Improving Income Assistance and Employment Support for Those with Disabilities

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Ministry of Social Development & Social Innovation

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Executive Summary

The Ministry of Social Development and Social Innovation (MSDSI) is developing potential reforms to its Income Assistance and Employment programs with the objective of helping more of those with self-sufficiency potential to become self-sufficient. That requires accurately identifying those with the potential to be self-sufficient and those whose disability precludes self-sufficiency. It also requires providing effective employment assistance to those needing help to become self-sufficient.

To support this work, MSDSI asked a Panel of three physicians expert in disability assessment and return to work to advise on best practices in disability adjudication and design of an effective employment program for those with disabilities.

Background

To the extent that physicians are relied upon to assess individuals' impairments related to disability benefits and employment programs, it is important that the language used used in the programs be what physicians use in their practice, which in Canada is defined by American Medical Association guides. The most important medical concepts identified by the Panel include:

- Work itself is therapeutic. From a psycho-social and medical perspective, there is a strong justification for supporting safe and appropriate employment for all those with the potential to achieve self-sufficiency;
- "Impairment" and "disability." Impairment is an actual physical/psychological loss, which can be assessed by a physician, more or less objectively. Disability relates to how that loss impacts an individual's ability to carry out a particular task or participate in a particular activity, which is a more subjective question. One would not state a person is "disabled" generally, but instead would indicate that a person is disabled with respect to a given task or role because of their medical condition. A physician or other health care professional can provide information about the impact of impairment on ability related to tasks or roles, but disability is ultimately determined by an adjudicator, not the physician.
- "Maximum Medical Improvement (MMI)." Whether a person's medical condition is temporary or permanent is important in disability assessment. The MMI concept relates to permanence by asking whether the person's condition is as good as it is likely going to get. If a person has not yet reached MMI, their level of permanent impairment and associated disability cannot be assessed.
- Objective medical evidence. It is important that findings of impairment by physicians be supported by objective medical evidence to the extent possible. Many common disability conditions are subjectively self-reported, including some physical conditions and many psychological conditions. Physical examination, and use of validated psychological testing and mental status examinations can provide important objective support for self-reported conditions. The Panel believes it is crucial that physicians be required to provide objective evidence of impairment to the extent practicable.

Structure

The current Income Assistance program has three categories:

- Expected to Work (ETW), which provides temporary assistance with employment obligations to impoverished people; [1]
- Persons with Persistent Multiple Barriers (PPMB), which provides temporary assistance at a slightly higher rate than ETW, without employment obligations, to impoverished people with significant impairments (but does not include addictions) who have been on income assistance for 12 to 15 months; and
- Persons with Disabilities (PWD), which provides long-term financial assistance at a somewhat higher rate than PPMB, effectively without employment obligations, to impoverished people with permanent severe disabilities;

All those with employment obligations have access to employment programs to assist in finding work, with the type and intensity of service available depending on a work-ready assessment conducted by the program.

The Panel finds that the most problematic part of the current structure in terms of encouraging self-sufficiency is the PPMB category, which effectively parks many of the people with moderate disabilities who might be able to return to work, but has no employment obligations. The category also omits an important segment of the target population by excluding those with addictions.

The Panel recommends changing the structure as follows to assist those with moderate disabilities to gain employment:

- Phase out the PPMB category by not accepting any new applications and allowing the category to disappear by attrition, with regular file reviews being continued to ensure continued eligibility;
- Create a sub-group within ETW called ETW Medical Condition (ETW-MC), subsuming a smaller existing sub-category by the same name, for those with temporary severe disability or permanent moderate disability which would:
    - have eligibility determined by adjudication;
    - receive medical supplements currently provided to PWD and PPMB clients; and
    - have employment plans appropriate to each person's situation. For example, those with temporary severe disabilities would not need to look for work until they have sufficiently recovered.
- Create an employment support program, known as Assisted to Work (ATW) specifically for those with disabilities who have the potential to work. This group would receive an ATW supplement equal to the current premium paid to PPMB clients to offset some of the costs of participating in the ATW program and seeking employment.

Eligibility Criteria

A key element of the task is to accurately distinguish between those who are so disabled that they have little or no self-sufficiency potential and those who, with support and accommodation, have reasonable potential. To do this, the Panel has suggested disability thresholds that should apply to PWD and the new ETW-MC category, depending on the severity and duration of the impairment and disability.

Recognizing that MSDSI is unlikely to able to change the PWD disability threshold in the near term, the Panel proposes that the disability threshold for PWD should eventually be changed to

[1] As determined by income and asset tests.

be: “The person has reached MMI and has severe impairment that directly and significantly affects the person's ability to perform daily living activities.” Severe and moderate impairment have been defined in detail by the Panel.

The corresponding disability threshold for ETW-MC is: “The person has not reached MMI and has severe impairment that makes them unable to look for employment or participate in employment, or the person has reached MMI and has moderate impairment that imposes barriers to looking for or participating in employment.” This covers those unable to work who may recover and those with stable conditions that should leave them with self-sufficiency potential.

The disability threshold proposed for ATW is the same as part of the ETW-MC threshold: “The person has reached MMI and has moderate impairment that imposes barriers to looking for or participating in employment.” In addition, it is proposed that only those who have sufficient retained ability to undertake at least one example entry level job for at least 18 hours per week qualify for ATW, so that the ATW resources are focussed on those who could reasonably achieve self-sufficiency.

Adjudication

The Panel believes that by making a few changes to the current adjudication process for PWD, the process can be made more timely and reduce errors in adjudication. The changes proposed are:

- **Triage** – Introduce a triage approach under which applications are assigned to adjudicators based on experience and training.
- **Full Initial Adjudication** – Where the application is incomplete or unclear, seek further information during the initial application process.
- **Equivalent Assessments** – Accept disability designations from equivalent disability assessment processes without requiring any further evidence in most cases.
- **Presumptive Diagnoses** – Where a person has been diagnosed with a condition that generally means that the person does or will soon meet the PWD disability threshold require less information and adjudicative effort.
- **Medical Advice** – Make medical advice available to all levels of the adjudication process.
- **Qualifications and Training of Decision-Makers** – Ensure that MSDSI decision-makers have the necessary knowledge, skills and abilities gained from education, training and experience.
- **Quality Assurance** – Introduce a quality assurance process focussed on continuous improvement of adjudication practice.

The Panel also recommends that the application form be redesigned to simplify and clarify the form, use diagnosis classifications used by the Medical Services Plan and adopt a recognized questionnaire about ability to perform activities of daily living produced by the World Health Organization. A draft replacement application form is included as Appendix D to the report.

ATW Employment Program

The Panel recommends that the ATW Employment Program be a vocational rehabilitation program, modelled on the type of case-managed return to work program used in workers' compensation and by employers, often through insured disability benefits programs.

The first step of the program would be to assess employability and needed accommodations. It is important that, at this point, there be close integration between the ETW-MC adjudication and the ATW case management processes. Case management should be a collaborative process of assessment, planning, facilitation, care coordination, and evaluation of options with the client.

The second step is to identify and work with potential employers. It will be crucial for the ATW employment program to develop relationships with a wide group of corporate employers who are interested and engaged.

The third step would be to pull together a potential job with a package of accommodations that could include job description adjustments, assistive technology and devices, physical workplace adjustments, accommodations to enable the person to get to and from work and, where necessary, post-employment supports that could range from continued access to medical supplements to time limited wage subsidies.

For applicants who are not job ready due to common mental health disorders such as depression, anxiety and adjustment disorders, the Panel proposes that the Ministry make available evidence-based psychotherapy modalities that have been scientifically shown to be effective in a work-based context. The only example of such a therapy known to the Panel after a thorough search is "Work-focussed Cognitive Behavior Therapy" (W-CBT).

Conclusion

The Panel has been asked for its expert advice on implementing best practices in disability assessment and on how to design employment supports that will enable more Ministry clients with disabilities to achieve self-sufficiency. The Panel's recommendations would make significant improvements to the current income assistance/employment program ecosystem, benefitting many MSDSI clients by improving the timeliness and accuracy of PWD adjudication, providing those with severe but temporary impairments with better access to medical benefits and providing a path for those with the potential for self-sufficiency to achieve that potential.

List of Recommendations

The Panel recommends:

1. The PPMB income assistance category be phased-out through attrition, possibly accelerated by providing an incentive for those currently in the category to leave the category.

2. The ETW-MC sub-category be changed by setting a specific disability threshold and providing access to medical benefits similar to those accessible by PPMB clients.

3. A specific ATW employment program be established to assist those with permanent moderate disabilities by providing support to overcome barriers to achieving self-sufficiency, including an additional monthly payment equal to increase in income assistance benefits received by PPMB clients.

4. The disability threshold to be eligible for ETW-MC should be:
    a. The person has not reached MMI and has severe impairment that makes them unable to look for employment or participate in employment; or
    b. The person has reached MMI and has moderate impairment that imposes barriers to looking for or participating in employment.

5. The disability threshold to be eligible for the ATW employment program should be:
    a. the person has reached MMI and has moderate impairment that imposes barriers on looking for or participating in employment; and
    b. the person has retained abilities that would enable them to meet the job requirements of at least one example low ability level job for at least 18 hours per week with reasonable accommodations.

6. When the Ministry is able, the disability threshold to qualify for PWD should be changed to be that the person has reached MMI (instead of the current two year expected duration) and has severe impairment, as defined below. That is, for example, “The person has reached MMI and has severe impairment that directly and significantly affects the person's ability to perform daily living activities.”

7. For the purposes of ETW-MC and ATW eligibility, “moderate impairment” should be defined as physical or mental impairment consistent with at least one of the following:
    a. Constant mild physical findings despite continuous treatment or intermittent moderate physical findings; or
    b. Pain and symptoms with normal activity. Able to perform self-care activities with modification but unassisted; or
    c. Moderate difficulty which restricts or interferes with day-to-day activities some but not a majority of the time.

8. For the purposes of ETW-MC and PWD, “severe impairment” should be defined as physical or mental impairment consistent with at least one of the following:
    a. Constant moderate physical findings, despite continuous treatment or intermittent severe findings; or
    b. Pain or symptoms with less than normal (minimal) activities and/or requires assistance to perform self-care activities; or

c. Severe difficulty which frequently restricts or interferes with day-to-day activities.

9. Triage be introduced into the adjudication process, including initial processing that identifies incomplete applications and immediately seeks the missing information.

10. Initial adjudications include asking for additional information if the information is not sufficiently complete or clear to make a decision.

11. Health care professionals be paid for providing additional information if requested.

12. Equivalent assessments, including Canada Pension Plan Disability, Disability Tax Credit, CLBC, Ministry of Health Palliative Care Program, and Ministry of Children and Family At Home Medical Benefits Program be accepted as evidence of severe impairment for the purpose of PWD (automatic ins).

13. A presumptive diagnosis list based on the SSA Compassionate Allowances list and the CPP Disability list be used to fast-track the assessment of impairment required for those whose medical condition matches the details of the presumptive diagnosis. Evidence supporting the diagnosis may be required by adjudicators as needed.

14. Medical advice should be made available to adjudicators at all levels, including the appeal system.

15. Adjudicators should have the knowledge, skills, abilities, training and qualifications needed to accurately adjudicate eligibility, including the ability to interpret medical evidence supplied in applications and supporting documents. That should include senior adjudicators with appropriate training and experience, such as NIDMAR qualifications or being a member of an appropriate health profession, such as nursing (especially occupational health nursing), physiotherapy and occupational therapy.

16. A quality assurance function should be added to enable continuous improvement in the organization.

17. The application and adjudication processes for ATW and PWD should be integrated to the extent possible and people should not be required to provide the same information twice.

18. The application forms be redesigned to be consistent with the proposed process, use terminology consistent with AMA definitions, give a better voice to applicants.

19. In the Physician Report, the WHODAS 12 version and additional page (as above) would replace both the Functional Skills section on Page 11 and the ADLs questions on Page 12.

20. In the Assessor Report, the WHODAS 36 version plus the additional page, would replace Section B in entirety, which is mental and physical impairment and Section C in entirety, which is ADLs.

21. Medical practitioners filling out application forms should be asked to provide medical evidence, including where possible objective findings to support their assessment.

22. Adjudication for the purposes of PWD, ETW–MC and ATW should all be undertaken by the same group of decision-makers following the same triaged administrative model to determine whether the disability eligibility criteria is met for each designation.

23. Determination of whether an ATW applicant meets the eligibility requirement of having retained abilities consistent with at least one standard job description should be the first step in the ATW employment program process.

24. The ATW employment program should be a vocational rehabilitation program modelled on the vocational rehabilitation approach used in workers' compensation and employee disability benefit programs.

25. The key to an effective program is good case management coupled with good working relationships with specific corporate employers who are willing to invest in employees with disabilities and to participate in making needed accommodations work.

