Stakeholder Roundtable on Catastrophic Impairment

Summary of Proceedings

Submitted to: Financial Services Commission of Ontario
Date: November, 2013

Table of Contents

1.0 Background and Introduction ... 1
1.1 Roundtable Discussion ... 1
1.2 Participants ... 2
1.3 Meeting Overview ... 2
2.0 Themes Addressed ... 4
2.1 Challenges associated with the current definition of catastrophic impairment ... 4
2.2 Combining of physical and psychiatric impairments ... 5
2.3 Definition of psychiatric impairment ... 5
2.4 Definition of catastrophic brain injuries ... 5
2.5 Definition of catastrophic spinal cord injuries ... 6
2.6 Other Issues ... 6
3.0 Evaluation ... 7
Appendix A: Roundtable Agenda ... 8
Appendix B: Roundtable Participants ... 10
Appendix C: Questions for Roundtable Discussion ... 13
Appendix D: Roundtable Participant Evaluation Results ... 16
Appendix E: Roundtable Participant Responses ... 17

1.0 Background and Introduction

The definition of catastrophic impairment has been a subject of government and stakeholder interest in the auto insurance system in recent years. A review of the definition of catastrophic impairment was recommended in the 2009 Superintendent's Five Year Auto Insurance Review.

In 2010, the government adopted a number of recommendations made by the Superintendent in the 2009 Superintendent's Five Year Auto Insurance Review, including the recommendation to review the definition of catastrophic impairment.

The government directed the Financial Services Commission of Ontario (FSCO) to consult with the medical community regarding the definition of catastrophic impairment. In 2010, the Superintendent struck a panel of medical experts that submitted a report proposing a new approach to the definition based on an assessment of the best available scientific evidence. In 2011, the Superintendent submitted a report to the Minister of Finance with his recommendations to amend the definition of catastrophic impairment based on the work of the Expert Panel and feedback from stakeholders.

In 2012, the government released the Superintendent's report. The Superintendent made recommendations with the objective of making the system more accurate, consistent and fair for seriously injured accident victims. While some stakeholders have raised concerns about some of the recommendations made in the Superintendent's report, the Ministry has also received positive feedback, particularly regarding proposed benefit enhancements.

It is a stated objective of this government to base auto insurance injury compensation on the best available scientific and medical evidence. A key element of this evidence-informed approach is to review and update regulations as required to reflect and ensure consistency with current scientific and medical evidence, helping to ensure that benefits in the auto insurance system are up to date. This is an approach in use elsewhere in the public policy sphere in Ontario, including within the Ministry of Health and Long-term Care.

The government faces important policy decisions on issues such as the definition of catastrophic impairment. These decisions must balance the need to ensure that accident victims receive the treatment they need with the responsibility to keep auto insurance available and affordable for Ontario drivers.

1.1 Roundtable Discussion

The Ministry of Finance held this Roundtable on Catastrophic Impairment to promote discussion of the issues among stakeholders in order to move forward in its review of the definition of catastrophic impairment. The objectives of the roundtable were to bring together stakeholders to help clarify major issues related to the definition of catastrophic impairment and promote exploration of potential areas for consensus through a discussion involving accident victims, consumers, legal professionals, health care professionals and insurers.

The Roundtable discussion focused on three key issues:

- Combining of physical and psychiatric impairments
- The definition of psychiatric impairment

- The definitions of catastrophic brain injuries and spinal cord injuries

This balance of this document provides a summary of the Roundtable proceedings, along with the key issues raised and consensus achieved.

The agenda for the Stakeholder Roundtable can be found in Appendix A.

1.2 Participants

Twenty-eight individuals participated in the Roundtable discussions. Participants were assigned to one of three tables for the small group discussions to allow for a more in-depth discussion and to provide an opportunity for all voices to be heard.

Organizations attending the Roundtable included:

- Advocates' Society
- Alliance of Community Medical and Rehabilitation Providers
- Association of Independent Assessment Centres (AIAC)
- Canadian Association of Direct Relationship Insurers (CADRI)
- Canadian Society of Chiropractic Evaluators (CSCE)
- Coalition Representing Regulated Health Professionals in Automobile Insurance Reform
- Fair Association of Victims for Accident Insurance Reform (FAIR)
- Insurance Bureau of Canada (IBC)
- Ontario Bar Association
- Ontario Brain Injury Association (OBIA)
- Ontario Psychological Association (OPA)
- Ontario Trial Lawyers Association (OTLA)
- Spinal Cord Injury Solutions

Table assignments were made in advance in an attempt to achieve the best possible balance and diversity of views and interests at each table. A complete list of participants is found in Appendix B.

