Ontario Society of Occupational Therapists

Supporting OT Practice in Ontario's Auto Insurance Sector

Assessment of Attendant Care Needs, Form 1 :

A Resource for Reflective Practice

OSOT
Auto Insurance Sector Team
Attendant Care Needs (Form 1) Task Force

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FORWARD

This practice resource was developed by the Ontario Society of Occupational Therapists to support member occupational therapists who work in Ontario's auto insurance sector.

The assessment of a client's occupational performance and need for attendant care is germane to occupational therapy practice. However, there are unique considerations that occupational therapists must be aware of when attendant care is a benefit to which a client injured in a motor vehicle accident may be entitled. The specific application and determination processes relating to the attendant care benefit as directed by the *Statutory Accident Benefits Schedule* (*Ontario Regulation 34/10 of the Insurance Act, 2010*) require occupational therapists to be knowledgeable about the regulation, the Assessment of Attendant Care Needs (Form 1) and relevant dispute resolution decisions, all of which inform the assessment and documentation of needs for attendant care. This resource was developed to address the need for this foundational knowledge which is a complement to the therapist's professional skills and competencies relating to client assessment. *Assessment of Attendant Care Needs, Form 1: A Resource for Reflective Practice* was first published in April 2009. Further to legislative and regulatory amendment which came into force in September 2010, the resource was updated and published as the Second Edition to ensure that as a practice resource it reflected current regulatory direction and context.

Disclaimer

An expert panel of OSOT members and several other stakeholders have reviewed the information in this publication to ensure its suitability. The Ontario Society of Occupational Therapists assumes no responsibility or liability arising from any error or omission from this publication, or from the use of any information or advice contained in this publication. It should be well noted that content within this resource is reflective of the policy environment of the period up to April 2011. Changes to the *Statutory Accident Benefits Schedule, the Assessment of Attendant Care Needs (Form 1)* or the emergence of new legal precedents or arbitration decisions relating to attendant care needs will affect the accuracy of this document over time. **Readers should note the caveat of this limitation. Updates to this document will be posted as required to the Members' section of the website of the Ontario Society of Occupational Therapists at www.osot.on.ca.**

With Appreciation….

Supporting Occupational Therapy Practice in Ontario's Auto Insurance Sector – Assessment of Attendant Care Needs (Form 1): A Resource for Reflective Practice was first researched and written in 2009 by OSOT's Auto Insurance Sector Team, Form 1 Task Force (2007 – 2009). It was subsequently updated in 2011 by OSOT's Form 1 Task Force (2010 – 2011). Both Task Forces were supported and assisted by the OSOT Auto Insurance Sector Team membership and input and feedback from OSOT member occupational therapists working in Ontario's auto insurance sector.

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I. INTRODUCTION

The *Statutory Accident Benefits Schedule* (SABS) of Ontario's *Insurance Act* sets out a provision for an Attendant Care Benefit for eligible claimants who have been injured in motor vehicle accidents. Access to this benefit is applied for with submission of an *Assessment of Attendant Care Needs (Form 1)* to the insurer that is completed by an Occupational Therapist or Registered Nurse[1] who is authorized by law to treat that person's impairment. Occupational therapists are well suited to complete attendant care assessments given their training in function and adaptation within the context of physical, cognitive and/or psychosocial dysfunction.

> ***Occupational therapists are health care professionals regulated under the Regulated Health Professions Act (1991) and by the College of Occupational Therapists of Ontario (COTO). "The practice of occupational therapy is the assessment of function and adaptive behaviour and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure." - the Occupational Therapy Act, 1991***

This document provides an update of OSOT's *"Supporting OT Practice in Ontario's Auto Insurance Sector Assessment of Attendant Care needs, Form 1: A Resource for Reflective Practice document (May 2009)* as a result of the regulation changes to the *Statutory Accident Benefits Schedule* which occurred on September 1, 2010. The Ontario Society of Occupational Therapists' Auto Insurance Sector Team has provided these changes in an effort to ensure accuracy of this practice resource for members, and to promote a consistent and objective approach to the assessment of need for attendant care. This resource is based on the previous resource document which was developed using input from OSOT member focus groups, frequently asked questions posed by occupational therapists working in the auto insurance sector and decisions of arbitration hearings of the Financial Services Commission of Ontario (FSCO) and the judicial system in Ontario in relation to disputes that address attendant care benefits.

Purpose

This practice resource is developed to support occupational therapists to provide high quality assessments of attendant care needs. A quality assessment meets all regulatory standards, is comprehensive in its approach, unbiased, clear and defensible. A goal of the Society is to promote confidence and consistency in the occupational therapy approach to attendant care assessments.

This document is intended to be a reflective practice resource for occupational therapists to consider as they complete the Form 1. Although it presents best practices and considerations consistent with current arbitration decisions and judgments, readers are reminded that this is a practice "resource" and not a guideline.

> **The content of this document is not intended to be prescriptive in any way. An occupational therapist's professional judgement should guide all client interactions and interventions.**

Therapists need to be cognizant that the body of knowledge that informs this document will continue to grow and evolve as new dispute resolution decisions are made.

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1. O. Reg. 34/10, *Statutory Accident Benefits Schedule s. 42(1)(b)*

Development of this Document

In development of this document the authors have considered the following:

- Review of the current SABS
- The clinical experience of the occupational therapists of the Ontario Society of Occupational Therapists Attendant Care Task Force
- Information from Ms. Anne Utley, Ministry of Health and Long-Term Care, Subrogation Unit, regarding first and third party payers for health care (Appendix 1 & 2)
- Information from The Ministry of Health and Long-Term Care, including two specific resources;"Who Pays for Healthcare: Injuries from Motor Vehicle Accidents" (Appendix 3) "Personal Injury Accidents: Recovering Healthcare Cost" (Appendix 4)
- Children's Aid Society of Toronto, Publication "Home Alone – How do you know when your kids can be left unsupervised?" (Appendix 5)
- Contact with representatives from the Children's Aid Society (CAS) of Toronto with respect to the CAS guideline for the determination of when children can be left alone unsupervised.
- Contact with the Metropolitan Toronto Police Department
- Contact and correspondence with the Financial Services Commission of Ontario (FSCO)
- The Ontario Society of Occupational Therapists Auto Insurance Sector Task Force proposed "Considerations for Completion of Assessment of Attendant Care Needs Form 1", April 2001
- Assessment of Attendant Care Needs (Form 1) – September 1, 2010 (Appendix 6)
- Various Legal Judgments as decided by the Court of Law and Arbitration decisions as decided by the Financial Services Commission of Ontario (FSCO) (Appendix 7 (a) and 7(b))
- Feedback from OSOT members working in the auto insurance sector which has included:
    - on-line survey feedback to drafts of the document
    - e-mail correspondence
    - in-person discussions at the OSOT Annual Conference in September 2006, the OSOT Auto Sector Workshop in May 2007 and an Opinion Leaders Meeting on July 20, 2007, and subsequent OSOT workshops in May 2009 and April 2010.

Occupational Therapy: The Skills for Assessing Attendant Care Benefits

Occupational therapists are self regulating health professionals who have expertise in the assessment of function and bring a unique focus on occupational performance or day to day performance of activities of daily living. Defined in the *Occupational Therapy Act, 1991,* "The practice of occupational therapy is the assessment of function and adaptive behaviour, and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure."[1] Clearly it is within the occupational therapist`s scope of practice to assess a client`s capacity to perform self care and daily living skills and to identify needs for attendant care.

Occupational therapists bring unique qualifications to the assessment of a client's need for attendant care. The OT's education prepares them to assess and analyze a client's physical, mental and/or cognitive impairment(s) that impact function in order to provide recommendations that will reduce the impact of the client's disability on his/her daily life.

II. STATUTORY ACCIDENT BENEFITS SCHEDULE AND THE ATTENDANT CARE BENEFIT

What is the Attendant Care Benefit?

The attendant care benefit is described in Section19 of the *Statutory Accident Benefits Schedule (SABS)*. This section clarifies that the insurer shall pay an insured person who sustains an impairment as a result of a motor vehicle accident an attendant care benefit unless their impairment is determined to be within the Minor Injury Guideline.

The attendant care benefit will pay for all "reasonable and necessary expenses incurred by or on behalf of the

1. The *Occupational Therapy Act, 1991*

insured person" for services provided by an aide or attendant or services provided by a long-term care facility, including a nursing home, home for the aged or chronic care hospital. The monthly amount payable by the attendant care benefit shall be "determined in accordance with the Form 1". The SABS further defines the maximum amounts payable for the benefit which depend on both the severity of the impairment and the date of the accident. See Appendix 8 and 9. Occupational therapists working in Ontario's auto insurance sector should be familiar with the *Statutory Accident Benefits Schedule*. Ontario Regulation 34/10 is the most current consolidation of the SABS and can be accessed with a Google Search of Ontario Regulation 34/10 or at http://www.canlii.org/en/on/laws/regu/o-reg-34-10/latest/o-reg-34-10.html.

Application for Attendant Care Benefit

As of September 1, 2010, Section 19 of the SABS describes the attendant care benefit and Section 42 of the SABS describes the application process for the claimant to obtain the benefit and the insurer's obligations.

Occupational therapists should be familiar with sections 19 and 42 of the SABS that relate to the attendant care benefit. See Appendices 8 and 9.

The Assessment of Attendant Care Needs (Form 1)

The *Statutory Accident Benefits Schedule* stipulates that an assessment of attendant care needs shall be in the form of and contain the information requirements in the "*Assessment of Attendant Care Needs (Form 1).*"

Since 1994 there have been seven reviews of the *Statutory Accident Benefit Schedule* by the Financial Services Commission of Ontario that have resulted in amendment to those sections of the regulation that relate to the Assessment of Attendant Care Needs as well as to the Form 1 itself. As a result of these reviews and revisions, there are several versions of the *Form 1: Assessment of Attendant Care Needs* currently in use in Ontario's auto insurance sector. **The form to be used when assessing a client is determined by the date of the claimant's loss as per the following chart:**

Date of injury for Assessment of Attendant care needs (Form 1)	Legislation	comments	Form to be used
January 1, 1994 – October 31, 1996	Bill 164 Regulation 776/93	Indexed*	Found in O. Reg. 776/93, Form 1 Search at www.canlii.org
November 1, 1996 – September 30, 2003	Bill 59 Regulation 403/96	Form not indexed Form did not change	Found in O. Reg. 776/93, Form 1 Search at www.canlii.org
October 1, 2003 – February 28, 2006	Bill 198 Regulation 258/03	Form changed	Use Form 1 dated June 2003 (PDF)**
March 1, 2006 – January 31, 2007	Bill 198 Regulation 258/03	Hourly Rates for attendant care services changed	Use Form 1 dated Dec. 31, 2005 (PDF) (Fillable MS Word)**
February 1, 2007- to February 28, 2008	Bill 198 Regulation 258/03	Hourly Rates for attendant care services changed	Use form dated December 31, 2006 (PDF) (Fillable MS Word)**
March 31, 2008 to August 31, 2010	Bill 198 Regulation 258/03	Hourly Rates for attendant care services changed	Use Form 1 dated March 1, 2008 (Fillable/Saveable PDF)**
On or after September 1, 2010, accidents occurring on or after March 31, 2008 to present		Hourly rates as per Superintendant's Guildeline issued under s.19(2)(a) of the SABs	Use Form 1 dated September 1, 2010**

***note**: Indexing is listed on the FSCO website at www.fsco.gov.on.ca.

****note**: PDF and Fillable MS Word Forms are available for download on the website of the Financial Services Commission of Ontario at www.fsco.gov.on.ca.

When assessing a client injured in a motor vehicle accident that occurred prior to January 1, 1994, it is advisable to contact the insurer and/or legal representative to discuss what format the documentation of the client's attendant care needs should follow. This may or may not involve the use of an *Assessment of Attendant Care Needs (Form 1)*.

Payment of Attendant Care Expenses

While the completion of the *Assessment of Attendant Care Needs (Form 1)* is necessary to identify the requirements for attendant care, **it is the insurer's role to address the issue of payment of the attendant care benefit** according to the *Statutory Accident Benefits Schedule*.

With respect to payment, the SABS stipulates that;

- "The amount of a monthly attendant care benefit is determined in accordance with the version of the document entitled "Assessment of Attendant Care Needs" that is required to be submitted under section 42 and is calculated by,

  (a) multiplying the total number of hours per month of each type of attendant care listed in the document that the insured person requires by an hourly rate that does not exceed the maximum hourly rate, as established under the Guidelines, that is payable in respect of that type of care; and

  (b) adding the amounts determined under clause (a), if more than one type of attendant care is required. O. Reg. 34/10, s. 19 (2)."

- "The amount of the attendant care benefit payable in respect of an insured person shall not exceed" the maximum monthly benefits

- An insurer may request of an applicant "Any information reasonably required to assist the insurer in determining the person's entitlement to a benefit" O. Reg. 34/10 s.33 (1)1

As per Section 42, the SABS stipulates that:

(3) Within 10 business days after receiving the assessment of attendant care needs, the insurer shall give the insured person a notice that specifies the expenses described in the assessment of attendant care needs the insurer agrees to pay, the expenses the insurer refuses to pay and the medical and any other reasons for the insurer's decision. O. Reg. 34/10, s. 42 (3).

(4) A notice under subsection (3) may require the insured person to undergo an examination under section 44 if the insurer has not agreed to pay all expenses described in the assessment of attendant care needs. O. Reg. 34/10, s. 42 (4).

(5) An insurer may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with this section is submitted to the insurer. O. Reg. 34/10, s. 42 (5).

(6) The insurer shall begin payment of attendant care benefits within 10 business days after receiving the assessment of attendant care needs and, pending receipt by the insurer of the report of any examination under section 44 required by the insurer, shall calculate the amount of the benefits based on the assessment of attendant care needs. O. Reg. 34/10, s. 42 (6).

The definition for 'incurred' costs for the purpose of Attendant Care has now been defined in the O.Reg 34/10 under PART I Section 3 "Definitions and interpretation". It states:

"3. (7) For the purposes of this Regulation,

(e) subject to subsection (8), an expense in respect of goods or services referred to in this Regulation is not incurred by an insured person unless,

(iii) the person who provided the goods or services,

(A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or

(B) sustained an economic loss as a result of providing the goods or services to the insured person;"

Please see Appendix 12 for details of this Regulation in its entirety.

The Occupational Therapist determines the client's "needs" and the Insurance Adjuster determines payment of the benefit.

Request for OT to Calculate Expenses

There may be situations in which an occupational therapist is requested by either the client, legal representative and/or insurer to assist in determining a client's attendant care expenses. This however, would be a separate role from assessing the individual's needs as per the Form 1. **The purpose of this document is to address the completion of the Form 1 which is to determine the client's "needs" arising from those injuries sustained in the subject accident. OSOT positions that this is the occupational therapist's area of expertise. Determining the amount of attendant care benefit payable to the claimant is the adjuster's area of expertise.** The occupational therapist's assessment and documentation provide an objective foundation from which to determine the amount of benefit deemed payable.

Part 4 of the *Assessment of Attendant Care Needs (Form 1)* provides a calculation based on the number of hours of attendant care required and the designated hourly rate for each level of care. Occupational therapists should be reassured that this calculation on its own does not create an automatic obligation for the insurer to pay the identified amount for the monthly attendant care benefit.[2] The insurer can request information from the claimant that substantiates their use of an attendant. For example, the insurer may request identification of the service provider, the dates and approximate times of the service, etc. to satisfy him/herself that the services were provided (See Appendix 10 - Section 33 – Duty of Applicant to Provide Information).[3] If the occupational therapist assessing a client's needs for attendant care is made aware of the client's current use of attendants, this is useful information to be noted in the therapist's narrative report. In such a case, the Form 1 would clearly identify what skills a client is unable to perform and their needs for attendant care assistance.

Part 4 of the Form 1 identifies the total number of hours and costs related to the client's needs. The therapist's narrative report identifies whether an attendant or family member is currently providing assistance.

Dispute Resolution Process for Attendant Care Benefit

Notwithstanding the process for payment as outlined in the SABS, entitlement and/or payment of the benefit can be open to interpretation. It is not uncommon for disputes to arise when insurers challenge the amount of benefit applied for. The dispute resolution process which, may involve arbitrations through the Financial Services Commission of Ontario or civil suits through Ontario courts, lends insight and precedence over time that helps interpret application of the language of the regulation. For this reason, it is important for occupational therapists working in this field to be aware of and understand the outcomes of both arbitration decisions through the Financial Services Commission of Ontario and Legal Judgments that result from civil suits in Ontario courts that are related to the entitlement for Attendant Care Benefits. This knowledge will assist an occupational therapist in understanding the views of those who must ultimately make decisions regarding the provision of attendant care services for his/her clients. While it is recognized that there is a difference between an Arbitration Decision and a Legal Judgment, both are considered when resolving disputes.

There is an important difference between a Legal Judgment (as decided by a Court of Law) and an Arbitration Decision (as decided by the FCSO). The primary difference is that judicial decisions establish precedents that are binding for future decisions, whereas arbitration decisions may only have a persuasive effect on decision makers. This distinction is explained further by Mr. David MacDonald, BA (Hons), LL.B.,Thomson Rogers:

> "A Judgment is a finding by a court (Judge or Jury) that creates a precedent that is binding upon all future decisions made by a court of the same or lower level. For instance, a decision of the Ontario Court of Appeal is binding upon all Ontario Courts, but not upon the Supreme Court of Canada or the British Columbia Court of Appeal. Judicial rulings may change the common law over time if fact scenarios are sufficiently different for a judge to *distinguish* a precedent. Otherwise, judicial rulings apply previous rulings as precedents. This is known as *stare decisis*.
>
> An Arbitration Decision is only binding upon the parties to the particular case at hand. Arbitration Decisions do not create precedents, although they may be of persuasive value to Arbitrators working on the same tribunal or even to a Court. With respect to the FSCO decisions, we can expect that previous arbitration decisions issued from that tribunal may inform future decisions, but there is no such guarantee."[4]

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2. McKnight and Guarantee Co. of North America, FSCO A02-000299, October 28, 2003 Fernandes and Certas Direct Insurance Company. FSCO A04B000737. Heard on November 14,15, 2005, May 26, 2006
3. Smith v. Wawanesa, McMichael v. Belair Insurance, S.D. v. TTC Insurance Company, Stargratt v. Zurich Insurance, McKnight v. Guarantee, Bellavia and Allianz Insurance Company, State Farm Mutual Automobile Insurance Company and LF
4. Communication with David MacDonald, L.L.B., Thomson Rogers, 2006.

Because the outcomes of disputes in this sector have an impact on interpretation of the regulation and benefit entitlement, recent and pertinent judgments and decisions as of the date of the writing of this document (April 2011) relating to the completion of the Assessment of Attendant Care Benefits (Form 1) were reviewed as background preparation for this document. It is acknowledged that, over time, there will be new judgments and decisions which may provide further insight into the interpretation of the regulation and the process of determination for attendant care benefits. For this reason, it is essential that the foundations of this document be revisited from time to time as new information is made available to ensure that occupational therapists remain abreast of current legal perspectives and decisions that may relate to their work when assessing their clients. Occupational therapists are encouraged to monitor decisions of the courts and the FSCO arbitration processes themselves. To find Legal Judgments that relate to attendant care visit www.canlii.org, type in "attendant care" in the full text search line and browse for decisions relating to insurance. The FSCO Arbitration Decisions are accessible through the FSCO website at www.fsco.gov.on.ca (see http://fsco.gov.on.ca/english/insurance/auto/drs/decisions/)

III. GUIDING PRINCIPLES FOR OCCUPATIONAL THERAPY ASSESSMENT OF ATTENDANT CARE NEEDS

The following considerations provide the recommended foundation for the occupational therapist when completing an *Assessment of Attendant Care Needs (Form 1)*.

1.1 Occupational Therapy Ethics and Standards of Practice

The occupational therapist's assessment of need for attendant care is guided by their professional ethics and standards of practice. As regulated health professionals, OTs should be reflective of the standards and guidelines of the College of Occupational Therapists of Ontario which exist to ensure safe, competent practice.

Current resources of the College of Occupational Therapists of Ontario that relate to the assessment of attendant care needs include;

- Standards for Occupational Therapy Assessments, May 2007 (see box page 7)
- Professional Misconduct Regulation (O.Reg. 95/07)
- Essential Competencies of Practice for Occupational Therapists in Canada, second edition, June 2003
- Standards for Consent, July 2008
- Standards for Record-Keeping, July 2008

These resources are available to occupational therapists at the College of Occupational Therapists of Ontario website at www.coto.org.

1.2 Transparency of Practice

The obligation of transparency is particularly important in occupational therapy practice in the auto insurance sector which is an environment in which occupational therapists can be assessing for the same benefit on behalf of the claimant or the insurer. An occupational therapist should be very clear with his/her client regarding issues such as:

- how and why the occupational therapist is completing this assessment
- who requested the occupational therapist to complete the assessment
- whether the assessment is completed under Section 44 of the SABS "for the purposes of assisting an insurer determine if an insured person is or continues to be entitled to a benefit under this Regulation" or as a Section 25 of the SABS assessment which sets out "an application for attendant care benefits for an insured person". In both situations, the focus of the occupational therapist is to assess the client's attendant care needs.
- who will receive the information gathered and analyzed through the assessment
- how this information will be used, e.g. to determine benefit entitlement

1.3 Informed Consent

The Occupational Therapist is responsible for obtaining informed consent prior to the Attendant Care Assessment. Refer to College of Occupational Therapists of Ontario's *Standards for Consent, July 2008.*

1.4 Maintaining a Client–Centered Focus

It is important that the occupational therapist maintains a client-centered approach and recognizes that, according to the College of Occupational Therapists of Ontario, "the clients may include the individual, family, caregiver, group or organization that accesses the services of an occupational therapist but the primary client is the direct recipient of services".[5] Reflection on this point is particularly relevant in the auto insurance sector where the occupational therapist may have been referred to undertake an assessment of attendant care needs by either a physician, client, lawyer or insurer. Although it is always important to recognize and understand the stakeholders' positions, the therapist must maintain a focus on the "client" he/she is assessing.

This fundamental underpinning assures that the therapist's assessment is focused on identifying the individual client's occupational performance issues and needs for attendant care. This focus enables the occupational therapist to retain both objectivity and consistency of approach when assessing for attendant care needs.

When assessing a client's need for attendant care the occupational therapist must remain focused on the client's needs in an environment of competing interests.

Standards for Occupational Therapy Assessments[6]

1. The occupational therapist will establish a personal scope of practice, know the related legislation and organization requirements and determine own competency to practice within this scope prior to accepting referrals for assessment.
2. The occupational therapist will screen the referral to identify the client and determine that the request for service is appropriate prior to, or during the initial contact with the client. The Occupational therapist will gather sufficient information to determine whether or not to proceed with the assessment.
3. The occupational therapist will identify the stakeholders and clarify the OT roles and responsibilities. The occupational therapist will ensure there is informed consent from the client.
4. The occupational therapist will consider and apply assessment methods that are client centered, evidence based and supported by clinical judgment and experience.
5. The occupational therapist will use safe tools and assessment methods to gather adequate information for the analysis of the client's occupational performance issues in relation to the request for service.
6. The occupational therapist will ensure he/she has sufficient pertinent information to proceed with analysis.
7. The occupational therapists will form an opinion and/or make recommendations based on a synthesis of the information and in relation to the request for services.
8. The occupational therapist will maintain documentation that includes consent, assessment procedures used, results obtained, and analysis and opinion/recommendations. The document will reflect client-centered practice and clinical reasoning.
9. The occupational therapist will ensure that relevant assessment information is communicated (e.g. results, opinions, recommendations) to the client in a clear and timely manner unless doing so could result in harm to the client and/or others. The occupational therapist will provide opportunity for clarification and feedback from the client.
10. The occupational therapist will ensure that all information shared with other stakeholders is provided with informed client consent. The occupational therapist will share the information in a timely and relevant manner for the intended use.

** See *Standards for Occupational Therapy Assessments,* College of Occupational Therapists of Ontario, 2007 for detailed performance indicators for each standard.

