February 5, 2019

The Hon. Victor Fedeli
Minster of Finance
c/o Budget Secretariat
Frost Building North, 3rd Floor
95 Grosvenor Street
Toronto, Ontario
M7A 1Z1

Dear Minister Fedeli,

**Re: Pre-Budget Submission to the Minister of Finance**

Lifemark Health Group ("Lifemark") welcomes the opportunity to make a Pre-Budget Submission that will focus on the government's commitment to make auto insurance more affordable for the millions of drivers in Ontario while at the same time ensure that injured claimants receive quality care and treatment so that they can recover and resume their pre-accident lives.

Lifemark is a national, Canadian company comprised of two main divisions: Lifemark and Viewpoint. Lifemark offers comprehensive rehabilitation programs and services, while Viewpoint is a leading provider of independent medical and functional assessments. As a diversified healthcare company in business since 1998, we have over 200 facilities across Canada with locations in eight provinces and access to over 1600 experienced assessors for independent medical, psychological, functional and allied health assessments. Viewpoint was the first independent assessment organization to receive accreditation from CARF International ("CARF"), an organization that evaluates organizations on stringent international standards for quality service and processes.

We are pleased to make the following recommendations in support of the government's intention to lower costs for consumers and promote better treatment and care for injured claimants:

1. Initiatives to resolve and reduce disputes relating to diagnoses of injuries
2. Reduce system costs and inefficiencies stemming from disputes
3. Implement appropriate standards for medical assessors
4. Compel assessors to acknowledge their duty to undertake neutral assessments
5. Enforce accreditation of medical assessment companies
6. Develop and implement Programs of Care

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**1. Resolution and reduction of diagnosis disputes**

Disputes relating to diagnosis or impairment and to what extent it was caused by a motor-vehicle collision often form the core of medical disputes among parties. Reasonable variations of opinions among committed, qualified, expert and credible medical practitioners can be anticipated in many situations, particularly those where the matters may be near a threshold. Adjudicators and courts have for many years, been asked to rule on the relative strength and bases of these opinions and to make findings of fact accordingly.

RECOMMENDATIONS:

i. Standardization of question sets related to specific benefits and medical issues (and based on any existing legislatively mandated tests) should be considered. Obtaining responses to the same questions from medical practitioners will improve clarity and potentially reduce disputes amongst providers and their opinions. This should be considered for both treatment providers and independent medical assessors, on all sides

ii. Set in place requirements that all documents on which opinions are based are provided to all assessors, to ensure that no one party has access to documents unavailable to another expert.

**2. Reduce system costs and inefficiencies stemming from disputes**

We recognize that many aspects of the insurance system lack efficiency and that disputes, while likely an unavoidable part of a consumer-protection scheme, will contribute to these costs.

RECOMMENDATIONS:

i. Standardize consent forms used within the medical side of the auto system, to reduce disputes related to the use of a consent form. These consent disputes often attempt to control processes and outcomes of assessments or extort a commitment from assessors or parties to specific actions that are secondary to allowing the assessment to proceed and produce an objective report.

ii. Enhance the efficient and effective management and treatment of injuries occasioned by motor vehicle collisions and bring the necessary resources to bear on such treatment, by implementing reasonable, outcome-driven, reasonably-priced and evidence-based treatment Guidelines.

iii. Ensure that assessment and treatment organizations are audited by FSCO, and ultimately the Financial Services Regulatory Authority ("FSRA"). These audits should include both an administrative and clinical best practice review.

iv. Set in place more functional restrictions within regulations or guidelines, regarding the costs and

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delays associated with late cancellations and no-shows of claimants to medical assessments or treatment. 20 to 25% of all scheduled assessments are cancelled and rescheduled by claimants and their legal representatives for no valid reason.

Since its introduction in 1990, the no-fault system has been offloading costs to Ontario's public health care system. The Insurance Act stipulates that Ontario's auto insurance policies are second payers to other public and private insurance plans, including the public health care system. Moreover, when claimants do not attend for medical assessment or treatment appointments, the impact on the public health system is substantial as it wastes public health resources when physicians are taken away from duties and other patients that they would otherwise attend to.

