Social Security Administration

"Use of Functional / Vocational Expertise" Project - Final Report

Core Report: Expert Panel's Recommendations

Transmittal Note

August 27, 2007

This document is the centerpiece of the final report for a project commissioned by the Social Security Administration. The purpose of the project was to obtain expert advice on how to best use functional and vocational expertise in SSA's disability programs. The project was conducted by Webility Corporation and SSDC. It involved extensive input from a panel of twenty experts in relevant professions.

The entire final report was recently accepted by SSA, which also granted permission to release it to the public. These materials will be of interest to a wide variety of audiences. We hope that readers will find them useful.

IMPORTANT NOTE: The opinions, findings, and recommendations expressed in this report reflect the professional expertise and recommendations of Webility Corporation, SSDC, and the expert panelists. The report should not be interpreted as representing the viewpoints or philosophy of SSA, nor should it be interpreted as representing any present or future changes to vocational or occupational policy administered by the Social Security Administration.

Other components of the Final Report and additional project documents can be found at www.webility.md. While the project has officially concluded, we welcome dialogue with interested readers. Questions about Social Security's program policy should be directed to them, however.

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Social Security Administration
"Use of Functional / Vocational Expertise" Project

Core Report: Expert Panel's Recommendations

Final Report

(See Supplemental Report for additional information.)

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Core Report: Expert Panel's Recommendations

SSA Use of Functional / Vocational Expertise Project

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SSA Use of Functional / Vocational Expertise Project

Executive Summary

Background: Early in 2006, The Social Security Administration (SSA) commissioned a project to obtain advice from an expert panel on how to best utilize functional and vocational expertise in administration of SSA's disability programs. SSA requested the project's expert panel to work within the context of the Disability Service Improvement (DSI) initiative, and to provide guidance to:

- Determine how to provide needed vocational and occupational medical expertise at all levels of the disability determination process to improve the quality of case adjudication.
- Determine how the needed expertise should be provided – specifically, should SSA create a national or regional cadre which would be available to all disability adjudicators?
- Determine what qualifications candidates should have to provide vocational and occupational medical expertise.

SSDC, working in collaboration with Webility Corporation, conducted the project, referred to as the F/VE Project. The project team, itself led by experts in this field, assembled and worked extensively with a 20-member panel comprised of medical, psychological, functional, and vocational experts along with policy experts, disability advocates, and SSA staff, culminating in a two-day panel meeting in July 2006.

Structure of Report: The attached documents – the Core Report and Supplemental Report – constitute the final report of the F/VE project.

- The Core Report lays out the expert panel's recommendations. It also includes appendices that describe the recommended expert qualifications in detail, expand on the recommendation to perform Multi-Dimensional Assessments, and provide hypothetical case examples that illustrate key recommendations in action.
- The Supplemental Report provides additional detail and background information.
  - Design Details for the Multi-Dimensional Assessment (MDA) describes the cornerstone recommendation. The MDA is a face to face assessment of selected disability applicants by credentialed experts in order to more fully understand their situation.
  - The Nature of Functional and Vocational Expertise defines these types of expertise, the professions which possess them, and how SSA can best access the appropriate experts to assist in reviewing disability applications.
  - Use of Functional and Vocational Expertise in Other Systems briefly describes how several related disability systems use functional and vocational expertise.
  - Project History presents a brief summary of the project's methodology.

Terminology: For clarity and to match common usage in the relevant professions, this report uses the term *functional* in lieu of *occupational medical* expertise. It also uses the term *medical* to cover physical, cognitive, and mental health issues.

The report begins with definitions that distinguish medical, functional, and vocational expertise, all of which may be possessed to varying degrees by a particular individual. The report uses the acronym mFV to

describe experts, meaning medical-functional-vocational. The three terms are combined because a mixture of these three expertise types is commonly found among highly experienced individual experts in the disability-related professions. Virtually all functional and vocational evaluations in the SSA disability programs benefit when involved experts have had substantial professional experience working with people with disabling medical conditions and therefore can fully understand and anticipate the effects of medical conditions and resultant issues. Many evaluations require that experience.

Purpose, Scope and Applicability of the Recommendations: The recommendations were formulated with the objective of making the correct decision regarding benefit award as early as possible, maximizing the likelihood that those who can return to work actually do so, and being a responsible steward of public funds. They assume that the current legal definition of disability (42 U.S.C. 423 (d)) remains in force. The recommendations apply to all uses of mFV expertise at all levels of the administrative process: in adjudicating applications for benefits, in conducting continuing disability reviews, and in any activity SSA might undertake with beneficiaries regarding return-to-work. In general, the recommendations apply primarily to claims reaching Steps 4 and 5 of the sequential determination process, where the applicant's ability to work is in question.

Recommendations: The recommendations cluster into five groups:

Group 1: Broaden the Range of Professions Involved and Maintain a Qualified Pool of Experts Adequate for SSA's Needs. All mFV expertise should be provided by a national pool of appropriately qualified individuals who meet specific credentialing as well as on-going training and performance requirements. A broad range of expertise should be included in the pool to meet the widely varying needs encountered across all SSA disability cases.

The seven recommendations in this group specify the eight professions that are the best sources for mFV experts to include in SSA's registry: (alphabetically) nurse case managers, nurse practitioners, occupational therapists, physical therapists, physicians, psychologists, social workers, and vocational rehabilitation counselors. Recommendations are made for requirements in education, experience, certification, and other areas for registry members. (Detailed specifics are provided in Appendix 1.) Suggestions are provided on how to recruit the mFV experts and manage the registry.

Group 2: Utilize Appropriate mFV Providers and Approaches on Each Case. The mFV provider(s) used on each case should be appropriate for its specific circumstances. The expertise actually provided must match or exceed both the nature and level of expertise needed given the circumstances. Similarly, the approach taken by the mFV expert(s) to address the questions at issue should fit the situation.

There are five recommendations in this group which lay out how SSA should rely on mFV experts to perform a triaging process that will divide all claims into three complexity classes, use pre-established protocols to determine how the evaluation will proceed, and then assign mFV experts appropriately using four expertise tiers. (Detailed specifics are provided in the appendices.)

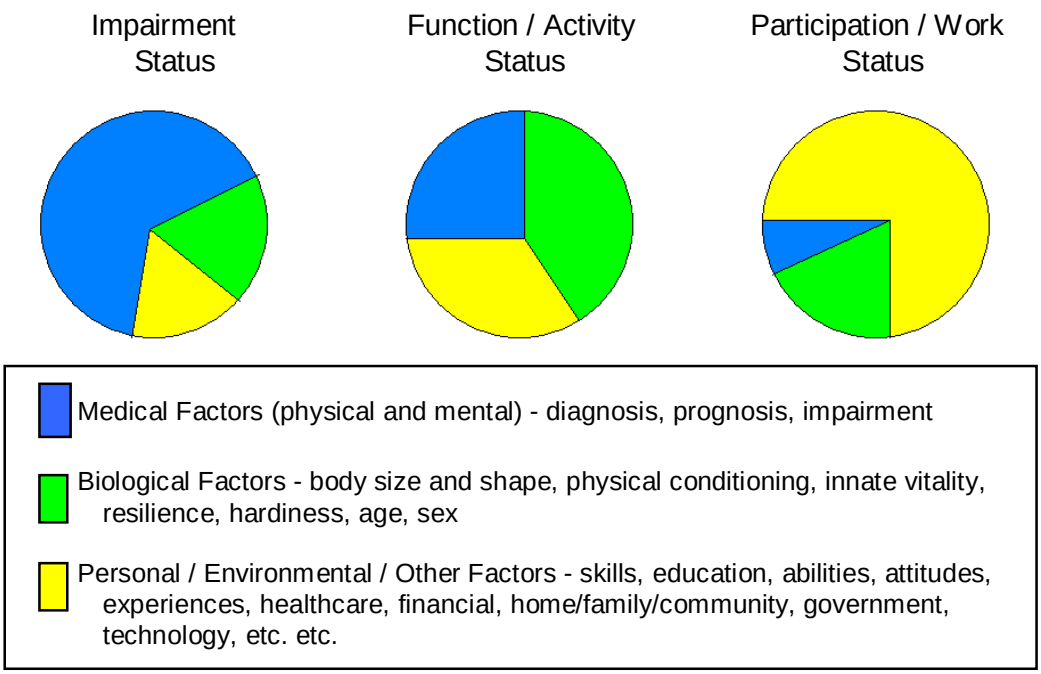
Group 3: Build a More Complete and Informative Picture of Work Ability Before Making Decisions. SSA should assemble a more complete picture, as early as possible, before making decisions on moderate to complex cases that are not resolved at Step 3 of the sequential determination process, using community-based mFV experts to do so.

Although strictly medical factors contribute heavily to impairment status, research has shown that they frequently have much less relative impact on work status. In order for the statutorily-required assessment of the causal relationship between impairment and claimed inability to work to be accurate, it should acknowledge the existence of the major known contributing factors in any given situation, even though some of these factors cannot by law be weighed in the disability decision itself. The panel feels

strongly that exploration and explicit acknowledgement of these contributing factors will lead to a fuller and clearer understanding of an applicant's whole situation more quickly which will in turn lead to earlier decisions, improved consistency among decisions, and greater acceptance of decisions by applicants and their advocates.

The following diagram depicts the relative contributions made by medical, biological, and other factors to each of the major status questions in disability determination. (The proportions shown for the hypothetical case below are illustrative only and will vary from situation to situation.)

ILLUSTRATIVE EXAMPLE: A HYPOTHETICAL CASE



All seven of the recommendations in this section are aimed at ensuring that adjudicators have access to more comprehensive information as early as possible to use as the basis for their decision making.

The expert panel's cornerstone recommendation is that face-to-face multi-dimensional assessments (MDAs) be obtained in order provide important information to help clarify the situation in appropriate complex, unclear, or seemingly inconsistent cases as soon as they reach Step 4 of the sequential evaluation process. The panel also recommends that a current MDA be required when an appropriate case nears its hearing date.