1.3 Meeting Overview

The meeting opened with an introduction from Patrick Deutscher, Assistant Deputy Minister and Chief Economist, Office of Economic Policy in the Ministry of Finance. Mr. Deutscher provided an overview of the key issues surrounding the catastrophic impairment definition, the background work that had been completed by the Ministry of Finance and FSCO and the issues still to be resolved.

The brief introductory remarks were followed by a presentation by Dr. Pierre Côté, the Chair of the Catastrophic Impairment Expert Panel. Dr. Côté's remarks outlined the panel's terms of reference, guiding principles and methodology for reviewing the current definition and improving

the accuracy and fairness of the determination. The Expert Panel's report was reviewed along with the outstanding challenges to be resolved.

Justin Peffer, Manager of the Economic Analysis and Evaluation Unit in the Ministry of Health and Long-Term Care (MOHLTC) made a presentation on evidence-based decision making in the health sector. He outlined the Ministry's relationship with the research and evidence generation community and the role that evidence plays in health policy development. He also outlined some of the issues and challenges associated with relying on the best available evidence in a dynamic environment of ongoing change.

Following the brief presentations, the participants convened in their small groups to discuss a number of issues and specific questions. A complete list of questions can be found in Appendix C.

2.0 Themes Addressed

Discussion during the meeting focused around 6 key themes. Robust and thoughtful discussion took place at each of the three tables. 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.

Each of the areas of discussion is summarized below:

2.1 Challenges associated with the current definition of catastrophic impairment

- Many participants agreed that the current definition lacks clarity for some types of injuries or impairments. Many felt that a new definition is needed; one that is not subject to change from its initial intent.
    - This view was not universal and it was suggested that there is a lack of data available to provide a full perspective of the extent to which the definition needs to be revised (e.g., how many people are identified as CAT, statistics to demonstrate under what section of the current definition claimants have qualified, etc.).
        - For example, many cases are clearly CAT, while many are not. It is the cases at the margins of the definition that are the focus of this discussion and it is not known how many “grey area” cases exist. Some participants noted that the definition is becoming clearer as a result of various court decisions.
        - It was suggested by some participants that there is a need to have a better understanding of how significant the problem with the current definition actually is.
    - It was suggested that, perhaps as a result of a lack of clarity around the definition, there are many “questionable” CAT assessments, which leads to the need for a more universally applied definition. On this point, many agreed with the Panel; there is a lack of training and qualification to conduct assessments.
- None disagreed that it is important to ensure that any new system does not disenfranchise claimants. It was suggested that some recommendations around the definition do not include analysis of who would “miss out” on benefits, if implemented.
- It was agreed by all that no “bright line” exists to define CAT impairment versus non-CAT impairment for some types of injuries or impairments. This leads to numerous disputes and money spent, lack of appropriate care and treatment, etc.
    - Given the challenges posed by this binary categorization of impairments (i.e., catastrophic vs. non-catastrophic), it was suggested by some that a more nuanced definition be created.
    - There was a shared acknowledgement that accident benefits should support the recovery of seriously injured and catastrophically impaired claimants.
- It was identified that the current situation is a legal versus medical definition.

2.2 Combining of physical and psychiatric impairments

- There was considerable discussion of this point in all three groups; however, there was no consensus regarding:
    - Appropriateness of combining physical and psychiatric impairments: some supported combining, others did not support combining without a reliable, medical evidence-based approach to doing so.
    - How best to combine
        - Some agreed if it can't be done properly, it should not be done
        - Some agreed it should be done irrespective
- Many participants did agree that there should be a "whole person impairment" (physical and psychiatric impairment considered together) assessment available for catastrophic impairment.
- There was agreement that further research should be conducted. However, groups were unable to reach consensus regarding how to proceed in the interim; i.e., whether combining physical and psychiatric impairments should be allowed or excluded while research is conducted. It was agreed that, to the extent possible, science and data should inform tools and procedures.
- Concern was expressed by some that tools must not allow for false positive and/or false negative outcomes.

