Trauma Care and the SAAQ

An Historic Overview

Société de l'assurance automobile Québec

Trauma Care and the SAAQ: An Historic Overview

Over the past three decades, significant progress has been made in the management and treatment of trauma victims. By drawing on experience acquired during the latest armed conflicts, new investigation technologies and recent scientific studies, the causes of death by trauma are now better understood, as are ways of reducing the number of preventable deaths.

Modern societies around the world have concluded that the surest way of improving trauma victims' chances of survival is to reduce all delays in providing victims with access to the required surgical services.

Since its inception, the Société de l'assurance automobile du Québec (SAAQ) has made prevention one of its uppermost concerns. Indeed, a substantial segment of its activities has been focused on primary prevention (accident prevention) and on secondary prevention (injury prevention).

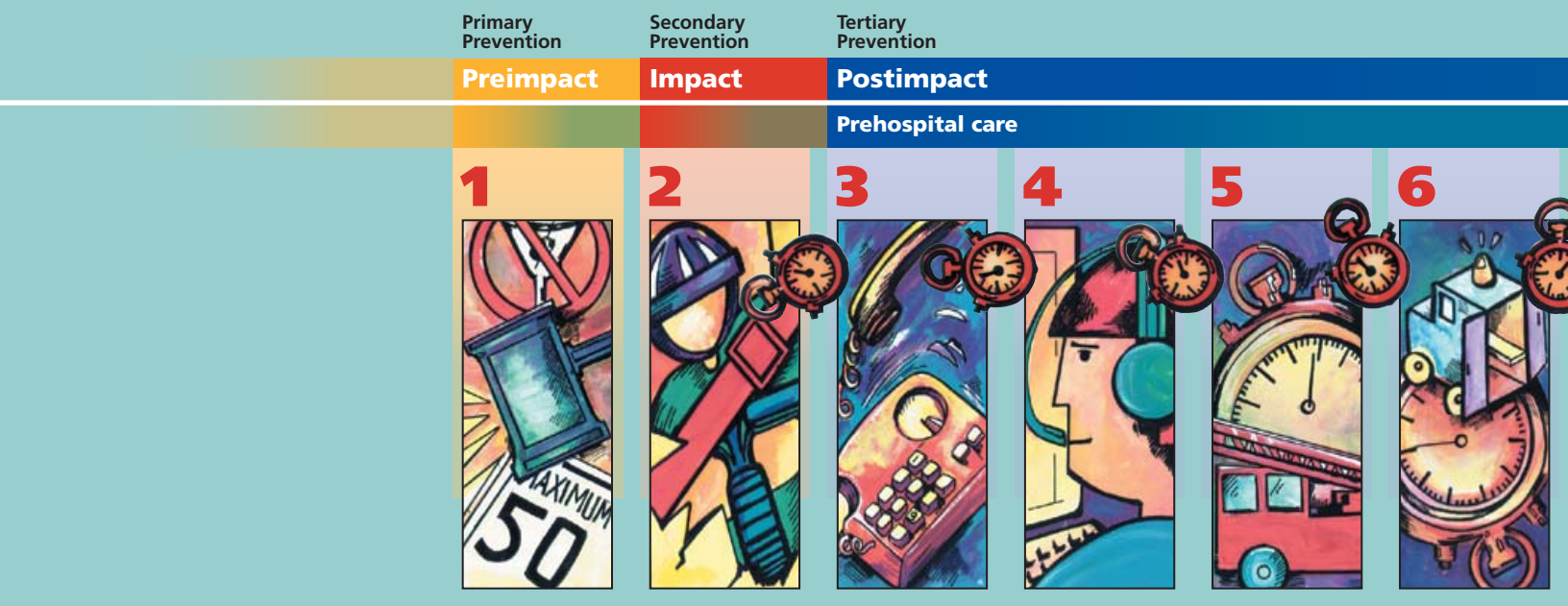
In common with other modern societies and as a consequence of the ever broader dissemination of the work of William Haddon, an American epidemiologist, the Société has also emphasized a third level of prevention—tertiary prevention—which is intended to improve emergency interventions and the care of injury victims following a collision.

In 1984, special attention was directed toward a global approach to care of head injury victims and, in 1987, agreements with rehabilitation facilities were reached. Today, these facilities form a major network of specialized services for neurological and musculoskeletal trauma victims.

The network essentially formed the **Integrated Trauma Care System**, which includes the three classic strategies of primary, secondary and tertiary prevention and recommends actions to carry out for each of the elements specific to the three strategic components.

The network model was widely circulated among the different organizations involved with trauma victims. In 1989, a partnership between the SAAQ and the department of Health and Social Services was forged—and has since grown stronger—paving the way for the implementation of the conceptual framework developed by the Société.

At that time, the Société played an active role on the different committees. In 1991, Health and Social Services gave it a mandate to create the *Groupe conseil en traumatologie* for the purpose of evaluating candidate facilities and subsequently designating a province-wide network of trauma care centres.



The traumatology advisory group, over which the Société presided, assembled a team of experts whose mandate was to make recommendations to the facilities involved and to the departmental authorities so as to create a service network that would comply with operating and performance standards recognized in North America.

By 1995, the first series of designations was completed, creating the network, and a program to periodically reevaluate the trauma centres was permanently established.

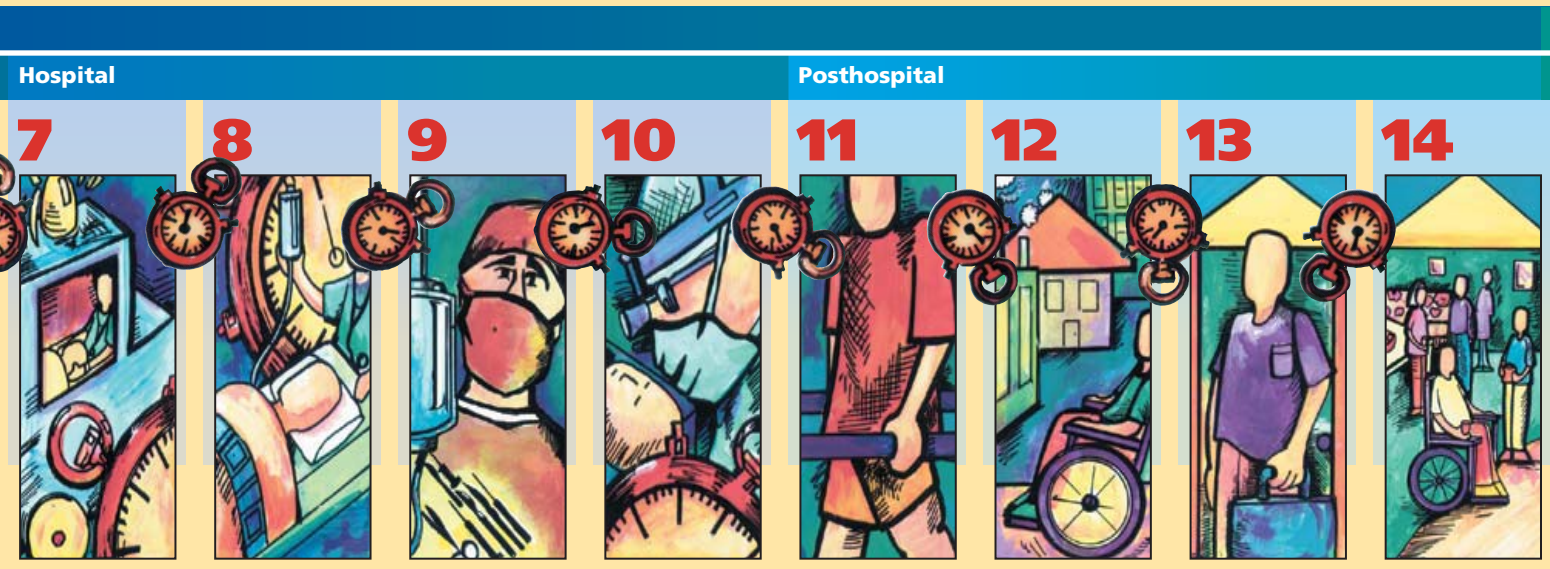
Using data gathered from the trauma registry, McGill University conducted a prospective study on the impact of introducing the Integrated Trauma Care System. For the period 1992 to 1998, the mortality rate of serious injury victims dropped from 52% to 18%.

A similar designation process, respecting the principle of "external auditing," was also set up for rehabilitation facilities. In addition, an evaluation matrix is used to make recommendations leading to compliance with standards and attainment of specific objectives.

Ever concerned with reducing waiting times to a minimum, not only with regard to the care of accident victims but also to compensation, the SAAQ introduced a rapid claim processing service in more than 20 secondary and tertiary trauma centres. With the cooperation of a health professional at the trauma facility, victims are provided with information on Québec's automobile insurance plan and, if they so wish, can open a claim file with the Société using an electronic interchange link. A unique service available to accident victims, this considerably shortens processing time and helps alleviate the worries and problems that can arise from an automobile accident.

A partnership with the health network paved the way for the realization of this unique integrated trauma care system model, developed by the SAAQ. Over 15 years' work and unremitting effort were invested in the model, whose ultimate goal is to minimize delays in providing accident victims with access to quality care, despite the geographic and demographic features of Québec.

From the perspective of the SAAQ and its clients, the establishment of the **Integrated Trauma Care System** has made it possible to attain the objectives set out in the initial departmental plan — accessibility, efficiency, quality and continuity.



The Departemental Plan

In the 1970s, Haddon proposed a matrix illustrating the three strategies involved in injury prevention based, on the one hand, on the different phases of an accident and, on the other, on the human, agent (motor vehicle) and environmental factors.

