May 15, 2009

The Honourable Dwight Duncan
Minister of Finance
7 Queen's Park Circle, 7th Floor
Toronto, Ontario
M7A 1Y7

Dear Minister Duncan,

The Ontario Society of Occupational Therapists appreciates the opportunity to provide comment on the Financial Services Commission of Ontario's *Report on the Five Year Review of Automobile Insurance, March 31, 2009.*

The Society represents over 3000 occupational therapists working across the province of Ontario. Over 500 of our members work in Ontario's auto insurance system. The Society is pleased to pledge support to work with government to achieve the Review's goals of *improving the effectiveness and administration of the automobile insurance product* because our members experience, on the front line, the importance of an efficient, affordable and effective accident benefits system that addresses the needs of Ontarians injured in motor vehicle accidents.

While we believe that FSCO has identified many valuable recommendations for consideration, we urge your thoughtful review of the inter-related impacts of many of these recommendations on a "system". We express significant concern that some recommendations targeted to address specific problems within the system have the effect of creating new problems. Most significantly, we are concerned that individuals who are seriously injured will suffer significant limitations to needed services that enable them to rebuild their lives after injury. In addition, sweeping recommendations intended to limit abuse of assessments within the system may have the unintended impact of limiting or preventing access of insurance claimants to important rehabilitation treatment such as occupational therapy.

We hope that our responses to the FSCO recommendations and the insights shared by occupational therapists working in the sector will enrich your review of options to improve Ontario's automobile insurance system.

Sincerely,

Christie Brenchley
Executive Director

Ontario Society of
Occupational Therapists

Response to the
Financial Services Commission of Ontario
Five Year Review of Automobile Insurance

May 2009

PREAMBLE

The Ontario Society of Occupational Therapists (OSOT) appreciates the opportunity to participate in the government's consultation on the Financial Services Commission of Ontario's (FSCO) *Report on the Five Year Review of Automobile Insurance, March 31, 2009*. The Society represents over 3000 occupational therapists living and working in Ontario. Over 500 occupational therapists report working in Ontario's auto insurance system. Our members working in the auto insurance sector have assisted us to comment on the proposed recommendations. As front line health care professionals, working across the province, they lend insight "from the trenches" and have shared frankly the challenges they see, the experiences of their clients and their recommendations for change.

Occupational therapists (OTs) are regulated health professionals whose scope of practice is focused on the promotion of function and adaptation after injury or illness in order to enable an individual's resumption of their day to day life occupations or activities of daily living. Occupational therapists work with clients across the continuum of acute injury management, rehabilitation, community reintegration and return to work with a background in both physical dysfunction and disability and mental health. The unique attention to life roles and the interplay of physical function, cognition and mental health as they relate to an individual's capacity to "get on with the job of living" after an injury places the OT's focus of treatment in congruent alignment with the goals of the accident benefits system.

In Ontario's auto insurance system, occupational therapists *assess and treat* clients with the goal of restoring function through remediation, adaptation, and environmental modification.

- Occupational therapists identify a person's residual abilities and assist clients to find ways to accomplish their life skills, to reduce their dependence on benefits and to return to work.

- Occupational therapists assess in relation to a claimant's need for benefits, including attendant care, housekeeping, caregiving.

- Occupational therapists provide direct treatment to improve a claimant's impairment. Physical, cognitive, and sensory motor therapies are aimed at remediating the problem and restoring the individual's ability to function.

- Occupational therapists introduce and teach compensatory strategies and use of assistive devices including mobility devices such as wheelchairs and walkers.

- Occupational therapists counsel around adjustment to disability, be it physical,

cognitive and/or emotional.

- Occupational therapists work to enable a person's functional capacity in all their living environments, including home, work and school

Occupational therapists are intrinsically involved in Ontario's auto insurance sector, working with clients whose injuries disrupt their ability to manage the day to day skills required to manage their pre-accident life roles and activities. The ability to work in a system that assists people to rebuild lives is meaningful and gives cause for OTs to offer support and input to the challenge of preserving Ontario's auto insurance system for now and into the future.

GENERAL COMMENTS

The Financial Services Commission of Ontario (FSCO) has conducted a review of Ontario's auto insurance system that, as may be expected in a report that was commissioned to make recommendations to *improve the effectiveness and administration of the automobile insurance system* for improvement in the system, has focused on the problems, inadequacies and abuse within the system. What is missing are the reflections of the accomplishments and successes that need to be considered in balance. There is no mention of the resourcefulness of the system for many claimants who quickly accessed necessary rehabilitation, got better and got on with their life. There is no mention of the individuals with spinal cord injuries whose lives, as they moved from hospital to home, readjusting to life roles and challenges were supported by a system that assured funding for necessary equipment, home modifications, treatment, and other benefits. There is no mention of the young mother who was able to focus on her rehabilitation without worry about the care of her children because she was able to access a caregiving benefit. There is no mention of the experienced, competent and ethical health care providers that are the vast majority of providers who treat and support injured individuals during a very traumatic time of their life, nor of the client-focused adjusters who go the extra mile to be fair. While we forgive the problem-focused report, we regret the sweeping negativism that it imparts and urge government to look critically at both the strengths and the weaknesses of the system.

Amongst the many challenges and problems identified in the system, OTs would concur most emphatically with the assertion that the current system is overly complex and that this complexity adds costs to the system. Many of the other important statements about the system, including the insurance industry's mounting financial crisis, the escalating costs of unrestrained assessments in the system or the fact that while rehabilitation costs are growing the duration of disability is also growing, are more difficult to fully embrace because the report provides little substantive data to both validate and quantify these claims.

Occupational therapists wish to be on record as supporting change required to ensure the timely and efficient delivery of effective rehabilitation; however, the lack of data made

available to stakeholders to clearly identify where the problems or excesses actually occur makes it difficult to comment on whether the proposed changes will truly "fix" the system. In a complex system with competing interests, it is particularly difficult to label problems without good objective data. FSCO has recommended sweeping changes to control assessment costs and abuse. We presume this is because there is good, objective, quantifiable evidence that assessment costs are out of control and that there is clear evidence of abuse versus anecdotal information from stakeholders. As a profession, however, we have not been privy to this evidence. We are committed to being part of the solution but are not even certain that we are a big part of the problem. Further, we would position that without baseline data available to all stakeholders, it will remain problematic to determine when or if successful outcomes are achieved if any or all of the recommendations are implemented.

To this end, OSOT requests that data from the Insurance Bureau of Canada be made available to provide a breakdown of costs relating to "uncomplicated injuries" in comparison to those relating to "serious injuries" (excluding catastrophic injuries). Such a comparison should be presented under each of the following categories:

- Costs for Section 24 assessments
- Costs for Sections 14, Medical Benefits
- Costs for Section 15, Rehabilitation Benefits
- Costs for Section 42 Insurers' Examination Assessment
- Data surrounding the usage of the PAF
- Compare "assessment" costs in 2005, at the end of the DAC system (DAC + Insurer Examinations) and post DACs in 2007 (only Insurer Examinations).

OSOT'S REVIEW OF KEY FSCO RECOMMENDATIONS

I. Tort/Accident Benefits Balance

FSCO Recommendation #31:
The government should consider reducing the deductibles to $20,000 and $10,000, eliminating the deductibles for fatal claims, and revoking the definition of serious and permanent impairment set out in Regulation 461/96. A closed claim study would assist in determining the impact of further tort changes being considered.

OSOT members believe that a component of the system's complexity and a significant cost to the system is the parallel existence of both the right to sue for bodily injury (for those innocent victims of MVAs) and the right to universal benefits for all injured victims as defined under the *Statutory Accident Benefits Schedule.* Occupational therapists, as health

care professionals acutely focused on a client's ability to function in their day to day tasks and return to work or former occupations, experience first hand the competing interests and resulting costs of the AB and BI components of the system as their assessment and opinion is often sought regarding benefit entitlement. Access to benefits is a process fraught with potential influence and bias.
OSOT members observe the challenging response of insurers to legally driven assessment of benefit entitlement and vice versa – situations that result in redundant assessment, delay in treatment and angst for legitimate claimants. The "dueling" nature of the tort and AB perspectives can leave the claimant a pawn in a world of assessment.