5. Essential Competencies of Practice for Occupational Therapists in Canada , 2nd Edition. College of Occupational Therapists of Ontario, June 2003, page 4)

6. *Standards for Occupational Therapy Assessments, May 2007*, College of Occupational Therapists of Ontario

1.5 Assessing "Need" for Attendant Care

The completion of the *Assessment of Attendant Care Needs (Form 1)* requires the occupational therapist to assess the future needs for attendant care required by the client as a result of injuries sustained in a motor vehicle accident.[7] The SABs does not provide any operational definition for "need" or "attendant". According to the Collin's Dictionary, "need" is defined as "a requirement," "a necessity". The definition of "attendant" is "a person who accompanies or waits upon another".

Part 1 of the SABS, Definitions and Interpretation, section (7)(c) states: "For the purpose of this Regulation, an aide or attendant for the person includes a family member or friend who acts as the person's aide or attendant, even if the family member or friend does not possess any special qualifications." O. Reg. 34/10 s. 1(7).

When using the Form 1, occupational therapists are responsible to assess in order to determine those activities that the client is not able to do for themselves as a result of injuries sustained in the accident as opposed to determining what they have others doing for them. This will identify and validate appropriate needs for attendant care.

The therapist's role is to determine the extent to which the client can perform the skills and activities identified on the Form 1 safely and functionally and to objectively identify what assistance, if any, is needed from the present time into the future until another such re-assessment may identify modified needs.

This *Assessment of Attendant Care Needs (Form 1)* is not simply the recording of what attendant care services are already in place because:

- many clients may not have the family support or financial means to put such services in place.[8]
- it is possible that some clients have more services in place than they actually require. A claimant's family may be providing attendant care services (which may appear gratuitous) and may leave the perception that there is no or little need for attendant care services.
- a facility may be providing attendant care services which may leave the perception that there is no need for attendant care services.
- a client may require the services of an attendant concurrent with the provision of professional services (e.g. medical or therapeutic).

For example, when a Community Care Access Centre (CCAC) is providing attendant care, the occupational therapist's role continues to be to assess future needs for attendant care required by the client. It is therefore important that the needs that the attendant care services provided by the CCAC worker address be identified on the Form 1 and explained in the Occupational Therapist's narrative report.[9]

In determining the amount of time required to address a particular need for attendant care, a therapist must consider the predictability and consistency of a client's performance (physical/cognitive/behavioural). For example, if a client is unsafe in using the stove due to cognitive limitations and can be taught to only use the stove when assistance is available, then the client's need for support is defined around meal times. However if this same client's use of the stove is unpredictable, then 24 hour supervision may be required given the safety risk this behavior presents to himself and to others.

When determining the amount of time required to address a particular need, the **predictability and consistency** of a client's performance (physical, cognitive, behavioural) must be considered.

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7. Kyle McKnight and Guarantee, Stargratt v. Zurich, McMichael and Belair Insurance Company). Form 1, Bill 198, December 31 2005 - Introduction "Use this form to report the ***future needs*** for attendant care required by the applicant as a result of an automobile accident on or after March 1 2006."
8. Smith v. Wawanesa, McMichael v. Belair Insurance, S.D. v. TTC Insurance Company, Stargratt v. Zurich Insurance, McKnight v. Guarantee, Bellavia and Allianz Insurance Company, State Farm Mutual Automobile Insurance Company and LF
9. According to the Ministry of Health Subrogation Unit, the auto insurer is first payer for non-professional services. See attachments from MOH 2 Docs Feb 05. Recovering and who pays for health care.

1.6 Determination of Needs to Restore Pre-injury Status

Occupational therapists are reminded that the *Assessment of Attendant Care Needs (Form 1)* is intended to identify **needs for attendant care that are the result of a motor vehicle accident.** It is important for the occupational therapist to understand whether the client had any previous limitations to their occupational performance that may have required attendant care services. Only if the motor vehicle accident resulted in new impairments that leave the client with new attendant care needs should such needs be identified.

1.7 Components of a Comprehensive Assessment

It is important that assessments of needs for attendant care reflect both subjective and objective information gathered from the client and other relevant sources. When assessing a client's attendant care needs, occupational therapists will select assessment approaches based on their review of the client's history and diagnosis, determination of potential risks/contraindications, etc. OTs will be guided by the expectation that their assessment findings be defensible should a dispute arise. In other words, validation of the claimant's subjective feedback through observation and trial is important.

When assessing a client, it is important to consider the following:

- The client's report of function.
- Identified barriers to function e.g. lack of knowledge, awareness and/or insight.
- Collateral information (e.g. from care provider(s),family, friends, injured person, educational assistant, teachers)[10].
- Medical / test results and information provided by the treatment team.
- Objective components which include direct observation and demonstration of activity as appropriate (motor and cognitive behavioral processes).
- Relevant physical evaluation as deemed appropriate such as manual muscle testing, balance testing, sensory evaluation, etc.
- Relevant cognitive screening and/or assessment, perceptual screening and/or assessment.
- Relevant psychosocial and/or behavioural assessment.
- Community independence: A client may have needs for attendant care both inside the home and in the community. Assessment should address all areas of a person's need and safety both inside the home and in the community.

Occupational therapists are uniquely prepared to assess the attendant care needs of their clients. The OT's assessment and/or screening of physical, psychosocial, behavioural, cognitive or perceptual functions lends a comprehensive insight to the client's ability to manage daily living skills independently. The OT's objective assessment may, for example, highlight if and why a client with a relatively limited physical impairment has significant need for attendant care as a result of cognitive impairment or for mental health reasons arising from the MVA injuries. Consideration must be given to the impact of all injuries and sequelae arising from the automobile accident which impact function, whether that be from a physical, psychosocial, behavioural and/or cognitive perspective.[11]

The OT's assessment and/or screening of physical, psychosocial, behavioural, cognitive or perceptual functions lends a comprehensive insight to the client's ability to manage daily living skills independently.

10. McMichael and Belair Insurance Company, FSCO A02-001081

11. Mark Faerber-MacMillan and Allstate Insurance Company

1.8 Identifying the Need for More Information

If the occupational therapist becomes aware of the need for additional information (e.g. medical consultation, further assessments etc.) to inform the therapist's opinion and/or to complete the assessment, it is important that the therapist identify this need in the narrative report. If this information cannot be made available for the current assessment, it is essential that the occupational therapist identify the potential limitation(s) to the assessment in the narrative report. Recommendation for a re-assessment once the information is made available is reasonable.

1.9 Recommendations to Reduce or Eliminate the need for Attendant Care

Occupational therapists bring unique skills and training to the task of assessing attendant care needs including the ability to improve or enhance an individual's occupational performance through adaptation. This might include the introduction of remediation, compensatory techniques and/or assistive devices/equipment, modification of the environment, counseling and education. These skills are valuable to both the client and the insurer who are each vested in the client's return to function.

A recommendation of an assistive device or equipment, environmental modification or further therapeutic interventions, however, cannot be assumed to be effective and reduce the requirement for attendant care **until it is sufficiently implemented and verified.** If such strategies are appropriate, it is important that the occupational therapist make the recommendation in their narrative report, provide a period for the client to trial the new device and/or strategy and then propose to re-assess the client to determine the solution's effectiveness after this trial period. Re-assessment will allow for an accurate determination of whether the client's ability to function with this modification is reliably safe and consistent. After a re-assessment, the identified need for attendant care may then be reduced on the *Assessment of Attendant Care Needs (Form 1).*

The occupational therapist's unique skills and training applied to the task of assessing attendant care needs include the ability to improve or enhance occupational performance through adaptation and modification.

1.10 Documentation

The inclusion of an accompanying narrative report allows the occupational therapist to document their rationale, recommendations and relevant information that relates to the application for this benefit.

1.11 Length of Assessment

It is difficult to set a prescribed length of time for an *Assessment of Attendant Care Needs (Form 1)*. The complexity of the client's injury, the acuteness of their injury, their mental and cognitive status, client tolerance, potential language barriers, the physical environment in which they need to function, etc. are all significant factors which can affect the scope and detail of the assessment. The occupational therapist's professional judgement will guide the assessment process and timing.

IV. COMPLETING THE FORM 1 - LEVELS 1, 2, 3 (Post October 1, 2003)

The occupational therapist is encouraged to follow the directions as stated on the *Assessment of Attendant Care Needs (Form1)* when determining attendant care needs arising from the accident injuries. See Appendix 6.

In Parts 1 to 3, give consideration to all of the following:

1. Person's general physical condition when assessing e.g. ROM, strength, mobility, tone, and fine motor coordination.
2. Other medical conditions (consider pre-existing and/or concurrent conditions, vision, cognitive issues).
3. Psychosocial/emotional, cognitive and behavioral issues e.g., cueing required, anxiety etc.

4. Periodic issues, e.g. when lower extremity amputees are forced to be non-weight bearing during episodic periods of skin breakdown.
5. It is important to review the definitions provided for each level of attendant care in order to determine where the occupational therapist's attendant care recommendations may best fit.
6. If there are care recommendations that do not fit in any of the sections (levels of care) identified, there may other benefits within the SABS (e.g., Housekeeping & Home Maintenance, Caregiving, etc.) to which the client is entitled.

Part 1: Level 1 Attendant Care

Level 1 attendant care is for routine personal care.

Dressing/Undressing:

- Amount of attendant time required can vary based on client functional abilities.
- Morning and evening routines could be included.
- Include clothing changes related to exercise, swimming programs, spillage, incontinence.
- Identify method client uses (e.g., one-handed dressing, other adaptive methods, positioning) and level. of proficiency and functionality.

Additional Considerations:

- Seasonal clothing issues i.e. winter coats, boots, etc.
- More time may be required when the client has equipment (e.g., splints, casts, halo, etc).
- Dressings and bandages.
- Cultural, religious dress and customs (e.g., sari, yarmulke, burkha).
- Age appropriate level and based on developmental scales.

Prosthetics:

- Amount of time required to apply and adjust prosthesis and exchange terminal device (can vary).

Additional Considerations:

- Acute or sub-acute amputees may require more assistance given swelling, pain, fearfulness etc.
- Unilateral versus bilateral.
- Upper versus lower extremity involvement.
- Above-knee versus below-knee.
- Use of stump shrinker socks.

Note: Level 3 also addresses the maintenance of supplies and equipment for prosthetic devices.

Orthotics:

- Time to don and doff garments, supports, splints, braces such as burn garments, air casts, edema garments, cervical collars and Jewett brace.

Additional Considerations:

- Skill and experience of client (education/training in application of device).
- Impact of cognitive and affective factors (e.g., cueing, anxiety).
- Hand dexterity, strength and coordination.

Note: Cleaning of orthotics is addressed under Level 1 "Laundering"

Grooming:

- Document assistive devices available at the time of the assessment.
- If client is confined to bed, consider time for grooming set up and describe the process i.e. fill bowl of water for shaving or bringing wash cloths to the bedside and then removing and cleaning up.
- Document ability to reach taps and faucets and position i.e., standing/sitting.
- Identify the client's regular shaving and/or waxing routine.s
- Identify the client's regular routine for application of cosmetics as desired or required. This could include additional time for application of cosmetics to cover scars or burns.
- Document whether client normally managed his/her own finger and toenail care and the frequency.
- Average time to trim fingernails and toenails, e.g. consider additional time required as it relates to medical conditions.

Note: Bathing is allocated under Part 3 Level 3 and is separate from hair care.

Additional Considerations:

- Note length of hair and type of hair to be brushed and/or washed.
- Hair styling preferences includes curling iron, electric rollers, pony tails, braiding, etc.

Feeding:

- Document time to prepare/cook and serve meals and snacks for the client only.
- Time required preparing client for meal including transfer to location as related to meals only and time to set up equipment such as bibs, trays, etc.
- Include assistance required to open containers, cut food and clear dishes after meal.

Additional Considerations:

- Client's own ability to prepare meals prior to the accident.
- Pre-existing conditions that may impact on client's dietary needs.
- Assistance is related to preparing only the client's meal and does not include the preparation of meals for the family. The latter will fall under housekeeping.
- Non-oral feeds (e.g., G-tube feeds) are included in this section.
- Preparation of special meals such as pureeing food and culturally specific diets.

Mobility:

- Time to perform or assist client with transfer times average number of transfers per day.
- Include all transfers both inside the home and out in the community (e.g., toilet, chair, car).
- Transfers for bathing and feeding are addressed under their appropriate sections.
- Supervision and assistance when walking includes: stair climbing, mobility on ramps, into and out of home and/or lobby, garage, in the community etc.
- Identify method and devices used for various transfers.
- Document stand-by supervision or physical assistance required.
- Assistance for routine walking/ambulation around the house (not as prescribed for exercise as per Level 3).

Additional Considerations:

- Indoor flooring conditions, outdoor terrain and weather conditions.
- Time to manage doors e.g., underground parking, lack of automatic openers.

Extra Laundering:

- Document extra laundering time for the client only.
- Does not include general laundry. Extra laundering includes such occurrences as: incontinence, spillage (food and drink), wound drainage, perspiration, skin conditions, use of creams/ointments etc.
- Includes time to sort laundry with special care e.g., bloody spillage.
- Includes washing separately e.g., soiled bedding and/or clothing due to incontinence.

Additional Considerations:

- Consider the length of time that the client spends in bed over a 24 hour time period e.g., traction, spinal injuries, etc
- Consider cleaning of special items such as orthotics, stump socks, mattress covers e.g., sheepskin.

Part 2: Level 2 Attendant Care

Level 2 Attendant care is for basic supervisory function.

Hygiene:

This area refers to the client's needs related to safety and hygiene, and not for the entire family/household.

- Cleaning includes wiping spills on surfaces following applicant's use.
- Allocate time for removal of devices such as toilet seats so that other family members can use the facilities.
- Make bed and straighten direct environment such as bedside tables, overbed table, lifts, bars, etc.
- Does not include full laundry tasks, only includes sorting the client's personal effects. Laundry tasks such as loading machines and folding are discussed under housekeeping tasks.
- These cleaning tasks are only related to the client and not family members.
- Location and accessibility of clothing e.g., low drawers, need for reaching, etc when allocating assistance.
- Describe bed mobility and need for comfort i.e., elevating a body part, provision or removal of pillows, wedge pillows, etc.
- Ensure comfort, safety and security in this environment. The occupational therapist may consider supervisory function for those who are emotionally, cognitively and/or physically in need of comfort (e.g., removing tripping hazards, emotional support for someone who is anxious or not coping well with their injuries; a child who requires comforting; advocating for a child or someone who is cognitively impaired or does not speak English).

Additional Considerations:

- Safety issues related to cleaning tasks such as wiping spills, removing articles from one's footpath, etc..
- Placement of bed such as against wall versus in the middle of the room.
- How infectious diseases, or external devices such as safety rails complicate cleaning tasks.
- Only handing the clothes to the client versus assistance necessary for dressing.
- Cognitive assistance with respect to selecting appropriate clothing.
- Assistive devices re: security such as monitors, panic buttons, access to telephone, etc.
- Clients who are confined to bed and therefore will likely require more frequent bed linen changes e.g., burns, infection, traction.
- Additional heavy cleaning of the bathroom and bedroom may be considered under Section 23, the Housekeeping and Home Maintenance Benefit, if applicable.

Basic Supervisory Care:

This section addresses the client's general supervisory needs. The care outlined in this section does not include the time for the physical "hands on" care which will be addressed under their specific headings. The time an attendant spends waiting to assist with a "hands on" need depends on whether the attendant care can be predictably scheduled. The scenarios listed in this section reflect needs that are unpredictable and/or may present a risk. For example, consider:

- the inability to be physically, cognitively, behaviourally and/or emotionally self-sufficient in an emergency situation.
- the potential risk of a bowel accident or condom catheter displacement for a client who is dependent on care.
- The need for assistance with toileting is often unpredictable.

Coordination of Attendant Care:

Consider the following:

Does the client have the organizational skills and/or problem solving ability to coordinate their own attendant care services including:

- the ability to deal with unexpected cancellations.
- the ability to organize the schedule for the attendant(s).
- the ability to physically, cognitively and/or emotionally utilize a communication device (e.g., phone, e-mail etc).

Part 3: Level 3 Attendant Care

Level 3 attendant care is for complex health/care and hygiene functions.

Genitourinary Tracts, Bowel care, Tracheotomy care, Ventilator care

Please refer to *Assessment of Attendant Care Needs (Form 1)* which outlines the specific sub-tasks of these activities in detail. Interview the client and/or the attendant to determine the frequency and length of time required to complete these tasks.

Exercises:

Must be prescribed exercise routine.

- Exercise can be physical, cognitive and/or speech related etc.
- Allocate time if the client needs hands-on assistance or cueing with tasks i.e. placement of over-door devices, passive ROM, etc.
- Assistance with "walking" under this section is reasonable if it was prescribed as an exercise routine.

Additional Considerations:

- Contacting the professional who prescribed the exercise routine to determine number of minutes expected for exercise and whether the client requires assistance, as appropriate.

Skin Care:

- Consider that the application of creams, lotions, pastes, ointments, powders can be found under "Skin Care" and "Bathing". The occupational therapist should be careful to avoid duplication.

Additional Considerations:

- Note special equipment such as wound vacuum pumps and their application.
- Medical orders re: wound care.
- Client's ability to self-check their wound.
- Traditional medicine (e.g. tiger balm or naturopathic medications) that are not prescribed.
- In the case of sensory impairment, the client's ability to self-inspect for the signs of skin breakdown versus the need for attendant care (what frequency is medically recommended).

Medication:

- Oral: describe the ability to access meds, open containers, need for water/apple sauce when taking meds, describe packaging of meds if necessary i.e. bubble pack versus child safe caps especially if the diagnosis indicates grip issues.
- Inhalations: describe the ability to access and apply oxygen mask, the ability to open canister.
- Attendant care assistance can be allocated to order, pick up and or purchase medication.

Additional Considerations:

- The client's ability to arrange for delivery of his medications and the availability of delivery service.
- The ability to keep medication within reach if there are children in the home.
- The client's physical, cognitive and emotional status i.e. suicidal with medication in close proximity, lacks fine motor coordination to handle pills.
- Provision of medications over a 24 hour period.
- Injections: consider additional medications and injection route i.e. for those who are diabetic, Glucometer™, insulin injection.

Bathing:

This section addresses issues related to bathing, showering and oral hygiene.

Tub and shower:

- Include all transfers related to bathing in this section.

Bed bath:

- Note the rationale and process required for bed baths i.e. traction, non weight bearing, etc.

Additional Considerations:

- The need to store devices (tub and shower devices) when there is only one bathroom shared by other family members.
- Additional time required to cover casts or wounds to prevent infection.

Oral hygiene

- Note the rationale and process required to set up the equipment (toothbrush, toothpaste, water) as required.
- Diagnosis i.e. broken jaw, broken teeth, etc as oral hygiene may be different in such circumstances.
- Dental restrictions e.g. avoid vibration.
- Medical/dental appliances i.e. braces related to accident.

Other Therapy:

Additional Considerations:

- Other therapies may be included under this section (e.g. contrast baths, paraffin wax, continuous passive motion, and bone growth stimulator).
- Review the use and application of devices with prescribing professional if the occupational therapist is unfamiliar with it.
- If these devices were used prior to the accident, consider the client's present physical, cognitive and emotional ability to safely continue its use.

Maintenance of Supplies and Equipment:

- Describe the client's organizational skills and/or problem solving ability for the coordination of their supplies and equipment.
- Review each device with client in order to ensure the ability to identify potential problems and safety risks.
- Review process for ordering of wound care/medical supplies.
- Consider maintenance (including cleaning) devices such as wheelchairs, commodes, lifts etc.
- Describe the client's ability to adjust devices i.e. height of tub chair, replace arm rests after transfers safely, etc.

Skilled Supervisory Care

It is important to note that, for those clients with unpredictable, violent behaviour over the twenty-four hour period, consider that all of the attendant care time may be allocated to this section.

V. SPECIAL CONSIDERATIONS WHEN COMPLETING AN ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

When a Client requires more than 24 Hours of Attendant Care Per Day[12]

Clients may require **more than 24 hour care** in cases where some tasks require the assistance of two persons. For example: transfers or positioning tasks for a person with high level quadriplegia. In these cases, the total number of minutes required exceeds 10,080/week. Given that requirements for more than 24 hour care is a unique situation, the assessor is encouraged to provide a clear clinical rationale in their written documentation. See Table below for explanation of calculations.

Example

Refer to Mobility Section "performs transfer needs as required (for example, bed to wheelchair, wheelchair to bed)".

Consider the example of an individual that requires 24 hour attendant care 7 days a week because of a serious disability (perhaps a client with a high level quadriplegia or a catastrophic brain injury) and who requires 2 persons to assist only with transfers.

TABLE: Calculation of Attendant Care Needs

Activity	Number of Minutes	Times per Week	Total Minutes per Week
Transfers	**First attendant** X 5 minutes/transfer	10 transfers/day X 5 min/transfer X 7 days/week	350
	Second attendant X 5 minutes/transfer	10 transfers/day X 5 min/transfer X 7 days/week	350
	TOTAL TIME PER WEEK		**700**

Assuming that the person requires full-time constant care (24 hours per day, 7 days per week), this would equal 10,080 minutes/week. Therefore, the total number of minutes of assistance required for the week would be: 10,080 minutes + 350 minutes (for the additional attendant) = 10,430 minutes per week.

Sample Presentation on the Assessment of Attendant Care Needs (Form 1)

		Number of Minutes	X	Times per Week	=	Total Minutes per Week
Mobility (location change)	assists applicant from a sitting position (for example, wheelchair, chair sofa)	0		0		0
	supervises/assists in walking	0		0		0
	performs transfer needs as required (for example, bed to wheelchair, wheelchair to bed) - INCLUDES 2 ATTENDANTS	**10**		70		700
			Subtotal			**700**

12. Daly vs. ING Halifax Insurance Company, December 21, 2006, Docket#C44930
Michalski and Wawanesa FSCO A03-001363

SPECIAL CONSIDERATIONS WHEN COMPLETING AN ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

Acquired Brain Injury

1) For clients who have sustained an ABI, it is essential to consider their attendant care needs based on their physical, psychosocial, cognitive and behavioural limitations.

2) For those clients with cognitive limitations, consideration of the need for attendant care services to provide ongoing cueing and prompts in order to complete the task is important. If appropriate, the time allotment for such support should be included in each area of the *Assessment of Attendant Care Needs (Form 1)*. However, it is important to note when assessing:

   - If a single cue is required to ***initiate*** an activity, then the time allotted should only reflect the time to provide the cue.
   - If multiple cues are required ***throughout the entire activity***, then the time allotted should reflect the times required to complete the entire activity.
   - If cueing can be scheduled, it may be helpful to look at the day in thirds (day/ evening/ night), to assist in determining the amount of times required for intermittent cueing throughout the day.
   - If cueing needs cannot be scheduled (ie. unpredictable), increased supervisory care may be needed.

3) The provision of cueing for clients with cognitive limitations can occur through direct stand-by methods or through the use of indirect methods. For example, indirect methods may include the client's contact to his/her attendant via such communication aids as phone contact, Blackberry contact, personal emergency monitoring service/device, etc. It is important that the occupational therapist understand the frequency, reason and predictability of the client's need to contact an attendant.

4) When a client is provided with various self care aids and devices (memory aids, call systems, cell phone, electronic organizers), it is important that the assessor does not make the assumption that the provision of such a device will automatically reduce or eliminate the need for attendant care services. Consider whether there is reasonable evidence that the client utilizes the device effectively and predictably in simulated and real life situations prior to eliminating or reducing attendant care supports.

   It is important to note that, although in the presence of a health professional the client may be able to use the device without any apparent difficulty, if left alone, he/she may not be able to initiate the activity without cueing and prompts, or may be inconsistent in its use. As noted in *Michalski v. Wawanesa*[13], improvement in one therapy session for a client who is variable in his level of function is insufficient proof of the person's ability to warrant a decrease in attendant care services. Collateral information and/or further testing of the client's abilities may be required.

5) When the client has demonstrated consistent ability in using a communication device, it may be appropriate at that time to reduce attendant care.

6) When assessing a client with cognitive limitations, it is important to note that the presence of the occupational therapist and the assessment process itself may provide artificial structure and/or cues for the person which may enhance his/her performance during the assessment.