The three prevention strategies are:

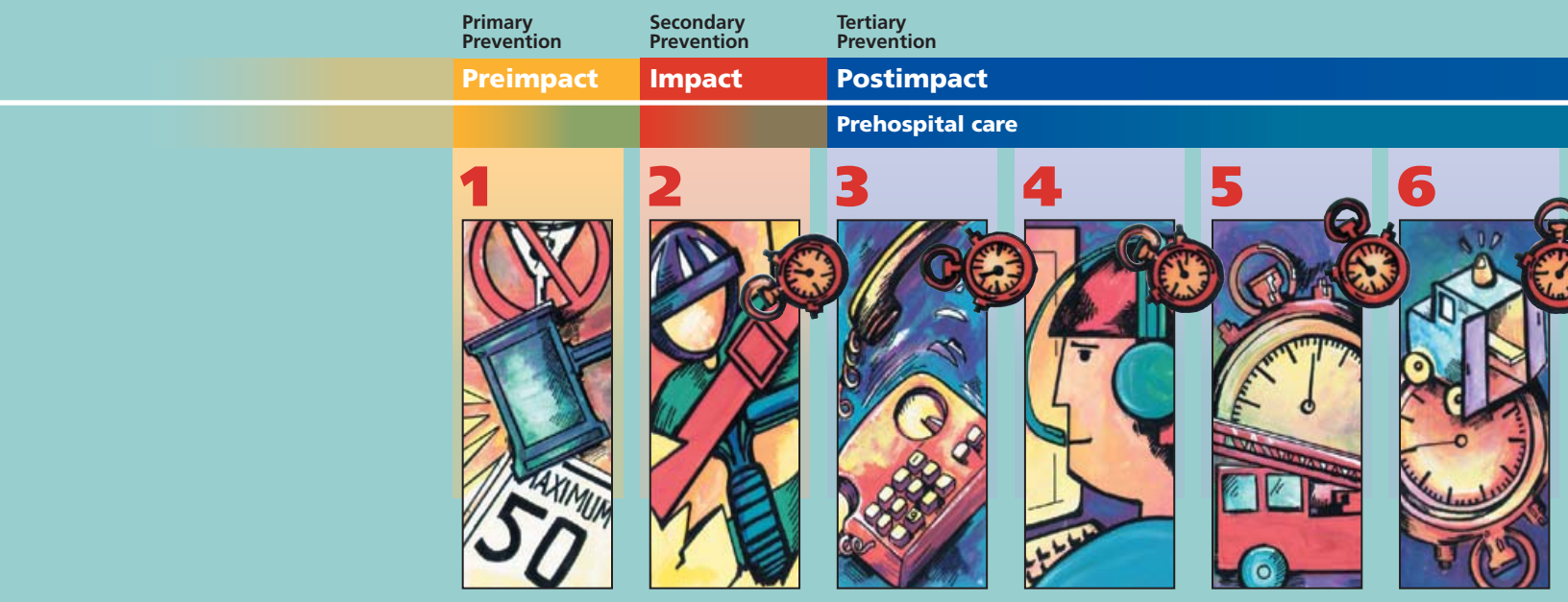
1 ■ **Primary prevention**, including all elements of intervention that exist prior to collision which favour accident prevention;

2 ■ **Secondary prevention**, including all elements involved during the collision that are designed to prevent injuries;

3 ■ **Tertiary prevention**, including all intervention elements that arise after the collision. The Société concentrates its actions on community health interventions for victims.

In Western societies, the notion of intervention is generally illustrated by a chain of services, each link of which represents an action with specific objectives.

The SAAQ drew on this notion in designing its Integrated Trauma Care System.



The system has four general objectives (accessibility, efficiency, quality and continuity of patient care) which, in turn, include the specific objectives of each of the links for which an action plan is specially developed:

1

Accessibility

- Accessibility must be universal and enable all victims of serious or potentially serious trauma to be managed by the system.
- Accessibility implies the integration of all resources in the service chain.
- Accessibility calls on all sectors: prehospital, hospital and posthospital.

2

Efficiency

- In trauma care, all delays must be kept to a minimum.
- Initial triage, according to the severity of injuries, is to be conducted at the scene of the accident, using the prehospital index (PHI).
- Victims are to be transported to designated facilities in the trauma care network and the receiving facility is to be given advance notice.
- Casualty management at the hospital and activation of necessary resources are set out in the agreements entered into with the facilities.
- Surgery, hospitalization or transfer must be carried out without delay.

3

Quality

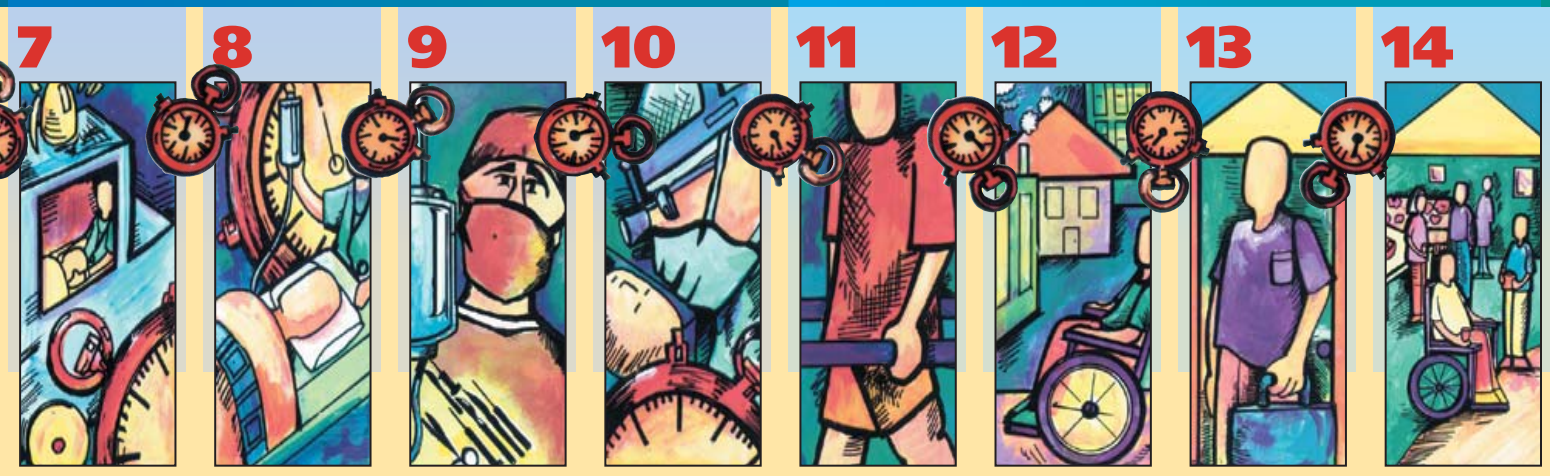
- All interventions within the chain of services are to be conducted and supervised according to terms in the agreements.
- All major trauma victim records must be reviewed by the local trauma care committees.
- All regional actions must comply with regional and supraregional objectives.

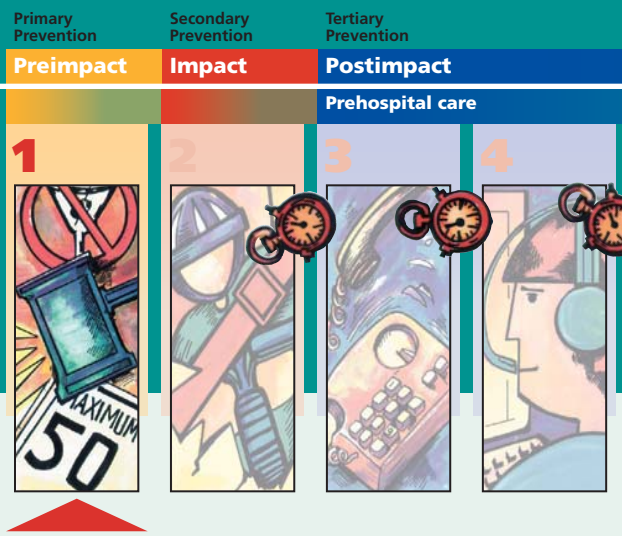
4

Continuity

- All trauma victims must have access to the ultraspecialized care required to treat their condition, by means of transfer service corridors.
- Transfers must be made without negotiation and expeditiously via the bilateral service corridors.
- Transfer refusals are abolished through agreements between the hospital administrations concerned.

Hospital | **Posthospital**





1

Accident Prevention

Definition

All measures intended to prevent accidents

Target

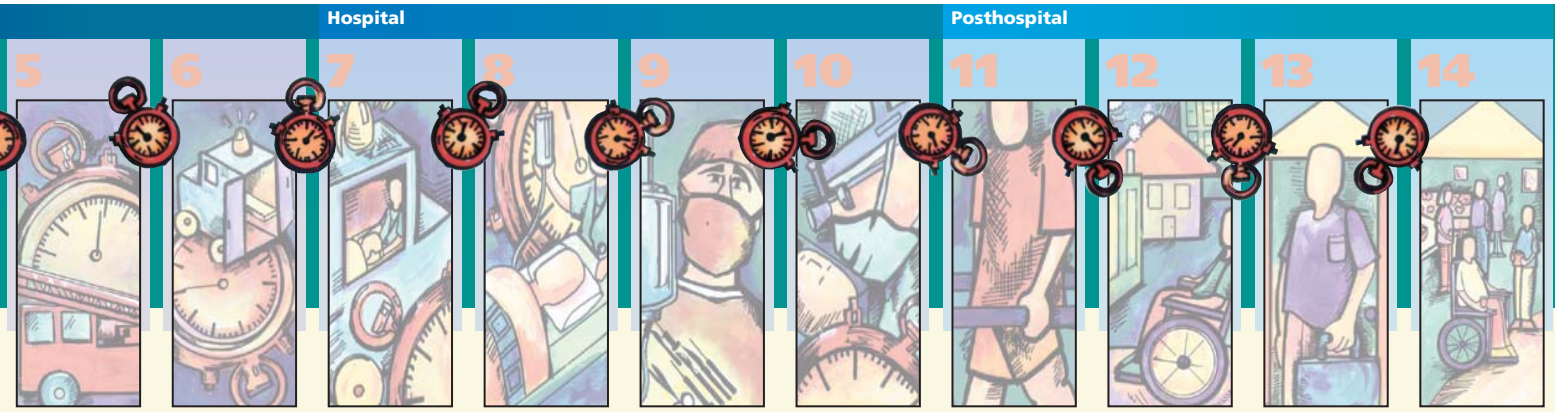
The general public

Effect

Reduction in accident risks

Basic description

This link in the chain of services includes all measures aimed at accident prevention that draw on several means, largely based on safety awareness and education campaigns for the general public.

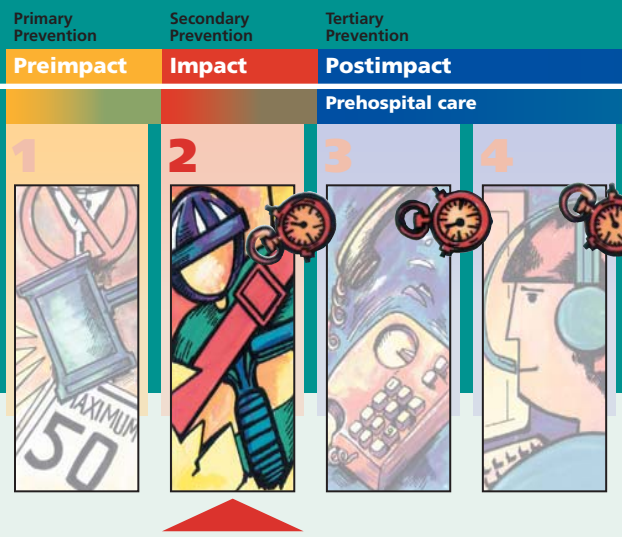


Involvement of the SAAQ

In an effort to bring road users to drive safely, the SAAQ has means of identifying dangerous behaviour as well as the segments of the population that should be targeted. The Société thereby promotes accident prevention through:

- safety awareness, education and joint action campaigns (e.g. drinking and driving, speeding, seat belts, car seats, headrests, helmet use by bicycle riders, pedestrian safety);
- controlled access to the Québec highway system, so as to ensure that persons wanting to drive a vehicle on a public road have the necessary knowledge and skills;
- recommendations concerning amendments to the Highway Safety Code that the Société believes are needed to facilitate compliance with and application of the Code (e.g. administrative sanctions such as demerit points, a fee scale for driver's licences according to the risk, fines, driver's licence withdrawal or suspension, vehicle seizure);
- increased monitoring of heavy vehicles, particularly the vehicles' mechanical condition.

