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GETTING TO CAT: A ROADMAP FOR HEALTH CARE PROFESSIONALS

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Getting to CAT: A roadmap for health care professionals

The new definition of catastrophic impairment is perhaps the most challenging test in *SABS* history for adults who have suffered a traumatic brain injury in a motor vehicle collision. Not only has the Glasgow Coma Scale been replaced with the Glasgow Outcome Scale/Glasgow Outcome Scale-Extended, injured adults must also have positive findings on a computerized axial tomography scan or other medically recognized brain diagnostic technology. Assuming the new definition is met, these adults will only receive half the amount of medical/rehabilitation and attendant care benefits that was available prior to June 1st 2016. This change represents a major shift in government policy. It moves away from ensuring seriously injured accident victims have prompt access to services during the acute injury phase to focusing on their functional outcome well after the onset of injury.

The elimination of the Glasgow Coma Scale has taken away the automatic catastrophic criterion. At a minimum, the most severely brain injured adults will have to wait 30 days before being deemed catastrophically impaired. Adults suffering a mild to moderate brain injury will have to wait at least 6 months before applying for the catastrophic impairment designation. This presents a host of problems for discharge, planners, case managers and other medical specialists who will struggle with assembling an appropriate community based treatment team. The provision of intensive treatment and attendant care services will be postponed, reduced and in some cases eliminated. Family members will be put under immense pressure.

To add insult to injury, the quantum of available *Statutory Accident Benefits* has been dramatically reduced. For accidents occurring after June 1, 2016 medical, rehabilitation and attendant care benefits for catastrophically injured accident victims is capped at $1 million. Non-catastrophic benefits for these categories are a paltry $65,000[1].

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[1] In cases where the collision occurs after June 1st 2016 but the client's insurance policy renews after June 1st 2016 the old limits remain available but the new CAT definition applies.

The goal of this paper is a to provide a roadmap to understanding the new catastrophic definition and how to successfully document your client's file to increase his/her ability to get to CAT.

The 2016 Catastrophic Impairment Definition

In order to successfully overcome the challenges present by the new catastrophic impairment definition, it is important to understand the wording contained within the *Schedule.* Firstly, the injury must be a traumatic brain injury (as opposed to a brain impairment, as set out in the previous version of the *SABS*)[2] diagnosed by a neuropsychologist who has been registered to practice neuropsychology in Canada for at least 5 years[3].

Secondly, as noted above, the traumatic brain injury must be supported by positive findings on a computerized axial tomography scan, MRI or other medically recognized brain diagnostic technology indicating intracranial pathology arising from the collision and a Glasgow Outcome Score – Extended score of[4]:

> *(a) Vegetative State (VS or VS*), one month or more after the accident,*
>
> *(b) Upper Severe Disability (Upper SD or Upper SD*) or Lower Severe Disability (Lower SD or Lower SD*), six months or more after the accident, or*
>
> *(c) Lower Moderate Disability (Lower MD or Lower MD*), one year or more after the accident.*

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[2] s.45 *Statutory Accident Benefits Schedule*
[3] s.3(1) *Statutory Accident Benefits Schedule*
[4] s.3.1(1)4(i) and (ii) 1 *Statutory Accident Benefits Schedule*

Understanding the Glasgow Outcome Scale/Extended

The Glasgow Outcome Scale-Extended (GOS-E) is practical index of social outcome following a head injury. It represents a simple, hierarchical rating scale that acknowledges a traumatic brain injury can seriously impair a person's quality of life at different points of time[5] and itself relies answers to questions focused on a limited number of broad categories. How the person scores on this test determines how their brain injury has affected function in major areas of life. It is the most widely used and accepted measure of outcome[6].