(MDAs are further described in the Core Report appendices and in the Supplemental Report.)

Group 4: Help People Return to Work, Cope Better. Medical and social science research continue to show that people's expectations for themselves in the future can play a major role in the extent of their recovery from medical conditions, the degree of functional self-sufficiency they are able to attain, and whether and when those who may eventually be able to return to work (or enter the workforce for the first time) do so.

Recommendations in this section address this fact, and are based on the successful experiences of the expert panelists and their colleagues in helping thousands of people return to work who were initially discouraged about their medical conditions.

The panel does not intend for any of its recommendations to be used to deny benefits to those who have serious medical conditions and no practical means of overcoming their effects and entering the workforce.

The three items in this group recommend that SSA ensure that communications to claimants during the disability determination process deliver empowering messages with appropriately positive expectations and recommendations for the future; that mFV experts who do MDAs should offer to share the individualized strategies they develop for removing barriers to work with claimants; and that claimants should be connected with (as far as legally possible) services that can help them remove those barriers.

Group 5: Provide More Individualized Determinations. The expert panel recommends moving away from reliance on generalized proxies towards more individualized disability determinations. The original goals of consistency and accuracy that led to the use of proxies can be better fulfilled by bringing in qualified mFV experts along with enforceable requirements for their training and satisfactory performance, protocols for how to apply their expertise, and provision for on-going use of specific methods to assure the quality and consistency of their work.

SSA must maintain efficiency in their processes as well as fairness and equity for all applicants in doing this, however, and must balance (a) the need for consistency and objective determinations based upon an agreed-upon set of criteria with (b) the desire to have more individualized and personalized collection and analysis of information for each applicant.

The two items in this group recommend a gradual and orderly retreat from relying exclusively on the *Dictionary of Occupational Titles* (DOT) and DOT-based methods and tools for addressing the questions of Step 5 in the sequential determination process; and revisions to and reduced dependency on the vocational grids.

Acceptance and Implementation Issues: The expert panel encourages SSA to seek creative approaches to implementing the recommendations that will work within existing laws and regulations, and if that seems impossible, to modify the recommendations to fit those constraints. Once the recommended changes are made, the panel anticipates that the number of appeals will drop along with the costs for administering them, and that more beneficiaries will eventually find a way to return to work, reducing both administrative burdens and future benefit costs. The panel had no basis for predicting specific changes to overall acceptance and denial rates.

Conclusion: The expert panel is pleased with SSA's intention to improve the information provided to disability adjudicators, and believes improving access to functional and vocational expertise throughout SSA's disability determination process will allow adjudicators to make decisions based on better measures of function and ability to work.

For more detailed information, we encourage readers to review the Core Report and its accompanying Supplemental Report.

Core Report: Expert Panel's Recommendations

SSA Use of Functional / Vocational Expertise Project

A. Introduction

This document contains the recommendations from a project commissioned by Social Security Administration (SSA) in January 2006 to obtain expert advice on how to best utilize functional and vocational expertise in administration of SSA's disability programs.

It provides concise statements of the expert panel's recommendations, along with essential underlying conceptual foundations for them. It is intended for readers already familiar with SSA's disability processes and current situation, and does not present any of that information as background (since it is readily available in publications available from SSA). Detailed appendices are included to provide additional support for key recommendations.

Useful additional material relevant to this project appears in the Supplemental Report, notably a discussion of functional and vocational expertise, and an elaboration on the recommendation to use multi-dimensional assessments.

B. Project Scope

SSA's RFP requested the project's expert panel to work within the context of the just-proposed revisions to the disability determination regulations (since implemented) and to give advice to (quoting from the RFP):

- Determine how to provide needed vocational and occupational medical expertise at all levels of the disability determination process to improve the quality of case adjudication.
- Determine how the needed expertise should be provided – specifically, should SSA create a national or regional cadre which would be available to all disability adjudicators?
- Determine what qualifications candidates should have to provide vocational and occupational medical expertise.

C. Terminology and Definitions of Expertise

For clarity and to match common usage in the relevant professions, this report uses the term "**functional**" in lieu of "occupational medical" expertise.

An important initial step in the project was deciding on a clear and useful definition of functional and vocational expertise. To do this, the project team inventoried the disability determination tasks requiring this expertise, and studied the professions appearing best prepared to do those tasks. Three clusters of expertise types emerged that will powerfully help distinguish professionals on whom SSA should rely from those it should not. The expertise types are medical, functional, and vocational. (Caution: these expertise types do not correspond to individual professions. For example, "vocational expertise" should not be interpreted as "vocational rehabilitation counselors." Many professions typically have varying amounts of expertise in more than one area.)

"**Medical** expertise" covers:

(1) medical and psychological diagnosis, treatment, pathology, prognosis; ability to assess impairment of body structures as well as of physiological and mental processes

(2) anticipating the current and future implications of a medical condition for function, and determining work restrictions required due to medical risks posed by employment. For our purposes, "medical conditions" include mental / psychiatric as well as physical ailments.

"**Functional** expertise" covers:

(1) detailed assessment of a person's ability (or lack thereof) to perform typical activities required to participate in daily life and work, and to do particular activities such as the component parts of a given job or carrying out social and workplace roles

(2) devising specific plans in concert with the person and delivering the services to enhance those abilities (though the Social Security Act precludes SSA itself from delivering these services to applicants).

"**Vocational** expertise" covers:

(1) knowledge of the nature and requirements (functional abilities, skills, aptitude, education, etc.) of the universe of jobs in the economy, and the patterns of availability of those jobs

(2) helping to find and create the best fit between a given individual and potentially available jobs and career paths, including general identification of and general planning for any preparation and development required, such as education and training, improvements to functional abilities, adaptive equipment, etc. (though again, the Social Security Act precludes SSA from delivering these services to applicants).

NOTE: In this paper **"vocational expert"** means someone who has substantial expertise with a broad range of vocational issues. This term is distinct from the capitalized term "Vocational Expert (VE)" used by SSA to describe someone who testifies at hearings.

This report uses the acronym **"mFV"** to mean "medical-functional-vocational." The three terms are combined because a mixture of these three expertise types is commonly found among individual experts in the disability-related professions. The "m" is lower case to indicate that the "medical" portion of the expertise may simply be familiarity with medical issues – it does not signify the deep technical knowledge required for diagnosis and treatment. Some "medical" must be included because virtually all functional and vocational evaluations in the SSA disability programs benefit when involved experts have had substantial professional experience working with people with disabling medical conditions – physical and/or mental – and therefore can fully understand and anticipate the effects of medical conditions and resultant issues. Furthermore, many evaluations require that experience.

See Appendix 1 and the Supplemental Report Part II for a more-detailed description of the tasks, professions, and expertise types.

D. Recommendations

This section documents the project's expert panel's key recommendations. The recommendations were formulated with the objective of making the correct decision regarding benefit award as early as possible in the process, maximizing the likelihood that those who can return to work actually do so, and being a responsible steward of public funds.

The panel consisted of experts from a wide range of professions and perspectives, although the majority was healthcare professionals with extensive work experience in dealing with situations with mixed medical, functional and vocational issues. (See Appendix 5: Project Participants.) None of the panelists held themselves out as experts on all topics of discussion. On specific points outside their own areas of expertise, each deferred to those panelists who were most expert in that area. Therefore, while unanimous expert agreement was impossible due to variability in the panelists' backgrounds and professions, there was (with only minor exceptions) general consensus among the panelists on each recommendation the panel makes in this report and no major objections.

The recommendations are grouped into several topic areas, with the most immediately actionable generally appearing first. The recommendations assume that the current legal definition of disability (42 U.S.C. 423 (d)) remains in force. Though the recommendations propose many changes, none are intended to alter that definition. Outside the definition of disability, some recommendations may require policy, regulatory or legislative changes.

The recommendations apply to all uses of mFV expertise at all levels of the administrative process: in adjudicating applications for benefits, in conducting Continuing Disability Reviews, and in any activity SSA might undertake with beneficiaries regarding return-to-work.

In general, the recommendations apply to claims where the applicant's ability to work is in question, and not to claims that resolve in Steps 1, 2, or 3.

D.1. Broaden the Range of Professions Involved and Maintain a Qualified Pool of Experts Adequate for SSA's Needs

All mFV expertise should be provided by a national pool of appropriately qualified individuals who have met specific credentialing requirements. A broad range of expertise should be included in the pool to meet the widely varying needs encountered across all SSA disability cases.

1. Expand the range of professions now involved in the disability determination process to include functional experts as well as medical and vocational experts. Include experts in physical, cognitive, and mental / psychiatric impairments, which often call for quite different knowledge, skills and approaches. The professions to supply mFV experts should be (alphabetically) nurse case managers, nurse practitioners, occupational therapists, physical therapists, physicians (with specialists in occupational medicine, physical medicine & rehabilitation and rheumatology preferred), psychologists, social workers, and vocational rehabilitation counselors, as well as SSA's disability claim examiners and vocational specialists. (See Appendix 1 below for more details.)

2. Build and maintain a Registry of individual mFV providers who meet the qualifications recommended below and in Appendix 1, designed primarily for use by disability adjudicators in selecting mFV providers. Include enough information about registrants' capabilities and expertise to support selection of mFV providers best-suited for particular cases. Keep the Registry up-to-date over time.

3. Establish, as proposed in detail in Appendix 1 below, minimum Registry qualifications to be met by all mFV experts.

    a. In addition to completing the basic required education for the profession, base initial qualification on credentials indicating mastery; evidence of substantial mFV-related

work activity; supplementary education on pertinent topics, including recent continuing education credits; and written work samples or other evidence demonstrating appropriate decision-making in the “real world.”

b. Place each individual mFV provider into one of four Tiers that define different levels of mastery. Tier I contains informally-trained mFV "Practitioners"; Tiers II, III, and IV contain increasingly-skilled mFV "Experts" – Expert, Senior Expert, and Sub-Specialist Expert. See Appendix 1 for specific definitions of the Tiers for each mFV profession.

c. Develop and deploy SSA-specific training for all mFV providers that teaches the basic required foundation of knowledge required to serve SSA well. Once this training is available, make completing it a pre-requisite for mFV qualification.

d. To remain qualified, require six hours of SSA-approved relevant continuing professional education annually. Also require continuing good quality work products evidenced as described below.