7) With respect to cognitive rehabilitation exercises, it is important to consider the role of the attendant and the amount of time and support required to provide repetition of activities/instructions and to ensure carry-over of learned skills. Time required could be considered under Level 3 - Exercise.

SPECIAL CONSIDERATIONS WHEN COMPLETING AN ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

Night Care

1) Night time care includes supervision and/or hands-on care from the time an individual retires for bed at night until the expected wakening time in the morning.

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13. *Michalski (Litigation guardian of) and Wawanesa Mutual Insurance Co.*, FSCO A03-001363 Arbitration Decision: December 13, 2005

2) Determining the need for night care can be considered independently of whether or not a spouse or a family member is present overnight as that family member is not obligated to provide the client's attendant care. Questions to consider:

- Is the client safe to be left alone at night (e.g. consider effects of cognitive, physical, behavioral and environmental issues)?
- Does the client have needs that potentially require night time hands-on care? Example: wandering, agitation, positioning, turning (skin care), toileting, mobility.

3) In the event that hands-on night care is required (e.g. toileting, turning), this is allocated under specific tasks and the balance of night care may be allocated under the following sections on the *Assessment of Attendant Care (Form 1).*

a) Level 2 - Basic Supervisory Care:

- Applicant lacks the capacity to reattach tubing if it becomes detached from the trachea.
- Applicant requires assistance to transfer from wheelchair, periodic turning, genitourinary care.
- Addresses issues of decreased mobility and need for assistance into wheelchair.
- Addresses issues of decreased bed mobility and prevention of skin breakdown.
- Addresses the need for an attendant to be available to assist with genitourinary needs as they arise e.g., the need for an attendant to be available should the client experience incontinence either during the day or night.
- Applicant lacks the ability to independently get in and out of a wheelchair or to be self-sufficient in an emergency.
- Applicant lacks ability to respond to an emergency or needs custodial care due to changes in behaviour.

b) Level 2 - Hygiene – ensure comfort, safety and security in the bedroom e.g., assistance to get drink of water or open window etc. for someone who cannot get out of bed; provide comfort for someone who has nightmares following accident/ injury.

c) Level 3 - Medication – if medications require monitoring and/or administration throughout the night.

d) Level 3 - Skilled Supervisory Care – if applicant's violent behaviour may result in physical harm to themselves or others, then nighttime supervision would be required.

SPECIAL CONSIDERATIONS WHEN COMPLETING AN ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

Client's Needs to support Community Access and Re-integration

1) A client's needs for assistance in the community may be best addressed in two sections on the *Assessment of Attendant Care Needs (Form 1)*:

a) Part 1 – Mobility

- Supervises/assists in walking.
- Performs transfer needs as required.

b) Part 2 – Basic Supervisory Care

- Applicant lacks the ability to independently get in and out of a wheelchair or to be self-sufficient in an emergency.
- Applicant lacks the ability to respond to an emergency or needs custodial care due to changes in behaviour. In the event of violent behaviour, Level 3 can be considered.

c) Skilled Supervisory Care

- Applicant requires skilled supervisory care for violent behaviour that may result in physical harm to themselves or others.

2) A client may require supervision/assistance in the community to:

- Attend medical, therapy, medical investigations and/or hospital appointments.
- Instrumental outings i.e. banking, grocery shopping, shopping for personal items, drugstore
- Other i.e. leisure[14] / family/ social events.

Consider not only physical supervision/assistance, but also cognitive and psychosocial limitations[15], language and/or communication barriers. In the event that a client requires supervision to travel to and attend community outings, include the attendant's travel and wait time, as per Section 19 1 (b).

To determine the time allotment for community mobility, consider the average number of visits for medical appointments or other outings over the upcoming ["future needs"] month(s).

Attendant care within the "Mobility Section" will be more relevant to clients who have sustained injuries affecting their ability to be physically mobile in the community. This section would also pertain to clients who would require assistance with transfers while they are in the community (e.g., toilet transfers, transfer to a vehicle). In terms of vehicle transfers, ensure that "attendant care assistance" is allocated over the entire outing if there is no person available at the end of the destination to perform this task.

Attendant care within the Basic Supervisory Care will be relevant to clients who have sustained injuries affecting their safety in the community due to physical, cognitive, or behavioural changes.

Examples:

- Applicant lacks the ability to get into and out of a wheelchair and to be self-sufficient in an emergency.
- Applicant lacks the ability to respond to an emergency or needs custodial care due to changes in behaviour.
- Maintaining the safety of others in the community such as a client uttering threats while in the community.
- Client getting lost or disoriented while in the community.
- Assistance with remembering/recording information/instructions provided during medical appointments which require follow through.
- Cognitively impaired clients who may be vulnerable.

SPECIAL CONSIDERATIONS WHEN COMPLETING AN ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

Paediatric Clients

1) When assessing the attendant care needs for children and adolescents, it is important to receive input and feedback from family regarding the client's ongoing issues and needs.

2) It is important to be aware of "typical parenting" responsibilities. Parents would ordinarily be expected to undertake tasks which are included in the *Assessment of Attendant Care Needs (Form 1)* such as laundry, bedding, meal preparation, etc. However, it is important to examine the nature of the tasks, the age of the child and the time which is now spent on these activities after the accident and to determine if need and demand has changed. In cases of parents caring for children with severe brain injuries, for example, there can be significant qualitative change in the nature of the services required to properly attend to the child's needs (eg. hands on assistance instead of general supervision, increased intensity of supervision); therefore, the parent's ability to complete the daily tasks as he or she would have prior to the accident may now have changed. In such situations it is reasonable to note the differential as an attendant care need.

Examples:

- Extra laundry due to incontinence.
- The need for a special diet such as a puréed meal or other special dietary needs. Prior to the accident, the parent would have made one meal for the family; now extra time is required to prepare a separate / special meal for the child.
- Feeding a child, who is 10 years old who otherwise would have been independent in this task
- Supervision of a child during meals to prevent choking.

14. David McMichael vs. Belair Insurance Company, FSCO A02–001081, March 2, 2005

15. Mark Faerber-MacMillan and Allstate Insurance Company

3) In order to determine a child's current attendant care needs, it is suggested that the occupational therapist be aware of the child's pre-accident needs and abilities in order to form a realistic comparison/ expectation.

   Consider the following:

   - Understanding the child's developmental level.
   - Child's ability to be left alone pre/post accident.

4) Assess the child's ability to be left alone unsupervised.

   The need for attendant care when a child is left alone should be considered in light of reasonable developmental issues related to leaving any child at home alone. The Children's Aid Society provides guidance on leaving children alone. In order to assist in understanding reasonable developmental issues related to a child being "left alone," contact was made with the Toronto Police as well as with the Children's Aid Society of Toronto. The Children's Aid Society stated that a number of factors including the maturity level and ability of the child need to be considered on an individualized basis in determining when it is appropriate to leave a child alone. (See Appendix 5 Children's Aid Society of Toronto, Publication *"Home Alone-How do you know when your kids can be left unsupervised?"*). When considering age and the child being left alone, The Children's Aid Society may consider the following in their practice. However, Children's Aid has re-iterated that it is ultimately determined case by case, based on a number of factors, including the maturity of the child.

   - Infants and children under the age of 9 years old should never be left alone.
   - Children 10 to 12 years old may be left alone unsupervised for short periods of time (not more then 2 hours); however, it depends on the situation and child, and there should be an adult accessible (i.e. a neighbour who is aware of their responsibility). The child should know how to use the phone, be aware of emergency procedures, and have the maturity and responsibility that is judged by the parent to be adequate to ensure his/her safety if left alone.
   - Children, who are 13 to 15 years old, can be left alone for 3 to 5 hours with an adult available by telephone (time of day or evening not specific). They must know how to contact an adult.
   - Teenagers who are 16 years old may be left alone; however, an adult should be available by phone and the child should know where and who is available to seek help.
   - Typically, leaving a child overnight should not occur until they are 16 years old. (Again, depending on the maturity level of the child).

   Please note that for the purpose of discussion with the Children's Aid Society and the Toronto Police Department, being "left alone" meant that no caregiver is physically available in the home environment. According to the Children's Aid Society, the onus is on the caregiver (i.e., parent/legal guardian) to ensure maturity level and age are taken into consideration when deciding to leave a child alone and what preparation is needed.[16]

5) It should also be noted that by the age of 12 years, children are able to baby-sit other children through the day and evening hours (assuming maturity and responsibility as judged by a parent to be adequate to be left home in charge of child).

6) If the child has cognitive and/or behavioural issues related to his or her accident-related injuries, which require supervision that would not have been required prior to the accident, then attendant care support is reasonable.

7) Night care

   - If the parent is up in the middle of the night to provide care for a child who would have been sleeping through the night but for his or her injuries, then this is an attendant care function.
   - The occupational therapist must be aware of the child's age and what is considered in a child's normal development.

16. Permission to release above from Mr. David Fleming, Assistant Branch Director, Children's Aid Society, Toronto Branch, September 12, 2006)

SPECIAL CONSIDERATIONS WHEN COMPLETING AN ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

Clients Attending School

1) If a student requires attendant care services during school hours that are in addition to their typical pre-accident routine needs, provision of such time can be allotted. Identify in your narrative report, who is providing the care and whether the amount and quality of the care has changed since the accident.

   Example: A student diagnosed with ADHD prior to the accident in which he sustained a brain injury. Prior to the accident, he required regular, consistent cueing to ensure he followed through with his academic program. Once cued, he would follow through with the activity without disruption. Post-accident the student requires repeated cues and direct 1:1 supervision to ensure he follows through with any task. He now wanders away from school and experiences behavioural outbursts. Post-accident, the school continues to provide the necessary supervision for the student, however, the amount and quality of the attendant care has increased considerably.

2) Consider the needs of the child on a day without school (i.e., PD day, holiday, weekend) to help you to determine the child's overall need for attendant care.

   - Remember the focus of the assessment is the client's extraordinary need because of injuries resulting from the accident, and not who is providing the service/care or where it is occurring.
   - Remember to consider "typical parenting".

SPECIAL CONSIDERATIONS WHEN COMPLETING AN ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

When a Client is in A Hospital or a Long-Term Care Facility

The purpose of the *Assessment of Attendant Care Needs (Form1)* is to identify the "future attendant care needs" of the client even if they are currently in a hospital or residential facility such as an acute or rehabilitation hospital long term care facility including a nursing home, home for the aged or chronic care hospital, half-way house and supported independent living units.

Particularly in the hospital environment, it is important to respect the client's need to receive ***comfort, safety and security*** in the hospital environment. This may be allocated in the Hygiene section under Part 2 - level 2.

When conducting attendant care assessments in institutions, it is important to consider:

- The role of the occupational therapist is to assess the client's **need for attendant care** as per the Form 1, i.e., to address those tasks listed on the Form 1 which cannot be performed at the pre-accident level as a result of accident related injuries (e.g. dressing, grooming), or which must be performed as a result of the accident (e.g. catheter care). The role of the insurance adjuster is to determine **payment** in accordance with the SABS.
- The Form 1 does not differentiate with respect to ***who*** is providing the attendant care services. Attendant care activities performed in facilities may be carried out by facility staff (e.g., nurses) family or others; however, the assessment is based on "need" and not who is providing the service. Therefore, it is suggested that the assessing therapist document **what** attendant care activities are being provided within a facility and **by whom** (ie., nursing or hospital staff, family members etc.) in a narrative report to accompany the submission of the Form 1.
- While it is best practice to consult with facility staff and review the medical records regarding the client's medical condition and care needs, this may not always be possible. There are often issues with access, time availability and/or hospital policy. Note any attempts to retrieve additional information and explanations for limitations.

- It is expected that the client or attendant will submit a record of the incurred attendant care services to the insurer in accordance with the Form 1 and Section 19. Section 33 of the SABS (Duty of Applicant to Provide Information) is also available to the insurer in order to obtain information regarding expenses incurred by the client. See Appendix 10

- While the Form 1 calculates a total dollar amount available for funding attendant care, that amount is not necessarily the expense incurred by the client or paid by the insurer.

Examples:

i) Person injured in a car accident is an in-patient at an acute hospital. Client was a diabetic who routinely injected himself with insulin. After the accident, he is unable to give himself the injection. It takes 3 minutes to prepare the medication and give the injection, and the injection is given twice daily and shared between the nursing staff and his wife.

The occupational therapist can:

1) indicate the following on the Form 1: 3 minutes X 2 times per day X 7 days = 42 minutes per week.

2) indicate in the narrative report: task is shared between family and nursing staff.

ii) If a nurse or family member is providing assistance to feed the client in a hospital, the need for attendant care for this function would be identified on the Form 1 and the assistance provided by a nurse or family members described in the narrative report.[17]

SPECIAL CONSIDERATIONS WHEN COMPLETING AN ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

Retrospective Assessment of Attendant Care Needs (Form 1)

Occupational therapists may be asked to complete an *Assessment of Attendant Care Needs (Form 1)* for clients whose attendant care needs were not determined during a certain period of time in the past. In such cases, the OT is asked to provide a retrospective assessment.

1) The occupational therapist should include the following in the scope of the report:
   - Identification that the assessor never assessed the client during the time frame of the *Assessment of Attendant Care Needs (Form 1)* being requested.
   - Clarification that the assessment is based on the client's subjective reports, along with collateral information (hospital records, medical and rehabilitation reports, caregivers, family etc.).
   - Clarification that the assessment is based on the occupational therapist's clinical experience and analysis.
   - Clarification of the exact time period that is addressed in the retrospective *Assessment of Attendant Care Needs (Form1).*

2) It may be necessary to defer the completion of a retrospective *Assessment of Attendant Care Needs (Form 1)* until medical records are available. This is addressed on a case-by-case basis.

3) If there is a discrepancy between the client/family's subjective report and the occupational therapist's estimate, it is especially important that the therapist present a rationale for the amount of recommended assistance.

17. Haimov and ING Insurance Company of Canada, FSCO A05002734, September 2006

VI. CONSIDERATIONS WHEN PREPARING A NARRATIVE REPORT

When preparing an *Assessment of Attendant Care Needs (Form 1)*, a supplementary narrative report is recommended although this is not a requirement of the SABS. Occupational therapists' documentation is guided by the *Standards for Record Keeping* (July 2008) of the College of Occupational Therapists of Ontario. It is suggested that the following be considered in documenting the findings and rationale of an *Assessment of Attendant Care Needs (Form 1)*:

1) Provision of an introduction to explain the purpose of the assessment, and the expectations of all parties. The following is a sample introduction:

   "The purpose of this assessment is to identify the attendant care needs of Mr. Client. This report will outline those areas in which Mr. Client requires attendant care assistance in relation to those injuries arising from the index accident. An *Assessment of Attendant Care Needs (Form 1)* has been completed in accordance with Section 19 and 42 of the SABS. The reader must be aware that the Form 1 does not differentiate who is providing the attendant care for Mr. Client. It is recognized that any attendant care service and/or cost incurred by the client would be submitted through the appropriate processes in accordance with the SABS. Payment for costs would be determined by the adjuster."

2) The narrative report would contain necessary subjective, objective information not reflected on the form in addition to the occupational therapist's rationale/clinical reasoning and recommendations.

3) Identification and description of any attendant care services the client received pre-MVA.

4) A statement that the recommendations and conclusions were based on the information provided (identify all documentation and information sources), collateral information as provided by family members/caregivers, treatment providers as well as objective assessment completed on the day of the visit(s).

5) The following is suggested to be identified in the report:

   - Professional services (e.g. therapies, RSW, CCAC etc.) or programs (e.g. Day programs, school) involved in the client's care and/or treatment that may or may not impact on the funding of attendant care hours. Identify the frequency and duration of services to the best of your ability
   - Individuals who are currently providing attendant care to the client and what services they are providing.

6) Identification of any further information (e.g., neuropsychological assessment, psychological assessment etc) required to determine specific areas of attendant care need. Reassessment may be recommended once additional information is received.

7) The occupational therapist may want to consider including a statement that reserves the right to change the recommendations/conclusions should new information be forthcoming.

VII. RE-ASSESSMENT OF ATTENDANT CARE NEEDS (FORM 1)

When there is an expected change or discontinuation of attendant care benefits, a new *Assessment of Attendant Care Needs (Form 1)* and, by extension, a re-assessment is required. At the time of completing an *Assessment of Attendant Care Needs (Form 1)*, the occupational therapist may recommend a proposed date for re-assessment based on anticipated change in condition, accommodations, support systems, etc.

Ministry of Health and Long-Term Care
Ministère de la Santé et des Soins de longue durée

Ontario

Supply & Financial Services Branch
Health Insurance and Related Payments
49 Place d'Armes 2nd Floor
Kingston ON K7L 5J3

Tel: (613) 548-6288
Fax: (613) 548-6763

June 23, 2005

Ministry of Health and Long Term Care
Anne Utley
Manager, Subrogation Unit (Special Projects)

Dear Mr. MacDonald

RE: Attendant care in Hospitals

In your e-mail enquiry of May 18, 2005 you asked for clarification of "whether attendant care is/is not within the list of insured [by OHIP] hospital services, such that it is or is not hospital's responsibility to provide attendant care".

First; provision of acute, chronic and rehabilitation hospital in-patient and out-patient services are governed under the *Health Insurance Act* (HIA) and are OHIP insured services. The regulations under the HIA, specifically R.R.O 1990, Regulation 552, S 7 entitled "Insured Hospital Services in Canada", provides a listing of services an insured person is entitled to receive while an inpatient without charge from the hospital. (copy of S 7 & S 10 --- where a co-payment is payable --- of Reg 552 is attached). Section 7 applies to all hospitals as defined under subsection (1) (listed under Schedule 2 and those under specific grades under the *Public Hospitals Act* --- typically providing specified care with defined number of beds) The insured hospital services are those which you referred to such as; accommodation and meals, nursing service, except for the services of a private duty nurse who is not engaged and paid by the hospital), labs and other diagnostic procedures, drugs and use of operating room and equipment.). Nursing services provided in hospital are those duties as defined under the *Nursing Act* and provided by a nurse certified by the Ontario College of Nurses. **Simply put, attendant care (or personal support service) is not a service provided by a nurse; is not an insured service under the HIA; is not an insured hospital service under the Act and lastly is not an OHIP insured service.**

Attendant care, or personal support services, are administered under the *Long-Term Care Act, 1994 (LTCA)*.

With respect to the insurer's belief that "as the Hospital Act stipulates that hospitals [be] required to provide the level of care a patient requires while in hospital", first I'm not clear on what Act the insurer is relying on (I'm personally not familiar with the "Hospital Act") or what section of that Act is being referred to. Although I am not expert in hospital administration, a hospital does indeed provide the level of care a person requires while an inpatient, but this is based on medical need and presumably why most hospitals have ICU and step-down units --- in order to provide more intensive medical monitoring, by reducing the patient to nursing ratio. **This is necessary to monitor a patients acute medical needs and not to provide such services that an attendant or aide might provide.**

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Ministry of Health and Long-Term Care / Ministère de la Santé et des Soins de longue durée

Ontario

Second, the Ministry of Health and Long-Term Care does not provide for attendant care (personal support services) which, as mentioned, is administered under the *Long-Term Care Act, 1994* and typically administered through a Community Care Access Center (CCAC) or other Third Party agency. Generally, the LTCA governs community based services and long-term care facilities and services (eg: nursing homes). A copy of the community based services provided under the Act "Provision of Community Services" is also attached. Section 2.1 and S3.

Set out the "Eligibility for Personal Support Services". There are a couple of significant references under this Regulation:

1. The person must be an insured person under the HIA
2. The CCAC must assess the need for services, and
3. Under S3.2(b) services are provided to a person at his or place of residence.

Third: as you reference accident benefit insurer's, I'm assuming that it is an automobile insurer who is objecting to the requirement to pay for attendant care/person support services. I know you are very familiar with the *Insurance Act* and Regulation 403/96, but I have attached a copy of S 58 ss 1 &2 "Social Assistance Payments" which requires an (automobile) insurer to pay benefits under the SABS, including those provided by the MOHLTC. Specifically, these are the services or benefits previously administered by the MCSS and transferred to the MOHLTC by Order-in-Council in 1993, most of which were brought together to form the LTCA, 1994.

In summary, attendant care services are not OHIP insured service provided in a hospital. Clearly, hospitals are not funded to provide one-on-one 24/7 hours of care for in-patients.

I hope this clarifies our position on the issue of attendant care services for in-patients in hospital. Please note this is not a legal opinion, but the interpretation and position of the Subrogation Unit of the Ministry.

If you have any additional questions, please feel free to give me a call.

Regards,

Anne Utley
Manager, Subrogation (Special Projects)

7198-93 (99/06)*

7530-4601

Supply & Financial Services Branch
Subrogation Unit
49 Place d'Armes, 3rd Fl.
Kingston, Ontario K7L-5J3

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November 8, 2007

Dear Mr. S:

RE: Your Client/Our Insured: A.L.
Date of Accident: July 1, 2005 (MVA)

My apologies for not responding sooner to your letters of September 4 and October 2, 2007.

I have had an opportunity to consider your request for information relating to the funding of attendant care services provided to an individual who is an in-patient in a hospital facility. I have also reviewed the Assessment of Attendant Care Needs (Form 1) completed on September 13, 2005 detailing the level of assistance required for each basic need.

I should make it clear from the onset that I am not able to comment specifically on the level of care required by our insured A.L. while at the Hospital for Sick Children and at Bloorview MacMillan Children's Centre or the (medical) necessity of such services. I will however provide an overview of the policy and interpretation of the Subrogation Unit pertaining to the issue of attendant care services for in-patients in hospital.

First; provision of acute, chronic and rehabilitation hospital in-patient and out-patient services are governed under the *Health Insurance Act* (HIA) and are OHIP insured services. The regulations under the HIA, specifically R.R.O 1990, Regulation 552, S7 entitled "Insured Hospital Services in Canada", provides a listing of services an insured person is entitled to receive while an inpatient without charge from the hospital. Section 7 applies to all hospitals as defined under subsection (1) (listed under Schedule 2 and those under specific grades under the *Public Hospitals Act* --- typically providing specified care with defined number of beds). The insured hospital services defined under the regulations include: accommodation and meals, nursing services, (except for the services of a private duty nurse who is not engaged and paid by the hospital), labs and other diagnostic procedures, drugs and use of operating room and equipment. Nursing services provided in hospital are those duties as defined under the *Nursing Act* and provided by a nurse certified by the Ontario College of Nurses. Services provided in hospital are based on medical necessity as determined by the attending or consulting physician, nursing staff or any other hospital staff with the authority to do so.

Attendant care, or personal support services (which includes services listed in the Form 1), are administered under the *Long-Term Care Act, 1994* (LTCA) and are not OHIP

Continued...

services. These services are typically administered through a Community Care Access Center (CCAC) or other Third Party agency. Generally, the LTCA governs community based services and long-term care facilities and services (e.g. nursing homes). A copy of the community based services provided under the Act, "Provision of Community Services" is attached. Section 2.1 and S3 set out the "Eligibility for Personal Support Services". There are a couple of significant references under this regulation:

1. The person must be an insured person under the HIA
2. The CCAC must assess the need for services, and
3. under S3.2(b) services are provided to a person at his or her place of residence.

I am sure you are very familiar with the *Insurance Act* and Regulation 403/96, but I have attached a copy S 58 ss 1&2 "Social Assistance Payments" which requires the accident benefit insurer (in this case, the automobile insurer, Economical Mutual Insurance Company) to pay benefits under the SABS, including those provided by the MOHLTC. Specifically, these are the services or benefits previously administered by the MCSS (Ministry of Community and Social Services) and transferred to the MOHLTC by Order-in-Council in 1993, most of which were brought together to form the LTCA, 1994.

As stated in the introduction of the letter, I cannot comment on the medical necessity of any service provided, however attendant care services are not OHIP services typically provided in a hospital.

As a matter of interest, I also refer you to the case (which again I'm sure you are familiar with) of *Haimov v ING Insurance Company of Canada* which was referred to in an article which appeared in the April 23, 2007 edition of the *Law Times* and written by Julius Melnitzer. The article dealt with matters heard at arbitration including the referenced case where the plaintiff insured was represented by David MacDonald of Thomson Rogers law firm. The subject matter was very similar to this specific case in which the first party automobile insurer challenged the need to make payment for attendant care services rendered to an insured who was an inpatient in hospital at the time. The arbitrator ruled in favour of the insured and the accident benefit carrier was required to make payment for these services.