The work that has gone into primary prevention over the years has resulted in lower accident rates despite a constant increase in the number of driver's licence holders and vehicles on the road. Specifically, over the past 20 years, primary prevention measures combined with new legislation and policing, as well as initiatives taken with respect to new drivers and drivers who have repeatedly been stopped for impaired driving, have had a clearly positive impact on the number of accidents.



2

Injury Prevention

Definition

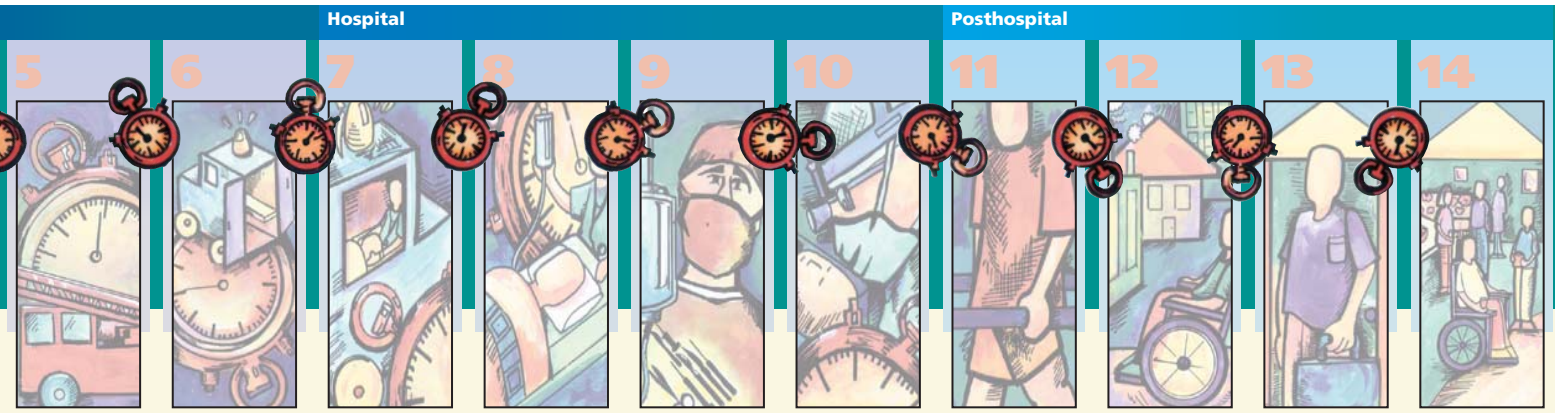
All active and passive measures intended to reduce accident-related injuries

Target

The general public

Effect

Reduction in the number and severity of accident-related injuries



Basic description

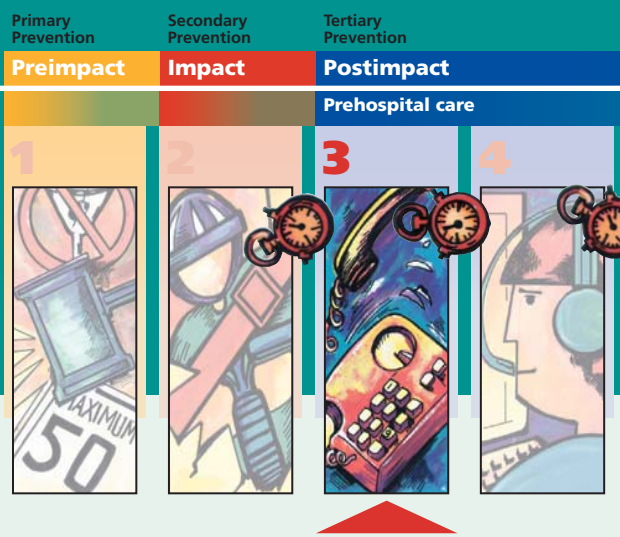
This link consists of all measures that result in a decrease in the number and severity of accident-related injuries.

Involvement of the SAAQ

As a result of rigorous manufacturing standards, road vehicles authorized for use in Canada are equipped with a sophisticated set of passive measures designed to protect occupants in the event of collision.

Apart from this type of protection, the SAAQ is involved in active measures to promote road safety, such as regulatory control of seat belt use or of child safety seats, as well as educating the public on the proper adjustment of headrests and helmet use by bicycle riders.

Whether passive or active, such measures have helped significantly reduce the severity of injuries and the number of fatalities resulting from collisions.



3

Emergency call, initial action agents, 911 centres

Definition

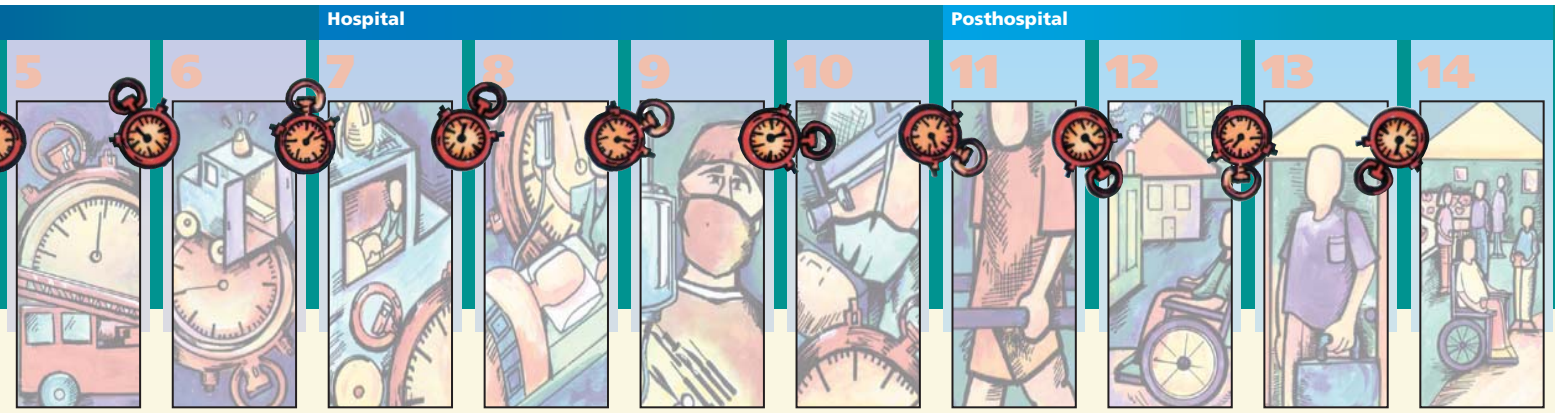
- An emergency call is any request for assistance from the public to have the SYSTEM respond to a distress situation of any type.
- Initial action agents consist of people, for example, bystanders, who happen to witness a distress situation and notify the SYSTEM of the incident and who, ideally, perform first aid on victims while waiting for the arrival of SYSTEM-designated responders.
- 911 call centres are single window systems that make it possible for anyone, including the initial action agent, to inform the emergency system of a distress situation.

Target

Trauma victim

Effect

Rapid communication to the emergency services network of all distress situations and initial first aid administered by the lay public



Basic description

This link consists, on the one hand, of the concept of the general public and of the initial help who, having witnessed an accident, informs the system of it and performs basic first aid on a victim. On the other hand, the link includes the concept of a 911 single window system through which anyone can reach all emergency intervenors apt to be involved in the systematic response.

The concept of a 911 single window system is becoming increasingly widespread, even in areas of low population density.

First aid performed on an accident victim by an initial action agent is gradually becoming part of Québec culture. We are increasingly aware of the need to assist accident victims and of the importance of quickly notifying rescue teams.

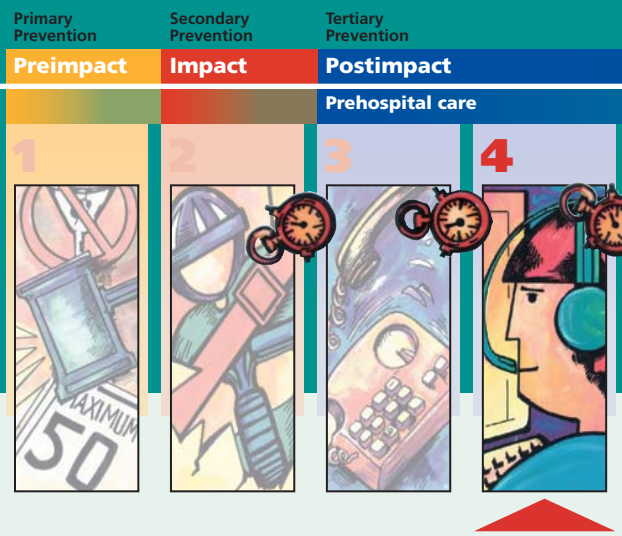
Involvement of the SAAQ

The SAAQ is currently developing information modules intended to heighten public awareness of the importance of administering first aid to victims in distress. The modules will be presented during public assembly events, forums or expositions in shopping centres or during any other public activity.

The Société is working with 911 centres to standardize the call management protocol across Québec.

It also strongly encourages the public to use 911 services in emergency situations and approves of the service being made available throughout Québec.

However, when a 911 call is made using a mobile phone, it can be difficult to pinpoint the caller's location. The Société supports the telecommunications governing body that is currently looking for a solution.



4

Emergency Care Communication Centres

Definition

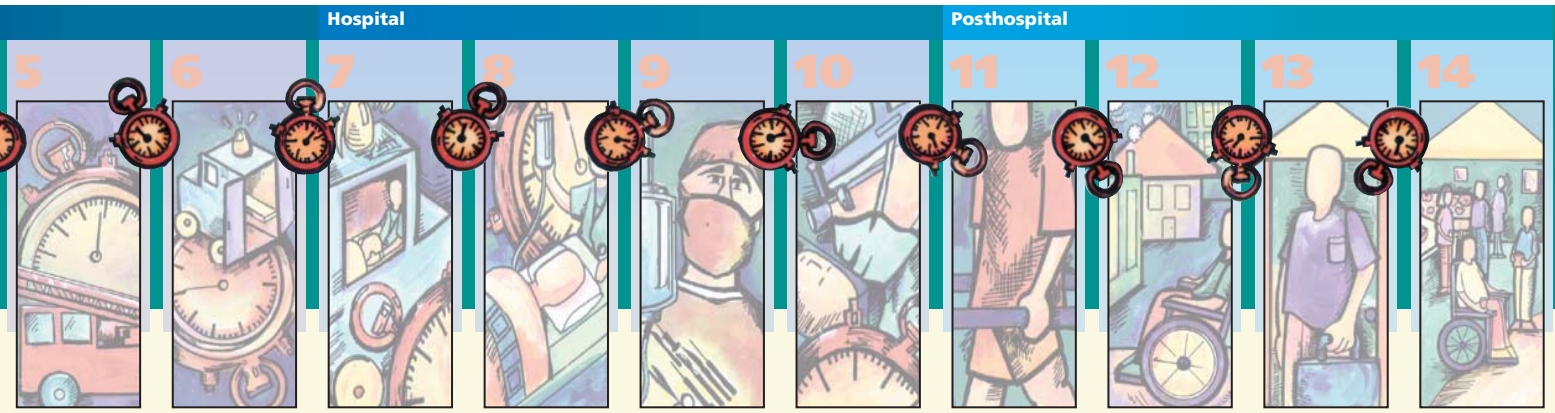
Organization that identifies and prioritizes care requirements, dispatches the necessary resources, oversees interventions and routes victims to the appropriate care facility

Target

Trauma victims requiring casualty management and transport to a care facility

Effect

Efficient handling of calls and their prioritization. Dispatching of resources in less than one minute for life-threatening situations



Basic description

Formerly known as dispatch centres, emergency care communication centres have undergone significant changes as a result of technological advances and regional groupings of ambulance services.