2.3 Definition of psychiatric impairment

- Many attendees felt that some of the existing tools (e.g., Global Assessment of Functioning or GAF scale) are not up to date.
- There was also some support for the notion that using an updated list of criteria to make the definition more reliable is positive but concerns were raised about the details of the criteria proposed.
- Concern was raised regarding inconsistent evaluations of psychological impairment. Consistency of application becomes more challenging when flexibility is a principle that is valued.
- Some participants raised concerns regarding:
    - recommendations regarding mental behavioural disorders
    - replacing current definition with new recommendations

2.4 Definition of catastrophic brain injuries

- Some participants raised issues with timing and threshold of tests for brain injury.
- While there was much discussion, groups did not reach consensus on use of the Glasgow Coma Scale (GCS). Some supported its use, while others were clear that if the GCS was to be used in determining catastrophic brain injuries the legal language needs to be clarified.

- Some expressed concern regarding the Expert Panel's proposal to determine CAT eligibility for certain injuries or impairments partly based on hospital or institutionalized care, given the unequal access to hospital-based resources across Ontario. This is further hampered by the limited number of trauma centers, which creates accessibility issues for rural claimants in Ontario. Others noted that the Superintendent's report responded to this concern, and did not recommend hospitalization or institutionalized as an eligibility criterion.
- Concern was raised regarding the inability to re-assess claimants determined to be eligible for catastrophic impairment benefits at a later stage in the process when recovery may have occurred.

2.5 Definition of catastrophic spinal cord injuries

- There was limited discussion of this issue at the three tables. This was primarily related to the intense interest in the preceding issues, as well as a perception by some that this issue is less problematic than the others.
- It was identified that there are few regulated health professionals educated in the assessment methodology and that the interpretation could be problematic.
- Some participants expressed support for the use of international standards in determining whether or not certain American Spinal Injury Association (ASIA) categories of spinal cord injuries should be considered catastrophic.

2.6 Other Issues

A number of other issues were raised throughout the day, including:

- Addressing paediatric brain injury
- Provision of interim benefits

Participants wished for the Ministry of Finance to recognize these additional issues and identify a process for engaging in further consultation.

3.0 Evaluation

At the end of the Stakeholder Roundtable participants were asked to complete a brief evaluation of the session.

Evaluation results were generally positive, particularly with respect to the small-group discussions and afternoon plenary. Participants reported that they were pleased to have attended and felt that their time was well-used. Most participants reported that they learned something new and enjoyed meeting and interacting with others who are interested in these issues.

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 set 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.

Participants reacted positively to the Stakeholder Roundtable format, appreciated the diversity of participants, the wide range of viewpoints conveyed and expressed support for further consultations using a similar methodology in the future. Participants confirmed a willingness to further engage with the Ministry and each other on these important issues.

A more detailed summary of the evaluation results is contained in Appendix D.

Appendix A:
Roundtable Agenda

STAKEHOLDER ROUNDTABLE ON CATASTROPHIC IMPAIRMENT

March 15, 2013
9:00 a.m. – 2:30 p.m.
Niagara Room, Macdonald Block
900 Bay Street, Toronto

AGENDA

Time	Item
9:00 – 9:20	**Registration – Coffee provided**
9:20 – 9:30	**Introduction** Patrick Deutscher, ADM and Chief Economist, Office of Economic Policy, MOF
9:30 – 9:50	**Approach taken by the Catastrophic Impairment Expert Panel** Dr. Pierre Cote, Chair of the Catastrophic Impairment Expert Panel
9:50 – 10:10	**Evidence-based approaches in the Ministry of Health and Long-term Care** Justin Peffer, Manager, Economic Analysis and Evaluation Unit, MOHLTC
10:10 – 10:30	**Break**
10:30 – 12:00	*Roundtable participants will be split into small groups to discuss key issues regarding the Superintendent's Report on the Definition of Catastrophic Impairment. Groups will be asked to outline their positions on these issues and discuss with other table members in order to explore any common ideas or possible consensus of views.* *Rob Crawford and Denley McIntosh, Roundtable Facilitators, will monitor discussions and ask for updates or discussion of a different topic based on the progress made by the groups.* **Discussion of key issues** **1. Combining of physical and psychiatric impairments** **2. Definition of psychiatric impairment**
12:00 – 12:30	**Working Lunch**
12:30 – 1:15	**Continued discussion of key issues** **3. Definitions of catastrophic brain injuries and spinal cord injuries**
1:15 – 2:15	**Report back from tables on key issues and conclusions**
2:15 – 2:30	**Concluding remarks** Rob Crawford, Roundtable Facilitator

Appendix B:
Roundtable Participants

The following individuals attended the March 15 Roundtable discussion. The table below provides the name of each participant and the organization represented.