I hope this clarifies our position on the issue of attendant care services for in-patient in hospital. Please note this is not a legal opinion, but the interpretation and position of the Subrogation Unit of the Ministry.

If you have any additional question, please feel free to give me a call.

Regards,

Anne Utley
Manager, Subrogation Unit

Corporate Services and Organizational Development Division
Supply and Financial Services Branch, Subrogation Unit

February 2005

Who Pays for Healthcare: Injuries from Motor Vehicle Accidents

When a person is injured in a motor vehicle accident, the Statutory Accident Benefit Schedule requires the automobile insurer to pay for *non-professional healthcare services* (such as personal support and attendant care services, community and homemaking services). These services may be provided at home or in community settings such as supportive housing units, long-term care facilities and chronic care hospitals.

Typically, non-professional services are provided through local Community Care Access Centres (CCAC), long-term care facilities or other third-party agencies funded by the Ministry of Health and Long-Term Care. Clients who may require these services include those suffering serious or catastrophic physical injuries, closed head or acquired brain injuries and the elderly.

Automobile insurers should arrange non-professional health services for their clients and pay the service provider directly.

It is only after statutory accident benefits have been exhausted, or the level of service required exceeds specified maximums, that the Ministry may consider funding these services, subject to assessment of the client and applicable Ministry limits.

The Ministry's subrogation unit is responsible for monitoring compliance of payment responsibility for persons injured in motor vehicle accidents and who require health services.

The Ministry of Health and Long-Term Care pays for:	**Automobile Insurers* pay for:**
• Medical costs (all physician services) • Hospital services • Mental health facilities • Air ambulance • Some professional health services such as nursing provided in the home, school or community. • Any other ministry-funded services not covered under the Long -Term Care Act	• Community Support Services - Meals and transportation - Caregiver support - Home maintenance and repair - Social or recreational services • Homemaking Services - House cleaning, laundry - Preparing meals - Banking, shopping • Attendant Care/Personal Support - Assistance with personal hygiene - Assistance with activities of daily living

Up to specified maximum limits (e.g., $3000 - $6000 per month and $72,000 per year to a maximum of $1 million if a catastrophic injury for attendant care; $100 per week for homemaking)

Ontario

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Corporate Services and Organizational Development Division
Supply and Financial Services Branch, Subrogation Unit

February 2005

Who Pays for Healthcare: Injuries from Motor Vehicle Accidents

Priority of Payments

When someone is injured in a motor vehicle accident, the priority of payment for healthcare services is:

1. ministry programs
- OHIP services
- professional services administered through CCACs such as nursing, physiotherapy, occupational and speech therapy (subject to eligibility and maximum amounts payable);
2. private supplementary health and disability insurer and private employer plans;
3. automobile insurers (statutory accident benefits available through injured person's own automobile insurance policy);
4. money awarded in a lawsuit;
5. provincial government plans are the last payer for:
- non-professional services administered or provided through CCAC such as attendant care, personal support and homemaking;
- all services and benefits such as vocational rehabilitation and welfare payments, administered by the Ministry of Community, Family and Children's Services.

Recovering Healthcare Costs

If the Ministry has provided services, such as attendant care or homemaking (that should have been paid for by the automobile insurer), the ministry will seek reimbursement directly from the automobile insurer.

The automobile insurer should contact the service provider directly to negotiate and pay for services.

What You Can Do

If your clients' injuries are due to motor vehicle accidents, you should know which organization should be paying for required healthcare services.

You can help by:

- knowing which healthcare services the Ministry of Health and Long-Term Care pays for, and which ones are paid directly by the automobile insurer.
- ensuring your client has made a claim to his/her own automobile insurer.
- verifying that your client has contacted the automobile insurer for provision and payment of attendant care, personal support and homemaking services.

If you have questions about health services and motor vehicle accidents, or would like more information, please call 613-548-6663.

The information on this fact sheet is not intended as legal advice. It is based on Legislation in the Insurance Act including amendments made through Bill 59 in November 1996. The contents are current as of today's date but are subject to change. Readers should satisfy themselves as to the currency/accuracy of the material at any particular time.

Ontario

Corporate Services and Organizational Development Division
Supply and Financial Services Branch, Subrogation Unit

February 2005

Personal Injury Accidents: Recovering Healthcare Costs

If a person is injured in an accident caused by someone else's negligence or wrongdoing, and makes a claim for damages or initiates a lawsuit, the Ministry of Health and Long-Term Care can recover its costs for healthcare and treatment.

Each year, the Ministry recovers over $12 million from insurance companies through *subrogation*. Subrogation is a legal term unique to Insurance Law. It means "the right to recover costs for an injury caused by the fault or negligence of another person." The Ministry's right to subrogation is enforced through legislation.

By being familiar with the principle of subrogation, those representing an injured person can ensure costs for appropriate healthcare and treatment are included in claims for damages.

(Providers of healthcare services should read the fact sheet, *Who Pays for Healthcare: Injuries from Motor Vehicle Accidents* to ensure costs for services are billed appropriately.)

The most common examples of personal injury accidents for which the Ministry recovers healthcare and treatment costs are:

- slip and falls
- boating, air and rail accidents
- product liability or manufacturing defects
- medical malpractice or professional negligence
- dog bites
- municipal liability
- assaults
- some motor vehicle accidents
- class actions.

The Ministry is notified by the injured person, their legal counsel or occasionally by the at-fault party's liability insurer.

The Ministry's right of recovery applies to any incident regardless of the location. This includes other provinces, and foreign jurisdictions that allow subrogation or other reimbursement rights.

The Ministry can recover costs for:

- OHIP insured services including:
    - physician services;
    - hospital services including in/out patient, acute and chronic care;
    - air ambulance; out-of-country/out-of-province medical and hospital services;
- Extended care services typically administered through Community Care Access Centres (CCACs) in a home, health facility or school including:
    - professional services such as nursing, physio/occupational/

Ontario

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speech therapy, social work or a nutritionist
- non-professional services:
- homemaking services such as house cleaning, laundry, banking, shopping, preparing meals;
- personal support or attendant care/outreach services such as assistance with personal hygiene and activities for daily living;
- long-term care accommodation and services in nursing homes, charitable homes and homes for the aged. (Accommodation costs cannot be claimed in other facilities such as supportive housing.)
- community support services such as meals and transportation, caregiver support, adult day programs, home maintenance and repair, social or recreational services.

Recovering Past and Future Healthcare Costs

The Ministry recovers the cost from insurance companies (or at-fault parties) for all OHIP-insured health services provided up to the time of settlement or judgement. It also claims the costs for **future** insured healthcare services that an injured person may need.

Where an injured person has been assessed for long-term care services and benefits, funding is provided on a bridge or interim basis until settlement funds have been received. The Ministry's claim includes these costs, and the subrogation unit endeavours to contact CCAC or other funding agencies upon settlement.

Subrogation does not apply for future non-professional healthcare services or benefits (such as attendant care, personal support and homemaking). The injured person must include a claim for the cost of these services in his or her personal claim for damages. Once settlement funds are received, he or she can then purchase these services directly.

For More Information

If you have questions about subrogation or would like more information about how it affects your client, please call 613-548-6663.

The information on this fact sheet is not intended as legal advice. It is based on Legislation in the Health Insurance Act, Section 30-36 and Regulation 552, Section 39, and in the Long Term Care Act, Section 59 (ss1-13). The contents are current as of today's date but are subject to change. Readers should satisfy themselves as to the currency/accuracy of the material at any particular time.

CHILDREN'S AID SOCIETY of TORONTO

Because children depend on all of us

fact sheet

Home Alone

How do you know when your kids can be left unsupervised?

Your six-year-old awakens from a bad dream. Padding into your bedroom, he sees you're not there. Searching the house in vain, he realizes he's home alone. And unlike the movie, there's nothing funny about it.

Leaving a child unsupervised is dangerous. It can lead to disaster and it's against the law. Although the legal term abandonment implies leaving a child with no intent to return, it's more common for parents to leave their children alone for short periods of time.

There is no law in Ontario that dictates a specific age at which a child can be left unsupervised. Dave Fleming, assistant director of intake at the Children's Aid Society of Toronto, explains, "The law is purposefully vague when it comes to choosing a specific age, because there are many variables to take into consideration." "One eleven-year-old may feel comfortable being left alone, and knows what to do in case of an emergency, while another eleven-year-old may feel nervous and unsure of himself," says Fleming.

When leaving children alone for the first time, parents should speak with them to see if they feel comfortable on their own. "Explain to the child where you are going, and specify how long you'll be gone," says Fleming. "Make sure that the child is emotionally and physically ready to be left alone."

Potential household hazards that threaten children's lives are everywhere. They lurk in the kitchen, the bathroom and the playroom. They come in different shapes, colours and sizes, and they can creep up on children even when parents are at home. These threats can be poisonous substances, unguarded stairwells, or balconies made accessible due to open doors and windows. Children, especially very young children, are not able to remove themselves from hazardous situations. In fact, even if children can remove themselves from danger, they may not realize when something poses a threat, and so it is important for parents to pay close attention to their child's development.

When parents decide that their children are mature and responsible enough to be left unsupervised, that judgement should be accompanied by a safety plan, so that children know how to respond to different scenarios when home alone. "Children should know how to dial 911, and what to do in case of a fire," Fleming explains. "Other rules should be in place in case someone phones, or comes to the door. Children shouldn't answer the door, and if someone calls, it's wise to say that their mom or dad is in the shower or unavailable at the moment." These are simple tactics to teach children, but may prove very useful. If someone can't be in the house with children when parents aren't home, neighbours can help by keeping an eye on the house, and parents should always leave a phone number where they can be contacted, in case of emergency.

Five patterns of suspicious behaviour

Parents who leave their children unattended base their decision on the maturity level of their own children, and must ensure that their children will be safe. If they are referred to a children's aid society (CAS) and if police deem that children should not

more...

Continued...

Home Alone (cont'd)

have been left alone, they can be criminally charged with abandonment.

If a CAS is called to investigate, child protection workers look for patterns:

Has the parent left the child unattended in the past?

Is the parent likely to leave the child unattended in the future?

What is the parent's reaction when he or she is confronted about leaving the child alone?

Does the parent understand the dangers that their actions posed for the health and safety of the child?

How long was the child left unattended?

If neighbours know for certain that a child has been left unsupervised they should immediately phone for help. "They can contact us or their local CAS," says Fleming. "If it's a high risk situation, say a toddler's been spotted on a balcony, we will call the police and they will send a car over immediately." Neighbours should call their local CAS or the police, if they suspect that a child's been left alone, and is in imminent danger.

Unlike child supervision or lack there of, wandering occurs by accident, usually when children escape the watchful eye of parents, or parents are not mindful. A parent may fall asleep, and a door or window is accessible to a child who is able to crawl or walk itself into a dangerous situation.

"There was the case of a five-year-old girl, who was found wandering in her apartment complex," Fleming says, "Her mother took some medication, and fell asleep." Parents and caregivers must always be on alert when watching children. Parents should also be aware when on new medication, and watch for side effects such as drowsiness. If a parent is feeling ill, or drowsy, they should call a friend to supervise the child for a short period of time.

Babysitting is the age-old alternative to leaving children alone. Although the law doesn't designate when a young person is old enough to baby sit, parents can do their part in safeguarding their children, by hiring people who have experience, references and training. Services like St. John Ambulance, teach a babysitting course, which includes first aid and emergency procedures.

Parents can get information from community services when searching for a daycare provider. "Local schools are a good source," says Fleming, "Secretaries know all the local mothers who watch kids." Parents need to look for someone responsible, who knows how to react to all situations and health concerns.

Leaving children alone for the first time can be overwhelming for both parents and children. Knowing when children are emotionally ready for this responsibility, and putting safety strategies in place, is all part of the important planning.

For more information please call the Children's Aid Society of Toronto at 416.924.4646 or inquiries@TorontoCAS.ca

www.TorontoCAS.ca

Return this form to:	**Assessment of Attendant Care Needs (Form 1)** *Use this form for accidents that occur on or after March 31, 2008*
	Policy No.:
	Claim No.:

Use this form to report the future needs for attendant care required by the applicant as a result of an automobile accident. This form must be completed by an occupational therapist or a registered nurse (in this form referred to as the Assessor). This form has five parts:

Part 1: Level 1 Attendant Care
Part 2: Level 2 Attendant Care
Part 3: Level 3 Attendant Care
Part 4: Calculation of Attendant Care Costs
Part 5: Signature of Assessor(s)

Please complete all relevant parts. You will have to make copies and give one to:

- the applicant
- the applicant's health practitioner
- the applicant's insurance company

Please note: Users of Form 1 should also review other accident benefits available under the Statutory Accident Benefits Schedule (SABS) for possible reimbursement of other losses and expenses (such as housekeeping and home maintenance, transportation, home modifications and other medical and rehabilitation expenses).

Applicant's Name

Applicant's Name		Date of Birth
Street Address		Date of Accident
City	Province	Postal Code
Name of Policyholder (if different than above)		Policy No.

What is the date of this assessment?

Is this the first assessment of this applicant? Yes ☐ No ☐

Date of Last Assessment
Current Monthly Allowance

Assessor

Name of Assessor		Telephone No.
Facility or Institution		
Street Address		
City	Province	Postal Code

Insurance Company

Name		Telephone No.
Street Address		
City	Province	Postal Code
Name of Policyholder		Policy No.

Continued...

Part 1: Level 1 Attendant Care

Level 1 attendant care is for routine personal care. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes	X	Times per week	=	Total minutes per week
Dress	Upper Body (for example, underwear, shirt/blouse, sweater, tie, jacket, gloves, jewelry)					
	Lower Body (for example, underwear, disposable briefs, skirt/pants, socks, panty hose, slippers shoes)					
				Subtotal		
Undress	Upper Body (for example, underwear, shirt/blouse, sweater, tie, jacket, gloves, jewelry)					
	Lower Body (for example, underwear, disposable briefs, skirt/pants, socks, panty hose, slippers shoes)					
				Subtotal		
Prosthetics	applies to upper/lower limb prosthesis and stump sock(s)					
	exchanges terminal devices and adjusts prosthesis as required					
	ensures prosthesis is properly maintained and in good working condition					
				Subtotal		
Orthotics	assists dressing applicant using prescribed orthotics (for example, burn garment(s), brace(s), support(s), splints, elastic stockings)					
				Subtotal		
Grooming	Face: wash, rinse, dry, morning and evening					
	Hands: wash, rinse, dry, morning and evening, before and after meals, and after elimination					
	Shaving: shaves applicant using electric/safety razor					
	Cosmetics: applies makeup as desired or required					
	Hair:					
	brushes/combs as required					
	shampoos, blow/towel dries					
	performs styling, set and comb-out					
	Fingernails: cleans and manicures as required					
	Toenails: cleans and trims as required					
				Subtotal		
Feeding	prepares applicant for meals (includes transfer to appropriate location)					
	provides assistance, either in whole or in part, in preparing serving and feeding meals					
				Subtotal		

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Part 1 continued...

		Number of Minutes	X	Times per week	=	Total minutes per week
Mobility (location change)	assists applicant from sitting position (for example, wheelchair, chair, sofa)					
	supervises/assists in walking					
	performs transfer needs as required (for example, bed to wheelchair, wheelchair to bed)					
				Subtotal		
Extra Laundering	launders applicant's bedding and clothing as a result of incontinence/spillage					
	launders/cleans orthotic supplies that require special care					
				Subtotal		

Part 1 Total – Add all Part 1 Subtotals. Fill in total here and in Part 4 on Page 7

Part 2: Level 2 Attendant Care

Level 2 Attendant Care is for basic supervisory functions. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes	X	Times per week	=	Total minutes per week
Hygiene	**Bathroom**					
	cleans tub/shower/sink/toilet after applicant's use					
	Bedroom					
	changes applicant's bedding, makes bed, cleans bedroom, including Hoyer lifts, overhead bars, bedside tables					
	ensures comfort, safety and security in this environment					
	Clothing Care					
	assists in preparing daily wearing apparel					
	hangs clothes and sorts clothing to be laundered/cleaned					
				Subtotal		
Basic Supervisory Care	applicant lacks the capacity to reattach tubing if it becomes detached from trachea					
	applicant requires assistance to transfer from wheelchair, periodic turning, genitourinary care					
	applicant lacks the ability to independently get in and out of a wheelchair or to be self-sufficient in an emergency					
	applicant lacks the ability to respond to an emergency or needs custodial care due to changes in behaviour					
				Subtotal		
Co-ordination of Attendant Care	applicant requires assistance in co-ordinating/scheduling attendant care (maximum 1 hour per week)					
				Subtotal		

Part 2 Total – Add all Part 2 Subtotals. Fill in total here and in Part 4 on Page 7

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Continued...

Part 3: Level 3 Attendant Care

Level 3 attendant care is for complex health/care and hygiene functions. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes	X	Times per week	=	Total minutes per week
Genitourinary Tracts	performs catheterizations					
	positions, empties and cleans drainage systems					
	cleans applicant and equipment after procedure/incontinence					
	uses disposable briefs as required					
	attends to menstrual cycle needs as required					
	monitors residuals					
				Subtotal		
Bowel Care	administers enemas or suppositories and performs stimulation or disimpaction					
	performs colostomy and/or ileostomy care					
	positions, empties and cleans drainage systems, including ilio-conduits					
	uses disposable briefs as required					
	cleans applicant and equipment after procedure/evacuation					
				Subtotal		
Tracheostomy Care	changes and cleans inner and outer cannulae as needed					
	changes tapes as required					
	performs suctioning as required					
	cleans and maintains suction equipment					
				Subtotal		
Ventilator Care	ensures volume rate and pressure are maintained as prescribed					
	maintains humidification as specified					
	changes and cleans tubing and filters as required					
	cleans humidification system as required					
	adjusts settings according to client needs (for example, colds, congestion)					
	reattaches tubing if it becomes detached					
				Subtotal		
Exercise	assists applicant with prescribed exercise/stretching program					
	assists applicant with walking activities using crutches, canes, braces and/or walker					
				Subtotal		

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Part 3 continued…

		Number of Minutes	X	Times per week	=	Total minutes per week
Skin Care (excluding bathing)	attends to skin care needs – wounds, sores, eruptions, (amputees, severe burns, spinal cord injuries, etc.)					
	applies medication and prescribed dressings					
	applies creams, lotions, pastes, ointments, powders as prescribed or required					
	checks body area(s) for evidence of pressure sores, skin breakdown or eruptions					
	periodic turning to prevent or minimize pressure sores and skin breakdown/shearing					
				Subtotal		
Medication	**Oral**					
	administers prescribed medications					
	monitors medication intake and effect					
	maintains and controls medication supply					
	Injections					
	administers prescribed medications					
	monitors medication intake and effect					
	maintains and controls medication supply					
	Inhalation/Oxygen Therapy					
	administers prescribed dosage as required					
	maintains and controls inhalation supplies					
	cleans and maintains equipment					
				Subtotal		
Bathing	**Bathtub or Shower**					
	transfers applicant to and from bed, wheelchair or Hoyer lifts to bathtub or shower					
	bathes and dries client					
	applies creams, lotions, pastes, ointments, powders as prescribed or required					
	Bed Bath					
	prepares equipment					
	bathes and dries applicant					
	applies creams, lotions, pastes, ointments, powders as prescribed or required					
	cleans and maintains bed/bath equipment					
	Oral Hygiene					
	brushes and flosses					
	cleanses mouth as required					
	cleans dentures as required					
				Subtotal		

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Continued…

Part 3 continued...

		Number of Minutes	X Times per week	= Total minutes per week
Other Therapy	**Transcutaneous Electrical Nerve Stimulation (TENS)**			
	prepares equipment			
	administers treatment as prescribed or required			
	Dorsal Column Stimulation (DCS)			
	monitors skin			
	maintains equipment			
			Subtotal	
Maintenance of Supplies and Equipment	monitors, orders and maintains required supplies/equipment			
	ensures wheelchairs, prosthetic devices, Hoyer lifts, shower commodes and other specialized medical equipment and assistive devices are safe and secure			
			Subtotal	
Skilled Supervisory Care	applicant requires skilled supervisory care for violent behaviour that may result in physical harm to themselves or others			
			Subtotal	

Part 3 Total – Add all Part 3 Subtotals. Fill in total here and below

Part 4: Calculation of Attendant Care Costs

This part must be completed by the Assessor. Calculate the monthly attendant care allowance for Part 1, 2 and 3. The sum of all three parts will be the Total Assessed Monthly Attendant Care Benefit.

	Total Minutes per Week	÷ 60 =	Total Weekly Hours	X 4.3 =	Total Monthly Hours	X Hourly Rate	= Monthly Care Benefit
Part 1 (from Pg.3)						X A*	= $
Part 2 (from Pg.3)						X B*	= $
Part 3 (from Pg.6)						X C*	= $

Total Assessed Monthly Attendant Care Benefit
(This amount is subject to the limits allowed under the Statutory Accident Benefits Schedule) $

***For amounts to be used in the above table, please refer to the following chart:**

	Accidents occurring between March 31, 2008 and August 31, 2010	Accidents occurring on or after September 1, 2010
A	$11.23	Please refer to the hourly rates as set out in the Superintendent's Guideline issued under s. 19 (2) (a) of the SABS
B	$8.75	
C	$17.98	

Part 5: Signature(s) of Assessor(s)

Name of Assessor		Registration Number
Facility Name (if applicable)		AISI number (if applicable)
Address		
City	Province	Postal Code
Telephone Number	Extension	Fax Number
Email Address		

I confirm that, to the best of my knowledge, the information in this form is accurate. I have obtained the appropriate consent from the applicant for the collection, use and disclosure of the information submitted.

Signature of Assessor	Date (YYYYMMDD)

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Form 1
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Assessment of Attendant Care Needs, Form 1: A Resource for Reflective Practice

List of Reviewed Judgments and Arbitration Decisions (FSCO)

1. *Smith v. Wawanesa,* Ontario Superior Court of Justice, Divisional Court
   Decision on Appeal December 4, 1998 (Campbell J.)

2. *Macartney et al. v. Warner,* Court of Appeal for Ontario
   Judgment: January 11, 2000

3. *John Pierre Moons and Co-operators General Insurance Company*
   Arbitration Decision: FSCO A99-000772, May 3, 2000
   Appeal Order Decision: P00-000033, May 28, 2001

4. *Caterina (Caranci) Pellecchia and Liberty Mutual Insurance Company,* FSCO A998-000603
   Arbitration Decision: November 2, 2000

5. *Mark Faerber-MacMillan and Allstate Insurance Company of Canada,* FSCO A99-000201
   Arbitration Decision: November 27, 2000

6. *Stargratt and Zurich Insurance Co.*
   Stargratt #1. Arbitration Decision: October 4, 2001 - FSCO A99-000521
   Appeal Decision: March 31, 2003 - P01-00045
   Stargratt #2. Arbitration Decision: September 12, 2003 - FSCO A99-000521

7. S. *D. and TTC Insurance Co.,* FSCO A00-000206
   Arbitration decision: May 23, 2002

8. *McKnight and Guarantee Co. of North America,* FSCO A02-000299
   Arbitration Order: October 28, 2003 (Decision on a preliminary issue)

9. *State Farm Mutual Automobile Insurance Company and LF,* FSCO Appeal Decision PO2-00026
   Appeal Decision: June 3, 2004

10. *David McMichael and Belair Insurance Company,* FSCO A02-001081
    Arbitration Decision: March 2, 2005

11. *Michalski (Litigation guardian of) and Wawanesa Mutual Insurance Co.,* FSCO A03-001363
    Arbitration Decision: December 13, 2005

Continued...