Conversely, it is a very basic test that is administered by way of a short unstructured interview. There are no written components other than the assessor's notes. The questions are open-ended, rely on patient compliance and encourage a subjective use of the scale. More often than not brain injured individuals lack insight into the full extent of their deficits and under report their ability to function in the real world. They are euphoric and oblivious to obvious personality changes which can be the commonest and most disabling sequele that is not dependent on the presence of neurological deficits[6]. There is an inherent risk of systemic bias and under / over estimation of the injured client's true functional state. Overall, the GOS-E gives a general indication of outcome and does not identify the person's specific functional impairments.

In response to these establish flaws found in the GOS-E test, J. T. Lindsay Wilson, Laura E. L. Pettigrew and Graham M. Teasdale conducted extensive research and developed a set of standards for administering the GOS-E. These standards are contained in their paper entitled *Structured Interviews for the Glasgow Outcome Scale*

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[55] Jennett, B. and Bond M., *Assessment of Outcome after Severe Brain Damage,* The Lancet, March 1, 1975, pp.480-484.
[6] whttp://www.abiebr.com/set/17-assessment-outcomes-following-acquiredtraumatic-brain-injury/glasgow-outcome-scaleextended

and the Extended Glasgow Outcome Scale: Guidelines for Their Use[7]. The paper is attached. The Guidelines are summarized as follows:

1. *Disability due to head injury is defined by a change from pre-injury status;*

    a. *The scale is designed to assess changes and restrictions that have taken place as a result of the head injury. Questions regarding pre-existing disability status makes it possible to assess outcome after head injury.*

2. *Only pre-injury status and current status should be considered;*

    a. *Do not consider:*

        i. *the initial state after the injury;*
        ii. *hopes for the future;*
        iii. *the fact that the person has made a remarkable recovery considering their initial state;*

3. *Disability must be a result of mental or physical impairment;*

    a. *Not all changes following the event is due to the injury;*

    b. *About capability to do the activity regardless of whether they actually do it;*
        i. *Note: Sometimes the precise question that is being asked is hypothetical: what exactly is the patient capable of even though they do not actually do it? If the answer to a question indicates that the head-injured person has some difficulty in a particular area, then it may be necessary to probe more deeply. After most of the main questions is a note amplifying the hypothetical issue that is being addressed, and there are further notes below. If necessary, the questioning should be continued to determine the answer to the hypothetical question.*

4. *Use the best source of information available.*

    a. *Be aware of the circumstances in which the information may be misleading;*

        i. *Interview collateral sources if the person lacks insight;*
        ii. *Most people with a brain injury will deny psychological change;*

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[7] Wilson, Pettigrew, Teasdale; Structured Interviews for the Glasgow Coma Scale and the Extended Glasgow Outcome Scale for their Use, Journal of Neurotrauma, Vol. 15, Number 9, 1998 at p.574-575. A copy of this article including the structured interview questionnaire is attached to this paper.

   iii. *A return to pre-collision activity such as work or school should not be given much weight as special accommodations may have been made that enable the person to do the activity;*

b. *Contradictory or inconsistent responses is a signal to dig deeper or interview a collateral source;*

c. *Further consideration may indicate that such a person should be considered to be moderately disabled rather than severely disabled, that is, that they are capable of activities of independence outside the home, even if they have some particular difficulties with them*

d. *Complete the entire questionnaire.*

These Guidelines have been accepted by the medical community and in particular have been incorporated catastrophic definition in the *SABS* by requiring assessors administering the GOS-E to complete the testing in accordance with these Guidelines.

Administering the GOS-E

The GOS-E is made up of 8 categories; each of which are made up of a series of yes or no questions dealing with not only the injured person's ability to complete certain activities of daily living but the frequency of participation as well. These categories include independence inside and outside of the home, ability to return work, participation in social & leisure activities with family and friends as well as the possibility of returning to normal life. The test is reproduced on the following pages.

Respondent: ☐ 0 = Patient alone 1 = Relative/friend/caretaker alone 2 = Patient plus relative/friend/caretaker

Conciousness:

1. Is the head-injured person able to obey simple commands or say any words?

◯ Yes ◯ No (VS)

Note: anyone who shows the ability to obey even simple commands or utter any word or communicate specifically in any other way is no longer considered to be in vegetative state. Eye movements are not reliable evidence of meaningful responsiveness. Corroborate with nursing staff and/or other caretakers. Confirmation of VS requires full assessment.