26. For applicants who are not job ready due to common mental health disorders such as depression, anxiety and adjustment disorder, medical supplements should include access to W-CBT (6 to 10 sessions) provided by a trained health professional, perhaps under contract to the Ministry as part of a pool of qualified service providers.

27. Where thoroughly justified as the only alternative available to attach an ATW person to the labour force, funded vocational training should be considered.

Purpose

The Ministry of Social Development and Social Innovation (MSDSI) is developing potential reforms to its Income Assistance and Employment programs to improve services provided to and outcomes for those who have moderate and severe disabilities.

The policy objective of the Ministry is to ensure that all those with the potential to be self-sufficient have the opportunity to be self-sufficient and that those who require ongoing financial support due to the severity of their disability receive that support. That requires accurately identifying those with the potential to be self-sufficient and providing them with the support needed for them to reach their potential and accurately identifying those in need of long-term financial support.

Among the reforms being considered are changes to the structure of Income Assistance categories and criteria, changes to adjudication processes and changes to employment programs. The goals are to increase the efficiency and accuracy of adjudication and to increase labour force attachment for those with disabilities.

In June 2015, MSDSI commissioned a Panel comprised of three physicians with expert knowledge of disability assessment to advise the Ministry. In particular, the Panel was asked:

1. What are the best practices in terms of application and adjudication processes to accurately and efficiently adjudicate claims for disability assistance under the current definition of persons with disabilities?
2. How best should the ministry design a program to assist those with disabilities to gain financial self-sufficiency through employment (Assisted to Work), including defining the group of persons who would most likely benefit from such a program and designing an employment support program that would provide the accommodations needed for these individuals to be successful?

Background – Relevant Medical Concepts

The Panel has been asked to provide medical expertise to advise the MSDSI about the questions posed above. That is because medical practitioners are given a key assessment role in disability assistance adjudication and play a key role in disability management related to return to work and benefits administration in other contexts such as insured employee benefit programs and workers' compensation systems.

Benefits of Work

To the extent that an Income Assistance client's medical condition acts as a barrier to employment, overcoming that barrier has many advantages for the client, society and the government. Society will be better off because of the increased labour force. Government will be fiscally better with a person contributing to government revenue rather than receiving benefits. Clients who are self-sufficient will of course be financially better off. However, from a medical perspective, the evidence shows that work also has significant health and social benefits and, in many cases work will itself be therapeutic, improving their medical condition.

A 2006 review of the evidence related to the medical effects of work and worklessness commissioned by the UK government concluded:[2]

> There is a strong evidence base showing that work is generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. The provisos are that account must be taken of the nature and quality of work and its social context; jobs should be safe and accommodating. Overall, the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of long-term unemployment or prolonged sickness absence. Work is generally good for health and well-being.

Waddell and Burton found that worklessness is strongly associated with poor health, largely because worklessness itself causes poor health. That includes higher mortality, poorer general health, poorer mental health and greater use of the health care system. They also specifically addressed the effect of work on people with medical conditions:[3]

> **Work for sick and disabled people**: There is a broad consensus across multiple disciplines, disability groups, employers, unions, insurers and all political parties, based on extensive clinical experience and on principles of fairness and social justice. When their health condition permits, sick and disabled people (particularly those with 'common health problems') should be encouraged and supported to remain in or to (re)-enter work as soon as possible because it:
>
> - is therapeutic;
> - helps to promote recovery and rehabilitation;
> - leads to better health outcomes;
> - minimises the harmful physical, mental and social effects of long-term sickness absence;
> - reduces the risk of long-term incapacity;
> - promotes full participation in society, independence and human rights;
> - reduces poverty;
> - improves quality of life and well-being.

Another example from the literature is the following list of the potential psychological benefits of work:[4]

1. Income and sense of security
2. Source of identity
3. Sense of purpose in life
4. Source of self-worth and self-esteem
5. Opportunity to develop skills and creativity
6. Autonomy and independence
7. Relationships outside the family
8. Structure

[2] Waddell, Gordon and Kim Burton, Is Work Good for Your Health and Well-Being?, TSO (The Stationary Office); 2006; pg. ix
[3] Ibid, pg. viii
[4] Gold LH & Shuman DW. Evaluating Mental Health Disability in the Workplace – Model, Process, and Analysis. Springer, New York, 2009 [p.45-48]

9. Defines leisure time and activities.

From a psycho-social and medical perspective, there is a strong justification for supporting safe and appropriate employment for all those with the potential to achieve self-sufficiency.

Definitions

A fundamental principle that the Panel feels is crucial is: To the extent that physicians are relied upon to assess individuals' impairments related to disability benefits and employment programs, it is important that the language, terminology and diagnostic classifications used in application forms and in defining thresholds for providing benefits or access to programs, be consistent and be the language, terminology and diagnostic classifications that physicians use in their practice.

Specific advice about language, terminology and other aspects of application forms is provided below, but this section provides background by setting out basic definitions used by the medical community that underlie medical assessments.

In both Canada and the United States, the source for official medical guidance related to medical impairment is the American Medical Association (*AMA) Guides to the Evaluation of Permanent Impairment, 6th edition, 2008.*[5]

First, the definition of disability and impairment. If you look up dictionary definitions of impairment and disability, you will see a lot more consistency in the meaning of impairment and a wide scope of meanings given to disability.

The basic concept is that impairment is the actual physical/psychological loss which will will be the same for anyone who suffers that loss, which in principle can be objectively measured. However, disability relates to how that loss impacts an individual's ability to carry out a particular task or participate in a particular activity, which is a more subjective question.

Therefore, one would not state a person is "disabled" generally, but instead would indicate that a person is disabled with respect to a given task or role.

The example often used in teaching to look at impairment and disability is that of a pianist who loses a finger on his hand as compared to a psychiatrist or office worker. They all have the same impairment, but the pianist may be disabled from work since using all ten digits is a critical job demand, while the office worker/psychiatrist will not be disabled from work since the critical job demands do not require all ten digits.

> **Impairment:** According to the AMA, impairment means "a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder, or disease." By way of comparison, the World Health Organization defines impairment as "any loss or abnormality of psychological, physiological or anatomical structure or function."[6]
>
> **Disability:** The AMA defines disability as "activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease." The World

[5] Rondinelli RD, Genovese E, Brigham CR, eds. Guides to the Evaluation of Permanent Impairment. 6th ed. Chicago, Ill: American Medical Association; 2008.
[6] International Classification of Impairments, Disabilities, and Handicaps. Geneva, Switzerland: World Health Organization; 1980.

> Health Organization definition is "activity limitation that creates a difficulty in the performance, accomplishment, or completion of an activity in the manner or within the range considered normal for a human being."

Beyond this, the AMA looks at how to think about ability related to a task using the terminology of Risk, Capacity and Tolerance, discussed in a related AMA publication.[7]

> **Risk:** The AMA definition of risk "refers to the chance of harm to the patient, co-workers or the general public, if the patient engages in specific work activities." These are activities you won't allow your patient to perform even if they beg you to, due to the risk of medical harm. There may also be regulatory standards that are required to be followed (e.g. in the transportation industry to drive, perform marine occupations or fly aircraft). Example is a patient with uncontrolled seizures is not allowed to drive due to risk. These are things individuals may or may not be able to actually do, but should not do…a physician prescription/proscription against a certain activity.
>
> **Capacity:** According to the AMA, capacity "refers to concepts such as strength, flexibility and endurance. These are measureable with a fair degree of scientific precision." These are objectively described. For example, a person with a frozen shoulder is unable to elevate it to perform overhead tasks. This becomes a physician/health care provider description of objective data that informs whether a patient can carry out an activity. Note that current ability may be less than potential capacity. Physicians are typically asked to comment on current ability and may be asked for a prognosis.
>
> **Tolerance:** The AMA Guides indicate "Tolerance is a psychophysiologic concept. It is the ability to tolerate sustained work or activity at a given level. Symptoms such as pain and/or fatigue are what limit the ability to do the tasks in question. The patient may have the ability to do a certain task…but not the ability to do it comfortably. Tolerance is not scientifically measurable of verifiable. Tolerance is frequently less than either capacity or current ability." Thus, tolerance is patient described and it depends on the context. Patients may show tolerance for symptoms in some circumstances, but not others. For example, in an episode of 'Survivor' contestants had to stand on a wood pole-column in the middle of a lake on a terribly hot and sunny day. The person who could tolerate the heat and discomfort best had a better chance at a substantial prize. Given this context, a lot of contestants tolerated the terrible conditions a lot longer than they might have if they were just asked to do it for no specific reason.

While the AMA uses the concepts of risk, capacity and tolerance to describe disability, often disability is described in terms of limitations and restrictions on activities imposed by impairment. The terms limitation and restriction are sometimes used interchangeably but actually have different meanings:

> **"Limitation"** means something a person cannot do as a result of injury or illness; and
>
> **"Restriction"** means something a person should not do as it may delay recovery, cause injury or illness to recur, or endanger that person or others.

[7] Talmage, Melhorn, Hyman, AMA Guides to the Evaluation of Work Ability and Return to Work, 2nd ed. Chicago, Ill: American Medical Association; 2011.

Another important concept is Maximum Medical Improvement (MMI). This concept addresses the potential for a person to improve from their current medical state. When impairment is being assessed for disability purposes, it is important to know whether or not a person's condition is likely to improve or remain stable/deteriorate over time.

The Panel recommends the following definition for MMI, based closely upon the definition used by the AMA and by WorkSafe BC:

> **"Maximum Medical Improvement"** means a status where the person is as good as they are going to get from the health and program care available to them. From this point, although the person's condition may show some change, the underlying course is mostly at a stable plateau with fluctuation or ongoing deterioration is anticipated. Ongoing treatment may be required to maintain this plateau state. Where it is uncertain if the individual is "as good as they are going to get", MMI will be considered reached if over the upcoming one year, one cannot anticipate an alteration in impairment that would result in significant improvement in retained abilities allowing a meaningful change in participation in the workforce.

It is important in assessing impairment to be able to distinguish between levels of severity. The Panel is proposing the following definitions to distinguish between severe and moderate levels of impairment:

"Moderate impairment" means physical or mental impairment consistent with at least one of the following:

a. Constant mild physical findings despite continuous treatment or intermittent moderate physical findings; or
b. Pain and symptoms with normal activity. Able to perform self-care activities with modification but unassisted; or
c. Moderate difficulty which limits or interferes with day-to-day activities some but not a majority of the time.

"Severe impairment" means physical or mental impairment consistent with at least one of the following:

a. Constant moderate physical findings, despite continuous treatment or intermittent severe findings; or
b. Pain or symptoms with less than normal (minimal) activities and/or requires assistance to perform self-care activities; or
c. Severe difficulty which frequently limits or interferes with day-to-day activities.

Another important concept is **Objective Medical Evidence.** As suggested above, it is often the case that medical evidence of impairment is objective and supported by examination findings, medical imaging, laboratory tests or other objective evidence, but that the implications for those impairments for the ability to perform specific tasks or participate in specific activities is generally subjective. In some cases, especially in a mental health context, both the medical evidence and effect of impairment on the ability to perform tasks or participate in activities are subject, based on subjective applicant self-reports coupled with clinical observation.

The Panel feels it is important that medical evidence of impairment should be as objective as possible and be supported and evidenced by appropriate tests, records of which should accompany applications. The following is Panel's advice about objective medical evidence, which will be referred to below:

- In order to allow for a reasonable level of rigour in adjudication of disability applications, documentation (by the assessing physician) of impairment level and diagnosis(-es) should be based, at least in part, on objective findings.
- Some conditions that are frequently associated with impairment or disability are not consistently based on objective diagnostic protocols, and are reliant on self-reported information. The diagnosis of such a condition may be primarily based upon the subjective self-reported complaints of the examinee and the subjective (clinical) impressions of the clinician or diagnostician. This is the case for most psychiatric disorders.
- Testing (psychological or other) is often dependent on cooperation from the person undergoing the examination (i.e. the examinee). A lack of cooperation may adversely impact the outcome.
- Examples of findings that would be considered objective findings, as present on clinical examination or in the medical records, include (only three examples are offered among a broad range):
    - For musculo-skeletal impairment, acceptable medical signs include[8]:
        - Loss of power;
        - Loss of range of motion;
        - Evidence of atrophy, and
        - Neurological deficits.
    - For mental disorders: Psychological testing (e.g. MMPI-II, MCMI, PAI, etc.) tools that have been scientifically validated introduce some degree of objectivity into what is otherwise deemed a completely subjective process. The only reliable source of objective findings for mental illnesses is relevant, scientifically validated psychological testing. For the purpose of objective findings, psychological testing should be required wherever possible, even though this only addresses fewer than 10% of the listed DSM-5 diagnoses[9].
    - A Mental Status Examination that documents the presence of delusions, hallucinations, paranoia, confusion, anxiety, phobias, depressed mood, manic symptoms, withdrawal or intoxication, abnormal behavior, or other positive findings is a proxy for objective testing.
- Where a clinical examination by a physician or medical records does not provide sufficient objective evidence, self-reported information should be augmented with further information for the determination of eligibility for benefits or program access. This should include all tests (including psychological tests), reports, and observations from medical records and collateral sources specifically outlining the presence and frequency of symptoms.