Name	Organization
Peter Athanasopoulos	Spinal Cord Injury Ontario
Joanne Davis	Canadian Association of Direct Relationship Insurers (CADRI) – CAA
James Daw	Consumer Representative
Rhona DesRoches	Fair Association of Victims for Accident Insurance Reform (FAIR)
Dr. David Dos Santos	Canadian Society of Chiropractic Evaluators (CSCE)
Tracey Glionna	Association of Independent Assessment Centres (AIAC)
Dr. Doug Salmon	Alliance of Community Medical and Rehabilitation Providers
Dr. Rocco Guerriero	Association of Independent Assessment Centres (AIAC)
Elizabeth Hall	Ontario Bar Association
Paul Harte	Ontario Trial Lawyers Association (OTLA)
Patricia Howell	Alliance of Community Medical and Rehabilitation Providers
Judith Hull	Advocates' Society
Dr. Faith Kaplan	Ontario Psychological Association (OPA)
Tammy Kirkwood	Fair Association of Victims for Accident Insurance Reform (FAIR)
Dr. Brian Levitt	Ontario Psychological Association (OPA)
Bill McClelland	Canadian Association of Direct Relationship Insurers (CADRI) – TD
Andrew McCormick	Canadian Association of Direct Relationship Insurers (CADRI) – State Farm
Ralph Palumbo	Insurance Bureau of Canada (IBC)
Dr. Moez Rajwani	Coalition Representing Regulated Health Professionals in Automobile Insurance Reform
Karen Rucas	Coalition Representing Regulated Health Professionals in Automobile Insurance Reform
Lee Samis	Insurance Bureau of Canada (IBC)
Dr. Doug Salmon	Alliance of Community Medical and Rehabilitation Providers
Phillipa Samworth	The Advocates' Society
Dr. Carlan Stants	Canadian Society of Chiropractic Evaluators (CSCE)
Barb Sulzenko-Laurie	Insurance Bureau of Canada (IBC)

Name	Organization
Dr. Charles Tator	Spinal Cord Injury Solutions
Adam Wagman	Ontario Trial Lawyers Association (OTLA)
Ruth Wilcock	Ontario Brain Injury Association (OBIA)

Appendix C:
Questions for Roundtable Discussion

QUESTIONS FOR DISCUSSION

General introduction questions

- From your perspective, what are the challenges associated with the current definition of catastrophic impairment?
- From your perspective, what are the positive aspects of the current definition of catastrophic impairment?
- What are the principles that should form the basis for any changes to the definition of catastrophic impairment? (Examples include: scientifically valid and evidence-based, consistency and fairness; widely accepted by practitioners using the methodology.)

Combining of physical and psychiatric impairments

- Should physical and psychiatric impairments be combined when determining catastrophic impairment?
- Keeping in mind the government's stated direction to rely on an evidence-based approach to determining funding for health treatment/services, is there a valid, reliable scientific method available for combining physical and psychiatric impairments?

Definition of psychiatric impairment

No single assessment tool exists to measure psychiatric impairment. To overcome this gap in medical evidence, it is being proposed that a combination of requirements be used to determine psychiatric impairment, including the use of the Global Assessment of Functioning (GAF) scale to measure impairment.

- From your perspective, what are the positive aspects of this proposal to update the definition of psychiatric impairment?
- From your perspective, what are the challenges associated with this proposal to update the definition of psychiatric impairment?

Definition of catastrophic brain injuries

It is being proposed that the Extended Glasgow Outcome Scale (GOS-E) replace the Glasgow Coma Scale (GCS) as the primary measurement tool to assist in the determination of catastrophic brain injury.

- From your perspective, what are the positive aspects of this proposal?
- From your perspective, what are the challenges associated with this proposal?

Definition of catastrophic spinal cord injuries

To incorporate current scientific knowledge about the classification of spinal cord injuries, it is being proposed that the definition of paraplegia and quadriplegia be updated to through the introduction of the American Spinal Injury Association (ASIA) scale as a measurement tool.