The centres receive the majority of health-related calls from 911 centres in the regions they serve. Their personnel identify and prioritize the needs of the person in distress; the emergency care communication centres' main role involves responding to emergency calls, identifying care requirements, dispatching the proper resources, overseeing interventions and routing the victims to the appropriate care facility.

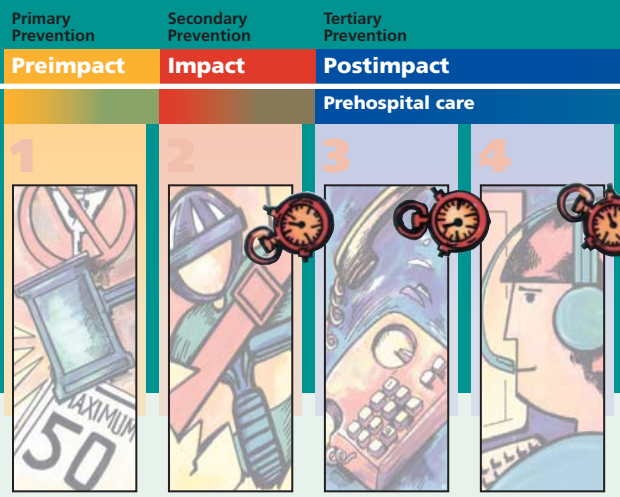
In order to obtain adequate information on intervention intervals and on the quality of care given to accident victims, the centres must maintain a data bank containing information on the distress calls to which they respond.

Health and Social Services adopted the concept of single-service emergency care communication centres across several regions, which means that each region is served by one centre. However, a single centre can cover a number of regions and can be interconnected with others in order to ensure effective backup in the event of a breakdown or natural disaster.

The efficient orchestration of prehospital services that results from the setting up of these centres thus improves accident victims' chances of survival.

Involvement of the SAAQ

With representatives sitting on the board of directors of a number of emergency care communication centres now operating, the Société has helped advance both the concept of the centres and their establishment.



5

First Responders

Definition

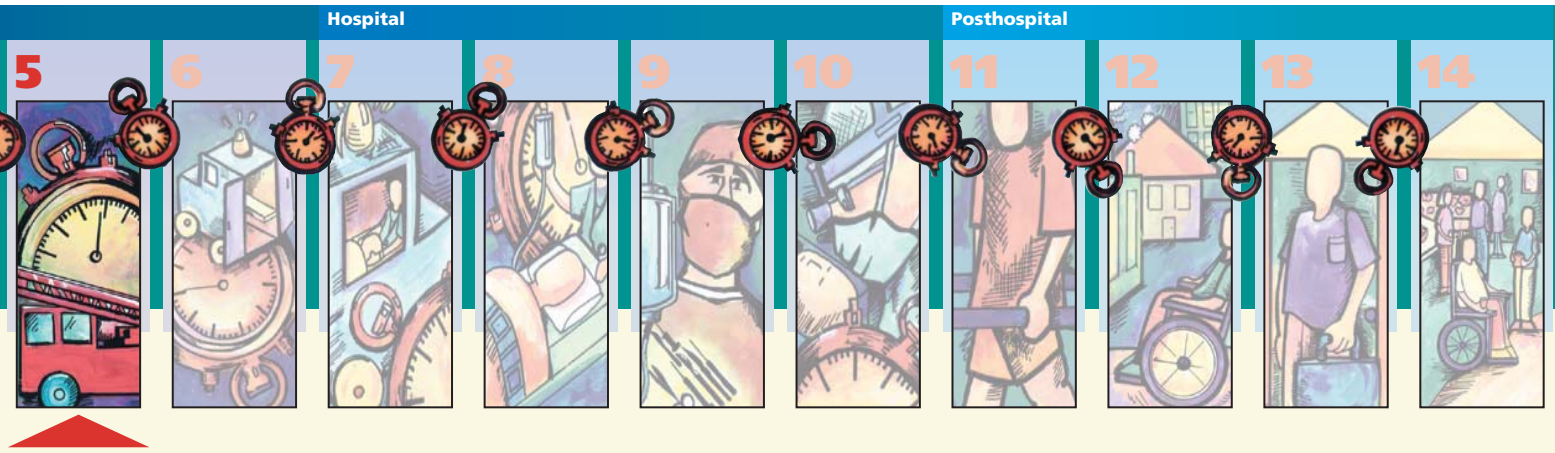
Municipal agency given mandate by the regional health board to provide primary care until the arrival of an ambulance

Target

Trauma victim in danger of dying

Effect

Rapid intervention under a service agreement when survival of an accident victim is immediately threatened



Basic description

First responders are persons who are trained and designated to provide trauma victims with emergency medical care. This early intervention improves victims' chances of survival while waiting for an ambulance to arrive. The increasing use of semi-automatic defibrillators has also meant improved chances of survival for victims of cardiac arrest.

The emergency care communication centre alone is responsible for managing the dispatch of first responders.

Owing to their availability, fire departments may be used to fulfill the role of first responder. However, municipal authorities in certain regions have designated other local agencies as such.

Firefighter training is standardized throughout Québec. The issuing of competency cards to these intervenors is approved by the regional boards, which also delimit interventions through clinical agreements.

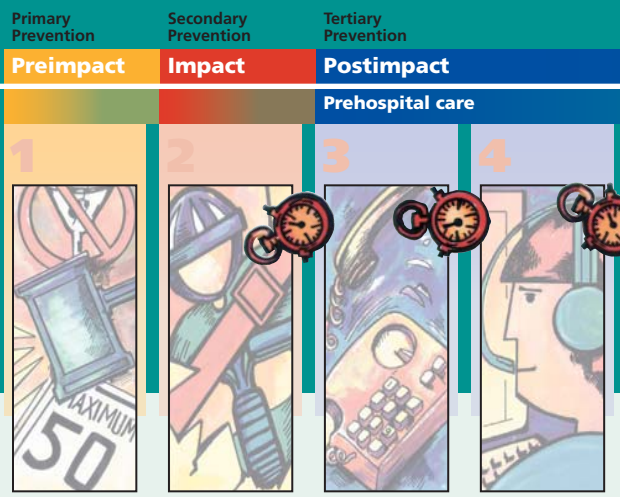
Few localities are currently covered by this type of first responder service. A departmental action plan, including funding and training, has consequently provided for the service to be established across Québec.

As a result of the first responder link, the negative consequences of trauma are significantly reduced. Such interventions make it possible to obtain a response time equivalent to an acceptable performance standard without having to multiply costly ambulance resources.

Involvement of the SAAQ

The SAAQ has promoted the concept of first responder and the widespread inclusion of these care providers in the chain of prehospital emergency services.

The Société is pressing ahead, with the objective of improving first responder availability in urban areas and remote municipalities alike.



6

Ambulance Services

Definition

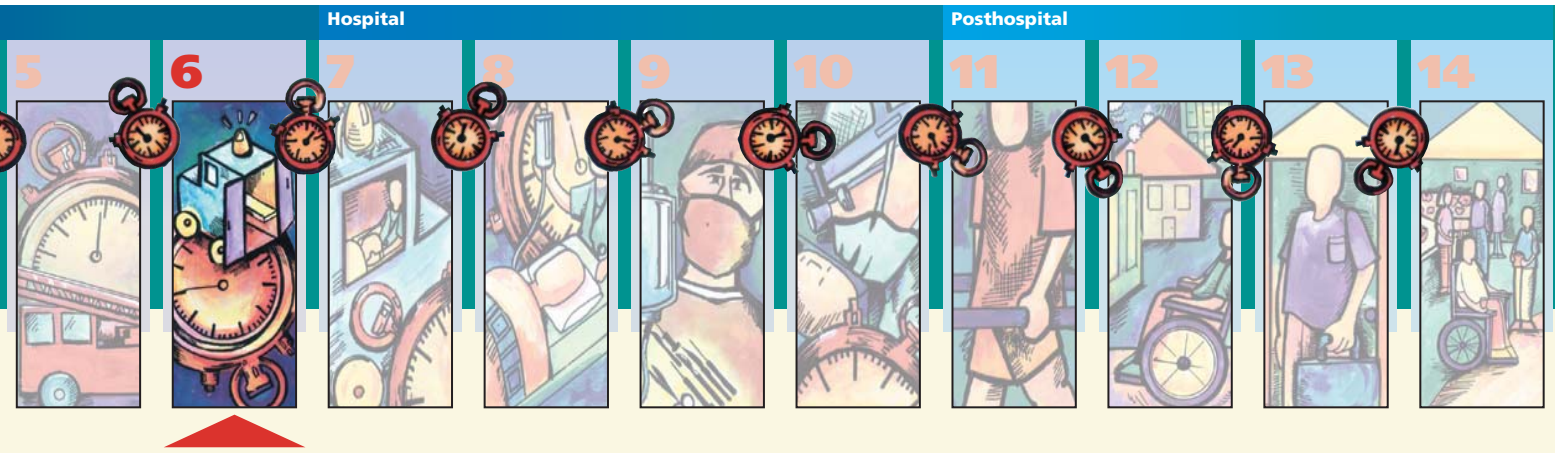
Health care intervenors trained in reanimation of trauma victims and their rapid transport toward a designated facility

Target

Trauma victims in need of emergency care

Effect

Reanimation of trauma victims in accordance with established protocols and their transport to a suitable hospital



Basic description

Ambulance services are provided by private companies, which have signed contracts with the regional boards, in all but two regions in the province: Montréal and Laval are served by a public corporation, Urgences-santé.

Ambulance attendants are trained to reanimate victims and to rapidly transport them to the designated care facility. For optimal routing of victims, trauma triage is conducted at the scene of the incident, based on the prehospital index (PHI). The attendants provide the receiving facility's emergency service with advance notice, thereby improving casualty management upon arrival at the hospital through timely activation of hospital trauma resources.

All clinical interventions by ambulance attendants are dictated by standard protocols throughout Québec. The initial situation is assessed by the emergency care communication centre's medical prioritization system, after which the centre determines the priority level. Resource deployment, the actions taken in the field, and timeliness are the object of a clinical supervision and are subject to an ongoing quality improvement program managed by the regional board concerned.

