THE TRANSITION OF PATIENTS FROM HOSPITAL TO HOME UNDER THE POST SEPTEMBER 1ST SABS

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The changes to the Statutory Accident Benefits Schedule as of September 1, 2010 drastically reduce the insurance coverage available to motor vehicle accident victims. This paper will review some of the particular challenges that will be faced by seriously injured people as they transition from hospital back into their community.

All fees and expenses for conducting assessments, examinations and preparing reports are now paid out of the medical and rehabilitation benefit limit (excluding examinations conducted at the request of the insurance company and accounting reports for income replacement benefits). Section 18(5) provides:

> For the purposes of subsections…(3), medical and rehabilitation benefits payable in respect of an insured person include all fees and expenses for conducting assessments and examinations and preparing reports in connection with any benefit or payment to or for an insured person under this regulation other than (insurer exams and accounting reports).

These expenses were formerly paid by the auto insurance company out of a separate category of benefit with no monetary limit. Therefore, other avenues to get assessments done or to secure funding are necessary.

A. Prior to a patient's discharge, we should take advantage of any opportunity for an in-hospital assessment.

We know that hospital admissions following trauma are getting shorter, not longer. There is pressure to discharge patients as early as possible. We know that hospital staff are often overburdened by their caseload and that in-hospital resources are limited.

However, Occupational Therapists, Physiotherapists, and other health care professionals who treat our clients in hospital, do make recommendations for our clients/their patients, on discharge. It is important to request consults by O.T. and P.T. prior to discharge and to secure a copy of their written recommendations.

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B. Prior to a patient's discharge, the community providers should connect with the in-hospital staff.

It is important to understand the recommendations of discharge planners and secure as much information as possible from the expert hospital healthcare providers that have cared for our clients. This allows not only a smoother transition from hospital to home, but may also provide cost savings by avoiding the duplication of some assessments.

The hospital specialists can often recommend clinics and out-patient programs to augment the community rehabilitation. Hospital Social Workers often have knowledge about alternate funding sources through government programs, community resources and private associations dedicated to the assistance of persons in need. Hospital staff can be an invaluable resource with no added cost.

Once a client has been discharged back to her community – even the best laid discharge plans inevitably change. Clients are usually still in the acute phase of their recovery when they are discharged and their needs will change. The move from a structured environment to a non-structured environment is a challenge in itself and often leads to the emergence of new or previously undetected deficits. The external influences of family, friends, employment, school and environment - that are minimal in the hospital setting – are prominent in the community. Assessments in the community therefore will always be required.

C. Assessments in the Community following discharge remain necessary – how do we fund in light of the new restrictions?

Funding for assessments is subject to two significant restrictions under the post September 1st SABS. Not only are assessment costs paid from your clients' category limits (s.18(5) reproduced above), but the fees and expenses covered by the Schedule for assessments, examinations and the preparation of reports (including assessments performed by the auto insurance company) are limited to $2,000 (s.25(5)(a)). Section 25(5) provides:

> Despite any other provision of this Regulation, an insurer shall not pay:
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> > (a) more than $2,000 in respect of fees for any one assessment or examination whether conducted at the insistence of the insured person or the insurer.

In many cases, assessments will simply be funded from your client's medical/rehabilitation benefits. In catastrophic cases – although this is concerning – it is unlikely to prevent necessary assessments from being performed. However, in serious injury cases that are not catastrophic, the $50,000 medical/rehabilitation

benefit category limit may force your clients to forgo assessments in order to "save their money" to pay for active treatment.

Some of your clients will have access to group health benefits through their place of employment or through a group health plan available to their spouse or parent. Group health plans typically do not cover assessment, examination or report writing costs – however, they do fund active treatment costs. Many persons are unaware of their group health coverage. Therefore, it is important to consider group health coverage to help fund treatment.

In those cases where your client has a viable claim against an at-fault third-party (another driver; a roadway authority for an ill-designed, non-repaired or icy road; a vehicle manufacturer; etc.) they can commence a civil action against that third party for their damages – often called a "Tort" claim.

In some tort claims – it may be advantageous for the wrongdoer's insurer to consider making an advance payment of money before the case is resolved. Advance payments are often made in order to allow funding for rehabilitation and care.

