.g. set up separate round tables or working groups for each impairment/disability e.g. Spinal Cord, Psychiatry, Brain Injury), and provide sufficient time for these groups to develop reasonable recommendations. We note that the Alliance's original submission on this topic recommended exactly that.

Lack of common ground:

Indeed, one point not made in the summary was that would be impossible to get a consensus amongst such a diverse group. For instance, we noted that insurance industry representatives in attendance were very open about wanting to ensure that no one is deemed CAT who should not be, even if that might lead to deserving people going without the needed support, in order to control costs. At the same time, lawyers, med/rehab providers and victim advocacy groups openly stated that they feel that some "false positives" are to be expected in order to ensure those with the most serious injuries are able to qualify. It is again worth reiterating that under the existing system the mere classification of CAT is not sufficient for payment of the benefit, but

rather, there is another "reasonable and necessary test" that needs to be met. Thus, a check-and-balance against false positives is already in place.

We feel that this type of forum may be useful to educate the policy makers about various stakeholder groups' views, and determine if indeed there is a reason for change, but it is not a suitable process for achieving any meaningful degree of consensus on how the definition should be changed.

2.2 COMBINING OF PHYSICAL AND PSYCHIATRIC IMPAIRMENTS

The following key points raised by the participating psychologist who complete CAT assessments, were not captured in the summary:

- **The AMA Guides offer a methodology for combining physical and mental impairments;**
- **The issue is that not all assessors follow that methodology; and,**
- **The solution is not to disallow the combination, but instead to ensure all assessors are trained in, and use the methodology correctly.**

2.3 DEFINITION OF PSYCHIATRIC IMPARIMENT

The following key points raised by medical/rehab providers who assess and treat those with psychiatric and other serious injuries were not captured in the summary:

- **Limitation of the GAF - e.g. better to use for groups vs. individuals.**
- **The cut off point for the GAF chosen by the panel is far too high. Those with a GAF of 50 or less (rather than 40 or less) should be deemed CAT. It is noted that a GAF score of 39-51 is equivalent to a 55% Whole Person Rating. These individuals are just as disabled as a person with paraplegia (if not more).**
- **Other criteria required are also too high - e.g. seeing a psychiatrist at least once per month, when almost no one has access to that level of care given the shortage of psychiatrist in Ontario.**
- **The list of psychiatric disorder as recommended by the Panel does not account for numerous other conditions arising from a traumatic event - e.g. Post-Traumatic Stress Disorder.**
- **Impairments due to pain should be considered in terms of their impact on the individual's psychological and psychiatric functioning.**
- **If the proposed changes were made:**
    - **The number of individuals with severe psychiatric disabilities deemed CAT would fall dramatically, leaving many people in dire need of support without help.**
    - **Those with severe psychiatric disabilities would not have equal and fair access to CAT benefits as compared to other groups (e.g. a person with a severe psychiatric condition who is unable to live independently or work may not qualify for CAT benefits, while an person with a spinal cord injury or amputation who can live independently and work may qualify).**

2.4 DEFINITION OF CATASTROPHIC BRAIN INJURIES

The following key points raised by medical/rehab providers who assess and treat those with brain injuries and other serious injuries were not captured in the summary:

- **The GCS should continue to be used as it is a useful tool to identify those who need intensive and early intervention and support.Within the Roundtable there was general support regarding the role of the GCS score following the MVA for early identification of those with catastrophic impairments due to brain injury. It remains essential to have a means of early identification. GCS is also a widely used tool. Rather than eliminating the GCS or creating a new definition for early identification, methodological requirements should be made clear (e.g., addressing blood alcohol level)."**
- **If the GOSE is used, the proposed cut off point is too high. Those with a MD (upper) at six months should also be deemed CAT. It is noted that this better equates to a 55% Whole Person Impairment Rating than the proposed cut off of MD (lower).These individuals are just as disabled as a person with paraplegia (if not more)**
- **If the proposed changes were made:**
    - **The number of individuals with severe brain injury deemed CAT would fall dramatically, leaving many people in dire need of support without help.**
    - **Those with severe brain injuries would not have equal and fair access to CAT benefits as compared to other groups (e.g.a person with a brain injury who is unable to live independently or work may not qualify for CAT benefits, while an person with a spinal cord injury or amputation who can live independently and work may qualify).**

2.6 OTHER ISSUES

We were glad to see that the summary noted that participants suggested that the Ministry of Finance needs to identify a process for engaging in further consultation around the important issues of paediatric brain injury and the provision of interim benefits.

A final note for the amended summary: Nick Gurevich is listed as a participant, but he did not attend the Round Table. Dr. Doug Salmon came in his place.