It is our opinion that in order to truly reduce costs in the system, a more neutral system is required. While some of FSCO's recommendations begin to address this issue we would position that the reduction in the deductible to sue and the elimination of the verbal threshold, coupled with a proposed reduction in the accident benefit cap to $25,000 will drive more consumers to the courts. It is our perception that this will only serve to increase the volume of claims for which lawyers and SABS representatives are involved in the assessment process.

The proposed increased access to tort is proposed alongside a recommendation to reduce the accident benefit cap, presumably in an effort to assure consumers that they will have access to tort to make up for the shortfalls in their reduced accident benefits and at the same time assure insurers that their benefit cap will assure cost savings. We question whether this will truly work in the best interest of either the consumer or the insurer. While it may create a short term reduction in claim expense, we query whether this will be sustainable over the long term. We worry, for example, that with a $25,000 benefit entitlement, seriously injured individuals will need to take advantage of the court system to access funds required to support their rehabilitation and long term support needs. This reality is doubly concerning when one considers the time that the court process takes and the resulting delay in access to treatment, services and equipment that may be required to support effective rehabilitation. It is our opinion that insurers will be left exposed to larger settlement obligations as a result of seriously injured claimants being more disabled at the time of their suit because of a lack of access to reasonable and necessary treatment and benefits to meet their needs.

OSOT's Recommendation

1. **For all of the above reasons we urge government to explore fully the impacts of increasing access to tort in order to ensure that the net result is not increased premiums or worse, yet, increased disability amongst those seriously injured in motor vehicle accidents.**

II. LIMITATIONS ON MED/REHAB BENEFITS

FSCO Recommendation #22:
Reduce the cap for medical and rehabilitation benefits for non-catastrophic claims to $25,000. Introduce a $100,000 optional medical and rehabilitation benefit along with the existing $1 million optional benefit.

FSCO Recommendation #11:
Section 24 assessments expenses should be subject to the same maximum monetary and time limits that apply to medical and rehabilitation benefits under section 19 of the SABS.

Based on the input of experienced occupational therapists working with injured individuals in the auto insurance system, it is OSOT's view that FSCO's recommendation to reduce the cap for medical and rehabilitation benefits is the most problematic of all recommendations listed.

If objectives of the 5 Year Review were, as articulated in FSCO's paper, "…to ensure that the most seriously injured accident victims are treated fairly" and "enhancing protection for auto insurance consumers", it is OSOT's view that this particular recommendation misses the mark and positions the reform framework to achieve virtually the opposite objective - to disadvantage the most seriously injured. The Society positions that FSCO's proposed reduction in the medical and rehabilitation cap and inclusion of assessment costs within the benefit allocation will seriously limit access to necessary treatment and benefits for a large cohort of people who have serious injuries that are not deemed catastrophic. The reduced benefit cap, combined with the proposed reduction in the threshold for tort will, we believe, serve to increase overall costs to the system as a result of an increase in the number of legal suits undertaken by those eligible for tort. Worse yet, we regretfully anticipate increased costs related to poor outcomes that yield greater disability for several impacted groups: seriously injured individuals hampered by restrictions in timely access to necessary ongoing rehabilitation treatment and supporting benefits once the $25,000 has been utilized; those awaiting outcomes of tort cases; those who are ineligible for tort; and those who are awaiting a designation of catastrophic impairment.

We find FSCO's recommendation regarding the benefit cap confounding, unless it is made to simply strike an arbitrary limit to engage discussion. OSOT would assert that it is difficult to set a benefit limit without clearly understanding the nature of the injuries and potential impairments that will be subject to any such limit. Recommendations 10 and 23 speak to further investigation of the definition of catastrophic impairment and expansion of the PAF Guideline respectively. The report references frequently the "seriously injured", but there is no definition of this group of claimants. We identify that those "seriously injured" claimants, that neither fit in a PAF nor are deemed catastrophic, are those most vulnerable to the proposed limit of $25,000 and yet, it is not clear exactly who these people are.

We recognize that there is significant pressure to control the costs of the majority of MVA claims which are uncomplicated soft tissue injuries. While we agree that these injuries can be well managed within a $25,000 cap (and OSOT has supported the development of PAFs to contain and control costs), we assert that those that do not have uncomplicated soft tissue injuries or uncomplicated fractures require far more than $25,000 to manage all their rehabilitation needs. It would appear that a recommendation to solve one problem will create yet another. We urge the government to consider the following.

Why isn't the $25,000 cap (which includes assessment costs) enough?

1. The med/rehab benefit addresses the costs for a broad range of services and products which include: a number of health professional services (assessment and treatment), medications, home modifications, vehicle modifications, workplace modifications, prosthetic devices, dental appliances, orthotics, equipment, aids and devices (such as wheelchairs, hospital beds, etc). $25,000.00 is simply not sufficient to meet the treatment, re-training and equipment/modification needs of those with serious injuries, especially when hospital cut-backs result in more acutely injured persons being discharged home with limited or no out-patient resources to manage their care. The purchase of one large ticket item, such as a home modification or vehicle modification, could wipe out almost the entire $25,000 leaving no funding for actual treatment. (Refer to attached Case Studies for specific examples.)

2. FSCO's recommendations not only lower the benefit cap by $75,000 but also impose the inclusion of assessment costs within the $25,000. While we are supportive of the need to control inappropriate assessment costs within the system, OSOT would assert that seriously injured individuals are those that typically have increased legitimate and necessary assessment costs because:

   a. Their impairments and needs require the intervention of a wider variety of health care professionals – e.g. speech language pathology, psychology, and home based occupational therapy, which increases the number of assessments required to determine treatment approaches

   b. Seriously injured individuals have legitimate need for additional benefits such as attendant care, homemaking, housekeeping, caregiving that require assessments to determine eligibility.

   c. Notwithstanding that FSCO has recommended that all assessments resulting in completion of a form be capped at $200, OSOT would assert that many assessments required by those seriously injured cannot be completed for this amount. In fact, because of the complexity of these clients' problems, they require some of the more expensive assessments, e.g. neuropsychological assessment, assessment of attendant care needs, etc.

We would assert that the inclusion of assessment costs within the medical rehabilitation benefit cap would only serve to reduce access to treatment and hinder

rehabilitation and functional restoration for this group of people who likely need more than $25,000.

3. A cap of $25,000 (which includes assessment costs) seems arbitrarily low. We question how this cap was determined. While $25,000 may be an appropriate cap for 70-80% of insurance claims that have uncomplicated injuries, in today's health system, we respectfully submit that $25,000 (which includes assessment costs) is simply not enough for serious injuries. We note that the cap for the med/rehab benefit in the 1970's was $25,000. An actuary estimates that, in 21st century terms, $25,000 translates to $137,000. This seems to present a great injustice to the injured auto insurance consumer.

4. When we compare a $25,000 cap (which includes assessment costs) to other jurisdictions in Canada, we believe the Ontario public would feel disadvantaged by comparison.

   <u>Med/Rehab caps in Canada (source IBC website *"Insurance Where you Live"*):</u>

Yukon, NWT	$25,000
Nova Scotia	$25,000
PEI	$25,000
Alberta	$50,000
New Brunswick	$50,000
Ontario	$100,000 (Non-CAT); $1 million (CAT)
British Columbia	$150,000
Saskatchewan	$5 million
Manitoba	No limit

   When you compare benefit caps from 'like' regions across Canada, it is clear that more densely populated urban provinces (with more motorists) have higher med-rehab caps. To suggest caps should be consistent with the maritime provinces, where there is a smaller population, number of motorists and cost of living and thereby the cost of healthcare is significantly lower, is not realistic.