- From your perspective, what are the positive aspects of this proposal?
- From your perspective, what are the challenges associated with this proposal?

General closing question

Is there another priority issue that you would like to identify and make recommendations about to the government regarding the potential update to the definition of catastrophic impairment?

Appendix D:
Roundtable Participant Evaluation Results

Catastrophic Impairment Stakeholder Roundtable

Workshop Evaluation Results

March 17, 2013

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Overview of findings

- Evaluation results were generally positive
  - Participants were pleased to have attended, felt that their time was well-used
  - Most participants reported that they learned something new
  - Positive feedback re: small-group discussions and afternoon plenary
  - Overall rating on the day was favourable

"I have never understood this until you just explained it to me."

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Overview (2)

- Negative feedback regarding the amount of time allocated to each segment of the agenda
  - Groups found it challenging to address all four issues and specific questions
  - Some said that they could have spent all day discussing the first two set of questions
  - Difficult to achieve consensus given the limited time and range of participants
- Some felt that the MOHLTC presentation was not relevant to the discussion; added little value

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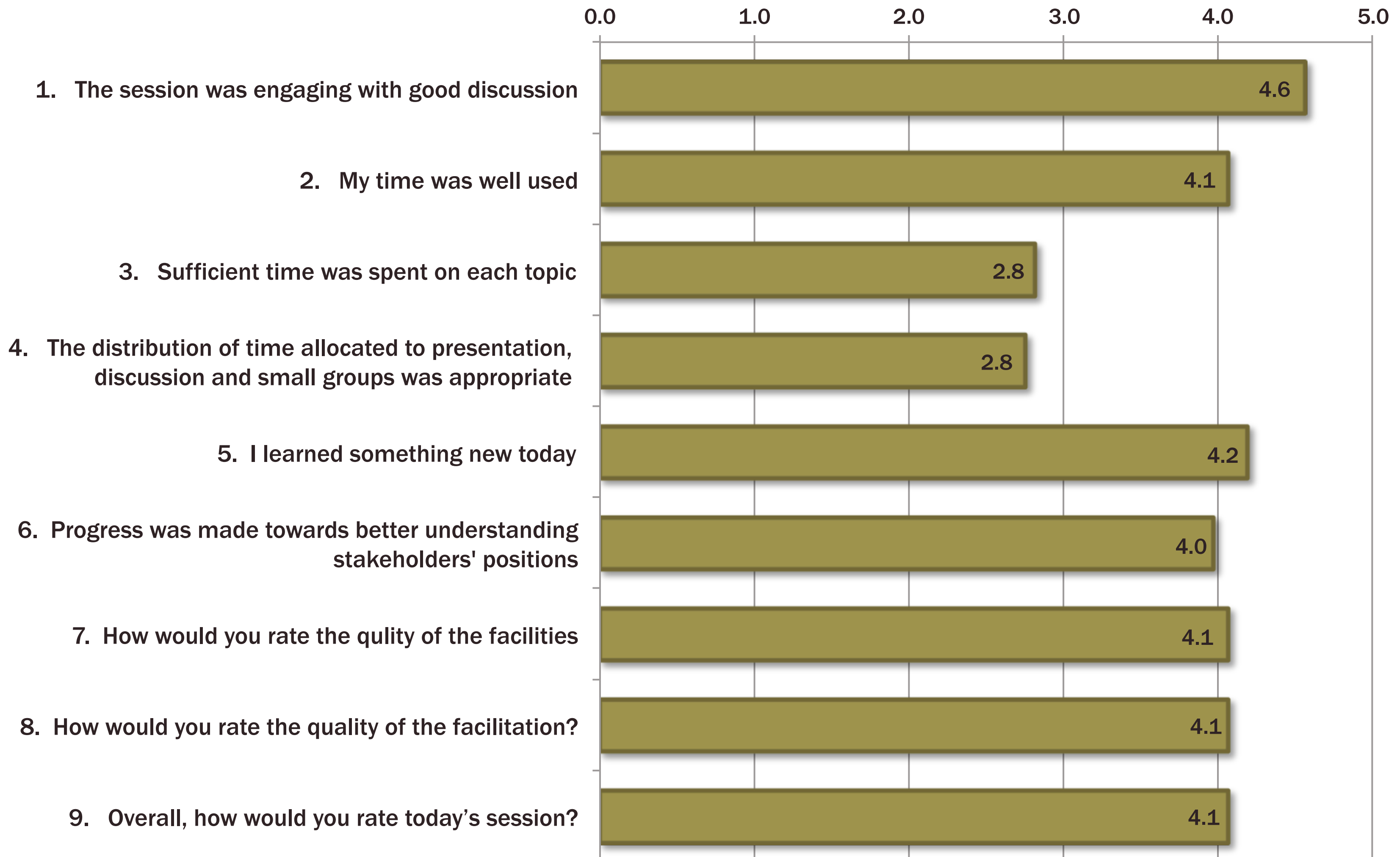
Evaluation results



n=16

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Written responses to evaluation questions