Covering the entire territory of Québec, the ambulance-service zones provide a maximum response time of 30 minutes for each of the zones. The number of vehicles within a zone is determined by its demography and the documented volume of activities in it.

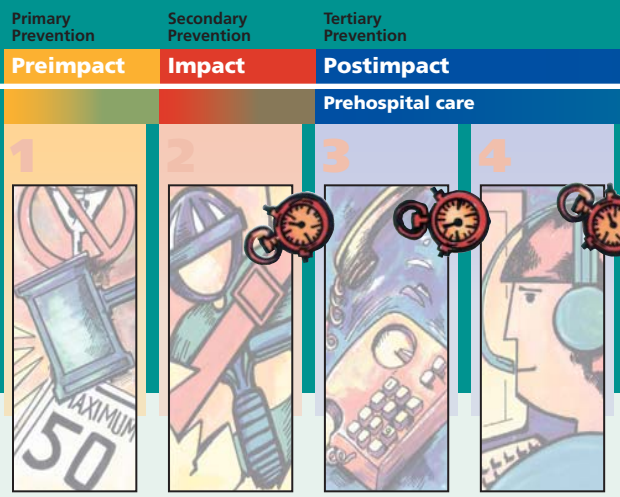
Involvement of the SAAQ

The SAAQ is playing an active part in the reform of emergency prehospital services, conceptually and operationally. It funds around one-quarter of ambulance service budgets yearly.

It also works with Health and Social Services in implementing the recommendations of the province's committee on the reform of prehospital emergency services.

The level of service quality and of attainment of clinical performance objectives is elevated through improvements to and the standardization of ambulance attendant training. Concerned about certain deficiencies in the training of intervenors, the Société maintains its partnership with the department of Health and Social Services and the regional health and social services boards in order to bring about the necessary changes.

Based on the recommendations proposed by the province's committee on the reform of prehospital emergency services, sweeping changes may be anticipated in the quality of services and in casualty transportation management as a whole. The Société remains keenly responsive to this reform and maintains partnership with the various parties involved.



7

Stabilization

Definition

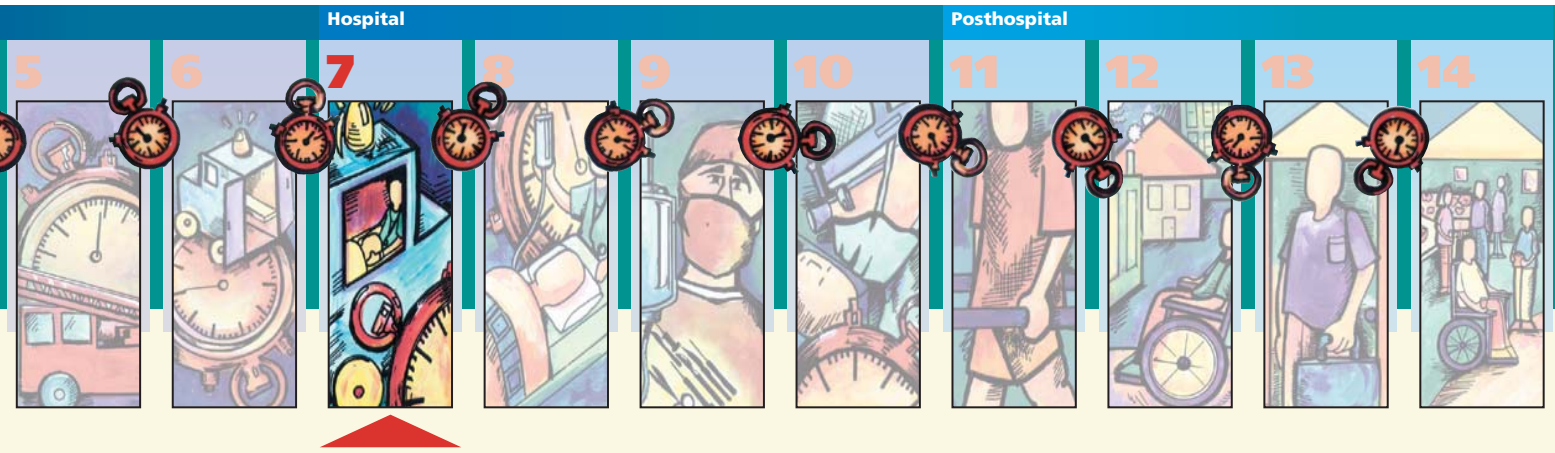
Facilities located more than 30 minutes from a trauma centre which ensure stabilization of victims in less than 10 minutes and provide physician accompaniment during transport of unstable cases to the trauma centre, designated according to the service corridors

Target

Severe trauma victims with a prehospital index at four or over or involved in a high-speed collision

Effect

Reanimation for vital functions and rapid transport of the trauma victim to the designated trauma centre



Basic description

Medical stabilization services are available in isolated localities, that is, more than 30 minutes from a primary, secondary or tertiary trauma centre. These units stabilize severe trauma victims (prehospital index of four or over or victims of a high-speed collision) and quickly take them to the hospitals designated according to the service corridors.

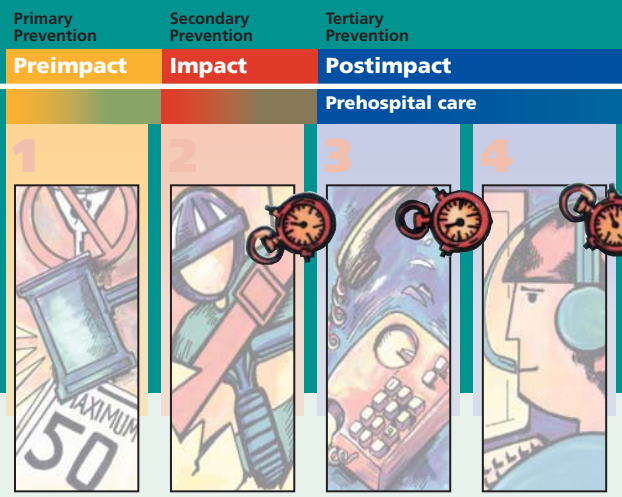
Severe trauma victims are taken to a stabilization unit, even if it has no surgical or anesthetic resources, so as to minimize the risk of complications during transfer to a trauma centre. Stabilization facilities have been integrated into the trauma care network in an effort to stymie the development of certain cases of distress and, if necessary, provide for physician accompaniment of the victim during the transfer. The response time must not exceed 10 minutes.

Stabilization facilities are not trauma care centres as such, since they do not provide surgical services. With only a minimum of equipment, the facilities cannot conduct radiologic work-up nor laboratory exams for severe injury victims.

Involvement of the SAAQ

As part of its mandate to evaluate facilities for designation within the trauma care network, the traumatology advisory group recommended the integration of 22 facilities as stabilization services. Health and Social Services has mandated the Société to ensure a permanent chair for the advisory group and to assemble teams of experts to evaluate the quality of services provided by the facilities in the trauma care network. The advisory group ensures that all facilities comply with Québec criteria and implements the recommendations.

The advisory group also examines certain problem areas and, when given specific mandates by either Health and Social Services or a regional board, formulates opinions reached through a consensus of the experts recruited for the specific mandates.



8

Primary Trauma Centres

Definition

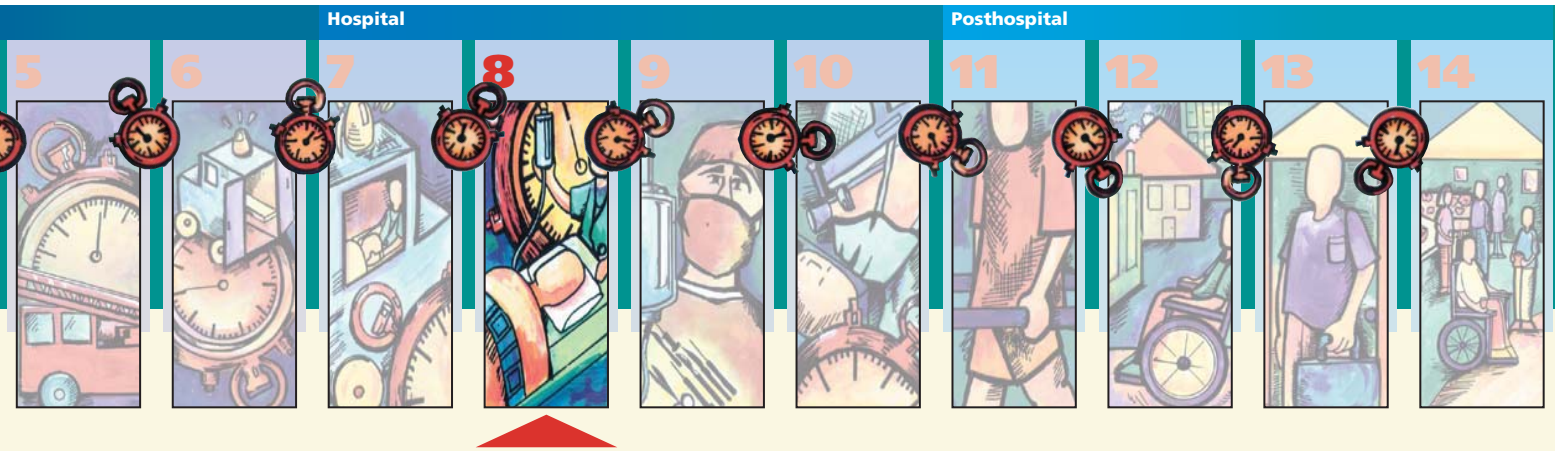
Facilities offering general surgery and anesthesia, located more than 30 minutes away from a secondary or tertiary trauma centre

Target

Trauma victims whose injuries do not show systemic complications or who are in need of surgical stabilization before transfer to a more specialized centre

Effect

Front line personnel administer critical and acute care to victims of moderate trauma not showing threatening comorbidity; once stabilized, the trauma victims in need of specialized treatment are transferred to a secondary or tertiary trauma centre.



Basic description

The primary centres are the second designation level in the trauma care network and form the first stratum of facilities offering specialized surgery and anesthesia. Since the issue inherent to trauma care is first and foremost surgical, primary centres are viewed here, as in many other Western systems, as the prime trauma centre.

To qualify as a primary centre, the facility must be located more than 30 minutes from a secondary or tertiary trauma centre. Primary centres are not required to have an intensive care unit nor offer orthopedics. Victims in need of intensive multidisciplinary support or orthopedic surgery are transferred to a secondary or tertiary trauma centre able to provide the specialized treatment required.