5. Those individuals who must wait 2+ years for a catastrophic designation, before accessing extra funding will deplete their funds ($25,000) within several months and will spend 18 + months without receiving treatment (refer to examples attached). Delay in treatment will result in unnecessary disability and is contrary to the literature supporting the efficacy of early intervention. Unnecessary disability is an avoidable outcome that is unacceptable to both the claimant and the insurer who is at risk of increased tort exposure. At-risk populations include but are not limited to: children and teenagers; claimants with mild to moderate brain injury with multiple orthopaedic injuries, emotional and mental/behavioural sequellae; and those with facial smash.

6. This proposal would leave many injured persons in a state of partial rehabilitation, including those not functioning at home and needing community services; not

returning to work and relying on welfare or disability pensions; in pain and turning to OHIP-funded pain clinics and the Ontario drug program or the streets; and with mental and/or behavioural disability leading to family breakdown and unemployment. These sequelae will overburden both Ontario's social system and Ontario's health care system.

7. Section 55 of the SABS informs of the injured person's obligation to mitigate his/her losses by seeking out rehabilitation. With a lowered cap available for this purpose, the injured person—*who has not yet returned to his/her daily activities or employment*--will be obliged to attend rehab yet, have insufficient funding available to do so.

8. With a lowered $25,000 cap, there will be more persons needing to sue for bodily injury due to insufficient funds and time to complete their rehabilitation and return to function. This will lead to backlogs in the courts as was the case prior to the introduction of no-fault insurance. Indeed, it is our recollection that this was one of the drivers to introduce no-fault insurance. It is our members' experience that within a higher cap of $100,000, injured persons are frequently able to complete their rehabilitation and return to their normal or near-normal life functions before depleting the cap of their benefits.

   Completing a tort action normally takes 4-5 years and even longer in cases of children. During this waiting period, injured persons will be left in limbo--disabled and unable to achieve a level of function commensurate to their prior life without access to timely physical, cognitive and/or psychological treatment. The final tort settlement is based on functional parameters such as the person's ability to return to daily living tasks, work, caregiver roles, etc... The loss of timely and sufficient rehabilitation will lead to *greater disability* which results in *larger financial awards* against insurers for bodily injury, e.g. pain and suffering, loss of income, future health expenses.

9. In many instances, there is no tort claim, so persons in these situations would be left with no person to sue for more funding to address their_ongoing rehabilitation needs.

10. A $25,000 cap is entirely insufficient to cover the combined prosthetic and wheelchair costs of any lower leg amputee, or to meet the prosthetic costs of above or below elbow amputee, even with the Ontario Ministry of Health and Long-Term Care Assistive Devices Program funding. The amount is insufficient for big ticket items such as home modifications, vehicle renovations, dental appliances and vocational retraining.

11. Attendant Care Applications: There are occasions when a person's condition deteriorates as a result of infection or the need to undertake revision surgeries, all of which impacts function and need for attendant care. If the insured has depleted their $25,000 and requires an updated Form 1, their lack of access to fund the

assessment impacts their ability to have a Form 1 completed and to access this benefit.

12. In all of the situations listed above, disabled persons/children who are not sufficiently rehabilitated will be forced to rely on family members longer or permanently for their care. This will create another subset of individuals who might be forced to leave their own employment and rely on Ontario's social safety net in order to manage the care of their loved one(s). For those without family, they will be reliant on Ontario's social services.

Optional Benefits – why "optional buy-ups" won't work

FSCO acknowledges the potential need for increased coverage by suggesting that insurers provide and promote "optional" upgrades in coverage to caps of $100,000 or $1 million dollars of medical/rehabilitation benefits. This recommendation would be a sound solution for keeping basic insurance premiums low and access to benefits reasonable… if the public generally purchased such buy-ups. But…they don't!

Currently, optional benefits are available to Ontarians, (e.g. to upgrade from $100,000 to $1 million in Medical & Rehabilitation benefits, upgrades in dependent care and attendant care); however, it is the collective experience of our members that the number of people who are aware and have purchased such upgrades is negligible. Assuming that the vast majority of purchasers of policies will purchase the mandatory minimum of $25,000 (which includes assessment costs), we feel that this will result in a shortfall of protection should the consumer be seriously injured in a motor vehicle accident.

Purchasers of auto insurance typically **do NOT** purchase optional benefits because:

- motorists do not believe that they will ever be seriously injured in a car accident.
- in an effort to keep their premiums low (particularly in these economic times), most Ontarians will opt to purchase at the minimum level, i.e. a $25,000 cap
- Ontarians mistakenly believe that 'universal health care' is readily available to manage their treatment and rehabilitation needs. Most are unaware that many goods and services are either NOT available through OHIP or, if they are available, services are subject to strict criteria (eligibility, geographic limits), waiting lists and are very time-limited. (Refer to Appendix re: Waiting Periods for PT and OT; wait lists for Pain Clinics).
- Many Ontarians choose to purchase their insurance products on-line, and therefore will not have access to a broker or advisor to provide education regarding the risks of not purchasing optional benefits.
- New immigrants may not understand the need for insurance (as this is not part of their culture), consequently they will tend to purchase the least expensive product available.

The introduction of this optional benefit will **discriminate against**:

a. People with lower socioeconomic status. Consumers who are least able to afford to pay for optional benefits will be those most affected. Vulnerable groups include; elderly individuals, those on fixed or limited incomes, those living with disabilities, students, and single parents. Given the demographics of an aging population and an increased probability of accidents amongst the aging population (due to reduced cognitive power, reduced reflexes, reduced eyesight, etc.), we predict this will mean greater burden on the publicly- funded health care system for necessary rehabilitation treatment. Furthermore if persons with serious injuries have inadequate funds to cover expenses related to equipment, environmental adaptation, etc. we believe these at-risk groups could also place greater strain on publicly funded chronic care found in hospitals and nursing homes.

b. Those persons whose first language may not be English, and do not fully appreciate or understand the concept of optional med/rehab benefits.

c. Young drivers whose income may be limited and who might not appreciate the concept of optional med/rehab benefits, feeling he/she will never be in a serious car accident. Statistics indicate that young drivers have the highest incidence of motor vehicle accidents, yet under this new scheme, will likely be those who do not opt for the additional coverage.

Persons WITHOUT auto insurance, such as the pedestrian, cyclist or passenger involved in an MVA, would be subject to the limitations of the at-fault driver's policy limits until they could sue which could be years later, again, causing unnecessary delays in their access to treatment. These individuals who are not at-fault have their ability to engage in rehabilitation and restore their lives unfairly limited because of decisions of a driver who, because of a lack of financial ability, knowledge and/or foresight did not purchase optional benefits.

We note that there is no cost projection for an optional buy-up. It is our understanding that costs of optional benefits are determined based on the pool of persons purchasing them...the fewer the purchasers, the greater the cost. Based on our collective experience, we expect few persons to purchase this optional benefit. Costs could be high.

OSOT's Recommendations

1. Retain mandatory med/rehab limits of $100,000 for serious injuries.

For all the above reasons, OSOT is of the position that $25,000 is inadequate for those individuals who have serious injuries but are not deemed catastrophic. Further, without substantive data to lend clarity as to the actual costs of Section 24 assessments, we are unable to comfortably support the inclusion of assessments into the cap. We note that the $100,000 cap has not changed since 1996, as a result, claimants are receiving less benefit in today's economy and paying a higher premium.

The Society positions that claimants with uncomplicated injuries and treated in the PAF can be well served with a cap of $25,000 and believe that as FSCO suggests, some 70 – 80% of claimants could be well served in an expanded PAF. We recognize that 1 – 2% of claimants have catastrophic injuries so position that the

insurer's exposure to claims up to $100,000 would only be for 20 – 30% of claimants.