Verbatim transcription of written responses

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What aspects of this meeting were most productive and/or informative? Why?

- Hearing different perspectives
- Persons like Dr. Tator, who has spent 30+ years treating these folks provides for very practical experience & adds to this discussion
- Multi-stakeholder communication was helpful in understanding all the relevant issues.
- Good discussion in small groups and final outcomes
- End discussion involving all 3 groups - different views
- Rob's facilitation & outreach was excellent.
- Learning from the individual health-care practitioners and assessors regarding what they needed was good. Clarity is important but flexibility to meet purposes of the SABS (appropriate compensation) was both possible & desirable.
- Engaging with different stakeholders; hearing new perspectives that I had not considered.
- Interesting to hear information from people with differing expertise.
- Hearing different interest groups try to reach agreement.

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What aspects of this meeting least productive and/or informative? Why?

- Not sure if outcomes were achieved
- I think that facilitators should be professionals who are very familiar with the medical term, tests, etc. That helps to facilitate conversation + consensus
- Overhead presentation was a waste of time; detracted from process
- MOHLTC presentation was not relevant
- Understandable bias of some stakeholders delayed discussions; hard for facilitator to control
- Difficult to gain consensus and make informed input given the time
- Non-medical people weighing in on medical/clinical issues. Did not look at system as a whole e.g., gaps in service; reason for change; what are major problems with the system - is it even CAT?
  - re: goals of the day -- it was not possible for us to reach a consensus on any specific CAT definition within this format given the variety of backgrounds (lawyer, insurance vs. clinicians). I feel this forum showed we need to study this further before making changes

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Appendix E:
Roundtable Participant Responses

The Ministry of Finance received three responses to the draft proceedings that were distributed to participants of the March roundtable.

These submissions are attached in the pages that follow.

Response to:

The Stakeholder Roundtable on Catastrophic Impairment, Summary of Proceedings (dated July 2013)

Submitted by:

FAIR

Fair Association of Victims for Accident Insurance Reform
579A Lakeshore Rd. E, P.O. Box 39522
Mississauga, ON, L5G 4S6
http://www.fairassociation.ca/

September 5, 2013

FAIR Association of Victims for Accident Insurance Reform appreciates the opportunity to participate in the roundtable discussions about the proposed changes to CAT definition. FAIR contributed from the perspective of an end-user and to represent the views of those most affected by the changes recommended, Ontario`s accident victims.

The Superintendent's report was to have been prepared "***with the objective of making the system more accurate, consistent and fair for seriously injured accident victims"***. Earlier stakeholder reactions to the Panel report were not supportive of many of the recommendations. FAIR agrees that implementing the proposed changes, as they are here, would make circumstances much worse for Ontario's most injured accident victims but would increase profits for Ontario's insurers.

FAIR did make an earlier submission with concerns about the original 8 member panel which we felt was not fairly chosen or large enough to include enough qualified members of the medical community or other stakeholders. We questioned the ability of that panel when reports surfaced that two of the eight members did not find that an MVA victim who was either quadriplegic or paraplegic should be classified as 'catastrophic'. FAIR indicated then, as we do now, that if changes are necessary, and we are not convinced that radical change is required, that a new panel should be struck and that these present recommendations should be thrown away.

1.1 Roundtable Discussion and 1.2 Participants

We were very disappointed to find that there were so few qualified physicians present at the roundtable. In fact there was only one medical doctor among all participants with experience treating and assessing catastrophically injured accident victims. Like the CAT Panel before this roundtable, there was a lack of qualifications at a serious discussion about important policy decisions that affect over nine million drivers.