[8] Crawford JO. The Nordic Musculoskeletal Questionnaire. Occupational Medicine 2007

[9] Melhorn MJ, Talmage JB, Ackerman WE, Hyman MH. The American Medical Association Guide to the Evaluation of Disease and Injury Causation, 2nd Edition. 2013.

Structure of Income Assistance and Employment Programs

Current Structure

INCOME ASSISTANCE

The following is a high level description of the current situation that describes only the main features of the current income assistance/employment program ecosystem that would be affected by the changes being recommended by the Panel.

First, it is important to note that the questions posed by MSDSI apply only to Income Assistance clients. Income Assistance is the last resort social safety net, accessible only by those who are impoverished because they do not have the income and assets to be self-sufficient. Some Income Assistance clients have impairments that make getting a job or working difficult or impossible and it is these clients that are the subject of this document. There are also many people with functional impairments that make working or getting a job a challenge who are self-sufficient and therefore do not qualify for Income Assistance. These people may receive income from sources such as employment insurance benefits, workers' compensation benefits, disability benefits under the Canada Pension Plan, benefits under an employee benefit program and other similar sources, as well as private means. In some cases these people may also benefit from return to work efforts associated with previous employment. However, this report is directed only at those who meet the needs tests to be eligible for Income Assistance.

There are three Income Assistance categories in BC, as described in the chart below:

- Expected to Work (ETW) is, in principle, temporary income assistance for impoverished persons who have the ability to work and become self-sufficient while they seek employment. The level of benefits is relatively low and the level of healthcare benefits is basic, reflecting the temporary nature of the support;
- Persons with Disabilities (PWD) is, in principle, long term income assistance for those who are not able to become self-sufficient. The level of benefits is relatively higher and health care and other supplements are more comprehensive reflecting both the long-term nature of the support and the higher costs associated with long term severe impairment; and
- Persons with Persistent Multiple Barriers (PPMB) is an intermediate category that applies to people with certain impairments (additions excluded) who have not achieved self-sufficiency for 12 to 15 months and will likely remain impaired for at least two years. Benefits are slightly higher than ETW, medical benefits are consistent with PWD and unlike PWD, PPMB is subject to regular reviews so it is a temporary assistance category.

PROGRAM	Work Obligation	Impairment Threshold	Monthly Benefit (Single)	Health Benefits	Review
ETW	Yes, with minor exceptions, managed through Employment Plan	None	$610	Full MSP and PharmaCare plus emergency dental	Yes, monthly reporting
ETW – MC	Yes, but Employment Plan may provide temporary relief	Temporary medical condition preventing employment[10]	$610	Full MSP and PharmaCare plus emergency dental	Yes, monthly reporting and review of MC as required by administrative officials
PPMB	None	Year + waiting period; Multiple barriers; Medical condition (except addiction) for 1 year, likely to last 2 more years, seriously impeding or precluding employment	$658	ETW health benefits plus health supplements cover most disability-related medical expenses	At least every 2 years
PWD	None	A severe impairment of daily living activities that, in a medical doctor's opinion, will likely continue for at least two or more years[11]	$906	ETW health benefits plus health supplements cover most disability-related medical expenses	None

The chart also describes a sub-category of ETW, ETW – Medical Condition (ETW–MC) under which people with temporary medical conditions can have an Employment Plan that provides them with accommodations and/or temporary relief from employment obligations to help them cope with their medical condition. There are also some ETW clients with no employment obligations for a certain period of time to enable them to deal with specific circumstances. The ETW–MC category has been included because it is part of the Income Assistance structure designed to help those with medical conditions that affect their ability to work or get work.

[10] Temporary medical, drug and alcohol or mental health condition that interferes to the extent of obstructing, impeding or preventing their ability to participate in employment, including part-time work

[11] The current legislation says "A severe mental or physical impairment that, in a medical doctor's opinion, will likely continue for at least two or more years. Impairment directly and significantly restricts the person's ability to perform DLA's and, as a result, the person requires assistance." This differs from the recommended definition of MMI.

There are conceptually two dimensions to the way the Income Assistance deals with impairment: duration (temporary or permanent); and severity. However, the current system is not fully consistent in the way it deals with these two dimensions of impairment. ETW is conceptually for those at the low end of the severity continuum and/or the duration continuum. PWD is for those at the severe/permanent ends of the two continuums.

However, the PPMB category seems logically out of place as it does not clearly identify a group between those two extremes and provide that group, which in principle should have considerable potential for self-sufficiency, with a path to self-sufficiency as there is no employment obligation. Many of the issues with the PPMB category have been pointed out by the Ombudsman.[12] They include many going on PPMB as a stepping-stone to PWD if they do not immediately qualify. This has led MSDSI to seek an alternative approach to those who have impairments that are not severe and permanent enough to qualify for long term income assistance but nonetheless require additional support to achieve self-sufficiency.

Employment Programs

The Employment Program of BC (EPBC) delivers an integrated system of employment services and supports to all British Columbians who are seeking employment and are legally eligible to work in British Columbia. The purpose of the EPBC is to support clients in achieving and sustaining employment as quickly as possible. Employment services are delivered at WorkBC Centres across the province. MSDSI clients may be referred to WorkBC sites or they may self-refer. WorkBC Centres assess a client's employment readiness and categorize them in one of four client tiers:

- Client Tier 1 – high Employment Readiness (job ready, but needing only specific, limited job search or job start services and/or Financial Supports available to Clients in Tier 1 to achieve Labour Market Attachment);
- Client Tier 2 – moderate Employment Readiness (near job ready, but needing comprehensive Case Management to achieve Labour Market Attachment);
- Client Tier 3 – low Employment Readiness (not yet job ready and needing comprehensive Case Management to achieve Labour Market Attachment); and
- Client Tier 4 – little or no Employment Readiness (not yet job ready, may have significant and complex needs and needing comprehensive Case Management to achieve Labour Market Attachment).

A majority of MSDSI clients are assessed in Category 3 or 4, although about 20% of ETW clients with employment obligations are assessed in Category 2. The proportion of clients assessed in Category 1 is insignificant.

The specific program resources offered to MSDSI clients include:

Tier 1

- Self-Serve Resource Area
- Self-Serve Job Search and Employment Focused Workshops (Job Clubs, Resume writing, Interviewing, etc.)
- Group Employment Support Services Topics (Employability Life Skills Topics, Essential Skills Topics, Employment Readiness Topics)

[12] *Last Resort: Improving Fairness and Accountability in British Columbia's Income Assistance Program, Office of the Ombudsman, 2009.*

- Job Start/Job Search Financial Supports (ex. Confirmed Job Supplement – work clothes, boots, bus tickets, etc.)
- Short Term Orientation and Certificate Training (STOC) – with confirmed job offer (ex. Food Safe, Fork lift operator, Truck driver, Serving it Right, etc).

Tier 2 – 4

- Self-Serve Resource Area
- Individualized Case Management
    - Employment Support Services Topics (Employability Life Skills Topics, Essential Skills Topics, Employment Readiness Topics)
    - Short Term Orientation and Certificate Training (STOC)
    - Self-Employment Support (Ministry Clients with PWD or PPMB only)
    - Unpaid Work Experience
    - Job Development Services (normally only Tier 3 and 4 Clients)
    - Customized Employment Development Services (normally only Tier 3 and 4 Clients)
    - Job Creation Partnership Projects (maximum 50% of clients on a project can be BCEA Clients, limited by location and availability of projects)
    - Skills Training for EO Clients (some restrictions apply)
    - Skills Training for PPMB Clients (usually only on a part time basis)
    - Skills Training for PWD Clients (full or part time basis)
    - Specialized Assessments
    - Job Start Financial Supports
    - Job Search Financial Supports
    - Project Based Labour Market Training
    - Wage Subsidy
    - Other Program Participation Supports.

Proposed Structure

Prior to undertaking this project, MSDSI had assumed that the objective of increasing self-sufficiency for those who have the potential to gain self-sufficiency would be achieved through a new Income Assistance category. That category would have, in many ways, been a revision of the PPMB category with changes to:

- eligibility criteria to be recommended by the Panel based on a level of disability;
- impose employment obligations; and
- eligibility for a specific intensive employment support program aimed at those with disabilities.

The concept included grand-parenting existing PPMB clients into the new category.

The Panel's deliberations related to this concept revealed a number of concerns related to:

- a desire to avoid having this new category simply take over from PPMB as a de facto holding category for those who have an impairment but do not qualify for PWD upon initial application but expect to at a future time;
- the belief that any disability threshold for the category should be related to permanent impairment, measured at MMI (as should PWD), which then implies yet another category for people have temporary impairment (i.e. they have not yet reached MMI); and

- the need for a way to identify those who are ready for an employment support program targeted at those with disabilities.

An alternative structural approach that the Panel believes could deal with these concerns would be simply to create the specific intensive employment support program for people who meet eligibility criteria based on their level of impairment. The following are the main elements to the proposed structural approach.

Income assistance would ultimately only have two categories, PWD and ETW.

Within ETW there would be a sub-group, replacing the ETW-MC sub-category that would be eligible for medical supplements, similar to those available to PWD and PPMB. Otherwise this category would be managed under the current ETW program:

- The group would be adjudicated for eligibility. The disability threshold for eligibility is discussed below;
- Available supplements would be consistent with temporary income assistance principles to provide assistance based on need rather than provide everyone with some impairment a higher rate of income assistance benefit;
- People would have employment obligations but their employment plan would be appropriate to their condition, impairment and disabilities related to work.

PPMB would be phased out. Those with a PPMB designation would remain in that category, subject to regular file reviews until the category disappears by attrition, but it would no longer be open to new applications. Consideration could be given to providing incentives for those with a PPMB designation to leave the category, perhaps through access to the employment program in certain cases.

An employment support program for people with impairments would be created, known as Assisted to Work (ATW). The objective would be to provide supports to those who need extra help, whether financial, training, or through accommodations to overcome barriers caused by their impairment and who want to work.

Eligibility for ATW would also be assessed (impairment threshold discussed below). That assessment would start with adjudication for the ETW-MC category, which would assess the level of impairment. Once the disability threshold has been assessed, the next step in determining eligibility for the ATW employment program would be undertaken in the context of preparing an employment plan by an employment program case manager. (See ATW Employment Program below).

The ATW program would provide a financial payment equal to the PPMB premium to offset some of the costs associated with looking for work, along with access to the various supports available through employment programs more generally. By limiting the extra benefit to those participating in the employment program, there would be an incentive to participate in the program.

Eligibility Criteria

One of the Expert Panel's major tasks is to develop eligibility criteria for the proposed ATW program. That is, to identify a population of income assistance clients who have the potential for gaining self-sufficiency through employment but whose difficult path to self-sufficiency due to functional impairment can be made easier through intensive, specialized employment supports, so that more of them achieve their potential than they could with the level of employment support provided to ETW clients who do not have significant barriers to employment imposed by their medical condition.

<table>
<tr><td rowspan="2">High Self Sufficiency Potential
Little Impediment to Work

ETW</td><td>Self Sufficiency Potential
Affected by Impairment</td><td rowspan="2">Little or No Self Sufficiency Potential

PWD</td></tr>
<tr><td>Self Sufficiency Potential
Unknown due to Temporary
Unemployability</td></tr>
</table>

As this graphic shows and the discussion above suggests, not everyone who is between the high potential for self-sufficiency associated with ETW and the low potential associated with PWD would benefit from the type of employment support being considered. Rather the Panel believes that there are two groups of clients that exist between those who are work-ready and need a job (ETW) and those unlikely ever to support themselves (PWD):

- Those who are unable to work because of a medical condition that may or will improve with treatment and therefore whose potential for self-sufficiency and need for employment support cannot yet be fully assessed; and
- The group of income assistance clients who have potential for self-sufficiency but who have functional impairment that makes reaching self-sufficiency more difficult (ATW).

That means that what is required is advice about the appropriate disability threshold for both ETW–MC and for participation in the ATW employment program. In addition, the Panel has been asked for its advice about the appropriate disability threshold for PWD, which may be considered at a later date.

Proposed Disability Thresholds

In the case of PWD, the intention is to accurately determine those who have a permanently low potential for self-sufficiency. In the case of ATW, it is to identify those who will have long-term potential for self-sufficiency but have long-terms barriers resulting from impairment to overcome. Both of these have a sense of permanence to them. Therefore, the Panel has concluded that the threshold for both of these designations should be assessed once MMI, as defined above, has been reached or can be determined.

The difference between the threshold for PWD and for participation in the ATW employment program would be the severity of the impairment and the abilities of the person to do specific tasks, similar to the current threshold for PWD.[13]

The Panel proposes that the disability threshold for PWD should eventually be changed to be: "The person has reached MMI and has severe impairment that directly and significantly affects the person's ability to perform daily living activities." The definition of severe impairment is described in "Background – Relevant Medical Concepts."