OSOT believes that support to several of FSCO's recommendations to control assessment costs (discussed later) will contribute sufficiently to system controls that can save insurers substantially. These cost saving measures can serve to protect the seriously injured's right to access reasonable and necessary benefits

2. **Expand the PAF to include more people with uncomplicated injuries including primary and secondary sprains and strains.** This represents a larger cost savings for insurers as the PAF provides predictable costs and reduces the administrative burden to insurers during the PAF period. Also, it protects access to initial care for more persons.

   Remove the restriction from receiving attendant care and income replacement benefits while in the PAF as this is seen to be one reason that claimants choose or are advised to avoid the PAF. Consider setting reasonable limits for these benefits for claimants treated in a PAF.

   Require that individuals applying for more treatment further to a PAF be seen by the proposed system navigator or family physician (see page 42 of the Report on the Five Year Review of Automobile Insurance).

3. **Introduce the proposed Primary Health Practitioner or system Navigator role as suggested in the FSCO paper and further detailed on page 34-36, 41, 42 of the Report on the Five Year Review of Automobile Insurance).** We believe that the introduction of a "neutral" system navigator can significantly impact and manage the number of assessments and ensure treatment is reasonable.

4. **Develop standards and qualifications for assessors in consultation with professional associations.** Many associations, like OSOT may have assessment guidelines that can inform this process.

5. **OSOT assumes that FSCO proposes maintaining $1,000,000 Med/Rehab coverage for Catastrophic claimants with the potential to review this designation to include other injuries such as moderate brain injury and limb amputees.**

III. OPTIONAL BENEFITS: Housekeeping and Home Maintenance expenses and Caregiver Benefits

FSCO Recommendation #29:
Make housekeeping and home maintenance expenses and caregiver benefits optional. Reimbursement for housekeeping and home maintenance expenses and for replacement caregivers needs to reflect actual economic losses.

Currently, the access to housekeeping and caregiving benefits is offered to all Ontario

motorists, if they qualify, similar to other jurisdictions such as Quebec, British Columbia and Manitoba. FSCO reports insurer concern that "a high proportion of payments are made to other family members and not to outside caregivers (or housekeepers)." Occupational therapists are normally the professionals who assess need for and arrange for this care. OTs identify that there are occasions when family members stop working to manage the care of their loved ones. In other cases, care from an outside agency may be arranged. The reality is that in both these situations, the amount of the weekly benefit is often not enough to cover the costs of securing an outside agency or reimbursing the family member who has taken time off work. For instance, if the agency costs $21/hour to provide care, the total benefit maximum per week would only cover 4.75 hours of housekeeping assistance and 12 hours per week of caregiving assistance. This may be enough for some people but it is definitely inadequate for many. In other words, the benefits have never provided sufficient funds to "purchase" *enough* outside services. Consequently, the injured person turns to family members who are willing to work for a lesser amount of money; this does not mean that the need is not there. We would not characterize these situations as abuse.

PROBLEMS MAKING CAREGIVER and HOUSEKEEPING BENEFITS OPTIONAL

1. **Affordability:**

   The cost of these optional benefits is yet to be determined. It is our understanding that costs of optional benefits are determined based on the pool of persons purchasing them...the fewer the purchasers, the greater the cost. Based on our collective experience, few persons ever purchase optional benefits.

2. **Stress on Public Funding:**

   a) Should an elderly person become disabled and cannot manage the care of a disabled spouse or disabled adult child, the disabled dependent would have to be housed in a local nursing home at a cost to the tax payer whilst the injured person recuperates and engages in rehabilitation versus the situation at present whereby caregiving services can be purchased.

   We note with concern the inter-relationship of the $25K cap and the loss of Caregiver Benefit. For example, consider an elderly woman who cares for her husband and is injured. As seriously injured elderly persons require more and longer rehabilitation simply due to their age, the $25,000 cap in this case will be insufficient, thus forcing two persons to be placed in an institution rather than keeping them both in their homes when caregiver benefits are not accessible.

   b) Should a young mother of one or more children become disabled and unable to adequately care for his/her children and this person is without a personal network of friends or family, regulated health professionals treating the young woman would be obliged to contact the Children's Aid Society to arrange for foster care, or send the children to the local hospital.

c) There are instances when persons may be injured, yet, able to manage their personal care and do not qualify for attendant care (e.g. air bag causing sternal fracture or rib fracture); however, the injured person is unable to clean his/her home, shop for groceries or clear the snow from their porch/stairs to exit safely to attend their medical and therapy appointments. This person is placed at additional risk in order to manage these day-to-day tasks without external assistance for housekeeping/home maintenance. Note: CCAC does not provide assistance for heavier housekeeping and certainly nothing for external home maintenance.

d) Currently, the CCAC refuses to provide homemaking services to those injured in motor vehicle accidents as it is currently covered under the SABS. If housekeeping is no longer mandatory, the Ministry of Health must be apprised as the need for CCAC's services will significantly increase.

More need nursing, personal Care in the Home Care System, 2003

In the coming years, the need for home care services in Canada can be expected to increase. As the number of elderly people in the population grows, so will the prevalence of age-related chronic conditions that may jeopardize an individual's ability to live independently in the community….

In view of shorter hospital stays, it was not surprising that, in 2003, people who had been hospitalized during the previous 12 months were significantly more likely to receive government subsidized home care (16%) than were their counterparts in 1994/95 (12%).
Of people who received home care, the **proportion receiving nursing or personal care was up substantially in 2003**. That year, 52% of home care clients received nursing care, compared with 39% in 1994/95 (Chart 1). By contrast, the percentage receiving assistance with housework dropped from 51% to 33%. Clearly, a shift to more specialized services occurred. The increase in the number of nursing care recipients is particularly important in the context of concerns about shortages of qualified nurses.

Seniors "who required such assistance did not receive any form of home care (Chart 2). The majority who needed help with household chores or with getting to appointments/grocery shopping (both IADL tasks) received no home care. As well, sizeable proportions who required assistance with ADLs received no home care. The fact that 42% of seniors who required help with moving about in their homes (53,000) did not report home care from
any source—not even friends or family—suggests a population who may be at increased risk of injury.
Statistics Canada, Health Reports, Vol. 17, No. 4

http://www.statcan.gc.ca/pub/82-003-x/82-003-x2005004-eng.pdf

3. **Discrimination**

a) Persons WITHOUT auto insurance, such as the pedestrian, cyclist or passenger, would be subject to the limitations of the at-fault driver's policy limits (e.g. no optional coverage for housekeeping or caregiving) until they could sue, which could be several years later. Until such time, the injured person would have to pay for these caregiving and/or homemaking expenses out of pocket. These people are unfairly at the discretion of the driver's financial ability, knowledge and foresight in purchasing these optional benefits.

b) For persons who must purchase auto insurance, this also discriminates against those in the lower socioeconomic bracket who lack funds to purchase these optional benefits. Such individuals include those living with disabilities, single parents, those who are unemployed, seniors living on fixed incomes or others living on social support.

c) The FSCO paper suggests that reimbursement of housekeeping or caregiving expenses **"needs to reflect actual economic losses."** This comment discriminates against and undervalues the contribution made by caregivers and homemakers, the majority of whom are women. In many situations, these persons are supporting those who are income earners. Furthermore, if a person must continue to manage their home and children while they, themselves, are under-rehabilitated, this only serves to further victimize the victim.

OSOT Recommendations

1. **Retain mandatory Caregiving and Housekeeping benefits.**

2. **Discontinue caregiving benefits when a claimant returns to work.**

3. **Develop defining language for "Primary Caregiver" as used in the SABS.** Currently the SABS requires that a caregiver must be a "primary caregiver", live with the person and not be paid for their services. OTs observe that the term "primary caregiver" is ambiguous, open to interpretation and consequently subject to potential abuse.

4. **Consider making the Income Replacement Benefit optional instead.**

    - People for whom income replacement is an issue are making an income and can afford to purchase an optional benefit. Furthermore, there are many persons whose employer already funds short term and/or long term disability, or persons who have purchased income protection privately so IRB is not a necessary coverage.