We found the discussions to be informative but the lack of qualified information provided less value than anticipated and likely added little to the original flawed recommendations. There was agreement that the recommendations were unworkable as presented and that these changes would unfairly punish accident victims. Specifically that the number of MVA victims that would qualify for benefits would be greatly reduced and many who would need assistance would no longer be eligible.

2.1 Challenges associated with the current definition of catastrophic impairment

There is a disparity in the way various participants described how they currently apply the test of disability. Most would welcome clarity of existing tests and Ontario's MVA victims would welcome standardization and real oversight of IME providers that would eliminate bogus IME reports from the system. The extent of the poor quality medical evaluations used at hearings is unacceptable - injured individuals need to rely on quality IMEs if they are to be used to decide whether or not they qualify for treatment and benefits.

2.2 Combining of physical and psychiatric impairments

FAIR could not speak to the medical issues of the combining of these impairments but our members have strong views about the outcome for them if they are to live with disabling pain. It was shockingly obvious that there are very few qualified CAT assessors in the system right now and relevant training needs to take place.

There are significant ongoing issues with the quality of Ontario's IME providers and the prevalence of poor quality reports in the system has caused a dysfunctional court system. The volume of worthless medical opinions that are harming accident victims and standing in the way of timely treatment is staggering. Accident victims, whose claims are deflated in the process, are awaiting hearings that are now years away and their rehabilitation benefits may have been denied or stalled. There is a lack of solid guidelines for assessors to follow, leading to unqualified or poor quality assessments by vendors who are unsure of the rules and expectations.

There was a further discussion that the exclusion of pain and the failure to address and treat those with pain may well be a constitutional issue.

2.3 Definition of psychiatric impairment

There was clear indication that many participants felt that the Superintendent's recommendations produced a threshold and range of criteria that would be impossible to meet, especially for those in rural areas. It was felt that many of those with pain and serious psychiatric disorders would be left behind if the proposed changes are to be implemented. It was felt that now, before any changes, there are inadequate resources for accident victims and the changed definition would make that situation worse.

There is no consistency in evaluations and genuine concerns about uneven testing. Many accident victims who should be able to access benefits have been denied due to the lack of understanding of testing protocols administered by assessors. These are issues that do need to be addressed now rather than later.

2.4 Definition of catastrophic brain injuries and spinal cord injuries

It was felt overall that there is a real need to have a clearer set of guidelines with clarity of method. There was a need to track children who suffer catastrophic brain injuries and that many of the recommended tests are not fully validated. While FAIR is not qualified to give an opinion on the types of testing protocols it doesn't require expertise to see that the medical professionals who were in attendance were dissatisfied with the recommendations.

Conclusion

FAIR, whose members are the end users or recipients of the treatment funding and testing discussed in the proposal, view these proposals as not in the interests of accident victims. The

changes are a cash saving manoeuvre by Ontario's insurers who stand to pay significantly less rehabilitation dollars to accident victims.

The proposal includes paying seriously injured accident victims $50,000 and requiring that if they do eventually qualify under some new guidelines, that they request more funds from their insurer. We cannot stress enough the value of timely treatment and that cutting off funds to those most significantly injured will have a negative impact on MVA victims and a positive impact on insurer profits. By raising the threshold for qualifying for more than $50,000 in treatment so high, Ontario's insurers will guarantee that those who most need it will spend many years in litigation before getting the resources for care that they need. By then many of the windows for recovery will be lost in the wait for coverage and is a disservice to our most vulnerable citizens. The proposal that an accident victim 'request' additional rehabilitation dollars once they are declared Catastrophic is to ignore that the only thing that works fast in our insurance system is the denial of claims.

Overall there was not enough time allotted to discuss all the issues in depth and we see that no further discussions have been scheduled. We hope it is an indicator that the government has been listening to past stakeholder submissions on this issue and will not advance insurer interests and profits by implementing these flawed recommendations. It would be irresponsible to the taxpayer who must shoulder the costs of care when Ontario's insurers decline to do so. These CAT recommendations were clearly prepared as another cost cutting measure for insurers and are a sure way of downloading costs to the taxpayer via social and medical programs. Our government should be looking to protect the interests of Ontarians and not to ensuring higher profits of insurers on the backs of our most injured citizens.

Given that ***"The goal of this review should be to ensure that the most seriously injured victims are treated fairly"*** then the FSCO must acknowledge that this has not been accomplished with a Panel that lacked the expertise necessary to arrive at a fair definition. No matter how cooperative and interactive the roundtable participants were, it cannot undo the flaws of the original Panel conclusions or the harm it will do to accident victims.