12. *Bellavia and Allianz Insurance Co. of Canada/ING, Insurer,* FSCO A05000807
    Arbitration Decision: February 21, 2006

13. *Jessica Keyes and The Personal Insurance Company of Canada* (Motion for interim benefits) Arbitration Decision: July 21, 2006

14. *Tyvon Whyte and Non-Marine Underwriter, FSCO A06-000028*
    Arbitration Decision: December 14, 2006

15. *Haimov and ING Insurance, FSCO A05-0027334*
    Judgment: May 9, 2007

16. *Lane v Economical Insurance Company, FSCO A06-000972*
    Arbitration Decision: June 18, 2008

SUMMARY OF JUDGMENTS AND ARBITRATION DECISIONS

Prepared by Lori Borovoy B.Sc.O.T., OT Reg.(Ont.) and
April Belbeck B.Sc.O.T., OT Reg.(Ont.)
September 2006

Reviewed by: David F. MacDonald, BA(Hons), LL.B., Thomson Rogers

In considering the following highlights, it is important to be aware that there is a difference between a Legal Judgment (as decided by a Court of Law) and an Arbitration decision (as decided by the Financial Services Commission of Ontario (FCSO)). The primary difference is that judicial decisions establish precedents, whereas arbitration decisions may only have persuasive effect. This distinction will be explained below.

A Judgment is a finding by a court (Judge or Jury) that creates a precedent that is binding upon all future decisions made by a court of the same or lower level. For instance, a decision of the Ontario Court of Appeal is binding upon all Ontario Courts, but not upon the Supreme Court of Canada or the British Colombia Court of Appeal. Judicial rulings may change the common law over time if fact scenarios are sufficiently different for a judge to *distinguish* a precedent. Otherwise, judicial rulings apply previous rulings as precedents. This is known as *stare decisis*.

An Arbitration decision is only binding upon the parties to the particular case at hand. Arbitration decisions do not create precedents, although they may be of persuasive value to Arbitrators working on the same tribunal or even to a Court. With respect to FSCO decisions, we can expect that previous arbitration decisions issued from that tribunal may inform future decisions, but there is no such guarantee.

Further, it is important to understand the role of "appeals", within the system. Decisions of a lower court, like the Ontario Court (General Division), may be appealed only if a judge makes an error in law or if there is a very significant new fact that arises following judgment. Decisions of the Financial Services Tribunal may be appealed if the governing statute allows for the appeal, generally on the basis of an error in law. Therefore appeals are available only in a limited fashion and it is critical to present cases as thoroughly and carefully as possible in the court or tribunal of first instance.

SUMMARIES OF JUDGMENTS AND DECISIONS:

The summary of Judgments or Decisions provided here reflects relevant issues related to attendant care only and tries to focus on issues that would affect the Occupational Therapist's practice in conducting an Assessment of Attendant Care Needs (Form 1). . Therefore please note that it does not review the details of other issues/recommendations provided within the Judgment or Arbitration decision. For a complete review the reader

Continued...

should directly review the documents. The Arbitration Decisions or Judgments reviewed were those available to the reviewers at this time. There may be other Judgments or Decisions which are relevant but have not been included.

1. *Smith v. Wawanesa*, Ontario Superior Court of Justice, Divisional Court
Decision on Appeal December 4, 1998 (Campbell J.)

Highlights

- The meaning of "incurred":
  - The person does not have to actually receive the item or service or spend money or become legally obliged to do so.
  - The reasonable necessity of the service and costs just needs to be identified within the appropriate time frame.

This appeal focused on the meaning of the word "incurred". It related to the Ontario Standard Automobile Policy S.P.F.#1 which confers statutory no-fault insurance benefits on accident victims and provides the insurer must pay the insured for

> "all reasonable medical and rehabilitative expenses incurred within four years from the date of the accident." (P442)

It relates specifically to the refusal of an insurer to pay for rehabilitation equipment and psychological services on the basis that the expenses were not incurred since the insured paid for those items after the expiry of the four year period available for claiming no-fault medical benefits under that auto policy. The estimate regarding the need for psychological services was completed within the four years. The confirmation of the need by a medical referral was completed within one month of the expiry of the four year period and the service was provided within seven months thereafter.

The issues raised in the Appeal include:

- does the meaning of "incurred" require that "the insured must receive the service and spend the money within the four years, or at least incur a legal liability for the expenditure?"; alternatively
- to meet the definition of an "incurred" expense, "is it sufficient that the reasonable necessity for the service and the amount of the expenditure is determined with certainty within the four years with actual performance and payment to follow at a later date? "(P 443)

Various meanings of incurred were reviewed through trial cases or other cases and an analysis of the three underlying principles of these cases are identified as follows:

1. "First, although capable of a narrow meaning the word "incur" is capable also of the wider meaning of "run into", "render oneself liable to", "bring upon oneself" or "be subject to". There is a wider sense in which the expenditure is incurred

within the time limit as soon as it is known with certainty that it is necessary and its amount is ascertained." (P448)

2. "Second, the provision should be construed *contra proferentem*, the coverage interpreted broadly and the time limitation narrowly." (P448)
3. "Third, a remedial and purposive interpretation suggests that unfairness would result from a narrow interpretation. As Osler J. pointed out in *MacDonald v. Travelers Indemnity Co. of Canada,* [1987] I.L.R. 1-2220 (Ont. H.C.), the narrow interpretation penalizes the insured who lacks the money or the credit to pay, or to become legally obliged to pay for, the insured services." (P448)

The Court concludes that for

> "an insured to incur an expenditure within four years within the meaning of the standard policy, he does not actually need to receive the items or services or spend the money or become legally obliged to do so. It is sufficient if the reasonable necessity of the service or item and amount of the expenditures are determined with certainty before the end of four years. It is a question of fact in each case whether the requisite degree of certainty has been established." (P 449)

***2. Macartney et al. v. Warner*, Court of Appeal for Ontario**
Judgment: January 11, 2000

Case reviewed, does not relate directly to attendant care. Related to Family Law Act and loss of a son in a car accident and the issue of loss of income the parents may have incurred. Decision of lower court upheld on meaning of "incurred" expenses.

3. John Pierre Moons and Co-operators General Insurance Company
Arbitration Decision: FSCO A99-000772, May 3, 2000
Appeal Order Decision: P00-000033, May 28, 2001

Highlights

Under the No-Fault Benefit Schedule previously in force under the Ontario Motorist Protection Plan if a person/family member is visiting an injured person in the hospital and providing a service to him/her, it is prudent to request reimbursement of services through:

- Section 16 of the *SABS-1996* as attendant care; or
- Alternatively, his/her recourse is under s.61 of the *Family Law Act*.

Issue: Can a family member, in this case the mother of the injured person, be reimbursed for her time while visiting her son in hospital as lost wages?

In this case, John Moons was injured in a motor vehicle accident on March 6, 1999 and hospitalized until May 6, 1999. His mother stopped working during this period in order

Continued...

to visit her son on a daily basis. Mr. Moons is seeking to recover his mother's lost wages under Section 21 of the *Schedule* which deals with visitor expenses. The lost wages are not being applied for as attendant care. The insurer did not dispute that the visits were reasonable or necessary, however disputes the claim to loss wages.

Initial arbitration decision: The Arbitrator ruled that Ms. Moons is entitled to recover her lost wages under Section 21 of the *Schedule* as visitor expenses.

Appeal decision: The insurer appealed the initial arbitration decision. Director's Delegate Draper overturned the initial arbitration decision and ruled that Co-operators General Insurance Company is not required to pay the claim for wages lost by Ms. Moons as visitor's expenses under Section 21 of the *Schedule*. In his reasons, Draper explains that the situation in this case is different if the person does more than visit.

> "If Mrs. Moons had done more than just visit, compensation may be available under s.16 of the *SABS-1996* as attendant care. Alternatively, her recourse is under s.61 of the *Family Law Act*." (P 13)

***4. Caterina (Caranci) Pellecchia and Liberty Mutual Insurance Company*, FSCO A998-000603**
Arbitration Decision: November 2, 2000

Note: This decision dealt with the entitlement of the claimant for weekly income benefits and housekeeping expenses. The focus of this review will be on the housekeeping expenses only.

> ***Highlights***
> The Arbitrator accepts the claim of a spouse for housekeeping tasks as being reasonable. The decision also provides an hourly rate of $10.00 as being acceptable for re-imbursement for the claimant's non-medical expense.

Issue: Is Ms. Pellechia entitled to housekeeping expenses under section 6(1)(f) of the *Schedule* in the amount of $50.00 per week from February 28, 1994 until July 2, 1999?

Decision: The Arbitrator found the Ms. Pellechia was entitled to housekeeping expenses at a rate of $10.00 per hour, payable to her husband. Because the husband did not track his time, the Arbitrator estimated that it would take him 2 hours per week to complete the following tasks: vacuuming, mopping, carrying laundry up and down, shopping for heavy groceries. (P 17/18)

***5. Mark Faerber-MacMillan and Allstate Insurance Company of Canada*, FSCO A99-000201**
Arbitration Decision: November 27, 2000

Highlights

- When assessing a claimant's attendant care needs, it is important to consider the impact of any psychological impairment on his/her care needs.
- An individual can sustain a psychological injury as a result of a motor vehicle accident which is considered separate from the physical injury sustained.
- This decision is most relevant to injuries occurring between January 1, 1994 and October 31, 1996

Issue: Mark Faerber-MacMillan, age 17, sustained a cervical spinal cord injury in a motor vehicle accident on March 14, 1995. The dispute is in regards to the rate at which Allstate is obliged to pay Mr. Faerber-MacMillan attendant care benefits.

It was agreed by all parties that Mr. Faerber-MacMillan sustained a cervical spinal cord injury and thus is entitled to attendant care benefits. (P2) However, the dispute is about the maximum amount of benefits to which Mr. Faerber-MacMillan is entitled. Under Section 47(5), if the insured person suffers cervical spinal cord injuries alone, s/he is entitled to $6000 per month. However, under Section 47(6), if the insured person suffers cervical spinal cord injuries and an additional injury that necessitates attendant care benefits, s/he is entitled to $10,000 per month.

Accordingly, to be entitled to the higher level of benefit, Mr. Faerber-MacMillan would have had to have sustained *more* than a cervical spinal cord injury. In dispute is whether Mr. Faerber-MacMillan's alleged psychological injury may be characterized as an additional injury. A psychologist, a neurologist and a psychiatrist provided evidence to determine whether Mr. Faerber-MacMillan suffered from a psychological injury. It was clear that Mr. Faerber-MacMillan suffered from a major depressive disorder, the question is whether the depression is a consequence of a separate "injury" within the meaning of 47(6) or is it caused indirectly by his spinal cord injury. (P 13)

The Arbitrator considered the following:

- definition of impairment, accident and psychological or mental injury.
- whether a person in an accident can have both a physical and psychological injury.

The Arbitrator determined that:

- There is no reason why a person who is involved in the accident cannot suffer both physical and psychological injuries as a result of an accident (P 15).
- The physical injury impaired most of Mr. Faerber-MacMillan's physiological and anatomical limitations but has not diminished his high average intelligence.
- Mr. Faerber-MacMillan's capacity to use his intellectual abilities has been impaired by a psychological impairment (P 15).
- The Schedule recognizes the possibility of psychological injury in some circumstances while not precluding the possibility of psychological injury in any other circumstance (P 16).

Continued...

Conclusion: Mr. Faerber-MacMillan's psychological impairment can be and is more accurately described as a direct consequence of a psychological injury he suffered as a result of the accident.

To determine if Mr. Faerber-MacMillan's psychological injury requires additional and separate attendant care services over and above those required by his cervical spinal cord injury, the Arbitrator considered:

- The words "by itself" in section 47(6) and determined that what needs to be established is whether his psychological injury requires *additional and separate* attendant care services (P17-18)

To evaluate this, the Arbitrator looked at the evidence from the DAC (West Park Hospital) for Mr. Faerber-MacMillan's attendant care needs which were assessed by an occupational therapist and a registered nurse. The Arbitrator noted from the DAC report that:

- Considerations were given exclusively to Mr. Faerber-MacMillan's physical limitations.
- Under Level 2 "Attendant Care on an Intermittent Basis"
    - The assessors did not refer to the claimant's "depression or his being left alone and made no attempt to determine the degree to which his accident may have rendered him psychologically impaired and dependent on others."
    - The assessors were aware of his problems with depression.
- The DAC assessors did not refer to the monthly maximums established by section 47(5) and 47 (6) or acknowledge that these sections might require them to identify or distinguish between different types of injuries.

The Arbitrator reviewed the report dated April 25, 2000 of Dr. Kaminska where it is noted that in addition to the specialized attendant care because of the serious physical impairments, he requires non-specialized, ongoing attendant care because of psychological impairment. (P 22)

The Arbitrator reviewed the report of June 21, 2000 by Dr. Kirkpatrick who noted psychological problems, his dependence on family and his being left alone as contributing to his residual depression. She recommended increased attendant care to address these problems. (P 23)

The Arbitrator concluded that:

- the DAC assessors took an unduly restrictive approach to the determination of Mr. Faerber-MacMillan's need for attendant care.
- the evidence does not support that the psychological injury has caused a psychological impairment which requires additional and separate attendant care services over and above those required by the physical impairments. If Mr. Faerber-MacMillan does actually receive 24 hour attendant care services in respect of his physical impairments, he would not be left either alone or dependent on his family and hence would not require additional and separate attendant care in respect of his psychological impairment.

- while he does not receive 24 hour attendant care because of the maximum stipulated by 47(5), the higher maximum of 47(6) does not apply in this case because the attendant care services required for the psychological injury is similar to and overlapping with, *not additional to and separate from,* those required by the cervical spinal cord injury (P 27)

Result: Allstate is obliged to pay Mr. Faerber-MacMillan attendant care benefits at the monthly rate of $6, 552.87

6. Stargratt and Zurich Insurance Co.
***Stargratt #1*. Arbitration Decision: October 4, 2001 - FSCO A99-000521**
Appeal Decision: March 31, 2003 - P01-00045
***Stargratt #2.* Arbitration Decision: September 12, 2003 - FSCO A99-000521**

Highlights:

In terms of **Attendant Care Benefits**:

- What is important is the client's reasonable entitlement to services, and not the identity of the individual care provider.
- Shopping for food and essentials is within the role of an attendant.
- Routine vacuuming, food preparation, cleanup and laundry could fall under either housekeeping and home maintenance or attendant care, depending on the context and the purpose of the service.

In terms of **Housekeeping and Home Maintenance**:

- Maintenance and upkeep of the fabric of the home fall under housekeeping and home maintenance, i.e. painting, washing windows, lawn maintenance as well as generalized maintenance-related cleaning such as spring cleaning.
- Routine vacuuming, food preparation, cleanup and laundry could fall under either housekeeping and home maintenance or attendant care, depending on the context and the purpose of the service.

In terms of **Caregiver Benefits**:

- Caregiving provisions of the *Schedule* only provide for assistance relative to dependents living with the injured person at the time of the accident. Any additional caregiving responsibilities bestowed on the person following the accident (i.e. having a child) are not compensable.
- Nonprofessional care that she received from her family was remunerated at a minimum wage level.

The issue in the appeal is the meaning of "incurred" expenses for attendant care and caregiver services. The Arbitrator determined that:

- While the insurer is entitled to require documentation of caregiver and attendant care services claimed, and they have reason to ask more questions when family members provide the services. Although detailed records of the services provided during the said period of time is ideal, the evidence must be taken in context of the situation.

Continued...

- The insured is not precluded from claiming attendant care benefits because her family did not expect or demand payment.

Stargratt #1 FSCO A99-000521, Arbitrator: John Wilson, October 4, 2001

Ms. Stargratt was a 29 year old stay at home mother with a 15 month old daughter when she was in a motor vehicle accident on March 14, 1998. She lived in Sudbury, Ontario. Her husband had started his first teaching job on Manitoulin Island, and returned to their Sudbury apartment on weekends. Before the accident, Ms. Stargratt:

- did most of the childcare, cooking and housework;
- had dystonia and tremors which primarily effected her right hand and head;
- had difficulty with fine motor control and problems doing delicate tasks with her right hand;
- had difficulty finding employment (she is not claiming for loss of employment);
- was functional as a mother and a homemaker. (P6)

Following the accident, due to her soft tissue injuries and increase in tremors especially those on her left side she reported being limited in caring for her child and herself. Ms. Stargratt's sister left her studies as a student to provide attendant care to Ms. Stargratt and to care for the 15 month old child when the husband was not there during the week. A couple of weeks after the accident, Ms. Stargratt had a severe sudden onset of low back pain, and following this, Ms. Stargratt and her daughter had to be cared for by both her parents and sister at her parent's home.

The initial Arbitrator found that Ms. Stargratt suffered a disability arising from the accident in relation to caring for herself (attendant care) and her daughter (childcare). He found attendant care and caregiving to be reasonable and necessary. He stated that

> "Ms. Stargratt has filed a chart summarizing the hours and duration of the services provided to her by her family. Unfortunately it doesn't break down the individual tasks performed and the hours devoted to each head of Ms. Stargratt's claim. Although useful in showing the aggregate hours put in by the family, it does not necessarily reflect Ms. Stargratt's entitlement to caregiver and attendant care services pursuant to the *Schedule*." (P13)

There was no indication in the arbitration order that a Form 1 had been completed at any time.

The Arbitrator explains that

> "The schedule breaks down homecare responsibilities variously into Housekeeping, Caregiving and Attendant Care. Necessarily, there is some overlap. In the real world, a single act, such as preparing and serving a meal could potentially be characterized as any of the three categories, depending on the surrounding circumstance." (P14)

Ms. Stargratt had claimed for caregiving and attendant care services. She did not claim for housekeeping and home maintenance services. The Arbitrator explained that her family was essentially providing 24 hour standby care until Mr. Stargratt returned to Sudbury.

In determining what is provided for attendant care and what is caregiving, the Arbitrator identified definitions of "Aids" in the Oxford Dictionary. (P14/15) He stated

> "Ideally, attendant care claims will focus on assisting or providing a service to the applicant, while caregiver services may be seen as focusing on services replacing those normally provided by the claimant to a dependent."

The Arbitrator further explained that the evidence showed that the sister and the parents of the Plaintiff provided care. He was concerned only with

> "Ms. Stargratt's reasonable entitlement to services, and not the identity of the individual care provider." (P 15)

He allocated time as follows:

> "Ms. Stargratt required assistance during the day, in grooming, dressing, having clothes prepared and washed, and having meals prepared and cleaned up. The same services were provided to Alexandra Stargratt (infant). At night Ms. Stargratt slept. She required no personal assistance. In the event of a fire she was mobile and could have left the apartment."

He explained that at night the 15 month old (Alexandra) still needed to be cared for including changing her, comforting her and watching over her in the event of an emergency.

> "In the event of a fire, she required someone to be able to carry her out of the apartment. Ms. Stargratt could not pick up and carry her daughter."

The Arbitrator found that Ms. Stargratt's sister was needed in the apartment at night for her duties as a caregiver and for no other reason. (P 15)

The Arbitrator explained that although Ms. Stargratt strived to become

> "independent in personal care, the preparation and clean up of meals, the washing and putting away of clothing and even the process of dealing with the insurance claim required assistance. Someone needed to shop for food and household essentials as well as be available for emergencies."

He explained the family assisted in the above and he found that within the scope of attendant care. (P 16)

Continued...

He explains that Section 22, Housekeeping and Home Maintenance,

> "suggests that this section is intended to target services concerned with the maintenance and upkeep of the fabric of the home. It would include painting, window washing, lawn maintenance, as well as generalized maintenance-related cleaning such as spring cleaning in this category." (P16)

He states that

> "Other cleaning such as routine vacuuming, food preparation cleanup, and laundry could fall under either housekeeping and home maintenance or attendant care, depending on the context and the purpose of the service." (P16)

He found that since Ms. Stargratt's husband was absent from the household, the majority of the incidental cleaning services were part of generalized assistance to Ms. Stargratt and not household or home maintenance services. He did not deduct hours for housekeeping and home maintenance.

The Arbitrator allocated eight hours for caregiving at night as a caregiving benefit and eight hours during the day. (P17) He was not convinced that the balance of the day was necessarily devoted to either Ms. Stargratt or her daughter, nor necessarily devoted to "compensable activities." (P 17) He stated

> "I find from the date of the accident to January 1, 1999, with the exception of July and August 1998, Ms. Stargratt is entitled to 40 hours of caregiving and 40 hours of attendant care services per week." (P17).

The Arbitrator explained that during July and August 1998 and January to June 1999, that Mr. Stargratt was working in Sudbury and available during the evenings, as well as weekends. "I find that, during those periods, there was no need for overnight caregiving. I find that further assistance was required during Mr. Stargratt's workday for both Ms. Stargratt and for Alexandra. This should encompass the entire time that Mr. Stargratt was absent from the home which I estimate, on average to be nine hours per day, five days per week." (P17)

> "As noted in the evidence, Mr. Stargratt was not working for either July or August 1999, and no claim has been made for either attendant care or caregiver services for that time frame."

<u>Pregnancy for second child after the accident</u>

During the period above Ms. Stargratt had another child. However, it was found that caregiving provisions only provide for assistance relative to dependents living with the injured person at the time of the accident and this was not the case for the Plaintiff's new born son, who was not even conceived at the time of the accident. (P 18)

For September 1999 the Arbitrator identifies that Ms. Stargratt's daughter attended Nursery School. He stated that Ms. Stargratt would require assistance with daytime meals, and in caring for her daughter on days when she was not at nursery school. (P 18) This left four days per week when childcare was required. He also provided for two hours of assistance per week in meal preparation and clean up during the time when childcare was not provided in the home.

The Arbitrator found that from Ms. Stargratt is entitled to caregiver expenses of 36 hours of child care per week, plus 2 hours of attendant care from September 1, 2000. He also identified that Ms. Stargratt is entitled to have the childcare expenses for nursery school reimbursed as a caregiver expense. (P19)

The Arbitrator states

> "Ms. Stargratt submitted that it was appropriate that the caregiver services be compensated at least the minimum wage level, which would be about $7.00 per hour. I find that this would be an appropriate level to compensate the nonprofessional care that she received from her family." (P19)

Appeal Decision of Stargratt #1 P01-00045, Arbitrator: Makepeace Dir. Delegate, March 31, 2003

Zurich Insurance Co. appealed the initial arbitration decision in which the Arbitrator ruled that Ms. Stargratt is entitled to caregiver, attendant care and physiotherapy benefits under the *SABS-1996,* and a special award in the amount of 50 percent of outstanding benefits. Zurich claims the Arbitrator erred in law by finding that Ms. Stargratt had "incurred" caregiver and attendant care benefits although she did not pay her sister and parents for the help they provided and they did not demand payment. It also submits that the Arbitrator exceeded his jurisdiction in raising the issue of a special award on his own initiative. (P1)

On appeal the Director's Delegate reviewed several cases on determining the word "incurred". He reported that he came to the same conclusion as *L.F and State Farm Mutual Automobile Insurance company* (FSCO A00-000364, August 21, 2002 and *S.D. and TTC Insurance Company Limited* (FSCO A00-000206, May 23, 2002) where the insured persons family provided attendant care without a promise or expectation of payment. (P12) He explained how s. 2(7) of the *SABS-1996* allows for payment for non-professional attendants, and this often means friends and family. The Arbitrator identified that this is sensible since friends and family may provide better care than third-party service providers, and at a lower cost. (P13)

The Director's Delegate also considered the insurer's request for information concerning assistance provided pursuant to s.32(2). (P13) He explained that the insurer is entitled to require documentation of caregiver and attendant care services claimed, and they have reason to ask more questions when family members provide the services. He stated that

Continued...

> "although detailed contemporaneous record-keeping is ideal, evidentiary requirements should be tailored to the information context. In this case, there is no question that the services were provided. I agree with the Arbitrator that Zurich knew Ms. Stargratt needed help." (P13)

The Director's Delegate further examined a letter sent to Ms. Stargratt from the Insurer that indicated that since no monies had been paid, an expense had not been incurred. Ms. Stargratt admitted she did not discuss paying her mother or her sister after receiving this letter and did not maintain a log of services rendered. The Arbitrator explained that this would have been damaging to Ms. Stargratt's claim if Zurich had explained to her that she could claim for services received by family members, or invited her to provide particulars of the services provided.