    - It is OSOT's position that, when motorists are renewing their policy, there is a greater likelihood of a person understanding the concept of "no income protection" versus no med/rehab protection or no caregiving/ homemaking protection.

5. **Provide income replacement benefits to a maximum of $500/week to an uninsured person struck by or injured as a passenger by an at-fault driver without income protection coverage.**

IV. CONTROL OF COST OF ASSESSMENTS

FSCO Recommendation #12:
The fee for completing forms including any assessment required to complete the form should be capped at $200. The cost of all other assessments should be capped at $2,000.

FSCO Recommendation #18:
The cost of insurer examinations should be capped at $2,000.

Recommendation #12 indicates that all assessments and the completion of a form such as OCF3 (Disability Certificate), OCF-18 (Treatment Plan), OCF 19 (Application for CAT Determination), Form 1(Assessment of Attendant Care Needs) would be capped at $200.

PROBLEMS WITH ASSESSMENT CAPS

1. While there are a very limited number of in-clinic assessments which can be conducted for $200, there are a number of more complex assessments and in-home assessments which cannot be conducted for $200.00 and some assessments may exceed $2000.

2. Occupational therapists working in the auto insurance sector are compensated based on rates in the Professional Services Guideline. The 2008 rate (current to date) is $91.97 per hour. Based on this rate, which is lower than OT fees were in 1998, a $200 assessment represents completing the following in roughly 2 hours: arranging an assessment, traveling to the client's home or work place if necessary, completing the assessment and preparing a report. OSOT has serious concerns that this recommendation would eliminate occupational therapy services from the auto insurance sector, leaving injured individuals without services directed at assisting them to re-establish their day-to-day living skills.

3. The regulatory bodies of health professionals establish assessment standards (Standards for Occupational Therapy Assessments, May 2007 - Appendix) which must be met by each Regulated Health Care Professional. There is no way to 'short cut' the process of assessment to meet a $200 or 2-hour window and at the same time meet obligations both as an independent third party assessor and provide a defensible report that might be required for litigation purposes.

4. We petition that occupational therapy, as a profession, is uniquely disadvantaged by the recommendation to cap assessment fees because of the nature of our home/community based work. We would submit that important assessments that may engage other professions will also be restricted by such assessment cap limits. The following occupational therapy and other assessments would be restricted by recommendation #12

a) Attendant Care Assessments – Assessment of needs for attendant care is an important gatekeeping role to the attendant care benefit. Occupational therapists are primary professionals involved in these comprehensive and objective assessments which are most commonly engaged for seriously injured claimants. The completion of the Form 1 and the related documentation constitutes an application for the attendant care benefit. These assessments must be conducted in the client's environment as the special features of the client's home impact the entitlement to this benefit (e.g. bathroom is located on the second storey and client can't climb stairs; width of the entrance into the bedroom is too narrow to accommodate a wheelchair, etc.), it is simply not possible to perform this specific assessment for $200. The therapist must be compensated for the time taken to travel to the client, assess the client and prepare the Form1 at a FSCO designated hourly rate of $91.97. Insurers also request that a detailed narrative report accompany the Form 1.

b) Home functional assessments to determine housekeeping and/or caregiving needs. The need to assess the person's continuing eligibility for these assessments (whether they are optional or not) must occur at the person's home using the person's equipment. Concurrently, the OT is determining the person's need for in-home occupational therapy treatment and/or adapted equipment needs which would be targeted to improve the client's function and independence and reduce their dependence on benefits. These assessments may require several hours to complete including time to arrange the appointment, travel to the client's home, interview and assess the client, order equipment, speak to the family doctor and other professionals, and prepare a report which is issued to the insurer and family doctor.

c) OT Assessments to determine treatment: Traditionally, occupational therapists who work with clients outside the hospital treat clients in the home, workplace and/or school environments rather than in clinic settings. This is a result of their focus on functional performance and functional restoration which is best addressed in the environment in which it is to be practiced. This is consistent with other sectors in which we work, e.g. WSIB, CCAC, DVA, LTD. Consequently, the assessments also occur in the home, school or workplace. These assessments help us to establish realistic treatment goals and programs, and to address issues of safety and productivity in the home, community and work environment. OSOT has established guidelines with respect to the timeframes for these occupational therapy assessments. (Refer to Appendix for OSOT Guidelines)

d) Occupational Therapy Cognitive and Sensory Motor Assessments These specialized assessments may require 2 to 3 visits to complete. These tests are designed in such a way as to permit little variance in their delivery and time taken to administer. (Refer to Appendix for OSOT Assessment

Guidelines)

e) <u>Pediatric Assessments</u> are very involved because the OT must address physical, developmental, cognitive, and behavioural issues. Establishing rapport may take more than one session. When working with children, you have to work at their pace and within their comfort level. These same issues apply to brain injury and other serious and complex injuries. (Refer to OSOT Guidelines for OT Assessment)

f) <u>Assessment in underserviced and remote areas</u> (either in Ontario or outside Ontario) where resources of qualified assessors are limited will not be undertaken for $200.00 and, because of the need for extensive travel, may be over $2000.

g) <u>Application for CAT determination:</u> The assessment to complete an OCF 19 to determine if the client's injuries are catastrophic is also subject to the $200.00 cap. This detailed assessment is essential for the client to access increased funding for his/her rehabilitation, and may be completed by more than one medical or psychological assessor. We do not understand how this assessment could be completed for $200.00.

h) <u>Assessments from other disciplines</u>, e.g. physiotherapy, speech and language initial assessments, neuropsychological assessments, psycho-vocational assessments, psycho-educational assessments. In an effort to provide an integrated treatment approach, OTs rely on a number of other assessments which provide valuable information and which may all result in the completion of an OCF-18. Given the complexity of these assessments and based on the hourly rate as set down by the Superintendant (PSG), it is not possible to complete these assessments, complete an OCF-18 and prepare a useful and meaningful report in 2 hours or less.

5. With such strict limitations within the $200 cap, professionals will have little useful information to enter onto the form (OCF-18, Form 1) and to submit to the insurer. Such limited information will prevent the insurer from understanding the full scope and needs of the claimant which will handicap the adjudication process. This would likely result in an increase in numbers of IE assessments.

6. Recommendation #18 indicates that an Insurer Examination (an assessment for the purpose of providing the insurer with information to determine if a person is eligible for a benefit) would be capped at $2000. This would mean, for example, that an OT performing an IE could charge $2000 to complete a Form 1 yet a treating OT could only charge $200 for this very same assessment. This presents a significant inequity, and discriminates against the claimant despite FSCO's claim to develop a system which would "provide appropriate balance to the system

7. OSOT asserts that assessments conducted in the auto sector cannot be compared

to other sectors (WSIB, CCAC, LTD). While similar assessment tools may be used, the need for more detailed reporting is essential given the litigious nature of the work. Since the SABS provides a dispute mechanism, either via mediation or arbitration, many of our members are asked to testify in arbitrations or at court many years after these assessments are undertaken. Without a comprehensive, objective and thoughtful report, their ability to testify is weak at best.

The introduction of assessment caps is one of many cost-saving measures being proposed in FSCO's 5 Year Review – strategies to reduce insurer costs. Upon reflection, health professionals wonder just how much more cost cutting is reasonable. Strategies that have already been put in place include:

- Introduction of the benchmark of "reasonable and necessary" and the ability of the insurer to apply this test against any proposed cost.

- The Superintendent of Insurance reduced hourly rates for all health care providers (except physicians and dentists) by 30-50% in October 2003 and continues to cap yearly increases by under 2% during the past 4 out of 5 years.

- The development of the Pre-Approved Framework (PAF) was introduced in 2003 as a means of managing the costs of whiplash and associated soft tissue injuries. Additionally, the Superintendant prohibited access to attendant care benefits and more than 16 weeks of IRBs for persons in the PAF.