Independence at home:

2a. Is the assistance of another person at home essential every day for some activities of daily living?

◯ Yes ◯ No (VS) **If no: go to 3**

Note: for a NO answer they should be able to look after themselves at home for 24 hours if necessary, though they need not actually look after themselves. Independence includes the ability to plan for and carry out the following activities: getting washed, putting on clean clothes without prompting, preparing food for themselves, dealing with callers and handling minor domestic crises. The person should be able to carry out activities without needing prompting or reminding and should be capable of being left alone overnight.

2b. Do they need frequent help of someone to be around at home most of the time?

◯ Yes (lower SD) ◯ No (upper SD)

Note: for a NO answer they should be able to look after themselves at home up to eight hours during the day if necessary, though they need not actually look after themselves

2c. Was the patient independent at home before the injury?

◯ Yes ◯ No

Independence outside home:

3a. Are they able to shop without assistance?

◯ Yes ◯ No (upper SD)

Note: this includes being able to plan what to buy, take care of money themselves and behave appropriately in public. They need not normally shop, but must be able to do so.

3b. Were they able to shop without assistance before?

◯ Yes ◯ No

4a. Are they able to travel locally without assistance?

◯ Yes ◯ No (upper SD)

Note: they may drive or use public transport to get around. Ability to use a taxi is sufficient, provided the person can phone for it themselves and instruct the driver.

4b. Were they able to travel locally without assistance before the injury?

◯ Yes ◯ No

Work:

5a. Are they currently able to work (or look after others at home) to their previous capacity?

◯ Yes **If yes, go to 6** ◯ No

5b. How restricted are they?

a. Reduced work capacity? ◯ a. (Upper MD)

b. Able to work only in a sheltered workshop or non-competitive job or currently unable to work? ◯ b. (Lower MD)

5c. Does the level of restriction represent a change in respect to the pre-trauma situation?

◯ Yes ◯ No

Social and Leisure activities:

6a. Are they able to resume regular social and leisure activities outside home?

◯ Yes **If yes, go to 7** ◯ No

Note: they need not have resumed all their previous leisure activities, but should not be prevented by physical or mental impairment. If they have stopped the majority of activities because of loss of interest or motivation, then this is also considered a disability.

6b. What is the extent of restriction on their social and leisure activities?

- a. Participate a bit less: at least half as often as before injury ◯ a. (Lower GR)
- b. Participate much less: less than half as often ◯ b. (Upper MD)
- c. Unable to participate: rarely, if ever, take part ◯ c. (Lower MD)

6c. Does the extent of restriction in regular social and leisure activities outside home represent a change in respect or pre-trauma

◯ Yes ◯ No

Family and friendships:

7a. Has there been family or friendship disruption due to psychological problems?

◯ Yes ◯ No **If no, go to 8**

Note: typical post-traumatic personality changes are: quick temper, irritability, anxiety, insensitivity to others, mood swings, depression and unreasonable or childish behaviour.

7b. What has been the extent of disruption or strain?

- a. Occasional - less than weekly ◯ a. (Lower GR)
- b. Frequent - once a week or more, but not tolerable ◯ b. (Upper MD)
- c. Constant - daily and intolerable ◯ c. (Lower MD)

7c. Does the level of disruption or strain represent a change in respect to pre-trauma situation?

◯ Yes ◯ No

Note: if there were some problems before injury, but these have become markedly worse since the injury then answer yes to question

Return to normal life:

8a. Are there any other current problems relating to the injury which affect daily life?

◯ Yes (Lower GR) ◯ No (Upper GR)

Note: other typical problems reported after head injury: headaches, dizziness, sensitivity to noise or light, slowness, memory failures and concentration problems.

8b. If similar problems were present before the injury, have these become markedly worse?