The corresponding disability threshold for ETW-MC proposed by the Panel is: "The person has not reached MMI and has severe impairment that makes them unable to look for employment or participate in employment, or the person has reached MMI and has moderate impairment that imposes barriers to looking for or participating in employment." In other words, the person is temporarily severely disabled and unable to work or is permanently moderately disabled with barriers to employment. Those with a temporary severe condition would be reviewed regularly and would be able to apply for another category if they become permanently impaired.

The proposed disability threshold for ATW is the same as the moderate, permanent disability part of the ETW-MC threshold: "The person has reached MMI and has moderate impairment that imposes barriers to looking for or participating in employment." This criteria would be adjudicated just once, with the adjudication for ETW-MC also meeting the disability threshold for ATW purposes. Meeting the permanent, moderate disability threshold would qualify a person for medical supplements and for consideration under the ATW program.

In addition to the disability threshold, it is proposed that the ATW program should also have an eligibility criterion related to their readiness to begin the path to employment. Only those able to take advantage of the ATW employment program should proceed. It is proposed that this criterion be that the person have sufficient retained ability to undertake at least one example entry level job for at least 18 hours per week. This requires that MSDSI develop a set of example, real-world job descriptions that have low job requirements. The set of jobs would include jobs that could be suitable for people with many different kinds of physical and mental disability.

The 18 hour per week minimum duration is based on the number of hours employment at minimum wage required before the person is better off working than being on income assistance and thus becomes minimally self-sufficient. This is an eligibility criterion to ensure that the person is at least physically and mentally able to do some part-time job, and in no way limits the job that person might be able to find.

Adherence to Treatment Plan

Since the MMI concept includes continued treatment where medically indicated, adherence to a reasonable, evidence based treatment plan is an important consideration. For those who have not reached MMI, reaching the highest level of improvement possible will depend on how well they adhere to recommended treatment. It is up to the patient and their medical team to determine what the best course of treatment is for them taking all of the benefits, risks and treatment options into account. However, having determined a reasonable, evidence-based treatment plan, it is the responsibility of the patient to adhere to that plan. The same often

[13] The current legislation says "A severe mental or physical impairment that, in a medical doctor's opinion, will likely continue for at least two or more years. Impairment directly and significantly restricts the person's ability to perform DLA's and, as a result, the person requires assistance." This differs from the recommended definition of MMI.

applies to people who have reached MMI and must continue medical treatment or rehabilitation of some kind to maintain that level or minimize deterioration.

The Panel suggests that anyone in the ETW-MC sub-category should be required, as a condition of eligibility, to adhere to a reasonable evidence-based treatment plan if one applies, whether the treatment plan is intended to bring a person to MMI or maintain them at MMI.

Recommendations – Program Structure and Eligibility

The Panel recommends:

1. The PPMB income assistance category be phased-out through attrition, possibly accelerated by providing an incentive for those currently in the category to leave the category.

2. The ETW-MC sub-category be changed by setting a specific disability threshold and providing access to medical benefits similar to those accessible by PPMB clients.

3. A specific ATW employment program be established to assist those with permanent moderate disabilities by providing support to overcome barriers to achieving self-sufficiency, including an additional monthly payment equal to increase in income assistance benefits received by PPMB clients.

4. The disability threshold to be eligible for ETW-MC should be:
    a. The person has not reached MMI and has severe impairment that makes them unable to look for employment or participate in employment; or
    b. The person has reached MMI and has moderate impairment that imposes barriers to looking for or participating in employment.

5. The disability threshold to be eligible for the ATW employment program should be:
    a. the person has reached MMI and has moderate impairment that imposes barriers on looking for or participating in employment; and
    b. the person has retained abilities that would enable them to meet the job requirements of at least one example low ability level job for at least 18 hours per week with reasonable accommodations.

6. When the Ministry is able, the disability threshold to qualify for PWD should be changed to be that the person has reached MMI (instead of the current two year expected duration) and has severe impairment, as defined below. That is, for example, “The person has reached MMI and has severe impairment that directly and significantly affects the person's ability to perform daily living activities.”

7. For the purposes of ETW-MC and ATW eligibility, “moderate impairment” should be defined as physical or mental impairment consistent with at least one of the following:
    a. Constant mild physical findings despite continuous treatment or intermittent moderate physical findings; or
    b. Pain and symptoms with normal activity. Able to perform self-care activities with modification but unassisted; or
    c. Moderate difficulty which restricts or interferes with day-to-day activities some but not a majority of the time.

8. For the purposes of ETW-MC and PWD, “severe impairment” should be defined as physical or mental impairment consistent with at least one of the following:
    a. Constant moderate physical findings, despite continuous treatment or intermittent severe findings; or
    d. Pain or symptoms with less than normal (minimal) activities and/or requires assistance to perform self-care activities; or
    e. Severe difficulty which frequently restricts or interferes with day-to-day activities.

Adjudication Process and Application Forms

PWD Adjudication Process

The adjudication process for PWD has been the subject of reports by the Ombudsperson and the Auditor General, both of whom found that the timeliness and accuracy of the process needs improvement. The process has been criticized for both not approving applicants who qualify and for approving applicants who do not qualify.

The basic process is:

- Every application received gets identical treatment, regardless of the nature of the applicant’s condition and situation;
- MSDSI decision-makers generally do not have previous disability assessment training or membership in a relevant health profession;
- The initial application is generally reviewed based solely on the information provided on the application form, without any additional information or clarification being sought, although there is no legal impediment to seeking further information;
- Written reasons are provided for every decision, including if the decision is negative, the specific reasons why;
- If the initial application is turned down, the applicant may request a reconsideration and may provide additional information;
- Upon reconsideration, the adjudicators generally seek additional information or clarification if there is any deficiency or lack of clarity in the application;
- If the application is turned down upon reconsideration, there is the opportunity to appeal to an independent tribunal; and
- There is no expert advice available to adjudicators at any of the three levels of adjudication (initial application, reconsideration and appeal).

The Panel believes that by making a few adjustments to the process the accuracy and timeliness of adjudication can be improved significantly. The main changes the Panel suggests are:

- **Triage** – Introduce a triage approach under which applications are first quickly reviewed to determine how simple or complex the adjudication is likely to be and assign the applications to adjudicators based on experience and training.
- **Full Initial Adjudication** – Where the application is incomplete or unclear, seek further information during the initial application process to ensure the required information is available to make a comprehensive assessment and to prevent people who are eligible but whose initial application was incomplete from dropping out of the process because they are unable or unwilling to apply for reconsideration.

- **Equivalent Assessments** – Identify other disability assessment processes where the disability threshold criteria are equivalent or more restrictive and accept disability designations from those processes without requiring any further evidence.
- **Presumptive Diagnoses** – Where a person has been diagnosed with a condition that generally means that the person does or will soon meet the PWD disability threshold, require less information about impairment related to daily living activities and focus on the medical condition itself instead.
- **Medical Advice** – Make medical advice available to all levels of the adjudication process.
- **Qualifications and Training of Decision-Makers** – Ensure that MSDSI decision-makers have the necessary knowledge, skills and abilities gained from education, training and experience and are assigned to the types of cases most appropriate given their background.
- **Quality Assurance** – Introduce a quality assurance process focussed on continuous improvement of adjudication practice.

TRIAGE

Introducing a triage approach will help to improve both accuracy and timeliness. When combined with acceptance of equivalent assessments and presumptive diagnoses, it will enable many applications to be dealt with quickly and accurately. The remaining applications can then be assigned to adjudicators based on the likely complexity in making a decision and the amount of additional information that is likely to be required. By assigning applications to the people best suited, based on experience and training, that should also enhance the timeliness and accuracy of adjudication of those cases which are relatively difficult to decide.

A triage approach would include:

- Initial Processing:
  - Review of eligibility
  - Review of applicant information (name, identification information, other)
  - Review that required information and documentation provided (if not, require applicant to provide before application can be processed)
  - Assignment to adjudicator (when application complete) based on nature of the application.
- Adjudication Review based on triaged workflow:
  - “low intervention” (straightforward cases with one physical condition leading to easily determined level of impairment and impact on abilities impairment or fast-tracked cases based on presumptive diagnoses) assigned to “first level” adjudicators;
  - “high intervention” (complex cases, co-morbid conditions, mental health conditions, unclear or conflicting information) being assigned to “senior/complex case” adjudicators, with certain kinds of cases (e.g. mental health and addiction) assigned to adjudicators who specialize in specific complex sets of medical conditions.

FULL INITIAL ADJUDICATION

When combined with triage so that incomplete applications are identified at initial processing and fast-tracked cases are identified early and assigned appropriately, encouraging adjudicators to seek additional information when necessary is expected to have a beneficial result in terms of

efficiency and effectiveness.[14] While some initial adjudications will take longer as additional information is sought, the overall time to complete adjudications where additional information is required should be reduced because fewer will need to apply for reconsideration. This will also reduce the number of abandoned applications that would ultimately have been successful if full information had been provided.

A shortfall of the current system is the inability to pay health care professionals for providing additional information. That is an oversight that the Panel feels needs to be addressed in the name of timeliness and accuracy.

Equivalent Assessments

The Panel feels that there is no need for someone who has already been designated as disabled by a process that has an equivalent or more restrictive definition of disability, unless there is reasonable doubt. Initially those processes should include Canada Pension Plan Disability, Disability Tax Credit, Community Living BC assessment, Ministry of Health Palliative Care Program, and Ministry of Children and Family At Home Medical Benefits Program. Additional processes could include disability assessment in other provinces, such as the Alberta Assured Income for the Severely Handicapped (AISH) program. It is understood that this is already under consideration for early implementation.

Presumptive Diagnoses

If a person has a medical condition that appears on a list of presumptive diagnoses (see Appendix C), they will be presumed to have impairments that meet the threshold provided that their diagnosis meets the detailed description of the condition on the list. For some conditions, such as ALS for example, having been diagnosed with the condition at all might be sufficient so that no further assessment need be done. In other cases, such as some cancers, the condition must be at a certain stage before the need for impairment to be assessed can be set aside. The fact that the diagnosis is present will not mean that the application form does not need to be completed but it does mean that the application can be fast-tracked provided the severity of the condition matches the criteria in the list for cases selected for fast-track.

The purpose of defining presumptive diagnoses is both to make the process more efficient and timely, and to make it more accurate. Adjudication decisions can be divided into four groups: true positives; false positives; true negatives and false negatives. Regardless of whether or not there is a list of presumptive diagnose or how effective the adjudication system is, there will always be the risk of false positives and false negatives because ultimately the decision unavoidably involves subjective human judgement. In general, inclusion of more diagnoses at lower severity levels in the list will tend to increase timeliness and reduce false negatives (thereby increasing true positives) but at the expense of increasing false positives. Up to some point, that is a reasonable trade-off.

The CPP list of Grave Medical Conditions, combined with the US Social Security Administration (SSA) Compassionate Allowances list (which overlap to a significant extent, except for some childhood conditions not included in the CPP list) are recommended as the list of presumptive diagnoses for PWD purposes. Both of these agencies have worked over time to find the right balance and both can be expected to continue to improve their lists over time.

[14] Improvements to application forms, discussed below, should have the effect of improving the information provided by medical and health professionals on the applications, leading to fewer application that are incomplete or that require clarification.

The list of conditions combining both the SSA Compassionate Allowances and the CPP – Disability Grave Medical Conditions is attached as Appendix C.

Other changes designed to reduce errors, such as triage, full initial adjudication, providing medical advice to adjudicators, increasing the professionalization of adjudicators and requiring medical evidence to support applications should act to reduce both false negatives (including abandoned applications) and false positives from current levels. One specific approach to avoiding false positives would be to provide specific training in detecting individuals found to be feigning symptoms, people who grossly exaggerate their symptoms or condition. Dr. Chris-Stewart Patterson, one of the Panel members, has written an article and provides training in screening for malingering through document reviews, which would benefit adjudicators.[15]

Notably, the U.S. Social Security Administration (SSA) requested an evidence-based review of the use of validity testing in psychological assessments. Subsequently the Institute of Medicine (IOM) convened a committee to explore the value of psychological testing in SSA disability determinations. Their 250 page report released in 2015, entitled "Psychological Testing in the Service of Disability Determination" concluded *"…..the committee finds that standardized psychological tests, including validity tests, are valuable and may increase the accuracy and consistency of SSA's disability determinations*."[16]

Medical Advice

It is common for disability assessment processes to have and make use of advice from physicians and other health care professionals in adjudicating applications, but that is not part of the BC Disability Assistance program.

There are two ways this advice can be utilized. The first is by asking advisors to review the information provided by the applicant to give an opinion about the meaning of the information and its implications. The second is to ask applicants to see a physician or other health care professional on a list of service providers maintained by MSDSI to get an opinion about the level of impairment. Both of these approaches may help to get a more expert and less biased opinion in some cases. The use of the resource would need to be carefully administered to ensure a return on the investment in this type of resources.