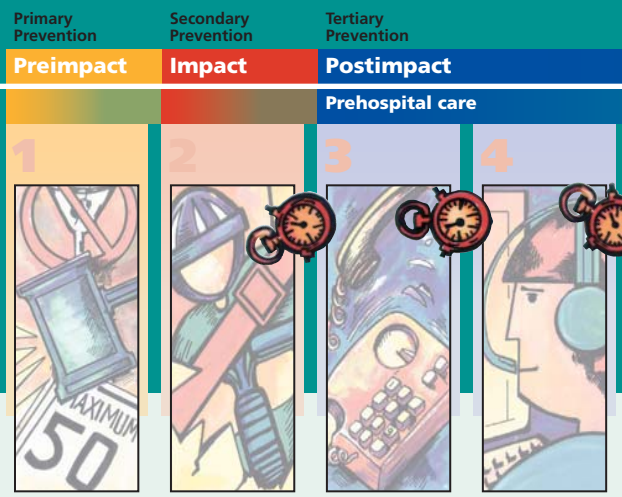
Primary centres are in communication with the prehospital emergency services who are to provide them with advance warning of the arrival of victims. Upon reception of this notification, the trauma team is activated so as to be ready to perform initial reanimation, investigation and routing for definitive care.

These centres provide critical and acute care to victims of moderate trauma not showing local or systemic complications. Trauma victims requiring specialized treatment are quickly stabilized and transferred to a designated receiving centre. The decision regarding the destination facility must be made within 30 minutes and the patient must have left the emergency ward within one hour of arriving at the primary centre.

It is essential that victims not suffer from delays resulting from facility negotiating or bargaining which may arise from their transfer to a designated receiving centre. To avoid additional delays, the medical information required by the receiving facility is faxed to it once the patient has departed. When the victim's condition is unstable or shows a potential of worsening during transport, a physician accompanies the victim.

Involvement of the SAAQ

Québec's trauma care network is currently made up of 26 primary centres. The traumatology advisory group, presided over by the SAAQ, periodically reviews the centres in carrying out its regional mandates.



9

Secondary Trauma Centres

Definition

Facilities offering general surgery, orthopedics, poly intensive care as well as early rehabilitation

Target

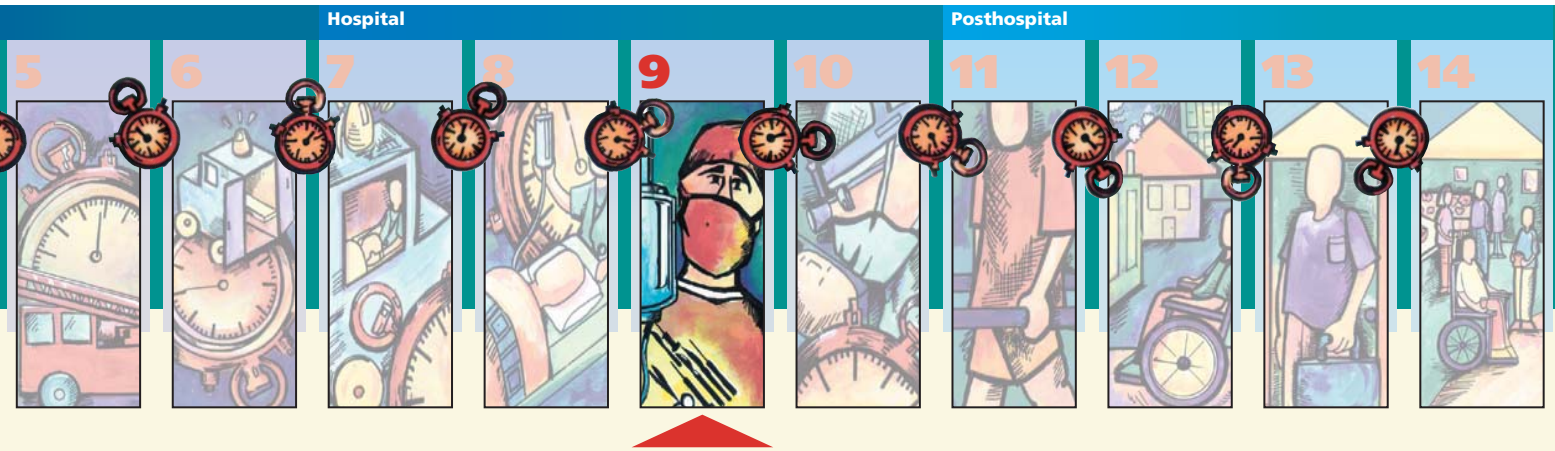
Severe trauma victims and polytrauma victims without comorbidity requiring highly specialized care

Effect

Critical and acute care are provided, without delay and without transfer, to severe trauma victims and polytrauma victims.

Early rehabilitation for trauma victims is available, as is psychological and social counselling for trauma victims and their family members.

Service corridors permitting the transfer of trauma victims in need of tertiary care or rehabilitation services



Basic description

Secondary trauma centres—the hub of specialized care in the trauma care network—are found in most regions of Québec. In addition to the range of services offered by primary centres, secondary centres provide specialized services in orthopedics, intensive care and internal medicine.

If a secondary centre does not offer neurosurgery, it is important that moderate or severe head injury victims not be detained there. For classification purposes, all secondary centres offering neurosurgery are designated as regional secondary centres and are responsible for providing highly specialized care in neurotraumatology in their region.

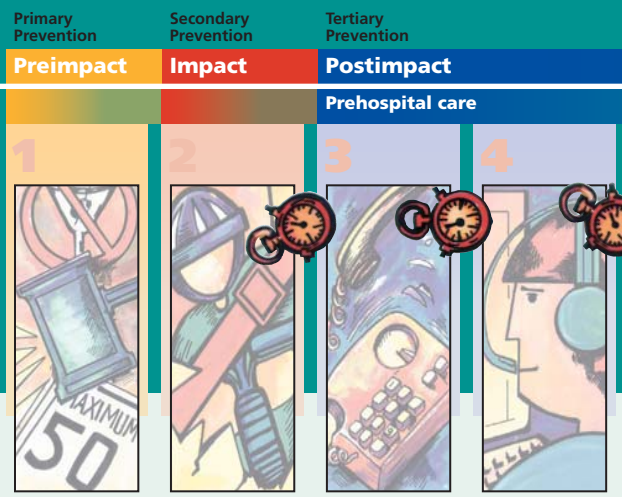
The traumatology advisory group recommended that 27 facilities be designated as secondary trauma centres, including 4 regional secondary neurotraumatology centres. The majority of these centres provide rapid casualty management service.

All secondary centres are responsible for specific service corridors that connect them to the primary care centres in their respective regions. Under the service agreements between these centres, transfers cannot be refused nor can there be any negotiating.

Involvement of the SAAQ

The SAAQ visits all secondary care centres from time to time as part of its visits to the regions. To monitor the clinical activity of the centres, the Société consults the trauma registries that Health and Social Services regulations require be kept by them.

In 1998, the Société introduced the rapid claim processing program in the majority of secondary trauma centres and in all tertiary and university centres. The Société now intends to expand this service so as to make it accessible to the greater part of hospitalized trauma victims.



10

Tertiary and University Trauma Centres

Definition

Facilities offering specialized and ultra specialized trauma care and neurosurgery as well as specialized intensive care and interdisciplinary early rehabilitation

Target

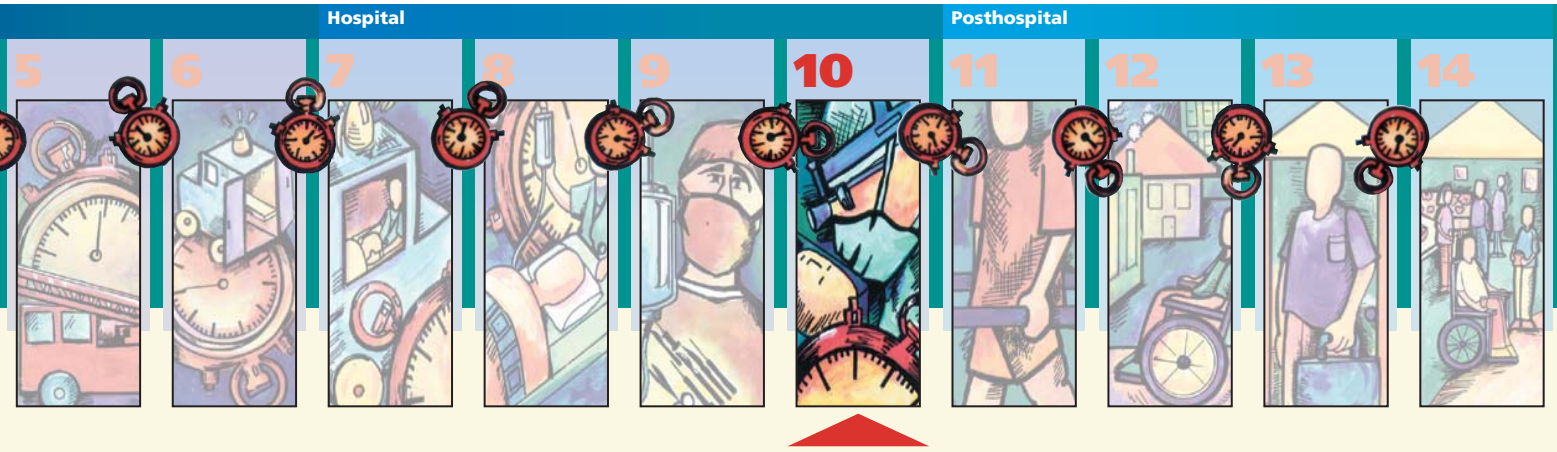
Severe polytrauma and neurotrauma victims

Effect

Severe polytrauma and neurotrauma victims are provided with critical and acute care.

Interdisciplinary early rehabilitation is available for trauma victims, as is psychological and social counselling for trauma victims and their family members.

Transfers of stable and recovering trauma victims to rehabilitation facilities are made via the service corridors in accordance with established protocols.



Basic description

All severe trauma victims have access to ultra specialized trauma and neurotraumatology care provided at the tertiary and university trauma centres. The goal of this care is to reduce complex deficiencies and prevent disabilities through early interventions.

Providing severe polytrauma victims with highly specialized care, these supraregional centres also offer a trauma care education and research program. They are thus becoming a key source of expertise in both training and consultation within Québec's trauma care network.

There are currently four tertiary trauma centres in the network. Two of them—-Hôpital Sacré-Cœur in Montréal and Hôpital de l'Enfant-Jésus in Québec City— belong to consortiums of expertise for spinal cord injury victims. The two pediatric centres designated in trauma care are Hôpital Ste-Justine and Montreal Children's Hospital. In addition to fulfilling a tertiary role for pediatric clientele, they offer a province-wide remote consultation service. The network also has two units for major burn victims which also provide a province-wide service. All of these facilities conduct rapid casualty management.

The centres are all required to keep their trauma registries up to date and take part in the provincial tertiary centres committee set up for the purpose of discussing the advances and changing trends in trauma care and of validating them before incorporating them throughout the entire network.