4. To ensure that enough qualified mFV experts are interested in participating, and also that a suitable mix of professions is interested, increase the fees paid to be reasonably competitive with open market rates. The project panel believes that if fees are set similar to current VE payment rates, SSA is very unlikely to obtain the experts needed. Consider varying rates based on profession, expertise level, tasks done, and prevailing regional fee levels.

5. Institute ongoing processes to build and maintain consistency, quality, and effectiveness levels of the mFV experts. Pro-actively engage them in activities that teach, provide feedback, provide learning opportunities, and build a sense of commitment and responsibility. Examples are mentoring programs, multi-expert panel reviews of complex cases, case study discussions, peer reviews, and focused training sessions in addition to the continuing education requirement mentioned above. These need not be extensive nor expensive to be effective.

   Find, sponsor, and create courses that help maintain and improve mFV providers' effectiveness for SSA.

   In addition, regularly assess the quality of mFV experts' work via peer reviews, quality reviews, and analysis of work product results including rates of appeals and reversal rates. De-certify those whose opinions are frequently rejected for accuracy, bias, poor science or other systematic causes.

6. Maintain a geographic distribution of mFV experts that is appropriate to SSA's needs, and that allows use of the best-qualified experts wherever possible. mFV experts who do the face-to-face multi-dimensional assessments and in-person objective testing recommended in section D.3 below should be widely dispersed to allow direct contact with applicants without requiring lengthy travel. Those who provide expertise on job market conditions should have regional knowledge, and generally should be regionally distributed. Those who will attend hearings in person should be distributed to allow that without substantial travel. Other than for these considerations, since case records are available electronically, no particular geographical distribution of experts is required, and centers of excellence or other concentrations of mFV experts can be used when that appears advantageous. Since local concentrations of experts can enable administrative

and quality management processes to be somewhat more efficient and effective, and can encourage productive inter-expert dialog about mFV topics, these should be sought as long as they raise the overall available expertise levels.

7. Engage one or more existing commercial organizations that build, manage, and support medical networks – and who thus have experience in finding, qualifying, contracting with, and managing medically-related professionals – to help efficiently assemble and maintain the registry of qualified providers (though SSA may choose to contract with some mFV experts directly or hire them outright), and to help SSA manage and support those providers. The numbers of mFV experts needed in the registry will become apparent over time as usage patterns emerge. Where feasible, use organizations that already include one or more of SSA's professions of interest in their credentialed networks. Use these organizations to administer at least some of the effectiveness management programs recommended above in item 5, such as case discussions, peer reviews, and multi-expert panels.

D.2. Utilize Appropriate mFV Providers and Approaches on Each Case

The mFV provider(s) used on each case should be appropriate for its specific circumstances. The nature and level of the expertise provided must match or exceed that needed, as dictated by the nature of the case. Thus, as a general rule, for each case with a clearly identified main area of impairment, the mFV provider assigned to that case should be the best available match. The project panel was united in agreeing that in many complex cases, particular rather than general mFV expertise is required to fully understand the case and draw appropriate conclusions about functional and vocational issues. The different domains of expertise required across all SSA cases span a very wide range, some overlapping hardly at all with others (for example, the ability to assess the implications of extreme psychiatric conditions in SSI applicants who have never worked, compared with ability to assess the implications of permanent debilitating physical injury in an SSDI applicant with a long and successful work history).

Similarly, the approach taken by the mFV expert(s) to address the questions at issue should fit the situation. For example, individual case circumstances may indicate that a face-to-face multi-dimensional assessment should be done, or that objective functional testing be performed, or that a panel of multiple mFV experts should jointly agree on conclusions.

Expect to learn how best to make the selection of mFV Experts with experience gained over time, improving on the initial approaches taken.

8. Develop and utilize a formal triage process to select (a) appropriate mFV providers and (b) claim evaluation pathways / strategies based on the specific characteristics of each case. Base these selections on the medical (physical and/or mental), functional, vocational, geographical, socio-economic, cultural and other information about the individual applicant included in the benefits application materials, and on inferences and risk assessments from that data. Assign a complexity class to each claim to help make the selection decisions. Specify the profession, expertise Tier, and particular domains of expertise required of the mFV expert(s) sought as well as the initial estimate of tasks to be done. Assign multiple experts when needed, and define how they will coordinate their work. Avoid assignment of the same expert for multiple hearing levels of the same case. Develop and use predictive software applications (like those in the Quick Determination Process) to automatically make these selections where possible. When automated selections are not possible or desirable, use well-qualified and trained mFV experts to

make the initial assignments. Re-look at cases as they unfold, especially if they meet defined "trip-wire" conditions, and re-assign experts or revise claim-handling strategies as needed.

9. Build and maintain a set of standard claim evaluation pathways to roughly structure the strategy for applying mFV expertise to individual claims, for use in the selection process described above. Cover a broad range of claim situation types in these standard pathways, but allow for custom-tailored strategies in cases that are unusual. Identify the linkages between situational factors and the appropriate choice of pathway. For example, psychiatric conditions require a very different approach than physical. For mFV purposes, these pathways should concentrate on mFV-related processes, but it would be beneficial to have these pathways include other aspects of the claim process as well to streamline and enhance the entire process. Early checking for undiagnosed mental health concerns should be a standard component of these processes. Consider dedicating teams to specific complex or difficult pathways to build and concentrate expertise.

10. Actively encourage interactive collaboration among mFV experts, and using a formal set of rules, require it when appropriate. Repeated exchanges of medical, functional and vocational information may be required to build an increasingly thorough and specific picture of an applicant's situation as a case moves through Steps 4 and 5. (A standard way that other insurers accomplish this is via regularly scheduled discussions of complex claims at multidisciplinary “roundtables” that also serve as informal training opportunities. Interdisciplinary teams in rehabilitation centers routinely address work disability and return to work planning issues.)

11. So that the process of selecting experts and pathways is effectively integrated into the entire adjudication process, train SSA and DDS staff to understand the distinctions between medical, functional, and vocational expertise; to distinguish between the various types of claims issues and tasks that call for mFV expertise, as well as the specific types of expertise required to address them; to know the typical skill sets of members of the various mFV professions; and to understand how to apply the defined pathways.

12. In order to assure that the most accurate opinion by the best qualified mFV expert is given appropriate weight in the determination process, train adjudicators on how to apply standards for weighing mFV evidence: spotting the hallmarks of an opinion with a solid basis, and assessing the relative degree of mFV expertise among varying opinion sources, including treating clinicians. This is important because opinions about applicant function currently come from many sources, and not infrequently are contradictory. Because the distinction being made between traditional medical versus functional expertise is new, adjudicators will need a strong conceptual framework to appropriately weight differing opinions about restrictions, limitations, and functional capacity.

    (Reminder: Medical expertise is different than functional expertise. While treating clinicians may have a global and intuitive sense of whether their patients are able to return to work, most traditionally-trained clinicians lack the clinical and conceptual tools that constitute disability-related medical and functional expertise, having never been educated in these areas. As a general rule, treating clinicians will readily defer on functional issues to another healthcare professional whom they perceive to have real expertise in that arena.)

D.3. Build a More Complete and Informative Picture of Work Ability Before Making Decisions

Even with the most appropriate internal mFV providers (Recommendation D.1) assigned to do the most appropriate tasks to provide evidentiary support for the determination process for each case (Recommendation D.2), the data about the applicant's situation with which those providers work must be adequate in order for them to do their job well. The project panel recommends that SSA assemble a more complete picture, as early as possible, before making decisions on cases that are not resolved at Step 3, using community-based mFV experts to do face to face multidimensional assessments (MDAs) and simple functional testing when the complexity or nature of the case makes such involvement appropriate.

An essential part of Steps 4 and 5 is establishing a credible causal relationship between the medical condition(s), the documented impairment(s) and the claimed inability to work (at or above the substantial gainful activity [SGA] level). According to the statutory definition of disability, inability to work must be "by reason of" an impairment which must "result from" a medical condition.

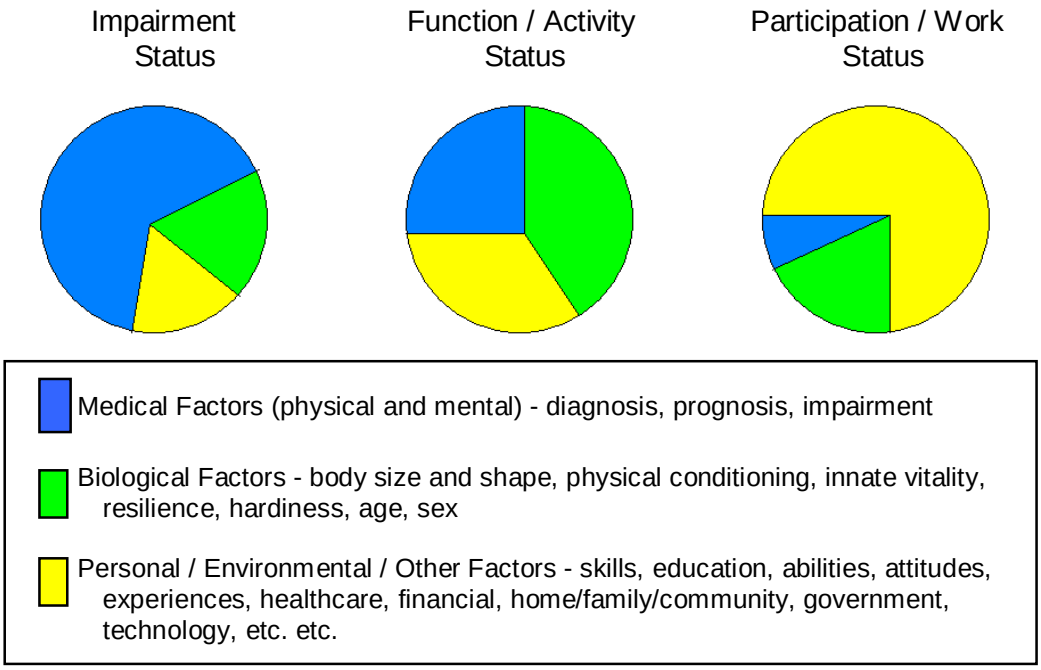
The mFV experts described in Appendix 1 are highly skilled professionals trained in assessing the impact of medical conditions on ability to function and to perform in the workplace. They should ask: What limitations on function has the applicant reported? Is it possible the claimed effect is being understated or overstated by the applicant? Are other limitations also typical for this medical situation, but the applicant has not mentioned them? Are the reported limitations consistent with the nature and severity of the diagnosed conditions and impairments, are they more likely the result of something else, or are they not consistent with known facts? These can be difficult questions to answer, and that is why experts are needed. The recommendations in this section are aimed at ensuring that mFV experts develop and use the best information possible as early as possible in answering these questions, and that adjudicators have full and complete answers to these questions for their decision making.