Health care advisors could also be useful in developing and providing training for adjudicators and for health care professionals who complete application forms.

Qualifications and Training of Decision-Makers

The following comments and suggestions were provided to the Panel by individuals in management positions of adjudication service providers working in the private sector related largely to employee disability insurance coverage. The knowledge, skills, abilities and qualifications recommended for adjudicators and resources that should be made available to adjudicators include:

- As discussed above, availability of medical advice is crucial;

[15] Stewart-Patterson, Dr, Chris, Detection of Potential Malingering Indicators through Document Review, IAIABC Journal, 47, 19-44, 2010.

[16] Psychological Testing in the Service of Disability Determination, Committee on Psychological Testing, Including Validity Testing for Social Security Administration Disability Determinations. Institute of Medicine 2015. THE NATIONAL ACADEMIES PRESS 500 Fifth Street, NW Washington, DC

- Skills and abilities required – decision-making; critical analysis; ability to assess evidence, ability to undertake phone interviews to extract and compile required information, ability to interpret and apply administrative guidelines;
- Knowledge of medical terminology; understanding of medical system; ability to understand and communicate with physicians and other health care professionals;
- An adjudicator must be efficient and focused and very detailed oriented – quite specialized.
- Two views on preferred qualifications:
  1) Disability Management Professional with specific education and training in disability management.
     Training in disability management is available through:
     - National Institute of Disability Management and Research (NIDMAR) (https://www.nidmar.ca/index.asp) provides courses and complete programs in adjudication and case management; completion of full program qualifies an individual as a Certified Disability Management Professional
     - SFU program (Rehabilitation and Disability Management Diploma) - https://www.sfu.ca/continuing-studies/programs/diploma-in-rehabilitation-and-disability-management/courses.html) a program for people working in the field offering training in adjudication and case management leading to a Certified DM Professional qualification.
  2) Regulated health care professionals - occupational health nurse or other regulated health care professional such as occupational therapists (If regulated health care professionals are not available, could move to functional backgrounds – i.e., kinesiology) – bring a medical perspective, understand the system and must meet ethical standards associated with their profession.
- Resources and Tools:
  - NIDMAR – as well as education and training, offers workplace program implementation, an audit tool, research and policy information and products, and access to a detailed information system – "Rehadat Canada" (http://rehadat.nidmar.ca/db/) - providing information to support the vocational integration of disabled persons.[17]
  - Medical Disability Advisor (MDA) – Workplace Guidelines for Disability Duration offered by the Reed Group (www.reedgroup.com/product/mdguidelines/) – best practice disability guidelines used by most insurers for adjudication purposes; through a licensing fee obtain access to MDA which provides data on typical duration of a disability and jobs for people with particular abilities (e.g., for a rotator cuff tear, would input applicant's information into system and system provides expected duration, recovery guideline, treatment and possible jobs).

Quality Assurance

Having a quality assurance program is an effective way of creating a culture of continuous improvement in the organization. This could include establishing benchmarks for performance and monitoring against those benchmarks to identify areas that can be improved, random review of decisions, reviewing problems that arise and seeking better practices as a result and providing ongoing training to staff and external resources used by applicants.

[17] NIDMAR's "Rehadat Canada" information system holds six data bases – assistive devices, case studies, disability management practices, literature, policies and language, research – intended to provide disability management professionals with information to aid in the vocational integration process.

Adjudication of ETW-MC and ATW

The forgoing is couched in terms of adjudicating applications for PWD. However, except for the discussion of accepting equivalent assessments and presumptive diagnoses, all of the rest of the discussion applies equally to adjudication of the level of impairment for the purposes of the ETW-MC income assistance sub-category and the proposed ATW employment support program.

The Panel believes that it would be most appropriate for the level of impairment to be adjudicated for all purposes by the same group, with access to the same reconsideration and appeal processes. The same triage process, full initial adjudication, medical advice, qualified adjudicators and effective quality assurance program should apply to all adjudications of the level of impairment.

For the ATW employment program, the recommended eligibility threshold requires both a specific level of impairment - moderate impairment at MMI - and retained abilities sufficient to participate in at least one standard job at a level that would provide self-sufficiency. That second part of the requirement is logically part of the employment assessment that would form the initial stage of the employment support program. It is therefore the Panel's view that part of the adjudication should be undertaken within the employment program.

However, eligibility for ETW-MC would be adjudicated by the same group as those that adjudicate PWD eligibility.

Application Form Design

Application forms are clearly needed for both PWD and ETW-MC/ATW. There are good reasons for those forms to share as much content as possible. It is recognized that it may take some time for the forms to become fully aligned.

Some of the recommendations in this report, particularly related to impairment eligibility thresholds, equivalent assessments and presumptive diagnoses will have a direct impact on the structure and details of the application forms. In addition, the Panel, after reviewing the existing PWD form in detail, is recommending some changes to make the forms easier for physicians to complete and to better support adjudicator decision-making.

In principle, physicians and other health professionals provide information about the level of impairment and adjudicators decide, based on that information, whether the person is sufficiently disabled to qualify for benefits. PWD applications require that a medical practitioner provide information about the person's medical condition, including its likely duration and that a medical practitioner or another approved health professional provide information about the person's ability to perform Activities of Daily Living (ADLs). That should provide enough information to the adjudicator about the person's impairments for the adjudicator to decide whether to approve or deny the application.

Based on this analysis, the Panel suggests that the most effective and appropriate way to utilize health care professionals is to clearly and specifically ask them on the application form to assess impairments, but not to opine on disability.

The Panel is suggesting that PWD application form be redesigned to address the following comments:

- There is repetition and duplication between the Physician's part and Assessor's part of the current PWD application form. In particular, duplication should be at least reduced where the physician completes both parts by making it clear that for some questions the physician must only complete the more detailed Assessors report and can leave the related question in the physician's part blank;
- There are inconsistencies between the two parts that should be addressed;
- The form should be subject to a plain language review to reduce the reading level of the form to Grade 4 and to eliminate unnecessary text;
- The option or requirement for online form completion would be beneficial in many cases, including providing physicians with user-friendly access to explanations and resource materials directly from the form, reducing incomplete submissions and ensuring legibility of submissions;
- An accessible process map/plain language guide should be developed to assist the applicant, and the physician and health professionals in completing the form..

Section 1 – Applicant Information -

- What is the applicant applying for? The Panel feels that it makes most sense if there are separate but very similar forms for PWD and ETW–MC / ATW but that MSDSI have the ability to use the information provided in subsequent adjudications for different purposes. The form should state what is being applied for and that the information may be for additional purposes;
- For PWD, this section should have a question about whether there has been a previous equivalent assessment, with the ability of the applicant or other person with the necessary authority to give permission to access the relevant information from another agency. An application made on that basis would not require any additional information for it to be adjudicated;
- The applicant has the opportunity to provide their own information at present, but not in a way that provides them with an effective voice in the application system. Changes to the form would give applicants a better opportunity to provide useful information to the adjudicator. For example, guidelines could be added about the type of information to be provided:
  - describe symptoms;
  - when did symptoms occur/condition start?
  - how does your condition impact your life?
  - is there other information that you believe would be useful in deciding if you qualify?

- Section 2 – Physician's Report -
  - Instead of including a verbatim extract from the legislation, plain language this section and focus on key information that the physician needs to know;
  - Diagnostic Codes – change to ICD codes because that is the classification system that physicians are used to using. Ensure the terminology is consistent with AMA terminology;
  - Include an instruction/question about whether the person has a condition on the list of presumptive diagnosis. For online forms, this could be automated using the ICD codes but physician would still have to indicate the status of the condition to determine whether it qualifies for fast-track consideration;
  - Part B - Health History – add:
    - Who made the diagnosis?

        - Has the client seen a specialist?
        - Questions about treatment – what treatment has person received (see Alberta's treatment questions, sections 8-13)
        - Requirement to include relevant medical evidence. See the discussion about objective evidence under Background – Relevant Medical Concepts above;
    - Part C - Degree and Course of Impairment:
        - Modify/reword to make this part about prognosis including whether person has reached MMI;
        - Add concept of severity until the current PWD threshold is changed – "will the impairment be severe for two years or more" (to parallel legislation).

The remainder of the form (Sections D to G of the Physician Report and the entirety of the Assessor Report) are focussed on assessing abilities. It was noted that there was some disparity between the Physician section and Assessor section in that they differ in what they cover, and for comparison purposes use differing assessment scales and descriptors.

The form is also over-inclusive and asks questions that most Physicians and Assessors are unlikely to answer in a reasonably accurate manner (with the possible exception of treating clinical psychologists or psychiatrists who have had a longitudinal view of any impairments) such as executive function of planning, organizing, sequencing, impulse control and increased or decreased goal oriented activity.

The Panel proposes that the best way to address these concerns would be to replace the sections of the current form that assesses function with the World Health Organization Disability Assessment Schedule 2.0, (WHODAS)[18] using both the 12 and 36 question versions. The 12 questions on WHODAS 12 version are completely replicated within the WHODAS 36 version questions. When WHODAS is updated in future, consideration should be given to also adopting those changes if and when they are published.

Importantly, the proposed use of the WHODAS forms is to just use the WHODAS questions without applying their scoring system. The rationale is that some of the best clinical experts globally have contributed to the format and selection of these questions to ensure that they accurately assess function and impairment. Therefore, the actual questions are considered state of the art. Currently, the Panel is not recommending using the WHODAS scoring system for routine assessments. The questions are meant to be only used as focused descriptions to accurately capture the client's function status.

The WHODAS 12 would be filled out in the Physician Report and the lengthier WHODAS 36 in the Assessor Report.

There are multiple advantages to adopting the WHODAS questions:

- Both the 12 and the 36 versions of the WHODAS are validated questionnaires that are well-established and accepted in clinical use.
- The WHODAS questions span concepts including impairment in ADLs such as washing and dressing, functional status such as walking and also assesses disability with questions about work. This allows the WHODAS, both 12 and 36 versions, to be used both for PWD (severe impairment in ADLs) and ATW (moderate impairment but the

[18] Measuring Health and Disability: Manual for WHO Disability Assessment Schedule (WHODAS 2.0), edited by TB Üstün, N Kostanjsek, S Chatterji, J Rehm, World Health Organization, 2010.

person has retained abilities that would enable them to at least meet the job requirements of one or more defined low ability jobs with reasonable accommodation sufficiently to be self-sufficient).

- The WHODAS questions cover both psychiatric mental health conditions and physical conditions.
- The WHODAS questions operationally define what "difficulty with an activity" means with any of four criteria descriptors of which could be included with the application form:
    - increased effort
    - discomfort or pain
    - slowness
    - changes in the way you do the activity.
- The WHODAS includes a script for the person administering the questionnaire, which clearly and simply explains the process in plain language. There is also a printable visual analog scale that could be showed to the claimant clearly describing that impairment is measured on a 5-point scale from "none" to "extreme/cannot do." The script and the visual scale tool could be included in the application form.
- The 12 questions on WHODAS 12 version are completely contained within the WHODAS 36 version. If both versions are completed (i.e. if the applicant's physician does not complete both the Physician Report and Assessor Report), this provides an opportunity for a senior case manager or Medical Advisor to review consistency, if indicated, by a comparison between how the duplicated questions are answered in each section. This would be a reliability check as they should ideally be quite similar.
- The Panel is not recommending that the WHODAS 36 version be routinely scored, but if there are concerns about a claim, then notably the WHODAS 36 version also comes with population based scores, including percentiles, against which the applicant's score could be compared. This ability to score the WHODAS 36 questionnaire and compare to norms could be used for assessment of congruency by a medical advisor or trained senior adjudicator. For instance, a person with a moderate impairment should not be scoring above the 95th percentile of overall disability in the WHODAS 36 version. There is a downloadable training manual for the WHODAS which includes scoring.[19]

There are some minor limitations to the WHODAS that the Panel believes are correctable. The industry "gold standard", the AMA Guides to Impairment 6th Ed., notes ADLs, include bathing, dressing, eating, functional mobility, personal hygiene and grooming, amongst others. It also notes that instrumental ADLs includes community mobility, financial management, meal preparation and cleanup and shopping, amongst others. In addition, there are ADLs outlined on the current PWD application.

The WHODAS questions do not directly assess speaking, reading, writing, hearing, management of medications, sitting, diet or meals although some are indirectly assessed through higher order questions such as "taking care of your house-hold responsibilities?" In terms of establishing both impairment in ADLs and compatibility with sedentary entry level jobs it is notable that the WHODAS does not directly assess lifting, carrying or stair climbing, or psychiatrically, persistence or pace to complete specific tasks for instance.