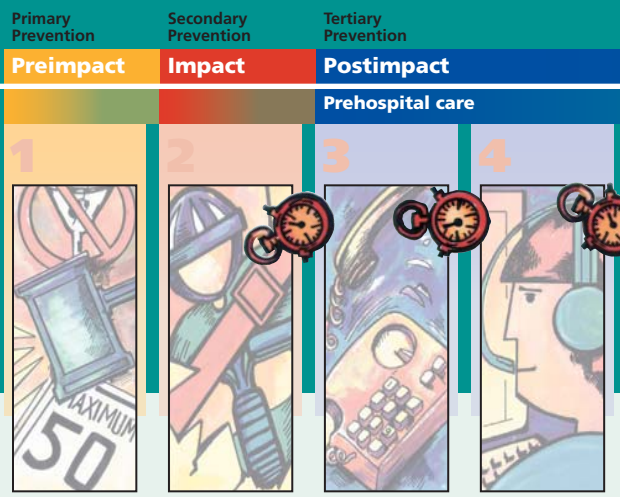
Involvement of the SAAQ

Before being designated, all facilities in the trauma care network were evaluated, then recommended, by the traumatology advisory group on the basis of their levels of service delivery. The department of Health and Social Services directed the Société to preside over the traumatology advisory group and to set up teams of outside experts in order to evaluate the facilities, make the necessary recommendations to achieve compliance and designate them.

The Société is also charged with following up on recommendations and maintaining the ongoing quality improvement program, monitored by the provincial trauma registry. The latter was created as a result of the efforts of certain tertiary centres, as well as multipartite funding, a significant portion of which was provided by the Société.

Within the scope of its mandate, the Société designated two consortiums for trauma care and spinal cord injury rehabilitation. Both have interdisciplinary teams so as to ensure integrated patient management: acute-phase transfers of stable patients are made in accordance with established protocols and an intervention program is established for cases of respiratory dependency.

The tertiary centres organize annual conferences, in collaboration with the Société.



11

Rehabilitation

Definition

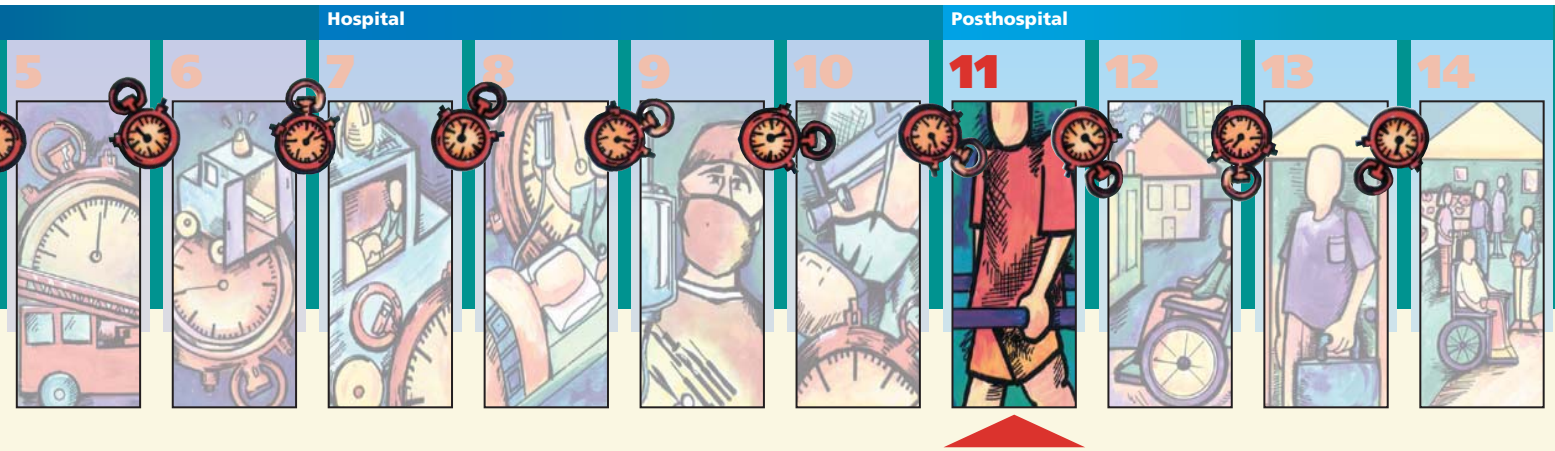
All measures intended to eliminate, reduce or compensate for disabilities (motor, cognitive, behavioural or other) resulting from accident-related injuries

Target

Accident victims with significant or persistent disabilities

Effect

Accident victims able to resume, as soon as possible, the personal, social, academic and occupational activities in which they took part prior to the accident



Basic description

When accident-related disabilities are temporary and have no significant long-term impact on the accident victim's activities, routine rehabilitation services are offered. They may be obtained at general hospitals (on an in-patient or out-patient basis), CLSCs, acute-care facilities or private clinics.

However, when the resulting disabilities are significant and persistent, the accident victim must be quickly taken to specialized rehabilitation services. Facilities offering rehabilitation are found in each administrative region. Some of them offer highly specialized province-wide services, particularly in the case of trauma victims. The network has two spinal cord injury centres, one of which is the receiving facility for eastern Québec, the other, for western Québec. Rehabilitation facilities advocate an early, global, multidisciplinary approach centered both on the client and on his or her family and friends.

Through the interventions of the multidisciplinary team and, as required, with the use of compensating technical aids, injury victims can, according to their potential, resume their activities in their usual social and cultural environment.

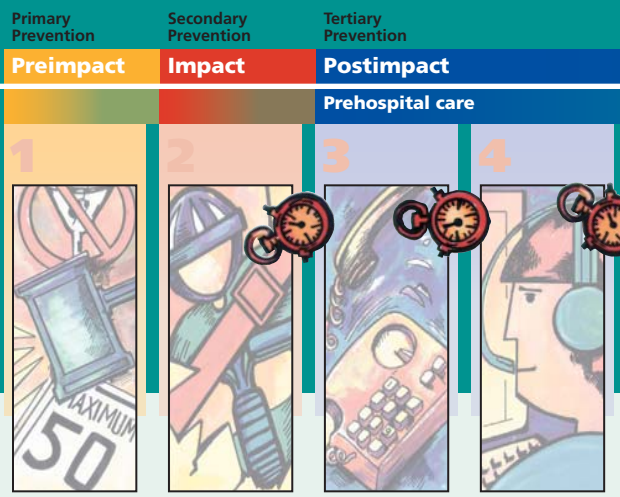
Involvement of the SAAQ

With the objective of favouring the optimal recovery of injured persons' capabilities, the Société has become directly involved in developing and advancing the health network's rehabilitation services. To this end, the Société has signed service agreements with 18 rehabilitation facilities, ensuring the presence of such facilities in each region of Québec.

Rehabilitation services, introduced in 1987, initially focused on head injury victims. Ten years later, these services were expanded to include spinal cord injury victims, then, in 2000, orthopedic and other serious injury victims of road accidents.

As a result of these service agreements, injury victims are, during their rehabilitation, able to benefit from early multidisciplinary rehabilitation services that are both specialized and ongoing.

The Société has invested nearly $200 million in these agreements since 1987. Its efforts in the field of rehabilitation are largely acknowledged as having a major impact on the quality of all rehabilitation services, to the benefit of all Quebecers.



12

Support for Social, Academic and Labour Market Reintegration

Definition

All measures aimed at supporting people in the process of social, academic and labour market reintegration

Target

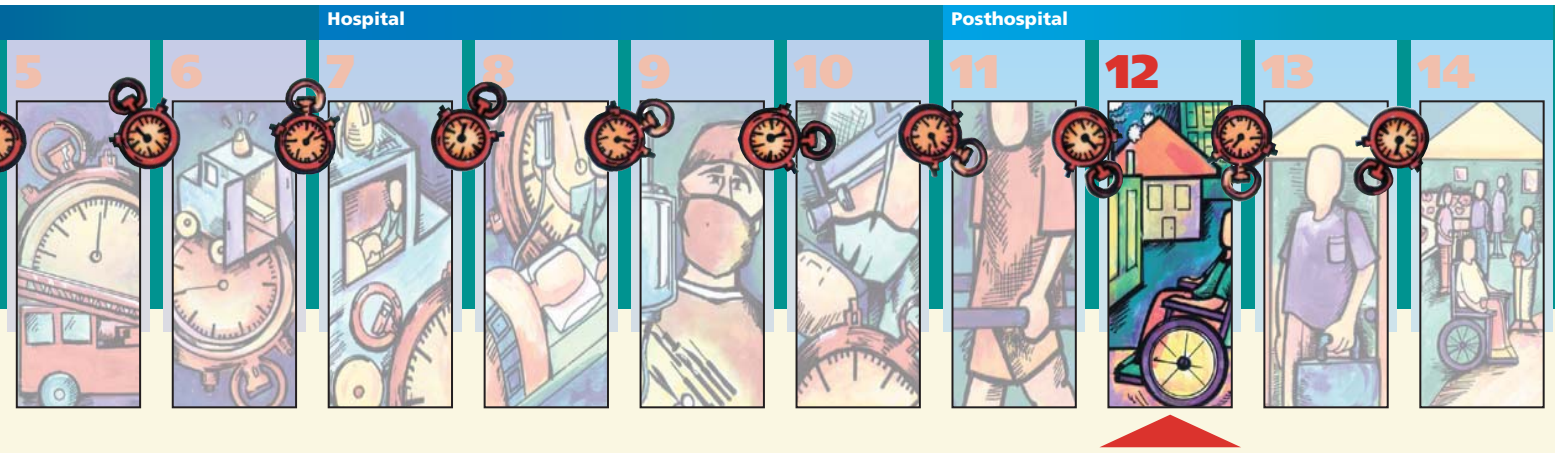
Accident victims with permanent disabilities who are having to function with a handicap

Effect

Optimal resumption of community, academic and occupational activities in which the injured persons took part before their accidents

Basic description

Reintegration support to persons with permanent disabilities which consists of services to help them live in the community and again take up, as far as possible, the social roles they fulfilled prior to the accident, with focus being placed on the three major dimensions of daily life, namely, personal, socio-residential as well as social and vocational



This type of service is offered through the collaboration of a number of different partners: rehabilitation facilities, CLSCs, acute-care facilities, community organizations, user associations, the OPHQ, agencies active in social economics, and funding parties (SAAQ, CSST).

Reintegration support services can be divided into four major categories:

- personal support services (for example, personal assistance, domestic help, paratransit, residence adaptation);
- a family and friends support service (for example, respite care and short-term emergency care, caretaking, psychological and social counselling, domestic help);
- universal accessibility measures, which promote the accessibility of public places and facilities that are pertinent to carrying out societal functions;
- support measures for the various reintegration environments, specifically, information, training and assistance services which enable the latter to more effectively tailor their services to the needs of persons with permanent disabilities.