The confusion demonstrated by the FSCO CAT Panel in dealing with this new catastrophic definition should be reason enough to go back to the consultation process. FSCO needs to better accommodate those most severely injured by removing the obstacles to recovery rather than creating new ones.

FAIR Association of Victims for Accident Insurance Reform

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
www.ontariorehaballiance.com

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.

Review of the Stakeholder Roundtable on Catastrophic Impairment Summary of Proceedings

Ontario Psychological Association

Dr. Faith Kaplan and Dr. Brian Levitt represented the Ontario Psychological Association at the Stakeholder Roundtable on Catastrophic Impairment. We are responding only to the Summary of Proceedings from the Stakeholder Roundtable, and we will be submitting further recommendations separately to the government regarding Catastrophic Impairment.

2.1 Challenges associated with the current definition of catastrophic impairment

It was recognized at the Roundtable that sufficient data are not available to determine the extent to which any substantive changes need to be made to the current CAT definition. Any problems identified (including false negatives and false positives) may be related more to lack of consistent utilization of appropriate experts and methodology, rather than to problems with the definitions themselves.

Rather than creating new definitions, we support the promotion of a sound method for CAT assessment. Use of a consistent and robust method is a more scientifically sound approach to address concerns regarding the reliability of Catastrophic impairment assessments. This is an essential foundational step prior to considering any substantive changes to definitions.

Specific direction regarding methodology could be incorporated into the current SABS criteria, or addressed in a separate guideline.

2.2 Combining of Physical and Psychiatric Impairments

There was agreement at the Roundtable that combining impairments **should** be done. Combining **can** be done properly (see Levitt, 2010). Failure to include impairment ratings due to mental and behavioral disorders in an overall whole person impairment rating discriminates against those with mental and behavioral disorders.

Many at the Roundtable acknowledged that they understood, only for the first time, the highly conservative nature of the combining rules in the Guides, including discounting and prohibition of "double counting," which result in underestimates of the true burden of co-morbid impairments of all kinds. There had previously been a false impression that patients with only minor physical impairments and minor impairments due to mental and behavioural disorders would have a combined whole person impairment rating that would easily meet the 55% threshold.

The AMA Guides instruct that where ratings are not offered for disorders, clinicians rate by analogy elsewhere in the Guides. Chapter 4 (Nervous System) offers a rating table

(Table 3) that relates directly to Chapter 14 (Mental and Behavioral Disorders), and assessors can rate by analogy by using this table once they have done a complete Chapter 14 impairment analysis. As with combining other impairments using the Guides, assessors must always consider whether impairment ratings overlap and result in inflated ratings, and in these cases not combine but choose the higher rating to represent the impairment.

2.3 Definition of Psychiatric Impairment

Roundtable participants expressed increased awareness that Chapter 14 of the AMA Guides, 4th edition offers a robust method for conducting assessments and rating impairments due to mental and behavioural disorders. It details a clear scientific approach that can improve reliability of impairment findings if simply adhered to by all assessors, it continues to be relevant for Catastrophic Impairment determination.

In contrast, the use of indicia are not universally applicable due to variability in patients seeking out treatment services for reasons related to stigma of mental illness, and family and cultural issues. Therefore, using indicia to determine catastrophic impairment status is clinically and scientifically unsound.

There was significant agreement at the Roundtable that the GAF should not be used as part of the criteria. We also note that the GAF is no longer endorsed by the American Psychiatric Assessment in DSM-5:

> *"It was recommended that the GAF be dropped from DSM-5 for several reasons, including its conceptual lack of clarity (i.e., including symptoms, suicide risk and disabilities in its descriptors) and questionable psychometrics in routine practice."*

The participants did not have sufficient time to discuss the equivalence of a marked impairment due to a mental or behavioural disorder to physical impairments (such as the loss of an arm, WPI = 60%) that significantly impede useful functioning. Therefore, it is inappropriate to require more than one marked impairment due to mental or behavioural disorder, as this would **preclude** useful functioning and would be discriminatory in comparison to requirements regarding physical impairment levels.

2.4 Definition of Catastrophic Brain Injuries

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, yet no alternative for early identification was proposed by the expert panel. 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).

There was insufficient time to discuss the implications of replacing the GOS with the GOSE.