- The removal of the Designated Assessment Centres in March 2006.

OSOT would assert that these strategies have already effected significant savings in the system. Further, FSCO has recommended a strategy that we feel can be effective in reducing abusive assessment practices through the introduction of a Primary Health Practitioner or system navigator. With these measures in place we urge government to allow health professionals to do the work they need to do to contribute meaningfully to their client's rehabilitation outcomes and to serve the accident benefits system effectively.

OSOT Recommendations:

1. **There is no need for a cap on assessments as a cap already exists in the regulated hourly rate.**

2. **Assurance of appropriate assessment utilization can be enhanced with the introduction of the proposed system navigator (Primary Health Practitioner) ensuring that only necessary assessments go forward.**

3. **Professional Associations provide insurers with guidelines for assessments to predict ranges of time required to complete profession-specific assessments (including assessment times, completion of reports, completion of forms).**

4. **All assessments costing over $200 should be submitted on an OCF-22 and wait for approval from the insurer except attendant care assessments.**

5. **We support FSCO's recommendation for a longer period of time for the adjuster to consider the OCF-22 and has recommended more discretion for adjusters in the adjudication process.**

6. **Insurers should take advantage of their ability to a) refer to a professional associations guidelines (e.g. OSOT Assessment Guidelines) with respect to usual length of time taken to perform typical assessments, and b) ask for a cost breakdown on the OCF-21/Invoice before payment is rendered.**

7. **The upper limit of $2000 is not acceptable provided the health care professional can provide appropriate rationale and this is approved by the insurer.**

8. **There must be equity in the allowable assessment fee for both Insurer Examinations and those assessments conducted for the purpose of treatment.**

V. "IN-HOME" ASSESSMENTS

FSCO Recommendation #14:
Availability of in-home assessments should be limited to seriously injured claimants and should only be used to evaluate their need for attendant care services and home modifications.

Since 1990, the auto sector has relied almost exclusively on occupational therapists to provide assessment and treatment inside claimants' homes as well as schools, work and their communities. Occupational therapists do not provide an "in-home assessment" in the home. We assert that when OTs are assessing in the home, they are completing an occupational therapy assessment, completed for the purposes of developing a treatment plan, or, when asked to determine a claimant's eligibility for a benefit, OTs complete a "benefit entitlement" assessment. OSOT is concerned about and confounded by the evolution of the term "in home assessment".

If the intent of Recommendation 14 is to limit any home based assessment other than benefit entitlement assessments for attendant care and home modification assessments then it effectively restricts occupational therapists from assessing their clients for treatment and therefore limits the ability for the occupational therapist to treat and provide services that are aimed at increasing an individual's function to a level that is as close to that which they enjoyed prior to their injuries. **Occupational therapy services will be effectively withdrawn from the sector.**

OSOT positions that only in the past 2-3 years has there been a concern regarding the over-utilization of the "in-home assessment". Occupational therapists have not had opportunity to view the data that creates such concern amongst insurers, nor has the profession had any feedback of concern from insurers. We question whether this concern is a result of OT service provider assessment practices or increasing utilization of home-based assessment by other professions. While we concur that home-based assessment and treatment has implicit costs that need to be reasonably controlled, we would advocate that the recommendation to eliminate all home-based assessment except for assessment for attendant care or home modifications has the potential to "throw the baby out with the bath water" so to speak. We believe that home-based occupational therapy assessments add real value to the system and would urge the Minister to seek input from all stakeholders in this regard.

While historically occupational therapists have conducted their occupational therapy assessments in clients' home environments, we are uncertain as to what constitutes an "in-home assessment" when completed by other professions. We think that occupational therapy practice has remained unchanged during this period of time. Therefore, further statistical data is required to understand which other professions are providing "in-home assessments", to clarify the purpose of their in-home assessments and to understand the parallel development in their professional training/scope.

Unlike other professions such as physiotherapy, chiropractic or massage therapy, the profession of occupational therapy is strongly focused on restoring functional performance and minimizing the disability that may result from an injury and affect an individual's ability to manage day-to-day living skills in the home, workplace and community. Attention to these occupational performance skills is critical to successful rehabilitation and restoration of pre-injury status.

Occupational therapists traditionally provide care to their patients in a community setting, whether in the WSIB, DVA (Department of Veteran Affairs), CCAC or auto insurance models. Normally, restoration of personal care and daily home activities precedes return to employment (or school), and it is essential to practice these skills in the context in which they must be practiced - the client's environment. Once the person is able to function in the home, they may proceed to school and work reintegration, and treatment may need to be provided at these locations.

PROBLEMS

1. If the intent of Recommendation 14 is to limit any home based assessment other than benefit entitlement assessments for attendant care and home modification assessments, then it effectively restricts occupational therapists from assessing their clients for treatment and therefore limits the ability for the occupational therapist to treat and provide services that are aimed at increasing an individual's function to a level that is as close to that which they enjoyed prior to their injuries. **Occupational therapy services will be effectively withdrawn from the sector.**

2. Recommendation #14 limits the "in-home assessment" to the seriously injured without a definition for "seriously injured". For the purpose of this discussion, OSOT assumes these include all persons who are outside of the PAF.

3. Until the home assessment is performed, the OT does not know if the client requires attendant care and/or home modifications.

4. Assessments in the home are valuable beyond the assessment of attendant care and home modifications. For example, there may be individuals who would benefit from re-training/remediation and equipment, but might not require attendant care support or home modifications.

5. The following home-based and important assessments would be restricted if this recommendation was supported;

    a) Post-discharge from hospital to ensure all safety and equipment needs are met, both inside and outside the home. These persons are often acutely injured and cannot easily leave the house.

    b) Functional Restoration: Whether the client is cognitively, physically or psychologically challenged, assessment within the home is needed to establish the client's need for remediation and/or compensation to promote independence with activities of daily living and life skills. Restoration of basic daily function is essential to remove the requirement for attendant care services.

    c) For persons who have sustained an acquired brain injury, it is well understood that transfer of skills is difficult. Therefore the skill must be taught and reinforced in the environment where they are going to use it. Teaching skills to an individual in a clinical setting (i.e., safety issues while cooking or organizing their workspace to increase their independence) will not necessarily transfer to their home or work environment.

    d) Persons with specific phobias or who have a severe mental illness may be unable to leave the house to receive treatment in a clinic setting.

***Sample Case**:*
45 year old woman who was run over in a parking lot and her right hand was crushed. She was fearful of leaving her home and being inside a taxi to go to therapy. She required a significant amount of community-based occupational therapy to teach her how to use one-handed devices, to address home modifications and eventually to work on desensitization in the community, e.g. walking on the sidewalk, crossing roads, crossing parking lots, walking to the grocery store. This was a slow, gradual process which took several years as she struggled with depression and, at one point, psychosis. Through intensive therapies, she eventually made a successful recovery.

OSOT Recommendations:

1. **Limit the in-home assessment and treatment to those professions where the environment is critical to the outcome of their intervention.**

2. **Ensure that occupational therapists are able to practice and provide treatment to their patients by permitting occupational therapists to perform assessments and treatment inside their clients' home, place of work or at school.**

3. **Engagement of proposed Primary Health Practitioner/system navigator can play a role in monitoring access to home based assessments.**

VI. PRIMARY HEALTH PRACTITIONER MODEL

FSCO Recommendation #15:
Consider having assessment requests completed only after a referral is made by the health professional primarily responsible for the claimant's rehabilitation (in most cases a family physician). Assessment requests would continue to be submitted by providers following a referral.

FSCO Recommendation #21:
Consider having treatment plans completed only after a referral is made by the health professional primarily responsible for the claimant's rehabilitation (in most cases a family physician). Treatment plans would continue to be submitted by providers following a referral.

PROBLEMS

1. *Shortage of physicians in Ontario*, particularly in rural and remote areas. Even in urban areas, many people rely on walk-in clinics to address their ongoing medical needs, which provides little opportunity for continuity or "coordination" of care. (Refer to Appendix: "Backgrounder Managing the Physician Shortage Crisis: Provincial Poll".)