The panel feels strongly that face-to-face contact between an applicant and an mFV expert will provide important information to help clarify the situation and lead to an earlier correct decision in complex, unclear, or seemingly inconsistent cases that reach Step 4, and should be required in those circumstances.

Strictly medical factors contribute heavily to impairment status, but research has shown that they frequently have much less relative impact on work status. A broad range of additional factors in non-medical life domains strongly influence whether applicants are able to work in the "real world." In some medical conditions and clinical situations, personal and environmental factors are tightly intertwined with the strictly pathology-related ones. In these cases, establishing a full and accurate picture of the factors that are the proper legal basis for decisions requires that factors in neighboring domains also be explored in order to determine the relative contribution of each. Building a more complete view of the whole situation strengthens the credibility of the investigation that has been done, especially if it is made clear what has and what has not been considered in the decision.

This more complete view will also help identify obstacles to working that have the potential to be removed, no matter what domain they are in. The route to return to work is to remove the obstacles when that is possible. For example, the inability to speak or read English whether due to lack of education, a different mother tongue or a treatable learning disability is a major vocational handicap which can often be remedied.

The following diagram depicts the relative contributions made by medical, biological and other factors to each of the major status questions in disability determination. (The proportions shown are illustrative only.)



In order for an assessment of the relationship between impairment and claimed inability to work to be accurate, it should acknowledge the existence of the major known contributing factors in that given situation. Failure to do so can create the appearance of inadequate mastery of the facts, of inaccuracy, of unfairness, or of irrationality. The panel feels strongly that exploration and explicit acknowledgement of these factors will lead to earlier correct decisions, more apparent consistency among decisions, and greater acceptance of decisions by applicants and their advocates.

13. As an aid to the disability determination process, in assessing whether inability to work arises by reason of the claimed impairments, mFV experts as well as adjudicators should be required to answer this question: "What specifically is preventing this person from working today?" Doing this will help focus the investigation on the causal relationship between impairment and inability to work, and help build a solid case for either awarding or denying benefits.

    A closely related question should also be informally addressed at the same time: "What would be required (have to happen) for this person to return to work or enter the workforce if not previously employed?" The response will help answer the previous question, and also will be useful to applicants under certain circumstances (see the next item and Section D.4, item 20 for details).

    mFV experts are uniquely qualified to address these questions, and to help disability examiners understand the implications of the answers. This is also the "natural" orientation of members of the helping professions that will be providing mFV expertise, and will make their involvement with SSA more professionally and personally satisfying.

14. As a supplement or alternative to the consultative examination (CE) now performed when additional medical information is required to process a claim, institute a multi-dimensional assessment (MDA) – a similar community-based evaluation but one performed by mFV experts – when additional functional or vocational information is needed to process a claim. In the quest to understand the causal relationship between the medical condition, resulting impairments, and their effect on ability to work, the MDAs should explore the full range of life domains relevant to those issues.

    Research has shown that people who are filling out written applications make mistakes, forget to mention relevant information, or do not realize that certain details are pertinent. They may also decide to leave out, minimize, or exaggerate pivotal facts. A structured face-to-face session between applicants and community-based mFV experts can address these key shortcomings of written forms. Structure can be provided via paper or electronic formats. In the face-to-face MDA, mFV experts will (a) observe applicants, elicit from them additional information that will provide a more complete picture of their situation, and perform simple functional tests as indicated, all of which will in turn provide a more solid basis for adjudicators' decision-making in complex cases, and (b) when appropriate, provide expert input to applicants about possible opportunities for their functional recovery and future participation in the workforce.

    MDAs should be performed during the initial disability determination process: (a) when systematically-applied selection criteria have identified complexities, uncertainties, or inconsistencies in a claim that an MDA could help resolve; or (b) when an application appears likely to be denied, or has been denied, **and** there is a good chance that an MDA might help the applicant return to work / begin to work, or might help the applicant cope more effectively with the life situation caused by their medical condition.

    Prior to any appellate proceeding in which functional or vocational ability are at issue, or under other circumstances where the report of a recent MDA would be materially useful, an MDA done no less recently than 90 to 120 days before should be provided to the ALJ.

    The panel recommends that MDAs be relatively brief – roughly 90-120 minutes (which is typical for an intake screening assessment of a complex new patient or client by most of the professions in which mFV experts are found). This duration will give mFV experts enough one-on-one time to use their professional skill at interviewing, listening, and observing to explore the applicant's situation in more depth. They will be asked to confirm essential facts and issues or identify new ones.

    The mFV experts will follow a structured format during the session to help ensure all relevant topics are covered. As an important example, this structured MDA format will include a screening for mental health issues for all claims with a primarily physical condition as the basis for claimed inability to work because mental health issues are often missed or not explicitly acknowledged by treating clinicians. This mental health screening will be simple and brief (five minutes or less), developed by psychologists for use by non-psychologists. Additionally, a pre-defined template and formally-articulated specifications will be used by the mFV expert to prepare the report.

    The expert conducting the MDA may recommend that additional evaluation or special functional tests be performed by another mFV expert prior to finalizing the report of the MDA if further objective information is needed. In this case, a second short telephonic follow-up session can be offered to the applicant / beneficiary.

The written MDA report will capture data, analyze results, and include the mFV expert's professional opinions. It will be separated into two parts. Part 1 of the MDA report will document the applicant / beneficiary's current functional status in domains in which key barriers to employability often exist (medical, physical, mental, socio-economic, environmental, perceptions); document results of observation and testing along with the applicant's behavior and comments; explicitly address the causal chain and consistency of findings; and identify specific barriers to work in any life domain. In addition, the mFV experts will opine as to what specifically is preventing the applicant from working today and what would be required (have to happen) for the applicant to return to work or enter the workforce if not previously employed.

Part 2 of the MDA report will not be created in all cases. When feasible, the mFV expert will prepare Part 2, which will lay out a general strategy for removal of barriers to employability, including examples of potential solutions and a timeline; and when appropriate, will suggest options for needed services. These RTW plans should not be lengthy, detailed, or highly-specific with vendors named, nor should any funding be attached or obligated. Self-referral by the mFV experts should be prohibited unless no other reasonable local resources exist.

SSA's disability determination staff and ALJs will receive Part 1 but not Part 2 of the MDA report. All the information in Part 1 including any functional testing results will be added to other information in the claim file, and enrich the basis upon which the RFC is determined and the adjudicator makes the benefit award decision. Part 2 will be offered to the applicant / beneficiary and made available to them upon request, and will also be sent to those responsible for linking the person to resources that can assist in implementing the plan, and to helping professionals to whom the applicant / beneficiary is being referred or is already working with. Data from Parts 1 and 2 will also be kept in the database referred to in item 15 below.

SSA should require that an interdisciplinary team of mFV experts develop the formal MDA process – its structured format, screening methods, interview guides, data capture tools, and the template and specification for the report.

(See Appendix 2 and the Supplemental Report for more information on MDAs.)

15. Key portions of the information in each MDA report should be captured in SSA's data system and used in program analysis efforts to improve system outcomes. Data captured should include the barriers to working faced by applicants / beneficiaries as well as the strategies and plans identified for removing them, and the mFV expert's assessment of the likelihood of success. This data, when analyzed in the aggregate, will permit researchers to identify important commonalities and patterns, especially when the data can be compared with benefit claim decisions, referrals for services, and vocational outcomes. The database could thus lead to specific program and policy changes to improve access to services that will improve outcomes. For example, research may reveal that a large number of SSA applicants are unable to work due to the lack of prosthetic and orthotic devices, but that those who are referred for and are able to take advantage of this type of service are more likely to leave the SSA rolls. In that case, an initiative could be undertaken to improve utilization of those particular services. .

16. On a selective basis, following guidelines that have yet to be determined, utilize community-based mFV experts to assess function, and as part of that process to administer appropriate, scientifically-validated tests to obtain objective evidence about applicants' functional abilities. (A few examples are hand/finger dexterity tests, treadmill

tests of aerobic capacity, automobile driving tests, assessment of communication and interaction skills, and tests of recognition and memory.) Build on work done in this area during previous SSA projects to develop and maintain a list of acceptable tests. Though these tests will not by themselves yield definitive proof of ability / inability to work (and should not be treated as if they do), they often open up productive topics of conversation with applicants, contribute additional useful data and detail for the disability determination process, and can help adjudicators achieve appropriate claim resolutions faster.

17. Over time, revise the written forms requested from applicants and mFV experts to ensure they collect the most appropriate and useful information for making accurate determination decisions. Rather than administrative conveniences, SSA's claim application forms should be treated like they are screening or testing instruments and thus be rigorously designed and field tested with significant support from experts in instrument design. This is crucial because SSA's written forms play such a major role in the disability determination process: they are **the** place where applicants describe in words what the impact of their medical condition is on "real life." Each form should be engineered to ensure its validity, meaning that the answers taken as a whole adequately portray the underlying reality. Individual questions should be phrased in a way that does not suggest the "right answer," should not be open to multiple conflicting interpretations, and should be tested for sensitivity and specificity. The physical layout should ensure that omissions and errors by applicants are minimized. The use of forms rigorously developed in this manner should be standardized throughout SSA and the DDSs. As possible, electronic versions should be deployed that help ensure accurate and complete information is provided by applicants. SSA should expect and plan for the ongoing need to test, update, and refine these forms over time.