These missing areas of functioning are pertinent in the assessment tasks required by MSDSI and some are actual ADLs outlined in the PWD application. They could be addressed, to the Panel's satisfaction, by the addition of about one page that parallels WHODAS by using the same 0 to 4 ICF scale. This would be especially useful if trying to assess if somebody can

[19] http://apps.who.int/iris/bitstream/10665/43974/1/9789241547598_eng.pdf

return to work in ATW. Factors of lifting, carrying and persistence/pace for instance, are factors that occupational physicians and occupational psychiatrists consider when considering ADL impairment or work fitness. The following are the additions proposed to both the Physician Report and the Assessor Report:

In the last 30 days how much difficulty have you had with:

	None	Mild	Moderate	Severe	Extreme/ Unable
Sitting					
Lifting					
Carrying					
Stairs					
Speaking					
Reading					
Writing					
Hearing					
Eating					
Preparing meals					
Shopping for personal needs					
Managing own finances					
Taking medications					
Completing tasks					

The Panel also suggests that both sections include the following question: “Is the applicant able to operate a motor vehicle and if so, is the applicant’s ability restricted in any way?“

A sketch of an ETW-MC / ATW application form based on these concepts is attached as Appendix D.

Recommendations – Adjudication and Application Forms

9. Triage be introduced into the adjudication process, including initial processing that identifies incomplete applications and immediately seeks the missing information.

10. Initial adjudications include asking for additional information if the information is not sufficiently complete or clear to make a decision.

11. Health care professionals be paid for providing additional information if requested.

12. Equivalent assessments, including Canada Pension Plan Disability, Disability Tax Credit, CLBC, Ministry of Health Palliative Care Program, and Ministry of Children and Family At

Home Medical Benefits Program be accepted as evidence of severe impairment for the purpose of PWD (automatic ins).

13. A presumptive diagnosis list based on the SSA Compassionate Allowances list and the CPP Disability list be used to fast-track the assessment of impairment required for those whose medical condition matches the details of the presumptive diagnosis. Evidence supporting the diagnosis may be required by adjudicators as needed.

14. Medical advice should be made available to adjudicators at all levels, including the appeal system.

15. Adjudicators should have the knowledge, skills, abilities, training and qualifications needed to accurately adjudicate eligibility, including the ability to interpret medical evidence supplied in applications and supporting documents. That should include senior adjudicators with appropriate training and experience, such as NIDMAR qualifications or being a member of an appropriate health profession, such as nursing (especially occupational health nursing), physiotherapy and occupational therapy.

16. A quality assurance function should be added to enable continuous improvement in the organization.

17. The application and adjudication processes for ATW and PWD should be integrated to the extent possible and people should not be required to provide the same information twice.

18. The application forms be redesigned to be consistent with the proposed process, use terminology consistent with AMA definitions, give a better voice to applicants.

19. In the Physician Report, the WHODAS 12 version and additional page (as above) would replace both the Functional Skills section on Page 11 and the ADLs questions on Page 12.

20. In the Assessor Report, the WHODAS 36 version plus the additional page, would replace Section B in entirety, which is mental and physical impairment and Section C in entirety, which is ADLs.

21. Medical practitioners filling out application forms should be asked to provide medical evidence, including where possible objective findings to support their assessment.

22. Adjudication for the purposes of PWD, ETW–MC and ATW should all be undertaken by the same group of decision-makers following the same triaged administrative model to determine whether the disability eligibility criteria is met for each designation.

23. Determination of whether an ATW applicant meets the eligibility requirement of having retained abilities consistent with at least one standard job description should be the first step in the ATW employment program process.

ATW Employment Program

As described above, the Panel proposes that people with moderate disabilities that have potential to attain self-sufficiency be provided with support to achieve that goal through a dedicated employment support program. That program would be a vocational rehabilitation program, modelled on the type of case-managed return to work program used in workers' compensation and by employers, often through insured disability benefits programs.

Most vocational rehabilitation programs work with people who have an existing occupation that they either cannot continue with or that they require accommodation to continue with because of workplace illness or injury (workers' compensation) or other illness or injury (corporate long term disability benefits). Most ATW clients will not have recent strong workforce attachment. That means that there is not an employer with an interest in the person returning to work. Nonetheless, the vocational rehabilitation approach provides a useful model that can be adapted to work in the ATW context.

The first step in vocational rehabilitation is to assess employability and needed accommodations. As suggested above, that can begin, in a generic way, with the adjudication of the ATW application. The eligibility criteria described above is comprised of two parts: moderate disability and retained ability to do at least one sample, low-ability, entry-level job with reasonable accommodations. Those sample job descriptions will need to be developed by MSDSI. As recommended above, the Panel believes that the first step in the ATW employment program process should be this assessment of retained abilities and types of accommodation that may be required.

That initial assessment may benefit from professionals able to translate application form information and additional information provided by the applicant into the first steps of employability assessment, such as Occupational Therapists, vocational rehabilitation specialists and psychologists. The employment program will also need these types of professionals as well as experienced case managers.

Case management is a collaborative process of assessment, planning, facilitation, care coordination, and evaluation of options. Case managers must be able to identify and facilitate access to services and accommodations to meet an individual's needs. That requires:

- Exceptional communication skills
- Understanding the individual's needs and interests – why they are unable to work and what would motivate them
- Vocational assessment and planning including assessment of barriers to employment – both physical and psycho-social
- Development of a case plan - a process to help define clear goals and determine how those goals will be achieved
- Counselling, negotiating, implementing and coordinating internal and external resources
- Skill development, employability assessments, job readiness
- Placement assistance, work site/job modification
- Monitoring progress
- Documenting and evaluating the process and outcomes.

The second step, having determined what types of jobs are a potential match to the person's situation and interests, is to identify and work with potential employers. The Ministry is

continuing to develop relationships with the business community and specific employers to provide increased opportunities for those with disabilities. It will be crucial for the ATW employment program to develop relationships with a wide group of corporate employers who are interested and engaged. It will also be essential to have the possibility of providing post-employment accommodation support to employees and employers to facilitate work placements.

The third step would be to pull together a potential job with a package of accommodations that could include job description adjustments, assistive technology and devices, physical workplace adjustments, accommodations to enable the person to get to and from work and, where necessary, post-employment supports that could range from continued access to medical supplements to time limited wage subsidies. Specific examples of accommodations include:

- Offer of scheduled periodic rest breaks away from the workstation
- Offer of an open door policy to the supervisor
- Provide more structure and/or written job instructions when possible
- Prioritize job assignments
- Provide memory aids such as schedulers or organizers
- Minimize distractions
- Allow a self-paced workload
- Assistive technology examples:
    - Large Keys Keyboard – this keyboard looks very similar to a standard keyboard, except that the keys are significantly larger. These keyboards are beneficial to those with limited fine motor skills.
    - Programmable Keypad – with this tool, a user can designate complex keystroke sequences to a single key, allowing those with learning or cognitive disabilities and one-handed users to complete tasks quickly and simply.
    - Ergonomic Wireless Mouse – this mouse looks a bit like a joystick, and is beneficial for those with grasping difficulties, or those experiencing wrist and hand discomfort.
    - Dragon Naturally Speaking – this speech recognition software allows employees with dexterity disabilities, learning and cognitive disabilities, and a range of other disabilities, create, format, and edit documents using dictation. It works with the Microsoft Office Suite, including Outlook, Excel and PowerPoint.

For applicants who are not job ready due to common mental health disorders such as depression, anxiety and adjustment disorders, the Panel proposes that the Ministry make available evidence-based psychotherapy modalities that have been scientifically shown to be effective in a work-based context. The only example of such a therapy known to the Panel after a thorough search is “Work-focussed Cognitive Behavior Therapy” (W-CBT). Two recent studies have found that using CBT with a work focus has significant benefits in return to work.

Lagerveld et al describe CBT and W-CBT as follows: [20]

> “The work-focused CBT intervention (W-CBT) employs the same conceptual framework as is used for regular CBT, which is largely based on the work of Beck (1976). In short, CBT theory states that dysfunctional (coping) behavior and mental health symptoms are not merely the consequence of a stressful situation (e.g., work

[20] Lagerveld, Susan E., Roland W. B. Blonk, Veerle Brenninkmeijer, Leoniek Wijngaards-de Meij, and Wilmar B. Schaufeli, Work-Focused Treatment of Common Mental Disorders and Return to Work: A Comparative Outcome Study, Journal of Occupational Health Psychology 2012, Vol. 17, No. 2, 220–234, American Psychological Association

> pressure), but that the appraisal of this situation (cognition) plays a crucial role. CBT can be used to intervene in any of these three components (situation, behavior, and cognitions) from both a cognitive and a behavioral perspective. The relationship between cognitive change and behavior change is complex and interactive, with change in one domain promoting change in the other, and vice versa …
>
> In W-CBT special attention was given to gradual exposure to the workplace because this element was included in two previous CBT-based interventions … that proved to be effective in RTW. Following graded activity principles, we assumed that work participation could best be stimulated by gradually exposing patients to the work setting. Gradual work resumption can help individuals develop more effective coping skills to deal with (return to) work-related stressors."

The study found that W-CBT significantly reduced times for partial and full return to work, compared to CBT only.

A more recent study compared W-CBT to the usual health care supports generally made available and found that W-CBT improved not only return to work but mental health outcomes and was especially effective for those on long-term benefits. In that study, CBT was combined with active case management, similar to the vocational rehabilitation approach described above.[21]

It is suggested that 6 to 10 W-CBT sessions with a trained mental health professional be offered as an accommodation during the job placement process to help clients with depression, anxiety and adjustment disorder cope with the workplace environment, the CBT preferably being started prior to the job placement itself, and continuing as W-CBT when the person is placed in a job.

There should be a requirement for the therapist to measure progress using a validated tool such as the PHQ-9 or OQ-45 used at each session, with an interim and final report outlining, the treatment goal, plan and progress.

This could be managed with a pool of qualified professionals contracted by MSDSI, as WorkSafe BC currently does. If so, the ministry could make W-CBT training available to those who already have CBT training and experience, since this modality has been recently developed, as well as providing training for case managers on when W-CBT is likely to be most effective and how to integrate the vocational rehabilitation program with the W-CBT treatment. The Bounce Back Program,[22] an online CBT program offered by the BC Ministry of Health with a doctor's referral, could be a stepping stone to access CBT, available earlier in the process as a starting point for some clients.

Another accommodation not mentioned above that could be considered in the rare case where a person has the potential for self-sufficiency but after trying all options is unable to be placed in employment in any occupation is access to vocational training. Training should only be considered based on a thorough vocational rehabilitation assessment justifying the specific training being proposed, explaining why it is not possible to find employment without the training and why the specific training is highly likely to result in self-sufficient employment.

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[21] Reme, Silje Endresen, Astrid Louise Grasdal, Camilla Løvvik, Stein Atle Lie, and Simon Øverland, Work-focused cognitive–behavioural therapy and individual job support to increase work participation in common mental disorders: a randomised controlled multicentre trial, Occupational & Environmental Medicine 2015;**72**:10 745-752.
[22] http://www.cmha.bc.ca/how-we-can-help/adults/bounceback

Recommendations – ATW Employment Program

24. The ATW employment program should be a vocational rehabilitation program modelled on the vocational rehabilitation approach used in workers' compensation and employee disability benefit programs.

25. The key to an effective program is good case management coupled with good working relationships with specific corporate employers who are willing to invest in employees with disabilities and to participate in making needed accommodations work.

26. For applicants who are not job ready due to common mental health disorders such as depression, anxiety and adjustment disorder, medical supplements should include access to W-CBT (6 to 10 sessions) provided by a trained health professional, perhaps under contract to the Ministry as part of a pool of qualified service providers.

27. Where thoroughly justified as the only alternative available to attach an ATW person to the labour force, funded vocational training should be considered.

Conclusion

The Panel has been asked for its expert advice on implementing best practices in disability assessment and on how to design employment supports that will enable more Ministry clients with disabilities to achieve self-sufficiency. This report makes 27 recommendations which would make significant improvements to the current income assistance/employment program ecosystem managed by the Ministry, based on the Panel's collective experience in occupational health, disability assessment and return to work. Those improvements would benefit many MSDSI clients by improving the timeliness and accuracy of PWD adjudication, providing those with severe but temporary impairments with better access to medical benefits until their medical condition stabilizes and providing those with the potential for self-sufficiency with a direct path to assist them to achieve that potential.

Appendix A – Terms of Reference

Objective

The Ministry of Social Development and Social Innovation (Ministry) is developing potential reforms to its Disability Assistance program to improve the way assistance is provided in several ways, including improving its ability to effectively and efficiently adjudicate applications for assistance and providing a pathway to employment for those who have the potential to gain self-sufficiency.

The Ministry has two essential questions:

3. What are the best practices in terms of application and adjudication processes to accurately and efficiently adjudicate claims for disability assistance under the current definition of persons with disabilities?
4. How best should the ministry design a program to assist those with disabilities to gain financial self-sufficiency through employment (Assisted to Work), including defining the group of persons who would most likely benefit from such a program and designing an employment support program that would provide the accommodations needed for these individuals to be successful?