Subsection 55(1) of the Statutory Accident Benefits Schedule ("SABS)" prohibits an insured person from applying to the Licence Appeal Tribunal where the insurer has provided the insured person with notice in accordance with the regulation that it requires an examination under section 44, but the insured person has not complied with that section.

We understand that this provision is not regularly enforced and while this would impact a claimant's ability to resolve his or her dispute, not enforcing it adds significant costs to the auto insurance system.

**3. Implement standards for medical assessors**

In the context of increased scrutiny of medical assessors and their qualifications and ability to conduct credible assessments we believe there is a significant opportunity to set in place standards for assessors as well as companies who engage them. This will have the effect of improving confidence in the neutrality of assessments.

RECOMMENDATIONS:

i. That the current licensing system administered by FSCO, and ultimately by FSRA, for service providers be extended to encompass credentialing and standards for providers of IMEs. This reform can be implemented in the short term and is the most practical and effective way of ensuring quality assessments.

ii. Increase standardization for how assessments are generally performed and reported on. Included in these requirements would be protocols for:

- how assessments are to be scheduled
- assessment and report timeframes
- recording of data
- compliance audits

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iii. Create contractual requirements to mandate:

- the regular review and qualifications of assessors and typically how many years of experience they must have in this specific work, and standing with their college
- the insurance requirements for assessors
- relevant clinical practice
- a working knowledge of relevant Ontario statutes and regulations such as the SABS
- knowledge of relevant case law in this area of insurance law
- ability to provide opinions without a conflict of interest (not having treated the person or intending to treat) and systems to ensure same
- AMA Guides, GOSE/KOSHI certification, etc. for CAT assessors
- mandating a specific external accreditation standard, such as CARF, be implemented by all IME companies who engage assessors in this system
- requirements related to the contents and quality of reports, such as

    - what kind of information must be included to be considered a quality report,
    - what findings the examinations need to measure and report on,
    - the methods used to collect findings,
    - the validity of tools, tests or instruments used for measurement, and
    - analysis of conflicting information and opinions.

iv. Require IT processes and standards to be in place for

- Claim / referral management systems to be utilized
- Secure data collection and storage
- System encryption
- Lengths to go to protect personal & private health information
- Annual penetration testing & vulnerability screening
- Annual business continuity testing

**4. Ensure that the opinions of neutral assessments are respected**

Previous attempts to ensure that assessment opinions generated by a specific authorized group of assessors are respected have been historically unsuccessful. The Designated Assessment Centre system, although it stipulated that all assessments had to be neutral and free of conflict of interest, ultimately missed the mark in that their opinions were seen as “another” opinion among others and not having sufficiently authoritative status to be held as binding. It is a significant challenge to accomplish this without abridging the rights of those in the system, and to convince authorities who adjudicate disputes to accept certain opinions as having an intrinsic higher status or credibility.

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One difference in the current state of affairs (which should be actively publicized) is the requirement of the License Appeal Tribunal (LAT) for experts to acknowledge their duty to the Tribunal as first and foremost. Form 53 under the Courts of Justice Act serves a similar function and this requirement should serve to reassure the public and triers of fact that the evidence being presented is neutral. The acknowledgement of this duty is captured by this acknowledgment:

*I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:*
*(a) to provide opinion evidence that is fair, objective and non-partisan;*
*(b) to provide opinion evidence that is related only to matters that are within my area of expertise; and*
*(c) to provide such additional assistance as the court (or Tribunal) may reasonably require, to determine a matter in issue.*
*I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.*

**5. Enforce accreditation of medical assessment companies**

Accreditation with internationally recognized bodies is a critical activity that organizations can employ to demonstrate accountability and commitment to neutrality, continuous quality improvement and excellence. "CARF" is the Commission on Accreditation of Rehabilitation Facilities and it has developed a program specifically designed for Independent Assessment organizations. We recommend implementation and promotion of this system as part of the regulation of IME providers, as it demonstrates the commitment to quality and consistency in providing the highest level of care to the Ontario consumer. More information can be found on their site at http://www.carf.org/home/ and we note:

CARF Mission: *The mission of CARF is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of persons served.*

CARF standards are rigorous and far-ranging and focus on a number of realms including:

- Leadership
- Strategic planning
- Input from persons served and other stakeholders
- Legal requirements
- Financial planning and management
- Risk management
- Health and safety
- Human resources
- Technology
- Rights of persons served
- Accessibility

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- Performance measurement and management
- Performance improvement

Standards also include specific criteria such as:

- Scope of independent evaluation services
- Resources
- Risk screenings
- Communication with persons served prior to evaluation
- Coordination of the evaluation process
- Composition of the evaluation team
- Responsibilities of evaluators
- Evaluation reports
- Semi-annual review of services
- Annual review of no-shows and cancellations
- Provision of services to any children/adolescents

Included in these independent accreditation processes are interviews with assessors, referral sources, and persons served, to ensure that the Policies and Procedures regarding independence and neutrality of assessors are not only appropriately designed but also adhered to. It includes a thorough review of the roster recruitment and scheduling processes, which demonstrates that the goal for working with experienced and objective assessors is a priority.

These processes also appropriately separate the IME company from the assessor in terms of responsibilities and ensure that neutrality is maintained by the assessor. They also
ensure that appropriate Policies and Procedures exist and are followed, regarding the roles of assessors and IME company staff. Also evaluated is the quality assurance program; not just on the report product itself, but throughout the process, including the financial health of the company and whether it is operated in a responsible manner. This helps to ensure that defensible, objective third-party opinions are provided with professional and unbiased service to all key stakeholders by a stable and credible business.

Promoting the requirement for accreditation will go a long way towards reassuring the public and other stakeholders that standards do exist and that companies and assessors are being evaluated by outside accrediting agencies, apart from FSCO or FSRA, and that they uphold the importance of neutral and credible assessments. Any organization not meeting the standards should be restricted from involvement in the system until standards are met.

Accreditation presents a substantial hurdle for smaller or less credible companies that lack the scope, resources (employees, corporate structure, support services like IT, health and safety, finance, human resources, financial/capital), or foundation to be able to effectively meet the standards laid out by accreditation organizations.

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**6. Standard Treatment Plans**

There has been much discussion and debate over the past few years about the need for standard treatment plans that focus on appropriate treatment and care and ultimate recovery. We believe that if standard treatment plans are to be introduced, they must adhere to the following criteria:

**i. Ensuring timely access to care**

*Educating Consumers & Physicians*

The key to ensuring car accident victims obtain access to timely treatment, is creating stronger initiatives to educate consumers and physicians on how to find a reputable treatment provider, how treatment services are funded, how to access these services and what services are pre-approved. The insurance company/adjuster or broker, as the first point of contact following an accident, must be the conduit of this education by informing the claimant of the benefits available to them. For some insurance companies this means a shift in focus to "how can I assist you in your recovery" as opposed to "no, you don't have coverage for that". It is essentially a shift from cost containment based on denying claims and treatment to cost containment based on providing appropriate treatment leading to faster recovery from injuries.

*Setting Timely Access Expectations*

Many insurers utilize preferred provider networks to ensure timely access to care. These agreements often include the promise to offer a claimant an appointment within one to two business days from the time of the referral. The outcome is that many claimants begin treatment within a few days of their accidents. Best practices certainly support early intervention, as a means to a successful recovery.

**ii. Focus on recovery, outcomes and appropriate care**

*Creation of Programs of Care*

We believe that a treatment guideline must be evidence based and outcome focused. In the 'Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person', Dr. Pierre Cote and his team described their objective as developing Care Pathways and Clinical Guidelines.

For any guideline to be effective, it **must be easily understood** by patients, clinicians and insurers. The clinical guidelines Dr. Cote has provided are extremely detailed (almost 200 pages), complex and highly prescriptive in nature. This level of complexity will not simplify the provision of treatment to motor vehicle accident clients from the perspective of either the health care provider or the insurer. In fact, it has a greater potential to perpetuate disputes and delay care.