    We suggest this process begin with the Activities of Daily Living Questionnaire and the several forms variously utilized by DDSs to gather more detailed information about specific conditions such as cardiac disease, depression, chronic pain, and so on.

    Perhaps most importantly, we recommend adding two questions to the basic SSA benefits claim form that all applicants fill out (subject to testing as described above). (1) "What is the obstacle to your participation in gainful employment – the specific reason why you are not working at that level today?" (The answer must describe functional or environmental causes – not the name of a medical condition.) (2) "Assuming that your medical condition remains unchanged, what would have to occur in order for you to go back to work or enter the workforce at the gainful level?"

18. Though it will take time and effort, the panel strongly recommends that SSA revise the way that restrictions, limitations and Residual Functional Capacity (RFC) are established and documented. Overall, SSA should begin with a realistic (though broad-brush) assessment of current functional ability, and then explicitly distinguish that from the narrowly-defined and theoretical RFC in order to provide a more credible foundation for subsequent decisions made based on RFC. In practical terms, rely on mFV experts to establish restrictions, limitations, and functional capacity, doing so in collaboration with strictly medical experts when guidelines indicate that is required. Ensure that these mFV experts have access to the additional information provided by any MDAs or functional testing done. Develop and use forms that record both current actual functional capacity (estimated ability to function based on all factors including deconditioning, age, sex, body habitus, voluntary restriction, etc.) and RFC (a finding of fact and a theoretical construct driven by SSA's legal definition of disability which excludes age, sex, and body habitus). This will highlight the contribution being made to the applicant's current situation by

factors that SSA is not allowed to consider, and make benefit decisions appear more rational. (Item #19 below makes a closely related point.) Develop training in how to do both of these assessments, and make the training mandatory for all those who do the work.

19. In the formal written explanation of the benefit decision, clearly and completely explain the rationale used for reaching the disability decision, covering all the prominent factors revealed during case development. Explicitly list the applicant's key and specific medical, biological, and objectively determinable personal, social and environmental factors that are contributing to the current claimed inability to work, and the effect each has. State whether each factor is or is not being weighed in the disability determination decision, and the reason for excluding any factors. Typically factors will be excluded because the legal criteria for determining benefit eligibility do not allow them.

    For a very rough example of the explanation for a single case with two prominent factors: "(1) The applicant has seizures which severely limit the range of occupations for which he qualifies. The seizures could be eliminated with medication. However, the applicant has no means to pay for healthcare and no current access to healthcare benefits. SSA's policy is that the potential effect of unobtainable medical treatment cannot be factored into the disability determination decision. Therefore the impact on ability to work due to the seizures is weighed in the disability decision. (2) In addition, the applicant is physically deconditioned and as a result currently unable to sustain prolonged exertion. However, this deconditioning is due to voluntary inactivity and not to a medical condition. Since the law states that in order for a factor to be considered, its effect on ability to work must exist by reason of an impairment which results from a medical condition, this factor is not weighed in the disability decision.") Applicants should be given this explanation when their decision is communicated, especially for denials.

D.4. Help People Return to Work, Cope Better

Using mFV providers as recommended above should result in correct decisions being made earlier in the process, on average. It should also result in an increased perception of thoroughness, realism, and fairness by applicants and their representatives, and thus fewer appeals. Because appeals will be averted, fewer people will take on the disability mindset in a long process where they must prove they are disabled, and make it easier for them to return to work when that is feasible. But the panel recommends other important steps to help both beneficiaries and denied applicants return to work when feasible.

Medical and social science research continue to show that people's expectations can play a major role in the extent of their recovery from medical conditions, the degree of functional self-sufficiency they are able to regain, and whether and when those who may eventually be able to return to work do so. The interactions that an applicant has with SSA, including those long before a benefit decision is made, have an effect on their expectations for themselves and for their future. Recommendations in this section address this fact, and are based on the successful experiences of the expert panelists and many professional colleagues in helping thousands of people return to work who were initially discouraged about their medical conditions.

The panel acknowledges that the concept of "return to work" is different for SSDI applicants than for SSI applicants who have no solid work background. The prognosis and issues to address can be very different between them. For many SSI-only applicants, there is no real work history to build on, so rather than "return to work" the issue is "entering the workforce." For SSI applicants

with serious mental conditions this is especially true. While there are clearly ways to successfully help many such people enter the workforce (and at least one expert panelist's research has shown that it is consistently possible), significant external support is typically required. The panel does not intend for any of its recommendations to be used to deny benefits to those who have serious medical conditions and no practical means of overcoming their effects and entering the workforce.

20. Design and implement a program to intentionally and actively create a beneficial experience for applicants in all of their interactions with SSA, recognizing that the decision to apply for benefits and the application process itself influence their expectations, their self-perception, and their response to the life situation precipitated by their medical condition. Draw on research, best practices in other disability benefits programs, and advice from experts in health and behavior change communications in doing this. Train SSA and DDS staff to use carefully crafted messages and materials in their interactions with applicants. Monitor outcomes to ensure the intended result is achieved.

21. Provide applicants and beneficiaries, especially applicants denied benefits (or beneficiaries found able to work in a continuing disability review [CDR]), with any information developed by mFV experts, or other experts, in the course of the determination process that might assist them in mitigating the impact of their medical condition. (Recommendation 14 above regarding MDAs has already covered some of this point.) mFV experts are trained to help their clients see other options in lieu of or in addition to disability benefits, and to assist them in pursuing those options, so those skills can be put to use here, within the constraints imposed on SSA by law. For example, an mFV expert might do an MDA and determine that return-to-work would be possible if certain steps were taken to overcome obstacles. Simply providing that information to the applicant could be valuable regardless of whether they are approved for benefits. The panel is aware that SSA has legal limits on what services it can provide. Even within those constraints SSA should be able to find ways to help the public they serve, because many will benefit from guidance or assistance in reducing the disruptive impact of their medical condition.

22. To the extent allowed by law, and building on existing programs, use linkages with other agencies in the public and private sector to help channel applicants and beneficiaries to sources of case management and other services designed to carry out the high-level plans in an applicant's MDA to remove barriers to return to work. The panel recommends that mFV experts be specifically prohibited from making self-referrals for services if other suitable alternatives are available, and avoid any appearance of conflict of interest.

D.5. Provide More Individualized Determinations

In line with our earlier recommendations to assign mFV providers who are appropriate to the specific circumstances of each claim, we recommend moving away from reliance on generalized proxies towards more individualized disability determinations. The original goals of consistency and accuracy that led to the use of proxies can be better fulfilled by bringing in qualified mFV experts along with enforceable requirements for training and satisfactory performance, rules for how to apply their expertise, and provision for on-going use of specific methods to assure the quality and consistency of their work.

SSA must maintain efficiency in their processes as well as fairness and equity for all applicants in doing this, however, and must balance (a) the need for consistency and objective determinations

based upon an agreed-upon set of criteria with (b) the desire to have more individualized and personalized collection and analysis of information for each applicant.

The panel recognizes these changes may take time and effort to establish.

23. Revise and reduce dependency on the vocational grids because they are inconsistent with the fundamental principles agreed to by the expert panel and documented in this report. The grids do not employ individualized assessments, coarsely and inadequately consider many important and relevant factors influencing ability to work, treat age in a general rather than individualized manner, and are based on out-of-date, incomplete, and inadequate DOT information about job demands and availability. Although the intention to standardize, simplify, and speed up decision making is a good one, making automatic final decisions using only the vocational grids is not appropriate in many cases. Moreover, the grids do not provide an adequate framework for decision-making in claims that do not exactly match grid criteria, and there are now many such claims.

24. Make a gradual and orderly retreat from relying exclusively on the Dictionary of Occupational titles (DOT) and DOT-based methods and tools for addressing the questions of Step 5. Allow both internal and community-based mFV experts to use (and defend the use of) supplementary or alternative approaches to describing functional job requirements, determining feasible occupations, and estimating job prevalence when they believe that the DOT information is either obsolete, incomplete, not applicable, or missing. Require that such methods and tools be based on the most solid evidence practically available and widely accepted by organizations nationally-recognized in their field. For example, utilize tools currently in wide use by vocational experts such as The Occupational Assessor by Economics Research Institute (www.erieri.com) or Choices by Bridges (www.bridges.com). Fund the development of specialized tools that will (a) support comparisons of non-exertional functional limitations with job demands, and (b) more fully describe the nature and prevalence of sedentary and light occupations and actual jobs in today's economy.

E. Implementation Considerations

Substantial numbers of mFV experts will be required to deploy all of these recommendations. Adequate resources may not be immediately available within some professions. (Over time, supply should adjust to meet demand.) We recommend multiple professions for inclusion in the Registry to reduce this risk, and to provide as many options as possible for building an adequate Registry for SSA's needs. However, monitoring and management of this issue over time will be necessary.

The challenges of creating and managing the large pool of Registry experts will be significant, especially since SSA has little experience with active management of a provider network. Working in partnership with medical network management vendors who have extensive experience should minimize the attendant risks.

Where face-to-face interactions between applicants and mVFs are needed (multi-dimensional assessments, functional testing), a video connection may be substituted only if there are no appropriate local mFVs available. The panel believes that it is far preferable to have physical face-to-face interactions.

While the panel is not expert at the legislative and regulatory constraints under which SSA operates, we endeavored to devise recommendations not requiring changes in those realms. Where such changes might seem required, we encourage SSA to seek alternative creative implementation approaches that work within existing laws and regulations, or to modify the recommendations to avoid the need for such change. Nevertheless, some recommendations may require statutory or regulatory changes.