850,000 Ontarians without family physician: OMA

Updated Thu. May. 15 2008 1:24 PM ET

The Canadian Press

The Ontario Medical Association says there are still 850,000 people in the province who do not have a family doctor.

OMA president Dr. Ken Arnold says Ontario is short about 2,500 doctors, and notes that 2,600 physicians currently working in the province are over the age of 65. He says if those physicians decide to retire, Ontario would lose about 10 per cent of its family doctors and about 13 per cent of its specialists.

2. Even for those Ontarians with a Family Physician, there is a waiting period to obtain an appointment which will unnecessarily delay access to needed treatment.

3. The FSCO 5 Year Review paper suggests that "a single professional responsible for rehabilitation can **fully and accurately respond to questions from the claimant and adjuster** concerning the appropriateness of the proposed assessments and treatment." It is our member's experience that:

   a) It is difficult to reach physicians by phone, fax or in writing, and occupational therapists may wait a week or more before the physician can make contact. We have been informed that some physicians in rural settings do not have fax machines in their offices.

   b) Family physicians are typically unfamiliar with the auto insurance process and frequently rely on occupational therapists to assist with the completion of forms. Physicians are not familiar with the HCAI system to submit their invoices.

   c) Family physicians have advised individuals who are injured in MVAs to seek an alternate family physician as they do not have the time to manage their care.

   d) Family physicians have limited knowledge of the community-based resources available to their clients to improve their level of independence and abilities.

   e) Many persons with complex injuries are followed by a number of medical specialists following discharge from hospital and often times do not attend a Family Physician, or their primary care is shifted to a medical specialist or clinic. (e.g. Bloorview Kids, Children's Rehab Clinic in Sudbury, Mild Traumatic Brain Injury Clinic in Sunnybrook and St.Michael's Hospital)

4. The FSCO report states: "The proposed changes will not significantly increase the number of doctor visits" and "increased involvement of physicians is not expected to impact on the doctor shortage", OSOT disagrees with this premise.

   a) First, the Physician is the most expensive resource amongst the health practitioner group with the least amount of time to coordinate rehabilitation and access to other benefits, and to reach other parties involved in the MVA such as the adjuster, lawyer and other treatment professionals.

   b) Second, given the need to seek out a GP each and every time a claimant requires a referral in relation to their treatment, equipment and/or vocational needs, or the person's need to establish their IRB/ attendant

care/ caregiver/non-earner eligibility by means of an assessment will create an enormous burden to the family physician, who now sees an average of 117 patients per week.

c) Consider situations such as the recent outbreak of H1N1 flu or the 2003 SARS outbreak which weigh heavily on family physician offices. According to the Canadian Press' report on May 3, 2009: *Canada's family doctors are gearing up for a potential onslaught of patients with suspected H1N1 influenza. But if cases reach pandemic proportions, the physicians warn they will not be able to bear the load on their own.* These sorts of situations impact GPs' offices for weeks or months on end; hence, MVA patients may wait a long time before they can access their family doctor.

The College of Family Physicians, the Canadian Medical Association, and the Royal College of Physicians and Surgeons collaborated on the National Physicians Survey in 2004. It found:

- Family doctors see an average of 117 patients per week during regular hours.
- When on-call hours are included, family doctors typically work between 70 and 80 hours per week. More than 70 per cent of family doctors provide some type of on-call service in addition to regular hours.
- About 60 per cent of doctors said they are not routinely accepting new patients.
- 42 per cent said they were only accepting new patients under certain circumstances, such as friends or relatives of current patients or referrals from another doctor.
- 18.2 per cent said they are not accepting any new patients
- Only 20.2 per cent said their practices were accepting new patients without any restrictions.

http://www.cbc.ca/news/background/healthcare/familydoctors.html

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5. In some complex cases, the Family Physician may not have a full appreciation for the client's entire needs. This will require more of the physician's time to the detriment of other patients.

6. As per the 5 Year Review, "In this particular [Primary Health Practitioner] model, FSCO also believes that designating a health professional who is not delivering services to coordinate rehabilitation would eliminate the potential conflict of interest situation inherent in the existing delivery model. As such, the designated health professional could not be another provider at the facility or clinic where the claimant is receiving treatment."

   This statement requires clarification and parameters given that some family physicians are owners or co-owners of healthcare/rehabilitation clinics. This statement is not consistent with The *Guideline Respecting Conflict of Interest in the*

Provision of Medical and Rehabilitation Services published by FSCO, August 26, 1997.

OSOT Recommendations:

1. **OSOT posits that a single health care practitioner or navigator would be helpful to coordinate or triage the care of the injured person, however, OSOT is not convinced that the Family Physician is the only RHP who could fulfill this role.**

   The Society introduces the term or title "navigator" in an effort to assert that this individual is not a health professional that is "directing" care nor deemed "primary" in any way. In the spirit of today's health system's interprofessional care models, the Ministry of Health and Long-Term Care through HealthForceOntario is working hard to develop models of collaborative care that acknowledge the importance of respectful, collaborative care that equally values each health care professional's unique contribution. The term navigator has a very client focused connotation that is intended to communicate the importance of support to the claimant, facilitating access to those services and benefits that are necessary, avoiding duplicative assessment, etc.

   Occupational therapists currently engage in the role of "coordinator" in other systems such as discharge planners in hospitals, WSIB (case coordinators), CCAC (coordinators) and auto sector (Case Managers). Occupational therapists have the requisite training to address the client's changing needs from the acute stage throughout their entire rehabilitation process towards returning to work, school and/or home function.

   With respect to seriously injured persons who are either hospitalized or discharged home from the emergency room, occupational therapists are often the first community-based RHP seen by the injured person. OTs assist in the *"transition to home following injury"* process; they prescribe and organize the delivery of specialized devices for home use and for mobility, and arrange for either temporary or permanent home modifications. Occupational therapists will link injured persons with other needed services such as physiotherapy as the profession's educational preparation and hospital-based clinical training is "team" based. Often, the occupational therapist is the first to inform the family physician of the accident. They may complete the disability certificate.

2. **OSOT proposes the following MODEL A**

   <u>FOR CLAIMANTS IN THE PAF</u>:
   The PAF has tightly defined parameters for eligibility, treatment and costs. OSOT would propose that there need not be a coordinator/navigator unless the person exits the PAF and requires more treatment. In this instance, we suggest the client must have the sign-off of his/her family physician at

the time of the first OCF-18 before pursuing further treatment.

FOR SERIOUSLY INJURED CLAIMANTS:
We assume that the term "seriously injured" is referring to persons outside the PAF for soft tissue injuries and not deemed catastrophic by virtue of their injury.

a) **OSOT supports the designation of a "navigator" or designated professional to triage and coordinate access to benefits and services for the seriously injured claimant. We suggest that this role should be filled by an experienced regulated health professional (RHP) who comes from a background that addresses the continuum of care for serious injuries – acute hospital care, rehabilitation, community integration and return to work and an educational preparation that enables them to address rehabilitation, acquired brain injury, physical dysfunction and disability and mental health**. This health professional would assist the claimant in navigating his/her way through the SABS in order to access reasonably required assessment and treatment services. Occupational therapists have the requisite training to address the client's changing needs from the acute stage throughout their entire rehabilitation process towards returning to work, school and/or home function.

b) **In the ideal world, this navigator role would be designated a "neutral" role and be assumed by an RHP who is not treating the claimant but designated from an independent roster of eligible RHPs.** The neutrality of a system assigned navigator eliminates the potential for any conflict of interest that may be perceived as a treating professional and further avoids any potential bias towards legal or insurer perspectives.

c) **The navigator role must be clearly defined to include vetting referrals, facilitating reporting and sharing of client health information, etc.**

d) **A fee structure for this role must be defined to support professionals who take on this additional responsibility whether the navigator is assigned from an independent roster or not.**

3. MODEL B

Alternatively, if the government does not consider MODEL A (above), and believes that the Family Physician is the best profession to guide the client's assessment and treatment, then the GP should be allowed to assign an "RHP delegate" if the GP's practice does not permit his/her full attention to this role. For those people who do not have access to a family physician, they would rely on either the hospital or walk-in clinic physician to assign a delegate. Given their primary role and in an effort to gather data, Family Physicians should participate in HCAI if they assume this role.