The Ministry is enlisting the assistance of a "Panel of External Experts" (Panel) to provide confidential non-binding expert advice to the Ministry to help answer the two questions posed above.

Background

The BC Employment and Assistance (BCEA) program administered by the Ministry provides supports and assistance to people with disabilities, individuals with persistent multiple barriers to employment and employable individuals who are in financial need and looking for work. The BCEA program is an income and asset tested program of last resort.

It has been over 10 years since the introduction of the BCEA program. Recently there has been a confluence of events that has provided an opportunity and requirement for reform of the BCEA program. These events include: growing pressure from disability groups to provide more opportunities for those with disability to become attached to the labour force and to reform the way income assistance is delivered to those with disabilities; reports from the Ombudsperson recommending changes to the way the Ministry deals with those with disabilities; and a recent Auditor General report criticizing the current program. The Auditor General found that the program is not easy to access, there are risks associated with the accuracy and timeliness of adjudication and there is no evaluation framework to demonstrate that the program is improving the lives of clients. The Ministry is also working with the community and professionals to develop an evaluation framework. The two projects, while distinct, may inform each other.

Structure, Approach & Work Plan

Structure

The Panel will be composed of a multi-disciplinary team of professionals, practitioners and/or academics with knowledge and expertise in the field. The Panel will be comprised of three individuals. Their expertise will be supplemented by information obtained through interviews with or presentations by a more extensive list of experts.

The Panel will be organized by a contracted facilitator who will also assist the Panel in developing a report. Ministry staff members will assist with briefing materials and will participate in all conference calls and in person sessions.

Terms of Agreement

Timeline: The Panel will be established by early July, with the substantive work of the Panel running through December 2015.

Time commitment: Expected to be up to 76 hours per Panel member in total.

Fees: $300 per hour plus, expenses at provincial government Group II rates.

Methodology and Approach

The work of the Panel will be focussed on answering the two questions posed above. It will be comprised of two phases, reflecting the two questions, as follows:

Phase I – Adjudication of Persons with Disabilities and Assisted to Work

- Best practice in assessing "severe impairment" including both severity and duration
- Criteria and methodologies for assessing disability arising from various conditions
- Triaging assessment including identifying:
    - Situations that should qualify for automatic-approval,
    - Grave conditions that qualify for less extensive investigation
- Developing a definition and selection criteria for participants in an Assisted to Work program that include both the potential for self-sufficiency and the desire to succeed, including
    - Nature of disability, severity, duration and recurrence over time
    - Existing knowledge, skills and experience
    - How motivation can be gauged.
- Streamlining the application and adjudication process, including:
    - Improving the usefulness of the application form(s) and
    - Introducing Medical oversight
- Improving the usefulness of information provided by medical professionals

Phase II – Design of an Assisted to Work Program

- Process/methodology for assessing needed accommodations including, training, technology, facilities and equipment needs, financial support, etc
- Mechanisms for engaging business community and specific employers
- Design of employment programs for this group
- Relationship between and interface with PWD program
- Potential future adjustments to the definitions of disability and approaches to adjudication for the long-term Disability Assistance program and the Assisted to Work program.

Each Panel member will be provided with a package of briefing and reference materials. The Panel members will be required to deliberate independently and work together as a group via conference calls and in person sessions.

The Panel members will be encouraged to engage in independent confidential research that will support panel discussions and deliberations. The Panel will be required to provide a written report outlining their findings and advice, to be drafted by the contracted facilitator.

Appendix B – Panel Member Biographies

Dr. Celina Dunn

Dr. Dunn's background is in family practice until 1992 when she joined WorkSafeBC initially as a Medical Advisor. She has been Manager of Medical Services since 2000 where part of her role has been dedicated to evidence based reviews, education and outreach to the physician community. Dr. Dunn co-chaired the BC Summit to Prevent Needless Work Disability as part of the 60 Summits project in 2008. She is a founding member of the non-profit society, BC Collaborative for Disability Prevention, where she co-chaired the research and education task group. She is currently leading a BCCDP research/pilot project in partnership with UBC Continuing Professional Development to provide curriculum in work disability prevention to physicians and other health care providers. Dr. Dunn is a clinical instructor with the Department of Family Practice at the University of British Columbia.

Dr. Charl Els

Dr. Charl Els is a psychiatrist, addiction specialist, and medical review officer. *He is* first Editor and co-author of a Health Canada-funded textbook on tobacco control. He was the lead on the Canadian Clinical Practice Guidelines for Tobacco Addiction in Persons with Mental Illness, also funded by Health Canada. Els is an Associate Clinical Professor at the University of Alberta's Department of Psychiatry. He serves on the Guideline Committee for the American College of Occupational and Environmental Medicine and co-authored the College's Opioid Guidelines for safety-sensitive positions. Dr. Els regularly conducts assessments on employees in a variety of occupations. He sits on the University of Alberta's Health Research Ethics Board as well as on the advisory board for Physicians Against Forced Organ Harvesting. Els recently published in the Lancet, BMJ, and BMC Health Ethics, and peer-reviews for a number of scientific journals. He is the first author on a Cochrane title related to opioid use. Finally, he works with the Edmonton Police Service's hostage negotiation team.

Dr. Chris Stewart-Patterson

Dr. Stewart-Patterson has practiced Occupational Medicine since 1989. He specializes in fitness to work evaluations for safety critical/sensitive occupations such as fire, police and correction officers. He was the lead author of the ACOEM law enforcement officers Substance Use Disorder return to work guides. Dr. Stewart-Patterson is a CME course director of "Medical Fitness to Return to Work" for Harvard Medical School and faculty at the Harvard Macy Institute. He has instructed for the American College of Occupational and Environmental Medicine lecturing on assessment of both musculoskeletal and psychiatric disability in workers. He is a clinical senior lecturer in Occupational Medicine at Wellington School of Medicine in New Zealand.

Appendix C - Comparison of CPP-D List of Grave Conditions and US Social Services list of Compassionate Allowances Conditions

	ICD9 codes	US Social Services	CPP - Disability		
		Compassionate Allowances	**Grave Medical Conditions**	**Other Names**	**Selected cases for Fast Track**
1	204.0	Acute Leukemia	Acute Lymphoid Leukemia	• acute lymphoblastic leukemia; • acute lymphocytic leukemia; • precursor B cell lymphoblastic leukemia; • precursor B cell acute lymphoblastic leukemia; • precursor T cell lymphoblastic leukemia; • precursor T cell acute lymphoblastic leukemia	All cases
2	194.0	Adrenal Cancer, with distant metastases or inoperable, unresectable or recurrent • Anaplastic Adrenal Cancer Adult	Adrenal Cancer	• adrenal carcinoma; • cancer of the adrenal cortex	all cases, due to late stage presentation at diagnosis
3	331.0 USSSA: also 290.0 290.1 290.10 290.11 290.12 290.1 294.1	Early Onset Alzheimer's Disease • EOAD • Presenile dementia • Presenile Alzheimer's disease	Alzheimer's Disease (AD)	• Early Onset Alzheimer's Disease (EOAD) less than age 60 • young-onset AD; • familial AD or FAD; • pre-senile dementia or AD	all cases of EOAD or other names listed diagnosis of AD for a person younger than age 65 years, and accounts for approximately 5 to 10 percent of all cases of AD
4	277.3 USSSA: also, 427.x 428.x	Creutzfeldt-Jakob Disease – Adult • Light Chain Cardiac Amyloidosis; • Cardiac Amyloidosis Light Chain Disease • Primary Amyloidosis	Amyloidosis	• primary amyloidosis; • secondary amyloidosis; • senile amyloidosis; • familial dementia (British, Danish, or Finnish); • aortic amyloidosis (of the elderly); • prion protein-related TSE (transmissible spongiform encephalopathy) such as Creutzfeldt-Jakob disease, Kuru, fatal familial insomnia, and Gerstmann-Staussler-Scheinker disease	All amyloidosis cases. An assessment of the extent of organ involvement is required.

	ICD9 codes	US Social Services	CPP - Disability		
		Compassionate Allowances	**Grave Medical Conditions**	**Other Names**	**Selected cases for Fast Track**
5	335.2 335.20	Amyotrophic Lateral Sclerosis (ALS)	Amyotrophic Lateral Sclerosis (ALS)	• Lou Gehrig's disease; • motor neuron disease; • Aran-Duchenne disease	All cases, due to late stage presentation at diagnosis
6	191 191.0 191.1 191.2 191.3 191.4 191.5 191.6 191.7 191.8 191.9	Astrocytoma – Grade III and IV -Astrocytoma Grade III: – anaplastic astrocytoma, – anaplastic malignant astrocytoma, -Astrocytoma Grade IV: – glioblastoma multiforme (GBM), – glioblastoma, – mixed glioblastoma sarcoma, – gliosarcoma astrocytoma grade IV, – giant cell glioblastoma astrocytoma, – spongioblastoma multiforme -Malignant Brain Stem Gliomas -Malignant Ectomesenchy-moma	Brain Cancer	• any primary cancer with brain (secondary) metastasis; • astrocytoma; • anaplastic astrocytoma; • spongioblastoma multiforme; • malignant glioma; • anaplastic glioma	All astrocytomas, glioblastomas, glyoblastoma multiforme, all cancer metastases to brain
7	150, 150.0 150.1 150.2 150.3 150.4 150.5 150.8 150.9	Head and Neck Cancers • Esophageal Cancer	Esophagus Cancer	• adenocarcinoma of the esophagus or the esophagus/gastric junction; • squamous cell carcinoma of the esophagus or esophagus/gastric junction	All cases due to the frequency of wide spread disease at time of diagnosis

	ICD9 codes	US Social Services	CPP - Disability		
		Compassionate Allowances	**Grave Medical Conditions**	**Other Names**	**Selected cases for Fast Track**
8	331.1 331.11	Frontotemporal Dementia (FTD), Picks Disease -Type A – Adult	Front temporal Dementia (FTD)	• frontal lobe dementia; frontal lobe degeneration; • fronto-temporal lobar degeneration; • Pick's disease/Pick complex; • Wilhelmsen-Lynch disease	All cases
9	156.0 156.1 156.2 156.8 156.9	Gallbladder Cancer	Gallbladder Cancer and Cancer of the Bile Ducts/Malignant Neoplasm of Gallbladder and Extrahepatic Bile Ducts	• adenocarcinoma of the gallbladder; • adenosquamous carcinoma of the gallbladder; • Klatskin tumour; cholangiocarcinoma; • biliary duct cancer	All cases
10	333.4	Adult Onset Huntington Disease & Juvenile Onset Huntington Disease	Huntington's Chorea Disease	• Huntington disease; • juvenile HD; • Westphal variant of HD	All cases
11	356.4	*Not on CAL list*	Idiopathic Progressive Polyneuropathy	• Increasingly general terms (neuropathy or neuropathy)	All cases
12	516.3	Idiopathic Pulmonary Fibrosis	Idiopathic Pulmonary Fibrosis	• cryptogenic fibrosing alveolitis; • diffuse fibrosing alveolitis	all cases of idiopathic pulmonary fibrosis/idiopathic fibrosing aleveolitis/idiopathic interstitial pneumonia
13	189 189.0 189.1	Kidney Cancer - inoperable or unresectable	Kidney Cancer	• renal cell carcinoma; • renal cell cancer; • renal pelvis cancer; • renal sarcoma; • clear cell sarcoma of the kidney	all cases of kidney cancer due to frequent late stage of disease at diagnosis
14	155, 155.0 155.1 155.2	Hepatoblastoma	Liver Cancer	• adenocarcinoma of the liver; • hepatocellular carcinoma	all cases of primary liver cancer

	ICD9 codes	US Social Services	CPP - Disability		
		Compassionate Allowances	**Grave Medical Conditions**	**Other Names**	**Selected cases for Fast Track**
15	162.2 162.3 162.4 162.5 162.8 162.9	Small Cell Lung Cancer • Small Cell Lung Carcinoma, • Oat cell Lung cancer, • Mixed small cell/large cell Lung carcinoma, • Combined small cell Lung carcinoma • Non-Small Cell Lung Cancer - with metastases to or beyond the hilar nodes or inoperable, unresectable or recurrent	Lung Cancer	• carcinoma of the lung; • bronchogenic carcinoma; • small cell lung carcinoma; • oat cell lung carcinoma; • non-small cell lung carcinoma; • squamous cell carcinoma of the lung; • adenocarcinoma of the lung; • large cell carcinoma of the lung	all small /oat cell lung cancer and all non-small cell cancers; other terms: inoperable, unresectable, metastatic, positive surgical margins, unresponsive to treatment, late stage, palliative
16	172 to 172.9	Malignant Melanoma with metatsis	Malignant Melanoma	n/a	all cases of malignant melanoma, as early successfully resected forms are not likely to apply for benefits
17	203	*Not on CAL list*	Multiple Myeloma	• plasma cell myeloma	all cases as applicants are likely to be at advanced stage of the disease
18	183.0 183.2 183.3 183.4 183.5 183.8 183.9	Ovarian Cancer – with distant metastases or inoperable or unresectable	Ovarian Cancer	• ovarian epithelial carcinoma • epithelial carcinoma of the ovary	all cases, due to the fact that the majority of individuals who apply for CPP-D benefits have widespread disease, carrying a poor prognosis.
19	157 157.0 157.1 157.2 157.3 157.4 157.8 157.9	Pancreatic Cancer • Exocrine cancer, • Pancreatic Adenocarcino-ma	Pancreatic Cancer	• adenocarcinoma of the pancreas; • pancreatic ductal adenocarcinoma	All cases of pancreatic cancer