Although development of financial models was not part of this project, the panel did keep financial impacts in mind during deliberations, and was mindful that costs will have to be reasonable and balanced by benefits in order for the recommendations to be implemented. Some administrative expenses will increase as a result of employing earlier and more detailed investigations, but it is likely that appeals will drop along with the costs for administering them, and it is likely that more beneficiaries eventually will find a way to return to work, reducing benefit costs in the future. The panel had no basis for making specific predictions about changes to overall acceptance and denial rates.

F. Conclusion

The panel feels that significant benefits can accrue from improving access to functional and vocational expertise in SSA's disability programs, and that many steps that can be taken immediately will have a big impact.

These recommendations are not based on merely theoretical precepts – the panel has hands on experiences of success in many settings relevant and related to SSA (although not identical to SSA) that support the recommendations.

Additional background for the recommendations in this report, analyses of mFV expertise, descriptive information about the professions included, and other relevant supporting materials appear in the Appendices that follow and in the Supplemental Report. Please read them for a fuller understanding of project results.

Appendix 1: Recommended Qualification Standards and mFV Expert Utilization Approach

This Appendix provides specific recommendations for criteria for membership in the mFV Provider Registry, and directions on how to utilize these providers in the disability determination process.

This appendix begins with a description of the principles and strategies that underlie the recommendations, and proceeds to concise statements of the specific recommendations. These appear in the form of several comprehensive tables with annotations. The tables:

- Lay out recommended eligibility criteria for providers in the mFV Expert Registry:
  - Table 1A – Recommended Basic Qualification Requirements for mFV Experts
  - Table 1B – Recommended Basic mFV-related Qualification Requirements for SSA Disability Examiners, Functional/Vocational Specialists, and ALJs
  - Table 2 – Recommended Additional Requirements for mFV Providers by Tier of Expertise
- Compare the relative suitability of mFV experts in various professions for different tasks:
  - Table 3 – Matching mFV Providers with Specific Tasks
- Describe in general the kinds of claim situations in which each type of mFV provider is qualified to contribute and the kinds of roles that they should be asked to play:
  - Table 4 – Assigning Roles and Responsibilities to mFV Providers Using Claims Complexity Classes and Expertise Tiers

(Additional detail, supporting materials, and related information appear in the Supplemental Report, as well as in Appendices 2 and 3, which describe the multi-dimensional assessment (MDA) and present a number of scenarios showing how the recommended approach to using mFV expertise will work in practice.)

Recommended Professions to Provide mFV Experts

One of the most important tasks for the panel was deciding upon the required qualifications for mFV experts. The panel gave this task the serious, thoughtful, and comprehensive consideration it deserves, realizing that some excluded professions or individuals would likely raise objections, and that the decision logic must therefore be very sound. The process began by analyzing and documenting in detail the tasks required of SSA's mFV providers. We then identified the professions we agreed are most likely to include a significant number of individuals able to do those tasks well. We then articulated further qualification requirements beyond basic professional preparation, thereby specifically defining subsets of the identified professions that will be fully qualified to meet SSA's needs.

These decisions were made difficult by the blurring and overlap among professions; the range of education, skills, and experience found in individuals within a given profession; and the political / economic implications of the territorial problems created by selecting one group but not another. The panel discussed these issues at length. In the end, for the sake of clarity and the project's larger purposes, the panel agreed to make distinctions that may appear arbitrary to some, but which were made after careful deliberation of experts with extensive relevant experience. The panel feels the criteria should provide useful and practical guidelines that will serve SSA well in ensuring that only appropriately qualified individuals provide mFV expertise.

The panel settled on the following professions as those within which SSA is most likely to find qualified mFV experts suitable to their needs in numbers large enough to warrant interest (listed alphabetically):

1. Nurse case managers (includes rehabilitation nurses)
2. Nurse practitioners
3. Occupational therapists
4. Physical therapists
5. Physicians (preferred specialties are occupational medicine, physical medicine & rehabilitation and rheumatology)
6. Psychologists (e.g. clinical psychologists, rehabilitation psychologists, and neuropsychologists)
7. Social workers
8. Vocational rehabilitation counselors and professions with similar basic preparation (vocational evaluators, work adjustment specialists, life planners)

Qualifications Beyond Basic Professional Education

The professions above initially prepare their members more thoroughly in some areas than others. Some are stronger on medical, others on functional, others on vocational issues. With the notable exception of Occupational Therapists and Physical Therapists, most mFV experts will have developed their specialized mFV expertise after graduation, most often through a combination of post-graduate education and work experience. Thus, beyond completing a basic professional education in one of these professions, SSA should also require their mFV experts to meet additional criteria, as follows:

1. **Credentials indicating mastery**. Experts should have the certifications, designations and/or licenses generally accepted within each profession as indicative of mastery (whether certification like CRC, CCM; academic degrees like an MA, MS, PhD; professional degrees like MD, DO, PsyD, MSOT, OTD or DPT; medical board certification; state licensure; or the like).

2. Evidence of **substantial mFV-related work experience**. This means regular and substantial personal involvement in situations where a major focus has been assessing functional and/or vocational ability, problem-solving, and facilitating return to work for people coping with an array of medical conditions. Preferably, mFV experts should have worked in settings where a collaborative problem-solving approach across disciplines has been regularly employed. They should be accustomed to a process where information is contributed by multiple sources, weighed and analyzed, and a course of action is formulated. A requirement of two years of mFV-related work experience is a reasonable minimum for most of the mFV professions.

3. **Supplementary education in F/V-related areas**. This means post-graduate training, which can take the form of either continuing professional education or additional formal schooling. Less extensive supplementary training can be required for professionals from the specialties whose core ethos involves taking a multidimensional (biopsychosocial) approach to understanding the patient's situation. More extensive supplementary education should be required for professions that are prone to take a narrower approach (either strictly medical, psychological, or biomechanical) which includes physicians of most specialties, psychologists, nurse practitioners, and physical therapists.

   Pertinent educational topics include, for example, the precepts of disability prevention and the

positive benefits of work during recovery, functional assessment, design of transitional work assignments, critical success factors in return to work, introduction to workers' compensation and disability benefit programs and regulations, and so on. At least 12 continuing education credits in return to work issues, assessment and planning (plus an ongoing annual minimum of 6 credits in pertinent topics) is a reasonable minimum.

4. A **history of appropriate decision-making** in the "real world". Since the quality of the expert's work product should be the focus, rather than the expert as a person, the typical quality of previous work products should be scrutinized before initial qualification. This could be done by evaluating written work samples, successful passage of an examination, observations made by colleagues who are SSA-certified mFV experts, and/or by an analysis of records in a database. The Registry should also explicitly provide for removal of previously-qualified providers if they produce low quality work too often. Both initial and ongoing evaluations will require SSA to establish and operate a standardized and objective quality review process using trained reviewers, including a second level review by trained peer reviewers.

(See Tables 1A, 1B and 2 below for specific details on each of the criteria above.)

Selection of Appropriate mFV Providers – Key Concepts

A key recommendation of this project is to assign mFV resources that are suited to the circumstances of each claim. This Appendix provides a detailed structure and approach for doing that.

Before selecting an expert from the mFV Registry, the following questions should be answered:

- What type of expertise is needed, based on factors in the claim situation?
- What type of expert is most desirable, with what other qualifications, in what location, and when?
- What is the expert going to be asked to do?

Before selecting an mFV expert from the Registry, a number of claim-related factors should influence the expertise requested, a number of provider attributes should be used to find a match, and a number of options should be chosen to employ in making assignments. Most of these factors are addressed in the tables later in this Appendix. Others will need to be addressed in the actual implementation process.

Key claim-related factors that drive the expertise needed include:

- Medical condition / diagnosis – whether physical or mental or both; the specific diagnosis or diagnoses and their implications (some will require subspecialist experts, some will imply difficulty of making functional assessments, etc.)
- Expected level of difficulty in resolving mFV questions, which in turn is based on medical factors and other situational factors available from the claim application
- The pathway that has been chosen for evaluating the claim, which also drives the selection of tasks that will be performed.
- The central or unresolved issues in adjudicating the claim which determine the tasks that need to be performed.

Key attributes of individual mFV providers to match against the needed expertise include:

- Which profession they belong to, including sub-categories (e.g. "Physician – PM&R")
- General level of expertise – see the definition of Expertise Tiers in Table 2
- Specific areas of expertise of importance, if any (e.g. "expert in assessing function of brain-injured individuals")
- Geographic location (though this is not always an issue)
- Availability to take on an assignment
- History of claimants worked on in the past (to prevent an expert reviewing their own work at appeal)
- Organizational affiliations (to help prevent self-referral or other conflicts of interest)

The key available options in assigning a case to an mFV provider (or providers) include:

- Which tasks need to be done
- Whether one or more than one mFV provider is to be assigned (either by choice or by necessity due to expert availability constraints)
- How much responsibility to delegate for the tasks, and to whom

Tiers to Indicate Mastery Level

The individual members of any profession listed above are not equally expert. Putting them in tiers provides a way to indicate differing personal levels of mastery, so that the required level of mastery can be specified when choosing an mFV provider for a claim. We have designated four tiers to provide useful general distinctions.

- Tier I – Practitioner – indicates individuals without formal education in the professions recommended in this paper but who have developed some familiarity with mFV subject matter through work experience.

- Tier II – Expert – indicates trained professionals who meet the minimum requirements to be an mFV expert.

- Tier III – Senior Expert – recognizes the value of years of effective hands-on practice and significant additional relevant formal education. Tier III experts will in general be better qualified than Tier II to handle more complex, unusual, difficult, or unclear cases.

- Tier IV – Subspecialist Expert – is <u>not</u> intended as a progression up from Tier III that is achieved with yet more experience, but rather as a category for highly specialized experts in specific medical conditions and impairment types that cannot adequately be handled by more generalist Tier III experts. Situations appropriate for Tier IV experts will require such narrow, focused, and deep expertise that few qualified experts exist. We have only designated physicians and psychologists as potential Tier IV members because this level of expertise is only likely to be required in situations where a unique combination of specialized medical/psychological expertise is required along with specialized functional/vocational expertise.