In addition there was an accompanying letter from the insurer indicating that Ms. Stargratt was not eligible for Non-Earner Benefits because she elected Caregiver Benefits, and was not eligible for Caregiver Benefits because she had not incurred any expenses. (P15) The Director's Delegate stated

> "Zurich's failure to explain that she could pay her family for looking after her is the critical factor in my decision that the Arbitrator did not err. I might add that this omission was compounded by Zurich's failure to explain the implication of Ms. Stargratt's election of caregiver benefits over non-earner benefits." (P15)

He explains that non-earner benefits would have been available whether or not expenses were incurred.

> "She might have used this money to pay her family or hire third-party services providers. Without any weekly benefits, she had few alternatives to accepting unpaid help from her family. In these circumstances, I agree with the Arbitrator that Ms. Stargratt is not precluded from claiming benefits because her family did not expect or demand payment." (P15)

With regard to duration of attendant care benefits, the Director's Delegate identified that the initial Arbitrator failed to identify a termination date for caregiver and attendant care benefits beyond the 104 week anniversary of the accident. He states that this was in error (P16) and cites the SABS in relation to the 104 week duration. With regard to caregiver benefits, Ms. Stargratt claims that she met the s.13 (Caregiver Benefit) disability test continuously which is: complete inability to carry on a normal life after the 104 week period. The Arbitrator refers back to the initial Arbitration decision in order to determine caregiving benefits. (P17) The order on appeal was Ms. Stargratt is entitled to attendant care benefits for expenses incurred between March 14, 1998 and March 14, 2000.

With regard to a Special Award, the Arbitrator at first instance awarded a special award in the amount of 50% of the outstanding benefits including interest, with regard to attendant care, caregiver and physiotherapy benefits. He identified that Ms. Stargratt was

entitled to caregiving and attendant benefits, that the Insurer was aware of her needs and the seriousness of her situation, and her unusual and vulnerable state. (P24/25)

Result: The appeal order of March 31, 2003 identified referral back to the initial Arbitrator (Wilson) for determination of the interest and special award owing.

Stargratt #2 FSCO A99-000521, Arbitrator Wilson, September 12, 2003

The benefit period was determined to be for the two years previous to the Arbitration for attendant care and caregiving benefits. The claim for caregiving benefits beyond the 104 week mark was withdrawn. The arbitration dealt with specific amounts relating to interest and the special award.

***7. S. D. and TTC Insurance Co.*, FSCO A00-000206**
Arbitration decision: May 23, 2002

Highlights
This decision addresses two issues:

1. The interpretation of "incurred expense"
   - In order to have "incurred" an expense, an individual does not have to present proof of out of pocket expenses for housekeeping/homemaking services.
2. If a family member is performing the service
   - Compensation for services provided by family members is based on whether such services are *"necessary and reasonable as a result of the accident*" and not dependent on who is performing the function. Therefore, the expectation that the services of family members are gratuitous is not reasonable.

Note: There are various issues relating to the Statutory Accident Benefits Section 14/15 (Medical and Rehabilitation Benefits) and the arbitration costs in this decision; however, only the information related to Attendant Care Benefits Section 22 of the schedule will be provided in this review.

Issue: Is Mrs. D. entitled to payment for housekeeping and home maintenance services provided by her husband from December 19, 1997 to August 15, 1999 pursuant to section 22 of the *Schedule*?

Result: The Arbitrator found that Mrs. D's husband should be compensated for housekeeping services such as assistance for meal preparation, heavier household cleaning (vacuuming, washing floors, cleaning the bathroom and changing beds) and laundry, at the current minimum wage of $6.85 per hour, for three hours per week for a period of 99 weeks.

Continued...

In this case, the Plaintiff requested payment through her solicitor for services for expenses for housekeeping services performed by her husband for a total of 12 hours per week, for six days per week. The services depended on the day of the week and included general household cleaning, light cleaning and cooking, shopping and laundry. (P42)

The TTC argued that the housekeeping expenses were not payable because they had not actually been incurred.

> "That is to say, Mrs. D. did not pay her husband any money in exchange for the housekeeping chores he performed." (P 42)

The Arbitrator stated

> "I find the word 'incur' admits of a broader interpretation than that submitted by the Insurer, both in its ordinary meaning and as a result of previous judicial interpretation in the no-fault insurance context." (P 42)

Various definitions are cited as well as reference to agreement with the decisions in *Stargratt v. Zurich Insurance Co.* (FSCO A99-000521, October 4, 2001) and *Jelisic v. Guarantee Co. of North America*.

The Arbitrator explained that the use of the word "incur" in subsection 13(2) of the *Schedule* does not restrict care giving benefits to actual out-of-pocket expenses. The Arbitrator states

> "I would go as far as to consider that a person who was unable to unwilling to promise payment in exchange for housework because of financial hardship, and who did not in fact make any promise, could nevertheless "incur" an implied obligation to pay within the meaning of the *Schedule*." (P 43)

The Arbitrator explained that

> "in most cases where an insured person is unable to afford to pay for a commercial housekeeping service or arm's length assistance, the natural tendency is for family members to pitch in to do the necessary work. An insured person, particularly an unsophisticated or impecunious one, has very little choice if he or she wishes to live in a reasonably clean home." (P44)

The Arbitrator also expressed that

> "the TTC's response to Mrs. D's application for housekeeping expenses were not payable because they were not "incurred" on the basis that 'one would think the services of a spouse are gratuitous given the special oath of marriage' is not only fatuous but clearly contrary to the intent of the *Schedule*." (P44)

The Arbitrator further explains that compensation for services is based on whether the services

> "are *necessary and reasonable as a result of the accident,* this specific criteria does not include ability to pay or the availability of a husband. "(P 44)

***8. McKnight and Guarantee Co. of North America*, FSCO A02-000299**
Arbitration Order: October 28, 2003 (Decision on a preliminary issue)

Highlights

In terms of Form 1 and payment for Attendant Care Benefits:

- The Form 1 on its own does not create an automatic obligation to pay attendant care benefit.
- The benefit is to be paid in accordance with the amounts set out in the Form 1, once entitlement to the benefit has been established. In some situations, the insurer is entitled to additional information.
- The Form 1 identifies attendant care needs, but does not constitute evidence that expenses have been incurred.
- The Insurer may require information identifying the service provider and the dates and approximate times of the service provision in order to satisfy itself that the services were provided and expenses incurred.

Issue: What information may Guarantee Co. of North America require from Mr. McKnight in order to pay an attendant care benefit under Section 16 of the *Schedule?*

In this case, Mr. McKnight was injured in an automobile accident on April 3, 2000. He has been declared catastrophically impaired as a result. Mr. McKnight applied to Guarantee Co. for attendant care benefits and submitted seven Assessments of Attendant Care Needs (Form 1) to Guarantee Co. Guarantee Co. has paid some attendant care benefits, but not the full amounts claimed.

The dispute in this case concerns the amount of information the Insurer is entitled to receive in order to determine that an attendant care benefit is payable under section 16 of the *Schedule.* (P2) Mr. McKnight submits that the Insurer is not entitled to any information beyond what is provided in the Form 1. Guarantee Co. submits that it is entitled to information about the identity of the service provider and the nature of the services actually provided.

Mr. McKnight identified that as per Section 39 of the *Schedule* the insurer has three options which include:

- Pay the attendant care as per section 39(1)(a).
- Request a certificate of health from a professional stating the expenses are reasonable and necessary pursuant to section 39(1)(b).
- The insurer may require the insured person to attend a DAC for attendant care benefits as pursuant to section 39(4). (P3)

Continued...

> "Mr. McKnight submits that the Insurer must exercise one of the options set out in section 39 and is not entitled to request any additional information. He points out that there is no specific section in the *Schedule* which permits the Insurer to request additional information concerning the provision of attendant care benefits." (P3)
>
> "Guarantee Co. submits that section 16 of the *Schedule* is intended to provide indemnity coverage for expenses actually incurred for serviced provided by an aide or attendant" (Guarantee Co. refers to subsection 16(2)a) of the *Schedule).* (P3)
>
> "Guarantee Co. also submits that the Form 1 on its own does not create an automatic obligation to pay attendant care benefits."
>
> "Rather, the insurer is entitled to satisfy itself that the services contemplated in the Form 1 have been provided and that an expense has been incurred before paying and attendant care benefit. If referred to section 33 of the *Schedule* which permits the insurer to request information reasonably required to determine entitlement to a benefit" (P4)

Section 33 is entitled "Duty of Applicant to Provide Information".

The Arbitrator agreed with the Insurer and explained:

> "I do not find that the Form 1 contemplated in section 16 displaces the insurer's right to request reasonable information to determine entitlement of an attendant care benefit under section 33." (P4)

He further states that he does not agree with Mr. McKnight's interpretation of section 16(4) of the *Schedule* that it is mandatory that the insurer pay the attendant care benefit in accordance with Form 1. He states

> "I find instead that the section requires the benefit to be paid in accordance with the amounts set out in the Form 1, once entitlement to the benefit has been established." (P4)
>
> "To determine entitlement, the Arbitrator identified that the Insurer may, in some cases, require additional information." (P4)

Furthermore, the Arbitrator found that Form 1 simply identifies attendant care needs, but does not constitute evidence that expenses have been incurred. (P5)

The Arbitrator reviewed cases such as *S.D. v. TTC Insurance Company Limited* (FSCO A00-000206, May 23, 2002) and he also cites the case *Stargratt v. Zurich Insurance Co.* (FSCO P01-00045, March 31, 2003) which provide that insurers are entitled to require documentation of caregiver and attendant care services claimed. To support his position,

Mr. McKnight referred to the decision in *L.F. v. State Farm Mutual Automobile Insurance Company* (FSCO A00-000364, August 21, 2002) arguing that it

> "stands for the proposition that the identification of need alone is sufficient to establish entitlement to a benefit." (P5)

However, the Arbitrator did not accept Mr. McKnight's interpretation of this decision.

Guarantee Co. asked that the Arbitrator

> "determine what information it is entitled to in order to determine eligibility for attendant care benefits". (P6)

The Arbitrator referred to the appeal decision in *Stargratt, supra* (P01-00045 May 31, 2003):

> "Although detailed contemporaneous record-keeping is ideal, evidentiary requirements should be tailored to the informal context. To require minute by minute accounting from the service provider may not be reasonable, particularly in informal arrangements. The reasonableness of the Insurer requirements would be assessed in the individual circumstances of each case." (P6)

The Arbitrator ruled it reasonable in this case,

> "that the Insurer would require information identifying the service provider and the dates and approximate times of the service provision in order to satisfy itself that the services were provided and expenses incurred." (P6)

***9. State Farm Mutual Automobile Insurance Company and LF*, FSCO Appeal Decision PO2-00026**
Appeal Decision: June 3, 2004

Highlights
The case involved incurred expenses for attendant care benefits. The Arbitrator found that a claimant's family is entitled to attendant care benefits, although the claimant has neither paid his family for looking after him nor does the family have an expectation to be paid.

The accident occurred January 1, 1997.

This appeal decision reviewed an arbitration award wherein State Farm was ordered to pay LF. monthly attendant care benefits (ACB) totaling:

- $744.18 from January 12, 1997 to March 30, 1997, when the client was discharged from the hospital and moved in with his parents;

Continued...

- $147.92 from April 1, 1997 to August 30, 1997, when he moved to Thunder Bay and was cared for by his Fiancée,
- $134.68, from August 31, 1997 to January 11, 2000, when he moved to Toronto.

No on-going benefits were ordered. (P 14/15)

The initial award was made based on four reasons: (P15)

(i) Although "Mr. F failed to comply within the 30-day time limit for submitting an application under s. 32(3))", the Arbitrator rejected this claim by State Farm as they found that State Farm did not provide Mr. F with the appropriate application forms, information and explanatory materials required under s. 32(2).
(ii) "State Farm argued that Mr. F. had not "incurred" attendant care expenses, as required under s 16(2) of the SABS-1996, because he had not *paid* his parents and fiancée for looking after him and they had *no expectation* he would do so. The Arbitrator rejected this based on previous Commission decisions."
(iii) "The Arbitrator concluded that the 104-week limit on ACBs under s.18(2) did not apply to Mr. F. because of s. 70(3), a transitional provision."
(iv) The Arbitrator concluded that "the ACBs ordered were 'reasonable and necessary expenses' resulting from the accident, as required under s. 16 (2). (P15)"

State Farm disputed each of these points on appeal. The Director's Delegate found that the original Arbitrator erred in law on transitional provision, and the order was revoked with respect to benefits after January 1, 1999, (two year mark) however found no other errors.

The reasons of the Director's Delegate concerning items (i), (ii), (iv), below.

<u>Procedure for Claiming Attendant Care Benefits (p20 to 24)</u>

The Director's Delegate explained the process for initiating an accident benefits claims. The insured person is required to give the insurer notice that he wishes to apply for a benefit within 30 days of the circumstances giving rise to entitlement, "or as soon as practicable thereafter". Then, the insurer must provide the appropriate forms and information for the benefits. Finally, the claimant must submit an application for the benefit within 30 days of receiving the materials.

Although the accident occurred in January 1997, Mr. F. did not request ACB's until October 22, 1998 when he obtained legal counsel. In response, State Farm asked for an attendant care certificate and retained an Occupational Therapist to complete a Form 1. Mr. F. provided details of his claim for past and ongoing ACB's in a letter of December 29, 1998 (nearly 2 years after the accident).

The Arbitrator rejected State Farm's argument that Mr. F had missed the 30 day deadline for submitting his application. State Farm had not provided Mr. F with sufficient information about the necessity of submitting an application in a timely matter:

> "The insurer bears the obligation to provide sufficient information to enable the consumer to claim benefits. There is no exemption from this rule where the insured person is represented."(P 23).

Given State Farm did not "provide the appropriate application forms and sufficient explanatory information to allow Mr. F. to make a meaningful decision about attendant care means it cannot rely on the 30-day time limit." (P 24)

Thus, this decision suggests that insurers have a duty to inform clients of their entitlements and facilitate application for same.

Incurred Expense

The original Arbitrator found that although Mr. F had not submitted sufficient documentation to State Farm about incurred attendant care, State Farm failed to establish that it had effectively notified Mr. F of the filing requirements. State Farm failed to explain to Mr. F what documentation would suffice for him to obtain an attendant care claim. State Farm failed to arrange an attendant care DAC assessment and failed to pay benefits pending receipt of the DAC report as per various sections of the SABS quoted. This finding was accepted as correct by the Director's Delegate.

Reasonable and Necessary

State Farm tried to argue that Mr. F's claimed benefits were not reasonable. On appeal, State Farm argued that the original Arbitrator does not adequately explain why he accepts the level of need for attendant care benefits when there are competing claims about the level of need Mr. F requires. The Appeal Arbitrator identified that, in this situation, given there are competing opinions of two parties experts,

> "it may be tempting to see the two reports as "either/or" options. Failing to consider whether the insured person has proven entitlement of any level of benefits would be an error of law." (P27)

The Appeal Arbitrator was satisfied that Mr. F. needed *some* attendant care and accepted that the Occupational Therapists which State Farm relied on offered the best evidence Mr. F's need. The Arbitrator did not explain why the State Farm O.T.'s evidence was better than the other.

Continued...

***10. David McMichael and Belair Insurance Company*, FSCO A02-001081**
Arbitration Decision: March 2, 2005

Highlights

- There is a need to consider "collateral evidence" and not just medical/test results.
- Supervision in the form of attendant care is considered reasonable if it is required to ensure an individual's safety and prevent risk of overdosing.
- When this client was in a facility, i.e.: Bellwoods, he obtained the supervision he needed and was already in receipt of the benefit. However, consideration was raised during times when he was on vacation as he would need an attendant (as Bellwoods would not provide such services).
- The focus is now on "incurred need" for the person and not on "incurred costs or expenses".

Issue: The overall case was in relation to the causal relationship, if any, between the car accident and Mr. McMichael's current difficulties (in particular his addiction to crack cocaine). Mr. McMichael states that as a result of the accident, he has become a crack cocaine abuser. It is primarily this addiction that forms the basis of his position that he is catastrophically impaired and therefore entitled to attendant care benefits and income replacement benefits (IRB) given that he is now unable to work. The Defendant argued that Mr. McMichael was a cocaine user before the accident and therefore there is no entitlement to IRB and attendant care benefits.

Result: The Arbitrator identified that Mr. McMichael has suffered a catastrophic impairment and was entitled to both attendant care and IRBs.

A: Collateral Information

An important issue raised in this decision is the need to consider "collateral evidence" during assessments rather than relying solely on medical information and testing.

> "It appears, based on various reports, that the assessments were based primarily on the medical information provided to the DAC (Designated Assessment Centers), the interviews with David McMichael, as well as testing conducted during the course of the various assessments. I note that there is limited reference and no analysis of Mr. McMichael's attempts to return to work, or as indicated earlier, little or no reference to any of the collateral evidence provided such as the transcripts for discoveries or letters from family members, marriage counselors, etc." (P 39)

The Arbitrator also notes that there is limited reference about the Plaintiff's admissions to the hospital, in one of which Mr. McMichael was in crisis, suicidal and detained at the hospital on a Form 1 under section 15 of the *Mental Health Act* for 9 days (P39)

Furthermore, the Arbitrator found that:

> "in adopting the protocol it did, the DAC deprived itself of useful information about Mr. McMichael's level of functioning that may have resulted in scoring him more favorably then the evidence taken as a whole would support. This deficiency was exacerbated, I find, by the DAC's failure to incorporate into its analysis much of the collateral evidence of family members and others which was provided to it." (P42)

B: Attendant Care:

Form 1 was completed almost 3 years and 9 months after the accident and was a request for attendant care 24 hours, 7 days a week

> "to assist him in resisting his urge to use crack cocaine." (P63)

The Occupational Therapist explained that the Plaintiff was in need of attendant care

> "to ensure his safety and prevent a risk of overdosing, Mr. McMichael requires ongoing supervision which does qualify as attendant care. Given that Mr. McMichael continually finds himself in crisis, this therapist supports the provision of attendant care, at least until such time as he is admitted to an in-patient drug rehabilitation program." (P65)

The Arbitrator ruled that Mr. McMichael was in need of attendant care at the time of the assessment and that given

> "Mr. McMichael's proven inability to stay clear of crack cocaine since that time, notwithstanding further treatment recommended by her and others, he remains entitled to the benefit." (P66)

The Arbitrator explained that Mr. McMichael's claim was based on his complete inability to stay off crack cocaine for any significant period of time over the six years since the accident. The Arbitrator determined that there was lack of evidence that "Mr. McMichael's substance use ever interfered in his day to day life" pre-accident (P14). He explained that prior to the accident he was an active family man, enjoyed sports on a regular, almost daily basis.

> "He was actively involved in his birth family's life, with regular visits to his mother and three sisters. He may have downplayed work and career in favor of other things in his life, such as sports and an active social life in the Beaches. Nonetheless, he maintained steady employment and met his sales targets. In short, he lead an active, productive and by all accounts a complete life in the years prior to the car accident." (P14)

Based on the evidence and opinions of experts (including CAT DAC), the Arbitrator concluded

Continued...

> "the drug addiction was a direct consequence of the accident" (P18).

The Arbitrator found that the addiction is "likely" the single most important impairment preventing him from leading a more socially useful life. The attendant care relates to supervision given Mr. McMichael's proven inability to stay clear of crack cocaine. The Arbitrator found Mr. McMichael entitled to attendant care benefits (P66/67).

The insurer sought a credit for the periods when he was under supervision and therefore not entitled to benefits. The Arbitrator agreed that

> "during the periods Mr. McMichael was in in-patient at Bellwood he would be supervised and not in need of additional attendant care (or notionally already in receipt of the benefit)." (P 67)

However, he did feel he would have required attendant care during a vacation in Jamaica. The Arbitrator felt that when he was in attendance with the social worker he might not need attendant care, however, he would require someone to be in attendance with him to and from these kind of appointments. He allowed the parties to work out the details of the precise quantum of attendant care, however, "remains seized" of this matter in the event there is any unresolved dispute in relation to attendant care. (P67)

C. Incurred Costs

Issue: Belair stated that the claim was unwarranted, that no expense for attendant care had been incurred and therefore that there was no entitlement.

The Arbitrator identified

> "that an applicant need not actually receive the items or services claimed in order to be entitled to an expense" (P66)

as set out in *Wawanesa Mutual Insurance Co. v. Smith (Committee of)* (1998), 42 O.R. (3d) 441 and *Stargratt v. Zurich Insurance Co.* [2001 Carswell Ont. 5212 (F.S. Trib.)] (FSCO A99-000521, October 4, 2001).

The Arbitrator further stated that

> "To do otherwise would allow the insurer to set up the inability of an insured to pay for a benefit as a shield from its obligation under the policy of insurance." (P66)

> "It is sufficient that the reasonableness and necessity of the service be established and that the amount of the expenditure can be established with certainty." (P66/67)

D. Appeal Decision

The decision of Arbitrator Muir was upheld on appeal to the Director's Delegate of the FSCO Arbitration Tribunal.

***11. Michalski (Litigation guardian of) and Wawanesa Mutual Insurance Co.*, FSCO A03-001363**
Arbitration Decision: December 13, 2005

Highlights:

- The Arbitrator finds that the insurer, an occupational therapist and a case manager displayed willful blindness to the needs of the applicant ("blindness arises where a person who has become aware of the need for some inquiry declines to make the inquiry because he does not wish to know the truth"). (P 13)
- It is not reasonable to base a reduction in attendant care services on one session when a person has variable function. (P 12)
- Family members are to be compensated for all time spent with and/or caring for the injured person, even though the family members would have been available in any event. (P 15)

Issue: Mrs. Michalski was injured in a motor vehicle accident on October 24, 2001. She claims attendant care benefits for services that her family members provided her under the Schedule. She also claims interest on the attendant care benefits and housekeeping benefits. Finally, she claims a special award because Wawanesa unreasonably withheld or delayed benefit payments. Wawanesa disputes Mrs. Michalski's entitlement.

It should be noted that Mrs. Michalski sustained a severe brain injury. Evidence indicated that Mrs. Michalski functioned much like a 2 year old child. She did not speak very much, she was not always responsive to questions, she was echolalic at times. She was dependent for meals, she had a seizure disorder 1-2 times per month (grand mal), at times could not recall the names of her children, could not say what she would do in the event of an emergency, unable to tell the season, month or year (even with visual cues). Her level of function was variable but was likened to a dementing individual as she could not be relied upon to recognize danger or make appropriate judgments while cooking. At times she was psychotic.

Mrs. Michalski's 13 and 10 year old children supervised their mother when they returned home from school, contacting their father at work when necessary. Mr. Michalski was responsible for evening and weekend (with the assistance of the children). Paid services were initially provided 8 hours per day 5 days per week while Mr. Michalski was at work and the children were in school.

1) Is Mrs. Michaski entitled to attendant care benefits?

Continued...

Based on the review of the information through professional reports etc. the Arbitrator determined that Mrs. Michalski had catastrophic injuries at the time of the accident and that Wawanesa was aware of the catastrophic nature of her injuries. (P 3 – 6) Examples include:

- Because they hired a case manager when Mrs. Michalski was discharged, Wawanesa acted on the basis that Mrs. Michalski had a catastrophic injury. A person is entitled to case management services only if they have sustained catastrophic impairments.
- Wawanesa accepted the report from the case manager they hired which indicated that Mrs. Michalski's GCS was 3/15 at the time of the accident.
- The ambulance attendants and hospital personnel evaluated the extent of her head trauma as being GCS between 3 and 9.
- "Mrs. Michalski met the definition of catastrophic impairment under section 2 of the Schedule: she could no longer look after herself, but required care; she could no longer give her children, aged 10 and 13 care; and she could no longer provide the housekeeping and homemaking services she once did for herself and her family." (P5/6)

The Arbitrator indicated that

> "Wawanesa determined Mrs. Michalski sustained a catastrophic impairment even before it received her completed application for benefits, because it retained a case manager" (P 7)

Wawanesa

> "failed to inform the insured that it made such a determination as required by section 40(2)(a) of the Schedule."(P7)

They treated

> "Mrs. Michalski as catastrophically impaired for some but not all purposes" (P 7).

Wawanesa took an inconsistent position in regards to Mrs. Michalski's level of disability. They hired a case manager (entitlement only if CAT), however then told the insured she was entitled to $3,000 in attendant care benefits (Non-CAT amount).

The Arbitrator determined Mrs. Michalski is entitled to attendant care benefits.