◯ Yes ◯ No

9. What is the most important factor in outcome?

◯ a. Effects of head injury

◯ b. Effects of illness or injury to another part of the body

◯ c. A mixture of these

Note: extended GOS grades are shown beside responses on the CRF. The overall rating is based on the lowest outcome category indicated.
Areas in which there has been no change with respect to the pre-trauma situation are ignored when the overall rating is made

The test is scored based on 7 outcome scales. These scales are vegetative, upper severe disability, lower severe disability, upper moderate disability, lower moderate disability and good recovery. A helpful chart summarizing the factors taken into account during the interview process and how it applies to the catastrophic impairment criteria is below[8]:

Meets CAT Def'n (VS, SD-, SD+, MD-)

VS [>1 mth]	SD- [>6 mths]	SD+ [>6 mths]	MD- [>1 yr]	MD+	GR-	GR+
Not VS if can communicate Y/N	For some activities of daily living Includes dependency on cueing and reminders Cannot be left alone for 8 hours	For some activities of daily living Need cueing and reminders Can be left alone for up to 8 hrs OR Need assist to shop – plan, purchase, appropriate behaviour OR Cannot travel without assistance – including taxi coordination	Unable to work - sheltered or non-competitive work only OR Rarely or never go out socially or for leisure OR Family and friend relationships disrupted – constant, intolerable	Reduced capacity to work OR Participate much less in social or leisure (less than half as much) OR Family and friend relationships disrupted – once a week or more but tolerable	Able to work OR Participate less in social or leisure – at least half as often OR Family and friend relationships disrupted – less than weekly OR Other problems that affect daily life	No problems that affect daily life

It is important to note that the catastrophic definition contained in the *SABS* excluded upper moderate disability from the catastrophic criteria.

According to Wilson, Pettigrew et al assessing an outcome category should be completed in the following manner[9]:

> ***Severe disability****. Obtain answers to all the main questions concerning independence and the questions concerning preinjury problems in these areas (Q2-4). If the patient was fully independent before the injury, and the answers to*

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[8] Milner, Tracy, Complex Injury Rehab Inc,. Catastrophic Impairment Definition, Functional Implications & Impact on Occupational Therapy,

[9] Supra at note 7, p 576.

one or more of the dependence questions indicate that this is no longer the case then they are Severely Disabled (SD).

***Moderate disability**. Obtain answers to all the main questions concerning disability, and the questions concerning preinjury problems (Q5-Q7). If the patient had <u>no prior problems</u> and the answers to one or more of the questions concerning current difficulties indicate that this is no longer the case, then they are Moderately Disabled (MD).*

If the patient <u>had prior difficulty</u> in one or two of the areas, then they can usually be rated on the basis of the answers to the remaining questions. Sometimes a patient will have had prior problems, but these have become markedly worse as a result of injury, and this change can be used in rating. If the person was unemployed and not seeking work before the injury, then they should be rated on the answers given to questions 6 and 7. For example if the person is long-term unemployed or retired, then they should be rated on social and leisure activities and personal relationships. Question 6c is included because people may have a very restricted preinjury social repertoire (for example, the chronically ill, or people who are socially isolated), and it may not be sensible to rate them on this question. In general, it is not uncommon for people to have preinjury difficulties in one or two of these areas, and it will usually be possible to determine an outcome on the basis of the other questions.

***Good recovery**. If the patient does not fulfil the criteria for any of the lower outcome categories, then they are considered to be a Good Recovery.*

***Preinjury disability**. There are some cases that are problematic because of the presence of very significant preinjury problems and severe preinjury dependency.. The approach suggested here is to rate such people on their current functional status and to indicate the existence of preinjury disability by putting a "*" beside the rating. These ratings can then be interpreted as meaning "still disabled at this level", or "disability no worse than this level" and dealt with appropriately in analysis. The circumstance in which we specifically suggest that cases are treated in this way is as follows. If the patient was not fully independent before injury, then they should be rated Severely Disabled* (SD*) (or upper or lower SD* on the GOSE depending on the degree of preinjury disability.*

It is too early to know what the Licensing Appeal Tribunal will do when faced with a catastrophic dispute where the injured person's scoring is denied based on an asterisk. It is anticipated that Arbitrators will take guidance from the well-established line of case

law that addresses whether the collision materially contributed to the injured person's impairments[10].