VII. ATTENDANT CARE

FSCO Recommendation #24:
Only occupational therapists and nurses who have been trained on the use of Form 1 should be permitted to assess auto accident victims for the attendant care benefit. This should apply to assessments conducted under both sections 24 and 42 of the SABS.

FSCO Recommendation #25:
The attendant care benefit should continue to compensate claimants for incurred expenses. However, to enhance consumer protection and transparency, the SABS could clarify that where an arbitrator has found that the insurer has been unreasonable in denying the attendant care benefit, payments should be made even if no expenses have been incurred.

OSOT applauds the government's recommendation surrounding the protection of the Attendant Care Benefit by selecting appropriately trained personnel to perform this assessment, and by reducing the number of professionals who perform this assessment, thereby reducing the potential for abuse. This recommendation is consistent with the Minister's DAC Committee (December 2000) along with the WSIB's protocol (Refer to Attached Appendix). Occupational therapists have assumed a leadership role in defining the quality and provision of attendant care assessments since its inception in the SABS, and OSOT continues to provide continuing education to occupational therapists working in this sector. See OSOT's practice resource *Assessing Attendant Care Needs, Form 1: a resource for reflective practice* appended.

While it may be argued that many practitioners are able to assess physical dysfunction, the completion of the Form 1 is multi-factorial as there may be a combination of physical, cognitive/perceptual, behavioral and psychosocial factors impeding functional independence. Occupational therapists are trained, not only in the identification of these impairments, but are able to determine how these impairments impact functional performance. Moreover, occupational therapists possess the training and skill sets necessary to remediate dysfunction through training or re-training of skills, the introduction of assistive devices, the modification of the task or environment, supporting and counseling of clients and their families, etc.

OSOT asserts that the effective assessment of attendant care needs requires not only the capacity to assess what a client can or cannot do, but also the skills to determine, based on assessment, what potential the client has to re-assume skills they need for their job of living and what supports are required to achieve this potential – treatment, equipment, benefit support, etc. Occupational therapists who complete Attendant Care assessments are simultaneously identifying appropriate aids/devices, adaptations, modifications and/or treatment modalities that will increase the injured person's level of independence and in turn decrease their need for attendant care support. This reduces long range costs to the insurer and the system.

The capacity to manage functional skills draws upon not only the client's physical capacity but also their mental health and stamina, cognitive and perceptual abilities as well as the environmental context in which they live or work, including availability of support. Assessment of Attendant Care Benefits must provide a holistic assessment of these complex components. Professions that have training and expertise in both the management of physical injury and impairment and mental health, cognition and social behaviours have the most to offer these complex assessments. OTs and nurses have such expertise.

Occupational therapists identify that there appears to be confusion among the insurers regarding payment of the Attendant Care Benefits to clients which may be contributing to the increase in costs. There are occasions when insurers will pay the amount on Part 4 of the Form 1, using the Form 1 more as an invoice rather than an Application. Based on arbitration decisions and feedback from FSCO, the insurer is entitled to detailed information of who is providing the care to their family member and what services are being provided in order that appropriate and fair reimbursement for services can occur. Such requests are not being made on a regular basis throughout the industry.

OSOT Recommendations:

1) **Reservation of the assessment of attendant care needs and completion of the Form 1 is appropriately designated to occupational therapists and nurses**. Standards and qualifications to perform attendant care assessments should include training in physical dysfunction, cognitive and perceptual dysfunction, and mental health. Furthermore, training in the remediation of physical, cognitive and mental health dysfunction is paramount if we are to restore injured accident victims to their pre-accident state.

2) Insurer education regarding payment for Attendant Care Benefits would assist to ensure that the insurers recognize that the Attendant Care Form 1 is NOT an invoice, rather, it is an application. Insurers should be requesting more information regarding who is providing the care and what services are being provided in order to provide payment of attendant care services that are "in accordance" with the Form 1.

VIII. REBUTTAL ASSESSMENT

FSCO Recommendation #20:
Revoke section 42.1 of the SABS which allows claimants to obtain an assessment from their health care provider to address issues raised in an insurer examination.

With the termination of the DACS in March 2006, Section 42.1 (Assessment or examination after denial of benefits) was introduced as a means of maintaining some level of balance in the system. Without a rebuttal, the injured person does not have

any clear support to advance his/her claim against the Insurer Examination which is denying benefit(s). In occupational therapists' experience, we have seen decisions over-turned, either by the insurer or at mediation or arbitration, based on the findings of the rebuttal.

While OSOT recognizes the potential for abuse in S. 42.1, there are a number of limitations already in place (described below) and others that would help prevent abuse of this important benefit which we recommend below.

Current Limitations:

1. Limits of only one (1) rebuttal every 12 months for Attendant Care.

2. Limits of only one (1) rebuttal over the entire life of the claim for specified benefits (IRB, caregiving, housekeeping and non-earner).

3. Limit of one in-person assessment every 12 months for a Treatment Plan.

4. Limits on cost: paper review: $450 and in-person: $775 for non-physicians

OSOT Recommendations:

1. **Retain assessments under section 42.1 to ensure balance within the system between the insurer's and claimant's interests.**

2. **Create a Rebuttal OCF-42.1 template which will serve to reduce the frequency of inappropriate rebuttals.** A template that would direct documentation of appropriate information would include the following fields:

   - Date of IE you are rebutting:

   - List those benefits which a) were denied by the above-listed IE and b) with which you disagree:

   - Your rebuttal (must demonstrate clear rationale disputing the findings of the IE) :

3. **Limit the number of paper rebuttals that can be done in relation to Treatment Plans.**

CLOSING REMARKS

OSOT appreciates an opportunity to participate in auto insurance legislation reform

on behalf of its membership and on behalf of those injured persons whom we treat. Our membership has first-hand understanding as to the day-to-day challenges facing injured persons and their families. As occupational therapists, it is our role to promote rehabilitation by facilitating function and by promoting safety and wellness, both physically and mentally. For almost two decades, the no-fault insurance scheme has sufficiently provided for injured persons such that they had every opportunity to overcome disability and return to productive lives. Unfortunately, we anticipate that the proposed changes will serve as barriers to rehabilitation and leave many injured persons in a state of partial or complete disability.

Simultaneously, during the past two decades, Ontario health care services have also changed. Ninety four physiotherapy clinics were delisted from OHIP and out-patient services are closing down or simply non-existent. Many Ontarians are without a family physician, and family physicians are working an average of 70-80 hours per week to keep up with their demanding practices. Simply put, injured accident survivors will not be able to find services offered in the public sector as they are no longer available.

The proposed changes will create, in some cases, insurmountable hurdles for the injured person and their families by arbitrarily limiting access to funding to pay for needed treatment and goods. They will increase disability, thereby, increasing tort awards. Ironically, for those with the ability to sue, injured persons will eventually obtain funding for treatment which was sorely needed in years previous, but too late to provide any qualitative benefit. For those who cannot sue, they will suffer with pain, disability and an inability to overcome their situation. The proposed changes will further serve to burden our already overly-taxed family physicians, walk-in clinics, hospitals, CCAC and welfare systems.

As one of many stakeholders in this process, we have come together in the past to help shape the insurance product and manage cost savings while protecting the needs of Ontario consumers. It is our hope that, by working together with government and other stakeholders, we can, once again, achieve the goals of affordable insurance while protecting and maintaining invaluable benefits to injured accident victims.