<u>2) Evaluation of Attendant Care Benefits – Issue of Willful Blindness</u>

In evaluating Mrs. Michalski's attendant care benefits, the Arbitrator reviewed the chronological history of her provision of attendant care, the evidence provided by the care providers (family members) and Dr. S. Dobrowolski's, psychiatrist, description regarding Mrs. Michalski's functional status and needs throughout her recovery process.

The Arbitrator found that Mrs. Michalski required 24 hour care and has since the time of the accident.

The insurer hired a case manager and Occupational Therapist to trial a reduced amount of attendant care in order to provide a less intrusive care. This was agreed upon by Dr. Dobrowolski, the case manager, the Occupational Therapist (OT), and Mrs. And Mrs. Michalski. Mrs. Michalski's functional status however deteriorated. She was described as "living in her own world". Dr. Dobrowolski's opinion 19 days following the trial was that Mrs. Michalski was worse than ever and required full-time care as she was starting to deteriorate and regress. Several months later Dr. Dobrowolski's opinion was that she had experienced a profound decline in her function, she required full-time supervision to prevent inadvertent harm to herself and others. Mr. Michalski requested an increase in attendant care benefits (approx 5 months after the trial) as only 3 hours of paid attendant care was being provided per day. The case manager recommended that the insurer double the number of hours but it continue to pay the same monthly amount as attendant care.

Mr. Michalski then retained counsel and a neuropsychological assessment was completed and an Occupational Therapist evaluated her attendant care needs. The OT determined she required 24 hour attendant care per day. The neuropsychological assessment determined a number of debilitating concerns one of which was that she should be supervised during periods of sleep because of the possibility of waking and putting herself at risk through random interaction with her environment.

The Occupational Therapist, reduced Mrs. Michalski's attendant care on a trial basis as agreed for a period of 19 days. The Occupational Therapist and the case manager, agreed to consult with Dr. Dobrowolski in relation to any further reductions in care. There is no evidence that either sought his opinion with regards to her care. The Occupational Therapist continued to reduce Ms. Michalski's attendant care to 10.14 hours per week based on "gains in functional performance" (P12), although Dr. Dobrowolski was not in support of a reduction. The Occupational Therapist reduced attendant care again based on "improved performance in one OT session". (P12). The Arbitrator stated,

> "I find improvement in function demonstrated in one session provides an unsound and unreliable basis for reducing attendant care for someone like Mrs. Michalski who had variable function."(P12)

The case manager reported in 5 reports that Dr. Dobrowolski continued to report improvement which is at

> "significant odds with the contents of Dr. Dobrowolski's notes, records and reports to third parties". (P12)

The case manager directed an Occupational Therapist who succeeded the original Occupational Therapist to

Continued...

> "assess Mrs. Michalski and to 'review and reduce' her attendant care." (P12)

The Occupational Therapist did this, despite her inconsistent statement that

> "the existing attendant care should remain in place because there is no medical release from Dr. Dobrowolski to reduce her attendant care; yet, at the same time, she opined that it was reasonable to reduce Mrs. Michalski's attendant care." (P 12)

The Arbitrator concluded that given the plan that "Dr. Dobrowolski was to be a part of the decision to effect any reductions in her attendant care", "recommending further reductions" the OTs and case manager

> "shut their eyes to relevant information which they agreed would be sought in making that decision, and were willfully blind." (P12)

3) Payment for 24 hours?

Two Occupational therapists stated that Mrs. Michalski required care 24 hours a day but only "allocated payment for 16.25 and 16 hours respectively". The Occupational therapist retained by the insurance company reasoned that

> "family members were to be paid for their services, but not during the evening hours when they would have been at home in any event." (P14)

The Arbitrator rejected this argument, and noted that this would essentially eliminate most of the claim put forth by the husband and children for their services. This argument was rejected because

> "it ignores the fact that care was being provided post accident which was not provided pre-accident". (P14)

Accordingly, the Arbitrator's decision supported the husband's and children's claim for 24 hour care, since

> "providing care and supervision to someone functioning at Mrs. Michalski's level is *of necessity different* from simply being present in the company of an adult who is functioning *without* such impairments (emphasis added)". (P 15)

4) Payment of a special award Michalski (Guardian of) v. Wawanesa Mutual Insurance Co., August 10, 2006,

S. Alves, Arbitrator (A03-001363) [006/250/029-7pp.] — In an earlier arbitration decision [December 13, 2005 (A03-001363) [006/012/021-49pp.]]

The Arbitrator found Wawanesa unreasonably withheld and delayed the payment of Mrs. Michalski's attendant care benefit and housekeeping benefit and identified that therefore a special award should be provided.

> "I ordered a special award on the attendant care and housekeeping benefits. To paraphrase the decision, the special award was based on Wawanesa's non-compliance with sections 32(b) and (c), 39 and 40 of the *Schedule* ; Wawanesa's failure to act with sound and moderate judgment in reassessing evidence from its assessors; and the overlapping and compounding effect of Wawanesa's actions and defaults. Mitigating factors were Wawanesa's prompt response to Mrs. Michalski's claim, that it hired a case manager, provided some assistance by way of paid attendant care, and increased the amount of her attendant care benefit pending an agreed upon DAC assessment. Aggravating factors were the degree of Mrs. Michalski's vulnerability; the impact on her children; the number and persistence of Wawanesa's breaches; their compounding effect; and Wawanesa's attempts to shift the blame to Mr. Michalski for the unfortunate manner in which the claim unfolded." (P4)

The Arbitrator further stated:

> "In all the circumstances of this case, I find that the appropriate amount of the special award is $150,000." (P6)

***12. Bellavia and Allianz Insurance Co. of Canada/ING, Insurer*, FSCO A05-000807**
Arbitration Decision: February 21, 2006

Highlights

The insurer is responsible to pay as attendant care benefits both the services of the long term care facility and the services that the family was reasonably providing the insured while he was residing in the long term care facility.

The Arbitrator also addressed "incurred costs",

- an insured person is not required to finance, or to pledge credit in order to secure the very benefits for which he is insured.

Issue:

Ignazio Bellavia was catastrophically injured in a motor vehicle accident on June 12, 2003. He was 76 years old and because he sustained severe quadriplegia, a brainstem infarct, and cervical fractures, he was in a chronic care facility at Baycrest Hospital. The insurer was paying $1500 a month for such service. At issue was whether the insurer was responsible to cover attendant care services provided by the family on top of the services provided by the hospital. It was found that the insurer was required to pay to Mr.

Continued...

Bellavia attendant care expenses incurred concurrently under both subsections 16(2)(a) and 16(2)(b) of the Schedule.

The Insurance Company disputed that it was responsible to pay for additional attendant care services based on statutory interpretation of Section 16 of the Schedule. The relevant provision reads:

> *"(2) The attendant care benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,*
>
> *a. Services provided by an aide or attendant;* ***OR***
> *b. Services provided by a long – term care facility , including a nursing home, home for the aged or chronic care hospital (emphasis added)"*(P5)

Alliance submitted that the "or" which separates subsection 16 (2)(a) and (b) is disjunctive and signifies two mutually exclusive possibilities. The arbitrator rejected this argument, holding that that "or" tends to be used inclusively in legislation; that is, A or B or both.

Although the facility provides numerous services, the DAC concluded that in addition to the supervision and emergency intervention available by the nurses/staff at Baycrest, Mr. Bellavia requires 24 hour supervision to ensure his well-being. Family witnesses outline a number of services they perform for Mr. Bellavia while at Baycrest to supplement the care being provided. This daily care includes: diaper care, tracheotomy suctioning of his tracheotomy, corking/uncorking of his tracheotomy, laundering clothes at home, assisting with dressing/undressing, face and hand washing, shaving, fingernails and toe nail care, feeding, and preparing homemade food.

The arbitrator found that the family has been performing those tasks related to the personal care that the attendant care which the DAC had concluded Mr. Bellavia required, in addition to the services performed by Baycrest. The tasks by the family are considered reasonable and necessary.

> "I cannot fault the Bellavia family for choosing to perform some of the services, which are also offered by Baycrest, in order to guarantee prompt, high quality care for Mr. Bellavia". (P 8)

In regards to "incurred costs", Killoran cited *Wawanesa Mutual Insurance Company v. Smith* where the court ruled

> "that the legislation be read so as not to require an insured person to finance, or to pledge credit in order to secure the very benefits for which he is insured". (P 9)

***13. Jessica Keyes and The Personal Insurance Company of Canada* (Motion for interim benefits)**
Arbitration Decision: July 21, 2006

Highlights

- This concerns a teenage girl who suffered a brain injury.
- There is a need to consider collateral information and demonstrative information in determining attendant care needs.
- The need to consider vulnerabilities pre-accident that are exacerbated by the injuries sustained in the accident.
- Reduction of attendant care when the injured person is at school or receiving therapies is a matter to be addressed by invoices submitted by the attendant care providers.
- The use of interim benefit motions as a timely alternative to the DAC process.

Issue: Jessica Keyes was in a motor vehicle accident on August 21, 2003. Attendant care benefits was terminated on or about May 16, 2006. The parties were unable to resolve their disputes through mediation. Arbitration has been applied for. A motion was brought for interim attendant care benefits to be paid to her pending the resolution of this dispute.

Result: The insurer was ordered to pay interim benefits.

By way of background, Jessica was 14 at the time of the accident. She had a prior history of ADHD, and other behavioral issues but was otherwise a physically healthy child. Before the accident, Jessica had accommodations for school work but was otherwise able to do activities on her own such as tidy up after herself, clean her room, baby-sit her sister, take public transit on her own and take some responsibility for meal preparation. She graduated public school (2002/2003 class) with her class and was to start high school in the fall. Jessica was injured in a pedestrian accident and had "significant head injuries" and a moderate brain injury.

The benefit in dispute is the need for 24 hour attendant care. According to her mother she reports that as a result of the brain injury sustained in the accident, this has impaired her ability to self direct many of her ADL activities, exercise proper judgment and keep herself safe in her home and community. There are also issues related to prompting required to completed some ADL activities but the focus of concern is the supervision needed to keep Jessica Keyes safe in her home and community.

According to the Arbitrator, interim benefits are an exceptional remedy only. The onus is on the applicant for *prima facie* evidence to support the claim and some urgency in the request. In this case, the Arbitrator was satisfied that there was urgency given the risk of harm to herself.

Continued...

The Personal submits that there is evidence that Ms. Keyes is no more impaired after the accident than she was prior to it, and there is no greater need for attendant care now then there was then. In addition, the Personal also takes issue with the CAT DAC determination and submits in effect that if it is to be bound to the determination then Ms. Keyes must abide by the decision of the North York DAC until there is a hearing on its merits.

Jessica's treating occupational therapist, identified that Jessica Keyes needs continual supervision because of the brain injury sustained in the MVA. The pre-existing concerns have been exacerbated by the brain injury sustained to the point that she cannot be safely left alone for even short periods of time. Dr. McKinnon, a treating neuro-psychologist, deposed that in an unstructured environment, the demands placed on Jessica Keyes' limited cognitive activities will overwhelm her and cause her to be unsafe. As she has gotten older, these demands have increased and her ability to respond to an emergency situation has been compromised such that her safety is at risk. Risk is related to her insight, dis-inhibition and impulsiveness which can be traced to the Brain Injuries.

The Personal relies upon the North York DAC's reports which claim that Jessica Keyes was in need of attendant care prior to the accident and that the motor vehicle accident has not added to her level of disability. Ms. Keyes contends that the North York DAC is in violation of the FSCO DAC Assessment guidelines and is a nullity. Specifically she alleges that the DAC rendered two reports, both of which are signed by two assessors. In addition, it has also submitted that the DAC assessors erred in relying almost exclusively on Jessica Keyes responses to questions and conducted no demonstrative testing to verify the responses she gave. Specifically, despite concerns about Jessica Keyes' difficulties in an unstructured environment such as at school, in the community or in a volunteer placement, the DAC erred by conducting no testing in such an environment or any environment other than her home. In addition, it is submitted that the appropriate specialist such as a psychologist, neurologist or psychiatrist was not used. The DAC had two reports submitted that were both signed by the assessors, identifying however that the first one was not complete.

The arbitrator concluded, based on the information provided, that there was little or no evidence that, prior to the accident, Jessica Keyes posed a risk to herself or others as a result of her disabilities. On the other hand, there is "very little doubt" according to the Arbitrator, that Jessica Keyes has required significant supervision since the car accident. The treating professionals identify Jessica Keyes is making progress but there remain concerns. (P10) Other non-treating assessors question supervision and other treatment three years post accident. According to the Arbitrator there are legitimate issues for debate which ultimately may be made by an adjudicator in the future.

The Arbitrator identified that it is significant that the DAC "declined to consider whether or not Jessica Keyes noted vulnerabilities pre-accident have been exacerbated by the injuries sustained in the accident." (P11) The Arbitrator stated that the DAC did not address the "thin skull" issues, leaving it rather to the Court or to the Arbitrator.

The Arbitrator agreed that the DAC failed to ensure it had access to the appropriate assessment team. In addition, the DAC relied, "to its detriment, too much on the report of Jessica Keyes and downplayed the input of her mother."

The Arbitrator ruled that Ms. Keyes had made out at least a *prima facie* case for entitlement to attendant care benefits for some amount for some period of time. Interim benefits were awarded.

Amount of the award:

The Personal suggested the Arbitrator order a new DAC and submitted that, if an order is to be made at this point, that it be for a lesser amount to take into account Jessica Keyes' attendance at school or when receiving therapies.

The Arbitrator awarded for the amount of the Occupational Therapist's report of June 13, 2006. The Arbitrator reported that with regard to the Personal's submission that a lower amount ought to be order to take account of Jessica Keyes' actual need on any given day, he was not "unsympathetic" to this view. However, he stated

> "It is clear that there will be times when the Applicant is otherwise being supervised, but I accept Ms. Keyes' submission that this is a matter of what is invoiced." (P12)

SUMMARY OF JUDGMENTS AND ARBITRATION DECISIONS

April 2011

1. Tyvon Whyte and Non Marine Underwriter, **FSCO A06–000028**

Arbitrator decision: December 14, 2006

Highlights

- When assessing a child's attendant care needs, one must determine the amount of care that is over and above what may be termed "normal parenting" as compared to children of a similar age without the same impairments.
- When assessing to determine the amount of supervision that is required, it is essential that the details of *the nature and degree* of supervision be noted.
- If the supervision needs of a child are on an intermittent, unpredictable basis due to behavioural issues then consideration must be given to whether his/her supervision needs are in fact continuous and vigilant in nature.
- When allotting time for supervision for a client, simply assigning an "extra minute or whatever other amount of time was determined additionally necessary, for every 5 to 10 minute increments of an hour" may not be reasonable as "this method is awkward at best and, at worst, is artificial and impossible to implement on a practical level" because "one cannot pay an attendant care provider for a minute of their time every 5-10 minutes of the day. Beyond this, even if one could find a way to pay for a service provider's time in this way, the result would be that the service provider could not be available to do any other work—there are very few activities or tasks that one can accomplish in 5 to 10 minute increments."

Issues:

Tyvon Whyte was a pedestrian struck by a motor vehicle. He was six years-old. It was determined that he suffered a catastrophic impairment as a result of the accident. He continues to receive attendant care benefits in the amount of $765 per month, which is the amount of his original application. From November 23rd, 2004 onward, Tyvon has claimed amounts for attendant care that exceeds the monthly amount being paid by the Non-Marine Underwriters, Members of Lloyd's ("Lloyd's").

Essentially, the additional attendant care benefits were for his attendant care provider, Vicki Mae Lewis, who is also his mother. This was to provide him with supervision at all times when he is not otherwise supervised.

The basis of his claim for additional attendant care is that he must be supervised at all times due to impulsive and unpredictable behavior which was an impairment resulting from the accident.

Lloyd's, on the other hand, asserts that some of the supervision provided to Tyvon by his mother is within the realm of regular parenting which is provided by every parent to every child of Tyvon's age and therefore attendant care benefits should not pay for that level of care. They related their opinion to a DAC assessment where the DAC assessors only identified the areas where *additional* supervision is required for Tyvon *by the minute*.

Continued...

Tyvon argues that the OT/Case manager's assessments are more reliable and informed because she has spent more time with Tyvon and she knows both him and his mother well. The OT/Case manager's conclusions are essentially that Tyvon's mother needs to be on call to deal with whatever the nature and frequency of his outbursts might be as his impulsivity and unpredictability are the problems here. As long as he has frontal lobe damage, both Tyvon's moods and behaviour will swing.

Furthermore, Tyvon argues that the DAC's methodology is erroneous in a case where the need is for constant supervision. The nature of the supervision required with Tyvon is always over and above that provided by the parent of a regular child. Tyvon's mother's duty towards Tyvon is the same as a regular parent.

In Lloyd's view, the OT/Case manager's approach does not seem to focus on what is truly an attendant care need compared to that which is needed by a child in general. In Lloyd's view, the DAC approach is more reasonable because it recognizes that regular parenting, which must still be provided in Tyvon's case, is less hands-on than is attendant care and is not to be compensated through attendant care benefits.

Lloyd's contends that, of necessity, the OT/ Case manager role is that of an advocate for Tyvon, given her job as his case manager, and therefore an inference should be drawn that her evidence is not impartial.

Result: Tyvon was entitled to attendant care benefits as they have been calculated by his OT/Case manager.

Arbitrator's Findings on the issue of Basic Supervisory Care for Tyvon:

The question that must be answered in order to adequately determine the amount of attendant care that Tyvon needs is what is the *nature and degree* of supervision that Tyvon requires

The argument is in regards to determining what is the nature and degree of regular parenting provided by every parent to every unimpaired child of Tyvon's age. The next step is to determine the nature and degree of the supervision required by Tyvon and compare it to the supervision provided by the parent of an unimpaired child.

Uniform evidence provided by the various members of Tyvon's rehabilitation team regarding the need for continuous supervision had an impact on the arbitrator's decision.

The DAC assessors were an OT and a nurse and they relied upon the reports of Mrs. Lewis, Tyvon's mother, to determine Tyvon's supervision needs. The fact that the DAC assessor did not witness one of his outbursts or his behavioural problems during the assessment, and therefore concluded that he does not have these issues, did not lead the arbitrator to question all of the other consistent evidence of Tyvon's issue.

The arbitrator concludes that Tyvon requires supervision that is **continuous and vigilant**. This kind of supervision requires the uninterrupted availability of the parent to respond as the need arises rather than the intermittent supervision that would suffice with an unimpaired child of similar age.

Calculations for Supervision of Tyvon

According to the arbitrator, there are some significant implications to the DAC approach which are not accounted for nor recognized. Their approach was to assign an extra minute, or whatever other amount of time was determined additionally necessary, for every 5 to 10 minute increments of an hour. This method is awkward at

Continued...

best and, at worst, is artificial and impossible to implement on a practical level. One cannot pay an attendant care provider for a minute of their time every 5 to 10 minutes of the day. The arbitrator noted that if one could find a way to pay for a service provider's time in this way, the result would be that the service provider could not be available to do any other work as there are very few activities or tasks that one can accomplish in 5 to 10 minutes increments. In order to provide the kind of attendant care that Tyvon really needs, a service provider must be available to him so frequently and in a manner such that they are practically prevented from being engaged in any other real activity.

2. **Haimov** and **ING** Insurance Co. of Canada - FSCO A05-0027334 (Arbitration Decision)

Judgment: May 9, 2007

Highlights

- The arbitrator summarized a letter dated June 23rd, 2005 from Anne Utley, Manager, Subrogation Unit (Special Projects) of the Ministry of Health and Long-Term Care, that Attendant Care (referred to as personal support service) is not a service provided by a nurse; it is not an insured service under the *Health Insurance Act;* it is not an insured hospital service under the Act and lastly is not an OHIP insured service.
- Collateral information from family, staff and other treating professionals assists in determining a clear understanding of the client's attendant care needs.
- The onus rests with the applicant to show that there is a *prima facie* case supporting entitlement to interim benefits in question.
- The staff to patient ratio when in a hospital or a long-term care facility and the impact of this ratio on the care and well-being of the client is important to consider when assessing a client's attendant care needs.
- Co-payment (i.e. accommodation and meals) is not quantifiable on the Form 1 and consequently found that the monthly co-payment is a medical benefit pursuant to s.14(2)(a) of the *Schedule* for "hospital…services" rather than an attendant care benefit.
- The parent/child relationship does not preclude a claim for attendant care if services required are above and beyond those provided in a hospital or long-term care facility.

Issues:

The Applicant, Markus Haimov, a 67 year-old man, was catastrophically injured in a motor vehicle accident on February 22nd, 2005. He applied for and received statutory accident benefits from ING Insurance Company of Canada ("ING"), payable under the *Schedule*. ING did not pay the Applicant any attendant care benefits at all because they believed that Mr. Haimov's attendant care needs were met by the various hospitals and the rehabilitation facility where he resided. As such, Mr. Haimov applied for arbitration and the issues on the motion was as follows:

- Provision of interim attendant care benefits pending the resolution of his dispute with ING
- Interest for overdue payments of benefits
- Entitlement to a special award
- Expenses in respect to the arbitration under subsection 282 (11) of the *Insurance Act*

Continued...

Background

It was agreed by all parties that Mr. Haimov sustained a catastrophic impairment as the result of a pedestrian/ motor vehicle accident. When he was at Sunnybrook Hospital, Toronto Rehab Institute (TRI) and Baycrest Centre for Geriatric Care, his family provided care and spent 24 hours a day, taking shifts on a rotating basis caring for Mr. Haimov during the night, and spoke with him in Russian to encourage brain activity. The nurses taught them how to care for Mr. Haimov, which included suctioning and assisting with skin integrity.

In addition, when his treating OT prepared the Form 1 on August 10, 2005, she noted that Mr. Haimov was more responsive when attendant care services were provided by his family who spoke to him in Russian.

On May 11, 2005, Mr. Haimov was transferred to TRI which has a chronic care facility. Although the family wanted to continue to provide 24 hour attendant care, TRI limited them to visits between 11:00 am and 9:00 pm.

On January 25, 2006, Mr. Haimov was transferred to Baycrest, a long-term care facility where he continues to reside. Although Baycrest permits 24 hour daily attendant care from family or a private attendant, his family can only provide care for him between 11:00 am and 9:00 pm as they are exhausted and they are financially unable to afford to pay for private attendant care. If funding were available, family would continue to care for him between 11:00 am and 9:00 pm and would hire an attendant to provide supervisory care between 9:00 pm and 11:00 am.

The staff to patient ratio at Baycrest was determined and it was established that if an attending nurse is dealing with another patient, it would take some time before he or she noticed that Mr. Haimov needed assistance.

While he was in Baycrest, his treating OT prepared the Form 1 and she received information from his family and the social worker indicating that Mr. Haimov's family members were providing Mr. Haimov with the following attendant care assistance:

a) Monitoring Mr. Haimov's need for suctioning and his ventilator;
b) Positioning Mr. Haimov to prevent skin break down;
c) Talking and reading to Mr. Haimov in Russian to stimulate brain activity;
d) Washing Mr. Haimov's hands and face to ensure proper hygiene;
e) Combing Mr. Haimov's hair daily;
f) Cutting Mr. Haimov's hair every other week;
g) Trimming Mr. Haimov's fingernails and toenails weekly;
h) Monitoring Mr. Haimov's feeding and providing assistance with feeding daily;
i) Providing laundry for Mr. Haimov to ensure he has fresh clothing twice weekly;
j) Wheeling Mr. Haimov to activities and concerts within Baycrest to stimulate his brain activity;
k) Wheeling Mr. Haimov outside for fresh air to stimulate his brain activity;
l) Suctioning and cleaning Mr. Haimov's tracheotomy several times daily;
m) Assisting Mr. Haimov with exercises to ensure Mr. Haimov continues to experience an adequate range of motion;
n) Massaging creams and ointments into Mr. Haimov's back, hands and feet to ensure Mr. Haimov's skin integrity;
o) Turning and checking Mr. Haimov throughout the day to ensure that he does not suffer from pressure sores;
p) Washing Mr. Haimov's underarms which become sweaty on a consistent basis;
q) Constantly monitoring Mr. Haimov's medical equipment to ensure it is clean and in good working order.