What we can do

Comprehensive documentation is key to overcoming the new catastrophic definition. Ensuring early intervention by a team of specialized rehab professionals and experienced, reputable legal counsel is critical. Everyone involved, including the injured person's family, need to work collaboratively in order to ensure detailed information about the injured person's ongoing challenges are included in the records. Descriptions about functional status must be clear and incorporate the not only language from the GOS-E but also strong words such as "likely" and "probably" rather than the more commonly used "possibly", "might", "may" and "at risk for".

Use Activities of Daily Living Checklists to track progress. Challenge the injured person to complete the tasks referred to in the GOS-E and document these demonstrative examples of his/her inability to function in the real world. Reporting styles need to shift from the usual goal oriented progression model to a more negative reporting style that discusses, at length, the ongoing challenges.

Family members and attendants should be urged to can assist in this process by keeping a daily journal that documents personality, behavioral & cognitive changes together with instances of dependence inside and outside of the home. Lawyers may also consider commissioning day-in-the-life videos in order to supplement narrative reports.

[10] *Monks v. ING Insurance Company of Canada* 2008 ONCA CanLII 269; *Lee and State Farm Mutual Automobile Insurance Co., [2006] O.F.S.C.O. No. 17;* B.P. and Primmum Insurance Co., [2006] O.F.S.C.O. No. 202; Hans-Jorg Reichert and Chubb Insurance Company of Canada, FSCO A12- 003518 (2014-02-05).

The importance of this type of evidence is highlighted in the 2015 decision in *Watters and State Farm';* the only case to find an insured catastrophically impaired based on the GOS. Arbitrator Feldman summarizes the evidence as follows:

> *Dr. Moddel admitted on cross-examination that, at the time he formed his opinion concerning the Applicant's GOS score, he had not recently reviewed the 1975 article and he was unfamiliar with the 1981 article or the standardized structured interview questionnaires referenced in the 1998 article.* ***He refused to consider or give any weight to reports (that were provided to him) by occupational therapists and others who observed the Applicant in real-world settings and that contained relevant information concerning the Applicant's level of function and independence with respect to various activities of daily living, inside and outside of her home. He also failed to conduct collateral interviews*** *of the Applicant's husband or other close associates that might shed light on personality, behavioural and cognitive changes of the Applicant as well as information about her daily activities and level of independence. Dr. Moddel* ***focused exclusively on neurological test results*** *(his and earlier neurological test results referenced in the documents provided to him)* ***and his observations and communications with the Applicant during his assessment of her****. This is because Dr. Moddel, incorrectly, sees the GOS as simply a measure of the severity of any neurological deficits caused by brain impairment. Since he found virtually no neurological deficits (other than an impaired sense of smell), he concluded that the Applicant had not sustained a "severe disability" under the GOS and felt that no further explanation was needed.* ***I find this interpretation and application of the GOS to be far too simplistic and I reject it***
>
> *… the evidence clearly shows that while the Applicant has made some gains since the accident, she still requires a substantial amount of attendant care and requires daily assistance. While she can be left alone in her home for several hours without undue risk of harm, she is not truly independent either inside or outside of her home.*
>
> *She requires constant monitoring and cueing to ensure that she is eating properly, changing into clean clothes, properly caring for her dog and taking the right medication at the right time. She only occasionally leaves her home; usually to attend medical appointments, engage in physical rehabilitation (such as swimming and aqua fitness) or going shopping. When she leaves the home, she is almost always accompanied by a family member or other attendant. Based upon the overwhelming weight of the evidence presented, I am satisfied that she cannot independently use public transportation or go shopping. There have been times when the*