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We would recommend that to link research completed by Dr. Cote and others into clinical guidelines, healthcare practitioners be engaged in the discussions to ensure the practicality of putting the guidelines into clinical practice.

The clinical guidelines should guide treatment, not dictate care. Healthcare professionals are responsible and accountable for assessing their patients and formulating an appropriate course of treatment taking into consideration best practices, patients' needs, beliefs and, **most importantly, preserving patient choice** of treatment interventions.

Creating change within the current system requires the creation of an outcome driven model. To evaluate the effectiveness of a program, the **collection and analysis of outcome data is a requirement**. In fact, many CARF accredited organizations like Lifemark already collect, analyze and report outcomes to our customers based on various metrics, including validated clinically relevant objective outcome measures (i.e. Patient-Specific Functional Scale (PSFS)), return to work and return to normal activities of daily living outcomes, cost of treatment, number of visits and duration of treatment. We would encourage the government to ensure that any guideline developed include the requirement to collect and report objective outcomes to ensure that the treatment provided was effective.

We also recommend dedicating time to analyzing all of the data already collected within the HCAI system, with respect to the effectiveness of the current guidelines, prior to implementing wide, sweeping changes. This information could prove valuable in the creation of new and improved care pathways.

**Other factors to consider**
*Block Billing Model*

Many programs of care, and even the current Minor Injury Guideline model that is in place for motor vehicle accidents, have a block billing system that is not dependent on the number of treatment sessions provided. For example, Block 1 under the MIG pays $775 and if the patient only attends a few sessions, the insurer may be paying more than the value of the amount of service actually received. FSCO already has a licensing and regulatory process in place to allow providers to directly invoice an insurance company and to monitor their billing practices.

Increasing the oversight and enforcement of proper billing practices should be considered to eliminate unethical billing practices within the industry and reduce the costs associated with these practices.

The block-billing model creates a great deal of misunderstanding and frustration when a claimant has Extended Health Care (EHC) insurance coverage. The legislation requires the EHC to be the primary payer but EHC insurers do not accept block billing, which leads to a lot of work on the part of the patient, the provider, and the adjuster to ensure all payments are processed correctly. A fee per visit payment system in the MVA market would alleviate much of these

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concerns and issues. These fee guidelines already exist through FSCO and the Professional Fee Guidelines.

*Extended Healthcare Benefits*

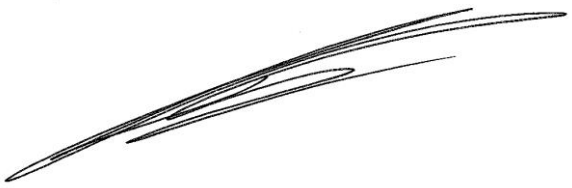
In our current system, claimants must access and exhaust their extended healthcare benefits prior to their auto insurance carrier funding treatment services. This often creates a negative experience for the claimant at the outset of their claim. These concerns can lead to delays in accessing care and a desire to seek legal representation, which heightens the likelihood of future disputes.

In Alberta and Nova Scotia, claimants whose injuries are appropriate for care under the Diagnostic and Treatment Protocol Regulation (DTPR) do not access their extended healthcare benefits unless their care goes beyond the pre-approved limits. A review of this model, including the prevalence of disputes in Alberta and Nova Scotia, may be beneficial in the creation of an Ontario model built to ensure timely access to care and minimizing disputes, which in turn would reduce costs within our current auto insurance system.

We recognize the need for significant changes to the Ontario auto insurance product and we have been pleased to work with your government to develop ideas for reforms that will ensure that injured claimants obtain the treatment and care they need to recover from their injuries and return to their pre-accident lives. We are also cognizant of the efforts by the government to reduce costs in the system and restore accountability and trust in how the auto insurance product is administered. We support those objectives and we look forward to continuing to work with the government in that regard.

Thank you for your consideration of our recommendations.

Yours truly,



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