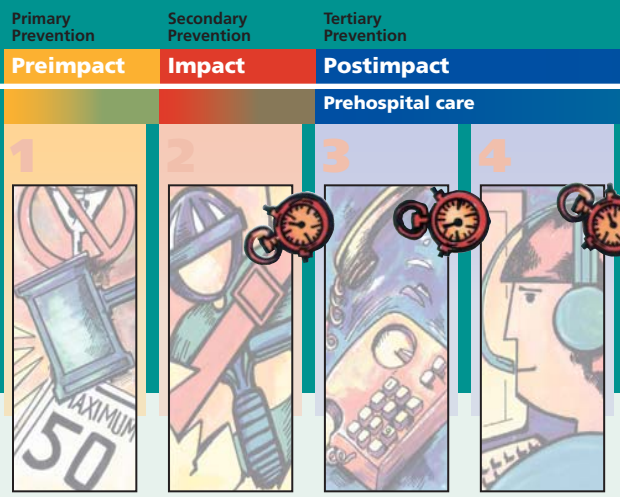
Involvement of the SAAQ

The Société's rehabilitation counsellors provide accident victims with personalized support in progressing as best they can through their social, academic or labour market reintegration. In order to ensure that support is nearby in each region, the Société has more than 70 counsellors throughout Québec.

When preparing rehabilitation plans, the counsellors involve both the accident victims and their family members. After suggesting the measures needed to carry out the plans, the counsellors coordinate implementation of the latter.

The measures proposed may include, for example, residential or vehicle adaptation, pedagogical support, and occupational training. The Société pays out more than $37 million annually in rehabilitation services to help road accident victims resume their regular activities.

Each year, rehabilitation counsellors provide assistance to nearly 6,000 accident victims, including 2,000 new claimants.



13

Long-Term Maintenance of Skills

Definition

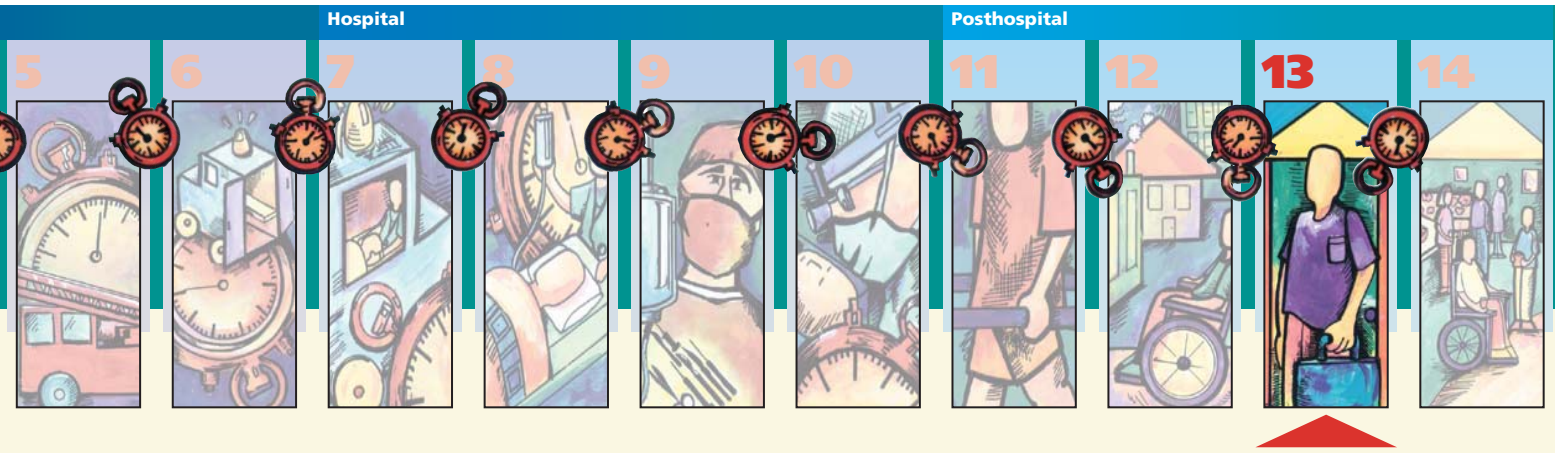
All measures aimed at the long-term support of the accident victim's participation in society

Target

Injury victims for whom after-effects of the accident have a long-term impact on their ability to live a normal life

Effect

Long-term maintenance of the skills acquired in rehabilitation and in social, academic or labour market integration



Basic description

The long-term maintenance of acquired skills encompasses a variety of services. They effectively enable accident victims who have persistent severe after-effects, live in the community and have again taken up their social roles, to maintain their level of social integration over the long term.

A number of partners work together in order to offer services for this purpose: rehabilitation facilities, CLSCs, community organizations, user associations and funding parties (SAAQ, CSST).

Accident victims may require long-term skills maintenance services with respect to the three major dimensions of life:

- personal autonomy (for example, a specialized selective follow-up by the rehabilitation facility, long-term home care, long-term paratransit services);
- socio-residential autonomy (for example, long-term domestic help services);
- social and occupational autonomy (for example, adapted recreational and leisure services, access to volunteer work, long-term selective academic integration support services).

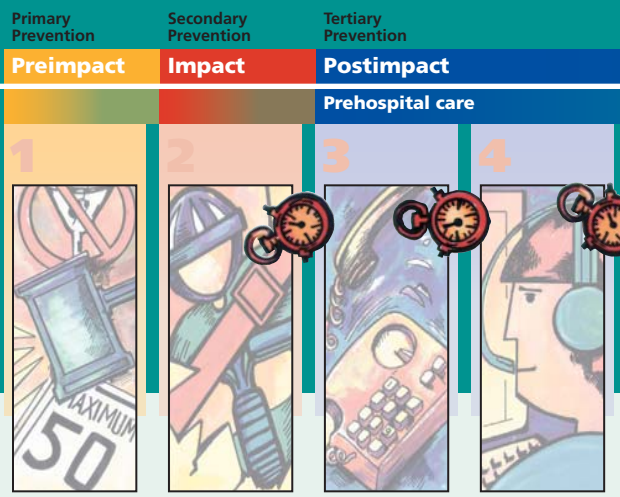
Involvement of the SAAQ

The Société has signed agreements with 14 mutual-aid associations to provide accident victims who have serious after-effects of their accident with community support. Located in all regions of Québec, these associations receive just under $2 million annually.

Under the agreements with the rehabilitation facilities, accident victims can also, as required, take advantage of a life-long selective follow-up, such as psychological counselling or the monitoring of a health or urological condition.

The Société covers personal assistance costs as well, in order to encourage accident victims who have difficulty carrying out their daily activities to live in familiar surroundings. In 2000, close to $33 million was expended for these services.

Finally, income compensation ensures that accident victims are able to maintain the standard of living enjoyed before the accident. Nearly $230 million was paid in income replacement indemnities in 2000.



14

Alternative Residential Resources

Definition

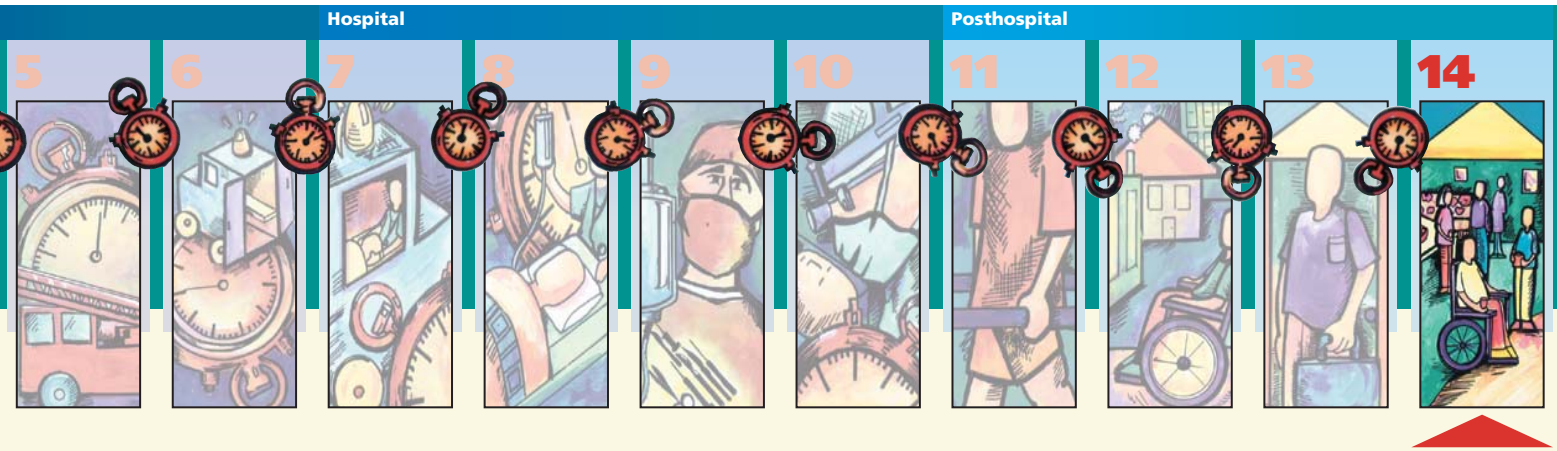
All measures whose objective is to maintain accident victims in an environment appropriate to their particular condition

Target

Accident victims with severe after-effects of their accidents who are unable to remain in their natural living environment

Effect

Maintenance of accident victims in an environment that is optimally suited to their needs



Basic description

Certain accident victims may need to temporarily stay in a transitional residence that provides a secure environment in which to put into practice and reinforce what they have learnt under supervision, before pursuing the process of integration.

Some accident victims cannot reintegrate into their natural environment because the long-term integration support services are unable to ensure that their specific needs with respect to supervision or care are met in their natural environment or because the victims' natural support resources have been exhausted. Under such circumstances, the accident victims can be directed to alternative residences based on the level of support required:

- institutional accommodation resources;
- intermediate resources;
- family-type resources;
- semi-autonomous accommodation.

Involvement of the SAAQ

When persons are unable to live at home because of the after-effects of their accidents, the Société assumes the costs associated with lodging them in an alternative residential resource. In terms of annual costs, the Société pays accident victims nearly $3 million and $9 million to the Consolidated Revenue Fund.

Conclusion

The SAAQ has, as its primary mission, the task of insuring and protecting Quebecers against the risks inherent in road use. It acts with the objective of further developing the insurance plan according to the expectations and needs of its clientele, while respecting the financial capacity of the population of Québec.

Since compensation is founded on the no-fault insurance concept, the Société is able to better concentrate its efforts on the quality of services available to accident victims. Only a governmental plan, like that of Québec, has a vested interest in funding the development and application of mechanisms or programs designed to enhance not only the care and services provided to accident victims but also victims' quality of life. The Société's initiatives have a direct impact on reducing damage and compensation costs.

The Société is in a privileged position to fully grasp the extent of the costs generated by automobile accidents and of the scope of the resulting damage. Implementation of the **Integrated Trauma Care System** has led to better quality and more rapid interventions being made following automobile accidents. Under the system, the actions taken by the different links of the care continuum are efficiently coordinated and exercise a direct and positive impact on injury outcome, specifically, on the number of survivors, injury severity and aftereffects of the accident.

The Société establishes its goals on the basis of originality and quality—an approach that is in the best interests of all Québecers, on both personal and economic levels.