> *Applicant has been unable to remember where she is going or why and when she has been unable to follow a shopping list, even if she helped to prepare it. Past incidents described by Derek Watters demonstrate that the Applicant can become confused and overwhelmed when out in the community and that she needs to have an attendant with her when she leaves her home. In short, the Applicant is dependent upon daily support. This ongoing need for daily support is, in large part, due to the brain impairment she sustained as a result of the September 29, 2011 accident.*

These documentary practices also apply to s.3.1(1)8 of the *SABS* which provides that a person meets the definition of catastrophic where he/she has suffered an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 results in a class 4 impairment (marked impairment) in three or more areas of function that precludes useful functioning or a class 5 impairment (extreme impairment) in one or more areas of function that precludes useful functioning, due to mental or behavioural disorder.

Where we go from here

The resources available to seriously injured accident victims have been significantly restricted with the introduction of the narrowed catastrophic definition and benefit reductions. It will be difficult for everyone involved to ensure that their client is getting the most out of their limited medical and rehabilitation dollars. Discharge planning will be difficult; especially where there is no case manager available to assist with securing community-based therapies. The provision of attendant care services will be delayed, reduced, or eliminated and families will be placed in the position of having to provide support/intervention that they are ill-equipped to do. There will also be intense pressure of admission to in-patient facilities, the limited OHIP funded services, or CCAC services

With that in mind, there are a few options that will be available to injured people. Repeat applications for catastrophic impairment can be made at several different points in time. For example, an unsuccessful application may be made at the 6-month mark under the GOS-E severe disability category followed by a further application at the 12

month anniversary under the GOS-E upper moderate disability category an again after 2 years.

Where SABS benefits have been exhausted and there is a viable tort claim, lawyers can ask insurers and opposing counsel to fund treatments plans in order to offset ongoing medical costs. If the request is refused, a court may order an advance payment if it can be proven that the injured person's prospects of recovery is real and beyond reasonable doubt[8].

There are also situations where advance payments are statutorily required. Subsection 258.5(2) of the *Insurance Act* provides "if the insurer admits liability in respect of all or part of a claim for income loss, the insurer shall make payments to the person making the claim pending determination of the amount owing". Subsection 258.5(3) limits the amount of the advance payment to the insurer's estimate of the amount owing in respect of the claim for income loss. Accordingly, provided that liability has been admitted and the plaintiff is advancing a claim for income loss, tort adjusters are statutorily mandated to make advance payments to an injured plaintiff.

Irrespective of whether the advance payment is made pursuant to a court order based on the prospect of real recovery or statutorily required, insurers will not consider an advance payment without a strong foundation of evidence of impairment and need established by the treating and expert medical specialists.

As a last resort, potentially catastrophically injured people can apply for third party financing or if the treatment provider is agreeable, instruct counsel to protect the rehab account. Either way, this is a risky proposition as the balance owing, including interest, as it is completely dependent on a successful catastrophic application.

Summary

It is trite law that "the legislature's definition of "catastrophic impairment" is intended to foster fairness for victims of motor vehicle accidents and ensure that victims with the greatest health needs have access to expanded medical and rehabilitation benefits[11]; that "the *SABS* are remedial consumer protection legislation[12]" intended to be interpreted in a manner that assists consumers and "the definition of "catastrophic impairment" to be inclusive rather than restrictive[13]. It remains to be seen how these past principles will impact future decisions.

Having said that, the June 1st changes have brought about a time for creativity and collaboration. As treatment providers, you are in the unique role of witnessing the injured person's daily struggles and accomplishments. As Lawyers, we will be working collaboratively you, our clients and their families in order to ensure that the ultimate decision makers will be forced to choose between a strong evidentiary foundation that focuses on real world functional impairment rather than isolated clinical testing. Together we will stand as a strong and committed team of specialists committed to a single goal.

Thank-you

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[11] Desbiens v. Mordini, [2004] CanLII 4121O (ON S.C.)
[12] Smith v. Co-Operators General Insurance Co.,[2002] 129 S.C.R.
[13] Supra at note 11.