It is well established that the longer disability persists, the more difficult it is to treat and the less likely it is to resolve. Therefore, with appropriate advocacy, some insurers do make advance payments. Counsel on behalf of your clients should be requesting rehabilitation and care funding from the tort defendants (insurers) in cases where no-fault limits are insufficient.

Greater no-fault funding for rehabilitation is available for those clients who have suffered a "catastrophic" injury (as defined in s.3 of the Schedule). Therefore, consideration of whether or not your client has suffered a catastrophic impairment should take place early. Under the post September 1st SABS, persons with injuries that are unlikely to cease do not have to wait until the two year anniversary of the accident before they can apply for catastrophic status under the Whole Person Impairment test. People who have suffered injuries that are unlikely to cease may apply for a catastrophic impairment designation prior to the two-year anniversary of the accident (s.3(5)).

Clients who also have a tort claim may enter funding agreements with service providers and provide an "assignment" of a portion of their future tort claim to pay for services rendered in advance.

Legal representatives of your clients may request assessments and reports to assist in the tort claim. Therefore, some of the assessment and report writing costs can potentially be covered on the tort side of the case. Thomson Rogers funds the cost of disbursements in its tort cases, as the case proceeds. Disbursements include the medical and rehabilitation assessments and reports that document the injuries suffered by the client, the treatment they have received,

their prognosis and the relationship between their injuries and the subject accident. If the reports of community service providers can serve the dual purpose of providing the information required in a tort case report (previously described) and documenting your services and informing the rehabilitation team about your client – this may provide another payment avenue for your assessments and report writing costs.

It is important that our clients understand that assessments and examinations identify needs and document their injuries. Without the identification of needs and description of injuries – there will be no treatment – regardless of the availability (or not) of funding.

D. Changes in Attendant Care claims

When patients are initially discharged home from hospital, they often require personal care. This is especially so as the length of hospital admissions decreases. The SABS provides that personal care is payable by the auto insurance company in accordance with the determinations made by a healthcare professional using a Form 1.

In the post September 1st SABS, attendant care assessments can only be conducted by Occupational Therapists or Registered Nurses (s.42(1)(b)). Previously there were no restrictions on who could complete a Form 1.

Form 1 assessments conducted in a hospital setting are rarely, if ever, applicable in a community setting. Therefore, there is no benefit to request an attendant care assessment by hospital staff – unless your client requires attendant care in hospital.

Attendant Care assessments must be completed in the community but should be combined with assessments for housekeeping and home maintenance[2] or with assessments for other medical and rehabilitation benefits.

The quantum of attendant care benefits available for persons with non-catastrophic impairment has been reduced from a total maximum of $72,000 over a period of two years to a maximum of $36,000 over a period of two years. Further, the new definition of "incurred" applies to attendant care claims and therefore your client must pay or promise to pay the expense before it becomes payable **and** the attendant care provider must either suffer an economic loss by providing the care or provide the care in the course of the employment, occupation or profession in which he/she would normally have been engaged.

[2] In catastrophic cases where the housekeeping and home maintenance benefit remains available. However, it is not longer available for non-catastrophic impairments.

The hourly rates prescribed by the Form 1 are far less than the rates charged by attendant care providers in the marketplace. Therefore, the friends and families of injured persons have historically provided most of the attendant care – although they were underpaid. The post September 1st SABS effectively precludes "non-professionals" (families and friends) from being paid for the care they provide. Your clients must know this before they are discharged from hospital. The discharge planner should also know that attendant care is not available because a request for Home Care funding should be made by hospital staff.

E. Potential cost saving measures in the transition phase

Once needs are identified, funds must be used cautiously, especially in cases with restricted $50,000 medical/rehabilitation limits. The rental of equipment that is required on a temporary basis may be more financially prudent than the purchase of equipment (although not in all cases). Initial treatment in a clinic setting may be less expensive than treatment in the home setting – at least in terms of avoiding the transportation costs of the therapists. Therapists working with the same client can be updated by Skype, email and telephone – rather than more expensive team meetings in person.

The involvement of community therapists may wax and wane several times – depending on the recovery stages and life stages of the client. It is important that the client and the therapist know that there may be times of intense involvement and other times when the therapist is not involved at all. It is important to use resources wisely, especially in light of restricted funding.

This paper has identified some of the many challenges that will be faced by injured persons and the people who help them – under the post September 1st SABS. Undoubtedly there will be more challenges. However, the hurdles are not insurmountable and creative solutions are available to assist injured people transition well from hospital to home.

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