See Table 2 below for recommended rules for placing mFV providers into these tiers. Ultimately, providers should be judged (and placed into the proper tier) according to the wisdom of their judgments and the quality of their work products, not their resumes.

In this report, the term "mFV provider" includes individuals in all four tiers. "mFV Practitioner" refers to someone in Tier I. "mFV Expert" refers to someone in Tiers II, III, or IV.

General Aptitude of Professions to Do Specific Tasks

Likewise, the various mFV provider professions are not equally prepared to handle all kinds of mFV-related tasks. See Table 3 below for an assessment of the *typical* aptitude of individuals within each profession for handling the major tasks involved in providing mFV expertise.

See the Supplemental Report for a complete description and analysis of the tasks referred to in Table 3.

Selecting mFV Provider(s) for Individual Claims

Because medical conditions vary as do their impacts on specific people and their life situations, SSA will need to designate and train internal mFV providers to select the appropriate type of mFV provider needed for each case, to prepare the referral form that tells the selected provider what to do, and to assign a specific provider to do the work. Table 4 below provides detailed recommendations about how to make these assignments. The central issue in some claims will require a combination of strong medical expertise along with functional or vocational knowledge; other claims will revolve primarily around functional evaluation; and still others will hinge on vocational issues. Assignments should reflect these circumstances.

Geographic Considerations

Because the availability of various types and tiers of mFV providers will vary within states and across the country, SSA will need to retain some flexibility in its selection of experts. However, this variability in availability should not be allowed to result in a “lowest common denominator” approach to selection of experts. A general rule of thumb should be to select an expert who is both well qualified in the specific issues of a specific claim and available on a timely basis.

For all claims in the DDS offices, the usual practice should be to seek input from well qualified mFV Unit providers (i.e. employees of SSA or contracted internal consultants to SSA) wherever they are – even in far-flung states – since the new technology permits it. Since face to face assessment is clearly superior for MDAs and functional testing performed by the mFV Network, every effort should be made to find the most highly qualified expert available in the applicant's local area, and, if necessary, to buttress a less-appropriate local expert by having a more appropriate one participate through the use of speaker telephone or videoconferencing.

Roles and Responsibilities

Individual mFV providers will play different roles and take on different levels of responsibility in claims. Sometimes their role will be limited to a preliminary assessment of some sort. Sometimes they will serve as F/V triagers. Sometimes they will be technical contributors, collecting and analyzing specific detailed data about some aspects of a situation in order to enrich the information available to other experts. Sometimes they will serve as independent experts who make a more global assessment or decision and sign off on a final report of some kind (such as a residual

functional capacity or an MDA, described elsewhere in this report). Table 4 presents a structure for these roles and responsibilities, and guidelines for assigning them.

F/V triagers should be mFV experts who are also healthcare professionals. They are the best prepared to do a quick global evaluation to place a claim into the correct Complexity Class (as defined in Table 4), to screen for obvious possibilities of undiagnosed mental or physical conditions; to determine the initial mFV "pathway" to be used; and to determine which kind of mFV expert(s) should be assigned to evaluate the claim further. Most healthcare professionals who are mFV experts are accustomed to working in multidisciplinary environments and will know where to go for advice when they need it.

About Professions Not Included

Other professions were considered but not included in the list of sources for mFV experts for several reasons: (a) limitations of professional preparation and typical work settings; (b) limitations in the projected size of the subset of potentially mFV qualified individuals within the profession; and (c) limited absolute numbers that make the profession impractical for SSA to rely on to solve their expert person-power needs. For example:

- Most career, outplacement, and vocational counselors lack the familiarity with medical issues required to anticipate the special needs of a clientele facing the challenges of serious medical conditions.
- The nature of the professional educations of most nurses, physician assistants, and mental health counselors usually does not prepare them for the kind of multidimensional analysis and practical problem-solving required of mFV experts.
- Kinesiologists, exercise physiologists, educational psychologists, school psychologists, industrial and organizational psychologists, podiatrists, optometrists, and speech/language therapists are either available in small numbers or do not usually possess the scope, worldview and work experience that are a good enough fit with the task clusters that constitute mFV expertise.

Some individuals in these and other professions may have developed themselves into real mFV experts through extensive and relevant post-graduate study and/or pertinent mFV-related work experiences. Such individuals could be considered for inclusion in the Registry if a careful review of their background reveals that their individual course of study and work experience is equivalent to that of qualified mFV experts, and that the demonstrated quality of their work products puts them on a par with those mFV experts in the list of recommended professions. An example could be an outplacement employment counselor with years of experience helping a disabled population find appropriate jobs and remain successfully employed, and whose work reveals high quality situation analysis and problem solving skills. This same process can be used for members of professions whose numbers are too small to have been included in the panel's list.

Care must be taken to assure that this exception intended for well-qualified individuals in tangential or low-population professions be administered so as to prevent it becoming a loophole admitting inadequately qualified individuals. One way would be to require that all applications for exceptions be reviewed and approved by a panel of Tier II and III mFV experts with mainline credentials.

Tier Membership Exceptions

In a similar vein, some individuals in the mFV professions may have more extensive and pertinent formal training than is the norm for their particular profession. An example could be a nurse or

social worker with a PhD in an area that has deepened their mFV expertise. On an exception basis and after due consideration of their qualifications, such individuals could be placed in a higher Tier than they otherwise would be placed using the criteria in this report. Applications for this special placement should be reviewed and approved by a panel of mFV experts with mainline credentials in the applicable Tier.

Table 1A – Recommended Basic Qualification Requirements for mFV Experts

(See the Notes at the end of the table for important additional information)

Profession	Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience (see footnotes)	Licensure
Nurse Case Managers	Registered nurse (RN) or bachelors degree	Certification: CCM, CDMS, CRRN, or equivalent	* For RN > 15 yrs * For bachelors degrees > 10 yrs * For masters degrees > 2 yrs	Nursing license (CCM, CDMS require licensure)
Nurse Practitioners	Completion of nurse practitioner program and bachelors degree in nursing.	Certification: NP-C	** For bachelors degree > 10 yrs ** For masters degree > 2 yrs	Yes
Occupational Therapists	Bachelors degree in OT prior to 2007; masters degree in OT for later graduates.	Certification: OTR	# For bachelors or masters degree > 2 yrs	Yes
Physical Therapists	Bachelors degree in PT prior to 2002; masters degree in PT for later graduates.	n/a	# For bachelors or masters degree > 2 yrs	Yes
Physicians	Medical school and internship or equivalent MD, DO, (or equivalent foreign degrees, e.g. MB)	Completion of residency training and board certification. (Preferred are: occupational medicine, PM&R, rheumatology) > 2 yrs of direct outpatient care practice	** For preferred specialties > 6 mos ** For other patient care specialties > 1 yr *** For non-clinical specialties > 2 yrs	Yes
Psychologists	Completion of graduate program in professional psychology (doctorate or masters)	2 yrs of direct outpatient care practice Passage of the EEEP exam or equivalent	** For doctoral degree > 1 yr ** For masters degree > 2 yrs	Yes, for independent practice as a psychologist
Social Workers	Completion of academic program in social work (masters or bachelors)	If not licensed by the state as a clinical social worker: CSWCM; QCSW, DCSW, CSWH, C-SWHC or CCM	+ For masters degree > 2 yrs + For bachelors degree > 10 yrs	Yes, as required per state law

Profession	Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience (see footnotes)	Licensure
Vocational Rehabilitation Counselors Employment Specialists Work Adjustment Specialists Vocational Evaluators	Masters degree in vocational rehabilitation or closely related field	Certification: CRC, CCM, NCC, CVE, CCWAVES	++ For masters degree > 2 yrs	Yes, as required per state law

General Notes to Table 1A:

A detailed discussion of each profession appears in the Supplemental Report, which provides important supporting information for the recommendations embodied in this table.

The years of experience recommended for each profession were agreed upon after discussion by the expert panelists (among whom were several with extensive experience in training, hiring, and managing mFV professionals), and reflect standard industry practice in hiring for similar positions. Individuals with less experience could be employed as trainees or in support roles as long as they work under the direct and active supervision of a fully-qualified expert.

Specific Footnotes to Table 1A:

The experience requirements presented in Table 1A include both the minimum length of experience appearing in the table itself and the following specific types of experience indicated by the footnote symbol appearing in the table.

* Case management in a workers' compensation or other disability management setting, with responsibility for obtaining functional limitations, medical restrictions, and communicating about return to work.

** Clinical practice in a setting characterized by a higher percentage than is typical for most physicians/psychologists of adult patients with workers' compensation and disability-related issues. Examples include an occupational medicine, physical medicine & rehabilitation, brain injury rehabilitation, psychiatric rehabilitation, or rheumatology center; a combined urgent care/industrial medicine practice; an employer's company medical department; OR experience as an independent medical/psychological examiner or medical/psychological consultant file reviewer for a workers' compensation or disability insurer.

*** Prior experience as a medical consultant file reviewer for a workers' compensation or disability claims administrator or for Social Security Disability Determination Services, with responsibility for assessing ability to function.

Requirements for experience beyond the basic preparation are reduced for OT and PT compared to other mFV professions since the basic professional preparation of PT and OT consists almost exclusively of training in assessing both impairment and function, and formulating plans and delivering hands-on care to improve it where possible. The 2 additional years of work experience must be in clinical practice in a setting characterized by a high percentage of working age patients with workers' compensation and other occupational disability-related issues. Examples include an independent physical or occupational therapy practice that specializes in workers' compensation among other areas; an occupational medicine, physical medicine, sports medicine, or rheumatology clinic; a combined urgent care/industrial medicine practice; or an employer's company medical department.

\+ Direct hands-on practice with a higher percentage than is typical for many social workers of working age clients with workers' compensation and other occupational disability-related issues.

++ Work experience must consist of direct services to clients with serious or disabling medical conditions; familiarity with local / regional world of work; familiarity with adaptive equipment / worksite accommodations.