Continued...

In addition, the client suffered a severe and prolonged seizure while at Baycrest and he needed to be transported by ambulance to Sunnybrook Hospital for emergency treatment. At the time of the seizure, Mr. Haimov's family was present and therefore ensured he received emergency assistance at the outset by notifying nursing staff immediately. He returned to Baycrest. It was determined that although Mr. Haimov has a device that allows him to call for assistance, he is unable to operate it due to his injuries. Therefore if Mr. Haimov were to suffer another seizure or medical emergency he must wait for a night nurse to complete his/her rounds before learning of Mr. Haimov's need for emergency care.

The treating OT recommended 24 hour care to ensure the client gets immediate attention if he were to have another seizure. The neurologist supported 24 hour a day attendant care in addition to the care provided by Baycrest. The neurologist felt the supervisory care provided by the family is "crucial" and it is "likely" that Mr. Haimov will suffer another seizure. Therefore, the nursing staff must be alerted immediately upon the onset of a seizure in order that he will receive immediate treatment to decrease his discomfort and minimize the effects of the seizure on his long term health.

The OT providing an Insurer's Examination (IE) upon request of ING determined that Mr. Haimov required $154.63 per month of attendant care, which consisted of assistance with exercise only. The IE OT further determined that "Given that (Mr. Haimov) is in a specialized unit, and under the direct care and supervision of a nurse, no additional attendant care is indicated for activities which fall under the responsibilities of nursing."

Result: ING was required to pay Mr. Haimov in accordance with the treating OT Form 1's which recommended 24 hours attendant care in hospital.

The arbitrator also concluded that the co-payment (i.e. accommodations and meals) is not quantifiable on the Form 1 and consequently found that the monthly co-payment is a medical benefit pursuant to s.14(2)(a) of the *Schedule* for "hospital…services" rather than an attendant care benefit.

On calculating Mr. Haimov's attendant care needs in hospital:

The arbitrator found that there is a "substantial likelihood" of danger to Mr. Haimov's life and health caused by inadequate attendant care because someone is not with him 24 hours a day. The attendant care that Mr. Haimov's family is providing helps **ensure his safety and maintain his health by ensuring his ongoing comfort and quality of life**. Mr. Haimov has demonstrated that there is a need, necessity, and urgency in the provision of 24 hour a day attendant care. In addition, because it is "likely" that Mr. Haimov will suffer another seizure, there is a realistic potential that if 24 hour a day attendant care is not provided, Mr. Haimov will suffer irreparable harm.

The IE assessment of Mr. Haimov's attendant care needs is unreliable for reasons that include the following:

The IE assessor failed to appreciate the staff to patient ratio and that if a nurse is with another patient, Mr. Haimov will not receive immediate nursing assistance. For example, when Mr. Haimov had a seizure his family was with him and alerted the staff to ensure that Mr. Haimov received emergency assistance quickly.

In addition, the IE assessor did not speak to any of the hospital staff regarding Mr. Haimov's needs and assistance that Mr. Haimov's family members provided.

He added that in a letter dated June 23rd, 2005 from Ms. Anne Utley, Manager, Subrogation Unit (Special Projects) of the Ministry of Health and Long-Term Care, to Mr. Haimov's counsel's office, she states the following:

Continued...

'Simply put, attendant care (or personal support service) is not a service provided by a nurse; is not an insured service under the HIA (*Health Insurance Act*); is not an insured hospital service under the Act and lastly is not an OHIP insured service.'

3. **Lane** (Litigation Guardian of) v. **Economical** Mutual Insurance Co. FSCO A06-000972

(Arbitration Decision) Judgment: June 18, 2008

Highlights

- When attendant care services are offered through a hospital and family is made aware of these services, such funding is analogous to collateral insurance. In such cases, it is not reasonable to ask the insurer to pay for services that have admittedly been funded under OHIP.
- However, if attendant care funding by the hospital is:
    - not offered to the family or
    - if the family is not made aware that such funding is available to them or
    - if the hospital is encouraging the family to access auto insurance funding then it is understandable that parents have no reason to inquire about the hospital funded services which could have been used to offset the cost of attendant care services. As such in this particular case, the insurer was asked to fund attendant care.
- The test for attendant care is reasonable and necessary

Issues:

The Applicant, Aaron Lane, was injured in a motor vehicle accident on July 1st, 2005. He applied for attendant care benefits from Economical Mutual Insurance Company ("Economical"). Economical denied entitlement for certain attendant care claims while Aaron was in hospital. The arbitration relates to a claim for attendant care benefits which were to be incurred while Aaron was a patient at Bloorview Kids Rehab.

Background

Aaron Lane was four years-old at the time of the automobile accident. He suffered significant head trauma which was so severe that he had to have a very specialized kind of head dressing to help his skull heal. Even the experts at The Hospital for Sick Children ("Sick Children's Hospital") had limited experience using this dressing. For a period of time after the accident Aaron was in Sick Children's Hospital. The level of nursing and medical care that he received while there was very extensive and around the clock. Despite the fact that his parents stayed with him at Sick Children's Hospital, no claim is being asserted for attendant care benefits while he was there. After being discharged from Sick Children's Hospital, Aaron was admitted as an inpatient to Bloorview Kids Rehab for the period from August 5th through September 8th, 2005. He continued regular participation at Bloorview in an outpatient program until September 30, 2005. It is noteworthy that even while he was at Bloorview he had to

Continued...

regularly return to Sick Children's Hospital to deal with changing his head dressings as they were so specialized that they could not be done by the staff at Bloorview.

He applied for attendant care benefits from Economical which were payable under the *Schedule*. Economical denied entitlement for certain attendant care claims while Aaron was in hospital.

Economical's argument is that the situation at Bloorview, at the time Aaron was a patient there, was that it had attendant care service providers available to care for Aaron, but that these services were not accessed by Aaron's parents. Rather, they chose to stay by their son's side and care for him personally. The point Economical makes is that Bloorview is a facility that does have attendant care services available for patients who need it. In fact, they have an actual budget for these services and designated service providers whom they can call on when needed.

In this case, however, Economical's claim is that Bloorview did not provide the attendant care services it had available to Aaron, and this was the cause for Aaron's parents to believe that they had to go beyond their means to provide as any loving and caring parent would do for a child in these circumstances.

In conclusion, Economical's view is simply that in this particular situation there were attendant care services available to Aaron at Bloorview which were not used and for that reason it cannot be concluded that the attendant care which the parents provided was both reasonable and necessary as required by section 16 of the *Schedule*.

In effect, Economical is arguing that the OHIP funding which Bloorview has to provide for its young patients who need attendant care, works analogously to the way collateral insurance works for other kinds of accident benefits. It was incumbent on Aaron's parents to exhaust what was available to them at Bloorview before they could plausibly claim that further attendant care was still required and that they were the reasonable people to provide it to him.

Dr. Rumney from Bloorview noted that the normal daytime ratio at Bloorview is about 5:1 and it falls to about 12:1 during the night. Patients do not always deal with the same nursing staff while they are there due to their rotation schedules.

He stated that prior to admission the family is interviewed to determine the level of need for services. Significantly, Dr. Rumney stated that if the head nurse who conducts the intake finds that the patient has additional needs that the normal nursing complement cannot properly handle, they will bring in additional staff. He advised that this is not nursing staff but rather an attendant or child care worker. These are individuals whom Bloorview brings in on contract for certain patients with specific needs.

The doctor was asked whether learning that the parents were willing to stay by the child's bedside had any impact on a decision to bring in additional attendants. His answer was that yes it did. He also clarified that the specific duties of nursing staff are not really attendant care related. For instance, attendants are hired to help children get dressed or go to the bathroom, whereas nurses primarily administer medication and attend to catherization.

On cross-examination, Dr. Rumney advised that on intake there is an inquiry as to whether there is a source of funding for any needed attendant care services. If there is auto insurance or some other source of funding, Bloorview expects that to be accessed. He was asked what would happen if a child needed attendant care but did not have access to other funding or parents who were willing and able to provide that care. His response was that Bloorview has a budget for hiring attendants in those circumstances and they would hire whoever was necessary in order to provide the care the child needed. This funding, he advised, is a specific element of the global funding his hospital receives from the government to provide health care. However, Dr. Rumney noted that it is a relatively small budget amount that is set aside for providing these services. He provided no evidence as to how the amount allocated for attendant care services is determined in Bloorview's annual budgeting process.

Continued...

Evidence was also provided by an occupational therapist at Bloorview who works specifically in their brain injury rehabilitation program. Her evidence largely related to her role in educating families of children at Bloorview about the kind of care they would need to give children after leaving the institution. This is a normal part of the interaction with all patients, as she emphasized that it is important that all parents learn what to watch for at home and how to respond to problems that might occur. She also stated that staff members known as "child youth workers" are available for children with high needs. She also confirmed that the hospital can hire attendants if necessary, but more often than not it is the family who stays with the child and assists when hospital staff is not available.

The arbitrator was pointed to the recent decision of Arbitrator Murray in *Haimov v. ING Insurance Co. of Canada* as support for the proposition that the parent/child relationship does not preclude a claim for attendant care if services required are above and beyond those provided in a hospital or long-term care facility.

He stated that he found that there is no dispute in this case and that some form of attendant care was both reasonable and necessary for Aaron during the period of time in question. And it is further noted that the parties agree on the quantity of attendant care if entitlement exists in this situation. However one can be persuaded by Mr. Samis' argument that it is not simply attendant care per se that is the object of focus in the section but the specific type of attendant care. Was it reasonable and necessary for Mr. and Mrs. Lane to provide this care to their son? That is the actual question involved here.

The arbitrator stated that it is unreasonable for Bloorview to treat auto accident victims differently than they do other people. In general, he found that Economical should be entitled to a credit against attendant care benefits in the amount that Bloorview would have paid for an attendant for Aaron while he was in their program.

However, in this case it is clear that these parents were not specifically advised that there was funding available for attendant care services nor did they have any reason to inquire about these services. Therefore in this specific case it would be unreasonable to expect them to have accessed them. He also found that Economical did not at the time advise them that they should inquire about what the hospital can provide if necessary.

Result: Aaron Lane is entitled to attendant care benefits for this period of time at the rates agreed on by the parties.

On supervision by parents for young children at Bloorview:

It was not reasonable and necessary for Aaron's parents to expect Economical to pay for the attendant care they provided without taking into account what assistance Bloorview was mandated to provide to him if necessary. However, given the unique status of Bloorview in having such funding and that it is not widely publicized that this funding is available, it was reasonable for Mr. and Mrs. Lane to provide the care which they had no reason to believe anyone else would do for them. Had they accessed what Bloorview would have provided there may still have been additional care needed, but there is no way at this point in time to determine what that level of care would have been.

Fairness, taking all things into account, requires that Economical pay the agreed upon amount for attendant care incurred for Aaron while at Bloorview. In the future there may be different results should this situation occur again now that it is clear that attendant care services are available at this institution if requested.

EXCERPT FROM

INSURANCE ACT – ONTARIO REGULATION 34/10

STATUTORY ACCIDENT BENEFITS SCHEDULE

SECTION 19

ATTENDANT CARE BENEFIT

19. (1) Attendant care benefits shall pay for all reasonable and necessary expenses,

(a) that are incurred by or on behalf of the insured person as a result of the accident for services provided by an aide or attendant or by a long-term care facility, including a long-term care home under the *Long-Term Care Homes Act, 2007* or a chronic care hospital; and

(b) that, to the extent any of the expenses referred to in clause (a) are for transportation, are authorized transportation expenses for which no medical benefit described in clause 15 (1) (g) is payable, no rehabilitation benefit described in clause 16 (3) (k) is payable and no amount is payable under subsection 25 (4). O. Reg. 34/10, s. 19 (1).

(2) Subject to subsection (3), the amount of a monthly attendant care benefit is determined in accordance with the version of the document entitled "Assessment of Attendant Care Needs" that is required to be submitted under section 42 and is calculated by,

(a) multiplying the total number of hours per month of each type of attendant care listed in the document that the insured person requires by an hourly rate that does not exceed the maximum hourly rate, as established under the Guidelines, that is payable in respect of that type of care; and

(b) adding the amounts determined under clause (a), if more than one type of attendant care is required. O. Reg. 34/10, s. 19 (2).

(3) The amount of the attendant care benefit payable in respect of an insured person shall not exceed the amount determined under the following rules:

1. If the optional medical, rehabilitation and attendant care benefit referred to in paragraph 5 of subsection 28 (1) has not been purchased and does not apply to the insured person, the amount of the attendant care benefit payable in respect of the insured person shall not exceed,

   i. $3,000 per month, if the insured person did not sustain a catastrophic impairment as a result of the accident, or

   ii. $6,000 per month, if the insured person sustained a catastrophic impairment as a result of the accident.

2. Unless increased by any optional benefits available to the insured person in accordance with paragraph 4 or 5 of subsection 28 (1), the amount of the attendant care benefits paid in respect of the insured person shall not exceed, for any one accident,

   i. $1,000,000, if the insured person sustained a catastrophic impairment as a result of the accident, or

   ii. $36,000 in any other case.

3. If the optional medical, rehabilitation and attendant care benefit referred to in paragraph 5 of subsection 28 (1) has been purchased and applies to the insured person, the amount of the attendant care benefit payable in respect of the insured person shall not exceed the monthly limit under subsection 28 (6). O. Reg. 34/10, s. 19 (3).

Continued...

EXCERPT FROM

INSURANCE ACT – ONTARIO REGULATION 34/10

STATUTORY ACCIDENT BENEFITS SCHEDULE

SECTION 42

APPLICATION FOR ATTENDANT CARE BENEFITS

42. (1) Subject to subsection (2), an application for attendant care benefits for an insured person must be,

(a) in the form of and contain the information required to be provided in the version of the document entitled "Assessment of Attendant Care Needs" that is approved by the Superintendent for use in connection with the claim; and

(b) prepared and submitted to the insurer by an occupational therapist or a registered nurse. O. Reg. 34/10, s. 42 (1).

(2) If a Guideline issued for the purpose of this section specifies conditions, restrictions or limits with respect to the preparation of an assessment of attendant care needs, the assessment of attendant care needs must be prepared in accordance with the Guideline. O. Reg. 34/10, s. 42 (2).

(3) Within 10 business days after receiving the assessment of attendant care needs, the insurer shall give the insured person a notice that specifies the expenses described in the assessment of attendant care needs the insurer agrees to pay, the expenses the insurer refuses to pay and the medical and any other reasons for the insurer's decision. O. Reg. 34/10, s. 42 (3).

(4) A notice under subsection (3) may require the insured person to undergo an examination under section 44 if the insurer has not agreed to pay all expenses described in the assessment of attendant care needs. O. Reg. 34/10, s. 42 (4).

(5) An insurer may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with this section is submitted to the insurer. O. Reg. 34/10, s. 42 (5).

(6) The insurer shall begin payment of attendant care benefits within 10 business days after receiving the assessment of attendant care needs and, pending receipt by the insurer of the report of any examination under section 44 required by the insurer, shall calculate the amount of the benefits based on the assessment of attendant care needs. O. Reg. 34/10, s. 42 (6).

(7) If an insurer wants to determine if an insured person is still entitled to attendant care benefits, wants to determine if the benefits are being paid in the appropriate amount or wants to determine both, the insurer shall give the person a notice requesting that a new assessment of attendant care needs for the insured person be prepared in accordance

Continued...

with this section and submitted to the insurer within 15 business days after the insured person receives the notice. O. Reg. 34/10, s. 42 (7).

(8) Subject to subsection (12), a notice under subsection (7) may also advise the insured person that the insurer requires an examination under section 44. O. Reg. 34/10, s. 42 (8).

(9) Subject to subsection (12), new assessments of attendant care needs may be submitted to an insurer at any time there are changes that would affect the amount of the benefits. O. Reg. 34/10, s. 42 (9).

(10) If a new assessment of attendant care needs indicates that it is appropriate to increase the amount of the attendant care benefits and the insurer has not already advised the insured person that the insurer requires an examination under section 44, the insurer may give a notice to the insured person advising that the insurer requires an examination under that section. O. Reg. 34/10, s. 42 (10).

(11) If a new assessment of attendant care needs is required under subsection (7) or the insurer requires an examination under section 44, the insurer shall, subject to section 20 and paragraph 2 of subsection 19 (3), continue to pay the insured person attendant care benefits at the same rate until the insurer receives the assessment of attendant care needs or the report of the examination, as applicable. O. Reg. 34/10, s. 42 (11).

(12) If more than 104 weeks have elapsed since the accident, the insurer shall not require an examination under section 44 to determine the insured person's entitlement to attendant care benefits and the insured person shall not submit nor be required to submit an assessment of attendant care needs to the insurer unless,

(a) the insured person is or may be entitled under section 20 to receive attendant care benefits more than 104 weeks after the accident; and

(b) at least 52 weeks have elapsed since the last examination under section 44 relating to entitlement to attendant care benefits. O. Reg. 34/10, s. 42 (12).

(13) Within 10 business days after receiving the report of an examination under section 44, the insurer shall,

(a) give a copy of the report to the person who prepared the assessment of attendant care needs; and

(b) provide the insured person with a notice specifying the benefits and expenses the insurer agrees to pay, the benefits and expenses the insurer refuses to pay and the medical and any other reasons for the insurer's decision. O. Reg. 34/10, s. 42 (13).

(14) If an insured person fails or refuses to comply with subsection 44 (9), the insurer may,

(a) make a determination that the insured person is not entitled to attendant care benefits; and

Continued...

(b) refuse to pay attendant care benefits relating to the period after the person failed or refused to comply with that subsection and before the insured person submits to the examination and provides the material required by that subsection. O. Reg. 34/10, s. 42 (14).

(15) If an insured person subsequently complies with subsection 44 (9), the insurer shall,

(a) reconsider the application and make a determination under this section;

(b) subject to the new determination, section 20 and paragraph 2 of subsection 19 (3), resume payment of attendant care benefits; and

(c) pay all amounts, if any, that were withheld during the period of non-compliance, if the insured person provides, not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with that subsection. O. Reg. 34/10, s. 42 (15).

(16) If an insurer determines that an insured person is not entitled by reason of section 20 to attendant care benefits for expenses incurred more than 104 weeks after the accident, the insurer shall give the insured person a notice of its determination, with reasons, not less than 10 business days before the last payment of attendant care benefits. O. Reg. 34/10, s. 42 (16).

EXCERPT FROM

INSURANCE ACT – ONTARIO REGULATION 34/10

STATUTORY ACCIDENT BENEFITS SCHEDULE

SECTION 33

DUTY OF APPLICANT TO PROVIDE INFORMATION

33. (1) An applicant shall, within 10 business days after receiving a request from the insurer, provide the insurer with the following:

1. Any information reasonably required to assist the insurer in determining the applicant's entitlement to a benefit.
2. A statutory declaration as to the circumstances that gave rise to the application for a benefit.
3. The number, street and municipality where the applicant ordinarily resides.
4. Proof of the applicant's identity. O. Reg. 34/10, s. 33 (1).

(2) If requested by the insurer, an applicant shall submit to an examination under oath, but is not required,

(a) to submit to more than one examination under oath in respect of matters relating to the same accident; or

(b) to submit to an examination under oath during a period when the person is incapable of being examined under oath because of his or her physical, mental or psychological condition. O. Reg. 34/10, s. 33 (2).

(3) An applicant is entitled to be represented at his or her own expense at an examination under oath by such counsel or other representative of his or her choice as the law permits. O. Reg. 34/10, s. 33 (3).

(4) The insurer shall make reasonable efforts to schedule the examination under oath for a time and location that are convenient for the applicant and shall give the applicant reasonable advance notice of the following:

1. The date and location of the examination.
2. That the applicant is entitled to be represented in the manner described in subsection (3).
3. The reason or reasons for the examination.
4. That the scope of the examination will be limited to matters that are relevant to the applicant's entitlement to benefits. O. Reg. 34/10, s. 33 (4).

Continued...

(5) The insurer shall limit the scope of the examination under oath to matters that are relevant to the applicant's entitlement to benefits described in this Regulation. O. Reg. 34/10, s. 33 (5).

(6) The insurer is not liable to pay a benefit in respect of any period during which the insured person fails to comply with subsection (1) or (2). O. Reg. 34/10, s. 33 (6).

(7) Subsection (6) does not apply in respect of a non-compliance with subsection (2) if,

(a) the insurer fails to comply with subsection (4) or (5); or

(b) the insurer interferes with the applicant's right to be represented as described in subsection (3). O. Reg. 34/10, s. 33 (7).

(8) If an applicant who failed to comply with subsection (1) or (2) subsequently complies with that subsection, the insurer,

(a) shall resume payment of the benefit, if a benefit was being paid; and

(b) shall pay all amounts that were withheld during the period of non-compliance, if the applicant provides a reasonable explanation for the delay in complying with the subsection. O. Reg. 34/10, s. 33 (8).

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Ontario

July 31, 2006

Ms. April Belbeck, B.Sc., O.T., OT Reg (Ont.)
Rehabilitation Management Incorporated
250 Dundas Street West, Suite 404
Toronto ON M5T 2Z5

Dear Ms. Belbeck:

Thank you for your e-mail of July 26, 2006 regarding the Form 1, Assessment of Attendant Care Needs.

The Form 1 statement referred to in your letter advises users to review other accident benefits available under the *Statutory Accident Benefits Schedule* for possible reimbursement of other losses and expenses. It was added to remind Form 1 users to check for other benefits, such as housekeeping and home maintenance, that are not reimbursed as part of the attendant care benefit. The statement is not intended to imply that any amount be deducted from the overall attendant care benefit calculations.

Thank you again for writing.

Sincerely,

Willie Handler
Senior Manager
Auto Insurance Division

Forwarded by email to;

Willie Handler, Senior Manager, Auto Insurance Division, Financial Services Commission of Ontario
Jason Wong, Policy Advisor, Financial Services Commission of Ontario

July 26, 2006

Willie and Jason,

I am writing to both of you as I am unsure who I should be reviewing this issue with.

I am an Occupational Therapist working with clients who have sustained injuries in motor vehicle accidents. I am also on a subcommittee for OSOT who are looking at the Form 1 for our members.

In a recent discussion it was raised that the new Form 1 has an addition of a sentence that reads somewhat like a bulletin on the first page. It states:

" Please note: Users of Form 1 should also review other accident benefits available under the Statutory Accident Benefits Schedule for possible reimbursement of other losses and expenses (such as housekeeping and home maintenance,transportation, home modifications and other medical and rehabilitation expenses)"

Could you please explain the intent of this sentence in respect to a therapist completing the Form 1. In other words, how does this information impact on a therapist who is completing the form and assessing the client's needs? If a client is with therapist(s), Rehabilitation support worker, educational assistant and possibly has a housekeeper is in the house and this client has 24 hour supervision needs, is this phrase implying that such time with the various professionals should be deducted from the overall attendant care calculations?

I also don't understand how transportation benefits and home modification benefits affects a therapist's attendant care assessment. Could you clarify please.

Your insight would be greatly appreciated. Thank you.

April Belbeck, B.Sc.O.T. OT Reg.(Ont.)
Rehabilitation Counsellor/Occupational Therapist abelbeck@rehabilitation.ca

EXCERPT FROM

INSURANCE ACT – ONTARIO REGULATION 34/10

STATUTORY ACCIDENT BENEFITS SCHEDULE

SECTION 3

DEFINITION AND INTERPRETATION

3. (7) For the purposes of this Regulation,

(c) an aide or attendant for a person includes a family member or friend who acts as the person's aide or attendant, even if the family member or friend does not possess any special qualifications;

(e) subject to subsection (8), an expense in respect of goods or services referred to in this Regulation is not incurred by an insured person unless,

(i) the insured person has received the goods or services to which the expense relates,

(ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and

(iii) the person who provided the goods or services,

(A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or

(B) sustained an economic loss as a result of providing the goods or services to the insured person;

3. (8) If in a dispute to which sections 279 to 283 of the Act apply, a Court or arbitrator finds that an expense was not incurred because the insurer unreasonably withheld or delayed payment of a benefit in respect of the expense, the Court or arbitrator may, for the purpose of determining an insured person's entitlement to the benefit, deem the expense to have been incurred. O. Reg. 34/10, s. 3 (8).

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