	ICD9 codes	US Social Services	CPP - Disability		
		Compassionate Allowances	**Grave Medical Conditions**	**Other Names**	**Selected cases for Fast Track**
20	295.3 295.9	*Not on CAL list*	Paranoid Schizophrenia	• paranoid type schizophrenia	cases diagnosed with paranoid (type) schizophrenia
21	332	Lewy Body Dementia	Parkinson's Disease	• Lewy body disease; • Parkinson disease dementia (PDD)	All cases
22	515	*Not on CAL list*	Postinflammatory Pulmonary Fibrosis/Interstitial (Non-idiopathic) Pulmonary Fibrosis (PF)	Diffuse Parenchymal Lung Diseases (DPLDs) Included DPLD/PF cases: Non-idiopathic: – granulomatous forms such as sarcoidosis and, hypersensitivity pneumonia or pneumonitis (HSP); – collagen-vascular disease-associated with interstitial lung disease (ILD); and – pulmonary Langerhans cell histiocytosis (PLCH), tuberous sclerosis; Hermansky-Pudiak syndrome, and lymphanioleiomyomatosis	all cases of postinflammatory pulmonary fibrosis
23	334.2 334.3 330.8	Leigh's disease (330.8) • SCA; • Infantile-onset Spinocerebellar Ataxia; • Autosomal Dominant Spinocerebellar Ataxia (ADSCA)	Primary Cerebellar Degeneration	• cerebellar degeneration; hereditary ataxia; • spinocerebellar ataxia (types SCA 1 to 36); • episodic ataxia (types EA1 to EA7); • ataxia-telangiectasis; • xeroderma pigmentosum; • named ataxia (Friedreich; Charlevoix-Saguenay) ; and • named syndromes (4H; Cockayne; Marinesco-Sjogren; Gerstmann-Straussler-Scheinker ; • diseases (Machado-Joseph; Leigh; Refsum); dentatorubral-pallidoluysian atrophy; • several specific enzyme deficiencies; and others	All cases of primary cerebellar degeneration, cerebellar stiff, or others as named

Appendix D – Sketch of ETW–MC / ATW Application

ETW–MC and ATW Application Form

PART I – To Be Completed by the Applicant

The purpose of this form to gather the information needed to determine whether you have a disability that qualifies for the ETW–MC income assistance category or the ATW employment program.

You qualify for ETW-MC if either of the following applies:

1. You have a medical condition that is temporary because you are expected to improve and you are not yet the best you are going to be, which severely impairs you to the point where you cannot work or seek work; or
2. You have a medical condition that is permanent in the sense that you are the best you are going to be, which moderately impairs you to point where you have barriers to working or seeking work.

For the ATW employment program, only number 2 above applies.

These are general descriptions of specific legal criteria. This form allows us to gather the information we need to decide if you you qualify. Some of that information must be supplied by your doctor and some of it may come from your doctor or another health care professional (registered psychologist, registered nurse or psychiatric nurse, occupational therapist, physical therapist, social worker, chiropractor or nurse practitioner).

You also have the ability to explain to us what your condition is and why you think that it should qualify you to participate in these programs.

If the application form is not completed, you and the appropriate professionals will be asked to add the missing information before the application will be considered.

A. Personal Information			
Name Last First Middle			Date of Birth (yyyy/mm/dd)
Personal Health Number	Social Insurance Number (optional)		Telephone
Street	City	Postal Code	Email Address
What are you applying for? ETW–MC Temporarily Unable to Work ETW–MC/ATW Permanent Barriers to Work			

B. Declaration

By signing below you declare that the information provided above is complete and true and that you are applying for designation as ETW–MC and/or ATW. Add needed legal language, as plainly as possible.

Applicant Signature & Date	Witness Signature
	Witness Name (Please Print)
	Witness Address and Telephone

Add Legal wording regarding someone signing on applicant's behalf

A. Applicant's Information (optional)
What are your symptoms?
When did the symptoms or the condition start? Have the symptoms been continuous or have they increased and decreased sometimes?

How do your symptoms affect your life and ability to work?
Is there any other information that you think would be helpful?

Part II – Physician's Report
To Be Completed by the Applicant's Physician Only

Instructions

In this section you are being asked for your diagnosis of the patient and, if you do not also complete Part 3 (Assessor's Report) your observations on how the applicant's condition affects their life and ability to work.

Your medical opinion must be supported by medical evidence, which to the extent possible should be objective medical evidence and copies of which must be submitted with the application. By objective medical evidence, for physical conditions that should include the results of tests and medical imaging, as appropriate. For mental conditions, to the extent possible the results of validated standard tests are acceptable such as: …

Diagnoses must be documented with the appropriate ICD diagnosis code, the same code used when billing MSP.

In addition to the diagnosis, the key information we need is whether the condition has reached Maximum Medical Improvement or not and the prognosis for the applicant.

This section also includes questions about how the applicant's condition affects their ability to do a number of things to determine the severity of their impairment. Part II – Assessor's Report asks about the same functions, but in somewhat more detail. Therefore, if you are completing both Part II – Physician's Report and Part III – Assessor's Report, there is no need to complete Sections E, F and G in this Part of the form.

A. Diagnoses		
ICD Code	Specific Diagnosis (details of each medical condition, such as location, stage, etc)	Date of Onset, if known

B. History

Describe the applicant's medical history in reference to the diagnoses listed above, including:

How long has the applicant been your patient or a patient of your group practice?
How frequently do you or a health professional in your group practice have contact with the patient?
Who made the diagnoses?
Have any specialists that have been involved in the applicant's care? List
Are the conditions continuous or intermittent – why?
List medical evidence in support of diagnoses (must be attached – mental health findings must be supported by validated tests or explain why that is not possible)

Do any diagnoses qualify as “presumptive diagnoses” (see guide for details);
Describe medication, prostheses and other treatment, past and present (including duration of, compliance with and impairment caused by current treatment)

Generally how severe are the applicants’ pain and symptoms when engaged in:	Minimal Activity	Normal Activity
(Use a scale of 0- None; 1-Mild; 2-Moderate; 3-Severe; 4-Extreme)		
For each indicate whether the pain and symptoms are continual or intermittent:		
Comments:		

C. Prognosis Describe the applicant's prognosis, including:
Has the applicant reached Maximum Medical Improvement (see Guide for definition)? Explain
If not, how long until the applicant is likely to reach Maximum Medical Improvement? Explain
Is the applicant's condition expected to deteriorate with and without ongoing treatment? Explain
What is the current treatment plan?

E. Difficulties Due to Health Conditions (If also completing Part III – Assessor's Report, do not complete)

To what extent was this information collected by?	Applicant Self Report	Clinical Observation

Is the applicant able to operate a motor vehicle? Yes No Describe any restrictions:

Think back over the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

At the end of this form is a page that can be torn off and given to the applicant, showing the scale from None to Extreme/Cannot. Please ensure the applicant understands the scale.

Standing for long periods such as 30 minutes?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Taking care of your household responsibilities?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Learning a new task, for example, learning how to get to a new place?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much have you been emotionally affected by your health problems?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Concentrating on doing something for ten minutes?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Walking a long distance such as a kilometre [or equivalent]?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Washing your whole body?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Getting dressed?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot

Dealing with people you do not know?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Maintaining a friendship?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Your day-to-day work?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Sitting for long periods such as 30 minutes?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Lifting 5 kilograms (10 lbs)?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Carrying 2.5 kilograms (5 lbs)?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Climbing a flight of stairs?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Speaking?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Reading?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Writing?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Hearing?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Preparing meals?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Shopping for personal needs?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Managing your own finances?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Taking your medications and renewing prescriptions?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Completing tasks?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot

Overall, in the past 30 days, how many days were these difficulties present?	Record number of days ____
In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days ____
In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days ____

F. Additional Comments – if you need more room, please attach additional pages

Certification by Physician (as per current form)

Part II – Assessor's Report
To be completed by the physician who completed Part II or by a "prescribed professional"(Medical Practitioner, Registered Psychologist, Certified School Psychologist, Registered Nurse or Registered Psychiatric Nurse, Occupational Therapist, Physical Therapist, Social Worker, Chiropractor or Nurse Practitioner)

Instructions

In this Part of the application form, you are being asked to provide an assessment of how severely the applicant's medical condition affects their physical and mental functions and their ability to perform activities of daily living. It is important that you be as complete as possible in explaining the reasons for your assessment when you believe that the effect is moderate or greater, and when you believe the effect is intermittent to explain why. Room has been left for comments but please feel free to provide additional comments if the space available is not sufficient. Where you have measured function or have received information that has been used in forming your opinion please explain what measurements or other tests you have performed or where you received the information from

A. Impairment (if being completed by the same person as the Part II - Physicians Report, do not complete this section) Briefly describe the condition(s) causing impairment

B. Difficulties Due to Health Conditions		
To what extent was this information collected by?	Applicant Self Report	Clinical Observation
Is the applicant able to operate a motor vehicle? Yes No		Describe any restrictions:
Script This interview is about difficulties people have because of health conditions. By health condition I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs. Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties that could be: • Increased effort • Discomfort or pain • Slowness • Changes in the way you do the activity. When answering, I'd like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30		

days, while doing the activity as you usually do it.

At the end of this form is a page that can be torn off and given to the applicant, showing the scale from None to Extreme/Cannot. Please ensure the applicant understands the scale.

In the past 30 days how much difficulty did you have in:

Cognition					
Concentrating on doing something for ten minutes?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Remembering to do important things?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Analysing and finding solutions to problems in day-to-day life?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Learning a new task, for example, learning how to get to a new place?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Generally understanding what people say?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Starting and maintaining a conversation?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Mobility					
Standing for long periods such as 30 minutes?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Standing up from sitting down?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Moving around inside your home?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Getting out of your home?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Walking a long distance such as a kilometre [or equivalent]?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Self-Care					
Washing your whole body?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot

Getting dressed?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Eating?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Staying by yourself for a few days?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Getting Along with People					
Dealing with people you do not know?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Maintaining a friendship?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Getting along with people you are close to?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Making new friends?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Sexual activities?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Household Activities					
Taking care of your household responsibilities?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Doing your most important household tasks well?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Getting all the household work done that you needed to do?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Getting your household work done as quickly as needed?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
In the past 30 days, on how many days did you reduce or completely miss household work because of your health condition?	Record number of days ____				
Work or School Activities					
Your day-to-day work/school?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot

Doing your most important work/school tasks well?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Getting all the work done that you need to do?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Getting your work done as quickly as needed?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Have you had to work at a lower level because of a health condition?				1 No	2 Yes
Did you earn less money as the result of a health condition?				1 No	2 Yes
In the past 30 days, on how many days did you miss work for half a day or more because of your health condition?	Record number of days ____				
Participation					
How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much of a problem did you have because of barriers or hindrances in the world around you?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much of a problem did you have living with dignity because of the attitudes and actions of others?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much time did you spend on your health condition or its consequences?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much have you been emotionally affected by your health problems?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much time did you spend on your health condition or its consequences?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much of a problem did your family have because of your health problems?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
How much of a problem did you have in doing things by yourself for relaxation or pleasure?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot
Other Activities of Daily Living					
Sitting for long periods such as 30 minutes?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/Cannot

Lifting 5 kilograms (10 lbs)?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Carrying 2.5 kilograms (5 lbs)?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Climbing a flight of stairs?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Speaking?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Reading?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Writing?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Hearing?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Preparing meals?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Shopping for personal needs?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Managing your own finances?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Taking your medications and renewing prescriptions?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot
Completing tasks?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/C annot

Overall, in the past 30 days, how many days were these difficulties present?	Record number of days ____
In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days ____
In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days ____

Describe assistance with daily living activities the applicant receives or needs:
Family Friends Health Professional Community Service Agency Other
Devices: (list devices to check off)
Assistance Animals

C. Additional Comments

D. Source of Information
Describe how and from whom this information was gathered:

E. Relationship with Applicant (if being completed by the same person as Part II - Physician's Report, do not complete this section)
How long have have know applicant?

How often do you see the applicant?
Describe any services that you or your organization provides or has provided the applicant:

Certification – as in current form