Table 1B – Recommended Basic mFV-related Qualification Requirements for SSA Disability Examiners, Functional/Vocational Specialists, and ALJs

Implementing the recommendations in this report will require some adjustment to the required qualifications, training, development, and career paths of the Disability Examiners and Vocational Specialists currently employed by SSA. The qualification and training issues to address for these positions proved different enough from those for the mFV Experts in Table 1A that they have been given their own table and notes. Table 1B, below, lays out a proposed set of qualifications specific to the F/V portion of a recommended certification program for DEs, ALJs and a new group called the SSA Functional/Vocational Specialists (F/V Specialists). The qualifications include basic education, subsequent formal preparation, and work experience requirements. These recommendations are intended to serve as a guideline rather than a prescription, since alternative designs might also prove effective.

Before presenting the detailed information in Table 1B itself, a number of important background points need to be made.

1. After the final report of the F/VE project had been submitted, SSA made a request for a more explicit description of the training necessary for existing staff (especially DEs, VSs and ALJs) to be successful at the new tasks and responsibilities that would be required if the recommendations made in the Core Report are implemented. Prompt turnaround was requested due to internal agency deadlines. Thus, the additional explanatory material contained in Table 1B was developed by the F/VE project team of consultants without review by the expert panel. However, the project team believes it is generally consistent with the philosophy and general approach previously agreed on by the expert panel.

2. The general management and personnel development strategies that underlie the specific kinds of training being recommended here are well-known and proven strategies that have already driven similar types of training initiatives in a variety of organizations in a wide array of economic sectors. (See for example Tom Peter's classic *"In Search of Excellence"* and Jim Collins' *"Good to Great"*). A basic premise of quality improvement that many employers in both the US industrial and service sectors subscribe to is that employees do better work when they can see and grasp the impact of the quality of their work on the whole process – and experience consequences as a result. In general, quality improves when employees:

    - know where their piece fits into "the big picture" and what specific impact their contribution makes;
    - see how the work done by others in earlier process steps affects the ease with which they can do their own piece – and can give performers of those earlier processes systematic feedback;
    - understand how the quality of their work impacts co-workers who handle later steps in the process, and can receive systematic feedback from them;
    - have seen the personal or practical impact of good vs. poor quality work on the end user or "customer," and are made aware of results;
    - see how the customers' satisfaction levels in turn affect their own working environment or job security within the organization.

Additionally, the specific topics of training being recommended here are grounded in the training program experiences of project team and panel members who have successfully managed disability or workers compensation claim organizations characterized by a strong focus on accurately assessing functional and vocational ability of claimants in the context of an effective overall claim administration process. This group has structured and implemented training programs in both public and private settings for both workers' compensation and non-occupational disability benefits programs.

3. The recommended requirements include general training for all DEs, F/V Specialists and ALJ's that incorporates increasingly more comprehensive awareness of the above elements, in addition to coursework, specific job assignments, and work experience to develop the following capabilities and characteristics:

   - a working, general knowledge of diagnosis, effects, and treatment of serious medical conditions that lead to difficulty in maintaining gainful activity – with particular emphasis on training in occupational medicine that would provide a general knowledge of how medical conditions lead to impairments which in turn lead to limitations in the ability to function and work
   - an in-depth knowledge of the laws, regulations, policies, procedures, rulings, and acceptable practices in handling SSA claims that involve functional and vocational issues
   - knowledge of the breadth and depth of relevant expertise of the various types of mFV expert professionals
   - familiarity with the new processes and procedures developed as a result of this report
   - familiarity with general principles of functional evaluation, with the nature of both exertional and non-exertional limitations and their implications for vocational suitability
   - knowledge of how to extract relevant data from reports produced by mFV experts and evaluate its quality, and a demonstrated ability to do so.

   Where available, existing SSA training covering such topics should be utilized (modified as required), with emphasis being gradually reduced over time on teaching the vocational guidelines (med-voc rules) and the Dictionary of Occupational Titles – assuming that the recommendations in this report are implemented and changes in SSA policies and procedures made. Any gaps would be filled with existing courses available from the public or private sector where available, although since a number of SSA's program features are unique, it is very likely that some materials will need to be custom-developed for SSA's use. The Core Report of this project along with key portions of the Supplementary Report, especially the portions entitled (a) The Nature of Functional and Vocational Expertise and (b) the Appendix entitled Detailed Information About the Professions Best Suited to Provide mF/V Experts can provide source material for training materials. Additional information about the professions in which mFV experts can be found is available from the Department of Labor.

   The use of case studies during training is critically important because it lets students apply the principles or techniques they have just learned in a controlled setting under the eye of an instructor. In addition, techniques of checking for and improving consistency ("calibration") among disability examiners are also mandatory. One easy method is to have a group of students all evaluate the same fictionalized teaching cases, and then jointly discuss any differences in their assessments. (The inventory of teaching cases should be large enough so that different batches can be put together for each class. This will discourage passing down the "right" answers from one class to another.) The instructor then would point out for each student what they need to do in order to become more consistent in their assessments. Consistency monitoring is so important that it should not just be done

during initial training but should be repeated at intervals on an on-going basis. For example, the same claim file could be sent for evaluation to a group of examiners in an area, and then their results compared and any differences discussed in an open forum. Again, the instructor or supervisor would need to "tune" the individuals in the group so they are consistent with each other and the applicable internal standard. Being able to evaluate claims in a consistent manner should be a requirement for satisfactory performance in a disability examiner or an ALJ.

4. Since the Core Report strongly recommends that claims be classified into three complexity classes (A, B & C - see Table 4 below for details) for matching with appropriately skilled mFV providers, the qualification requirements and training recommended for DEs tracks with that same scheme. DEs will require different amounts of preparation and skill to appropriately handle the three complexity levels.

5. The list of qualifications in Table 1B below is a suggested minimum guideline for functional / vocational topics. However, as implementation of the proposed training transpires, it may become clear that additional specific training or qualifications are necessary. Obviously, in addition to the items specified below, the imparting of technical knowledge and skill in other relevant areas will be required for adequate performance as a DE or F/V Specialist (for example teaching new employees how to use the SSA computer system.)

6. The years of experience suggested below for the different levels of DEs and the SSA F/V Specialists are general guidelines based on informal discussions with SSA staff about how long it takes to become proficient. The actual requirements will need to be made definitive by SSA after due deliberation by staff familiar with the positions involved.

Table 1B – Recommended Basic mFV-related Qualification Requirements for SSA Disability Examiners, Functional/Vocational Specialists, and ALJs

Basic Professional Education	**Subsequent Preparation**	**Specific Functional / Vocational / Rehabilitation Experience**
SSA Disability Examiners: Entry level position. Adjudicates Class A claims only.		
Minimum: Per SSA current practice Preferred: Bachelor's degree	Entry level disability examiners should adjudicate only Class A claims. In addition to current SSA training deemed still relevant within the new Multi-Dimensional Assessment (MDA) paradigm, preparation for handling Class A claims should include the following: A. At least 40 hours of introductory training on: • Basic principles and philosophy of the new mFV approach to evaluating claims. Discuss the role of the disability examiner, mFV experts, and ALJs in the mFV process. Detail how the DE will develop and document functional and vocational detail, make a preliminary evaluation of what additional information is needed, and then after it has been obtained, assess it for adequacy and credibility. Discuss methods and tools	None required

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
	available for determining availability of suitable occupations, particularly Department of Labor resources such as O*NET and the Occupational Outlook Handbook. Describe competing paradigms: (a) the biopsychosocial model of disability vs the strictly medical one; (b) the disability prevention paradigm that focuses on achieving an optimal resolution of the claimant's entire life situation in multiple domains vs. the benefits adjudication paradigm that focuses only on claim adjudication decisions. Describe how thorough evaluation of the causal chain and providing value to claimants requires use of both paradigms. Articulate SSA's intention to provide value to SSA claimants beyond prompt and accurate claim benefit decisions. • Enhanced communication techniques for claimant contact and effective communication with the public. Also, the terminology and phrases that are unique to the occupationally- and vocationally-oriented professions. This would include medical terminologies as appropriate. • The details of triaging disability claims according to nature of diagnosis, extent of claimed impairment and functional limitations. Basic criteria for classifying (or re-classifying) claims into complexity classes; when MDAs are needed and why. • The legal standard for disability and the causal chain. Detailed review of the Sequential Evaluation Process – particularly steps 4 and 5 and the proper methodology to make vocational assessments. Describe why asking and answering the two questions (1. "What specifically is preventing this person from working?" and 2. "What would be required (have to happen) for this person to return to work [or enter the workforce if not previously employed]") is required in order to explicitly analyze each element in the causal chain, and to provide helpful counsel to claimants regarding any post-determination referrals for vocational or other services • Overview of the Disability Determination Process from initial determination through ALJ decision. Details as to what each of the participants in the claim adjudication process do, and how the work done by the DE affects the work of the ALJ and vice versa. Presentation from additional experts including: internal mFV experts who triage claims, scheduling staff who find mFV experts to do MDAs, field-based mFV experts who do MDAs, vocational experts who assess availability of appropriate occupations, ALJ's who evaluate evidence and hold hearings. (It would be best if DDS adjudicators could sit in on a few ODAR hearings). • Effective writing for documenting functional limitations in rationales and consultation requests -- the purpose and required elements of the decision, its audiences and their needs/expectations; what a good decision/recommendation/rationale looks like vs. a	

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
	mediocre vs. a poor one. B. Ongoing refresher courses of 4 to 6 hours covering similar material, 3 months after hire and every 6 months thereafter. C. Periodic reviews by experts of a sampling of their cases, concluding with feedback to the examiner about patterns observed. (It is critical to review a series of cases at the same time, since detecting and correcting systematic weaknesses or patterns of behavior will improve the way that multiple claims are handled in the future. Critiquing the approach taken in a single individual claim file or decision is unlikely to have that impact.)	
SSA Disability Examiners: Mid-level position. Can adjudicate Class A & B claims. Generally includes adjudicators with at least 2 years of experience in adjudicating ALL levels and types of claims received in the DDS.		
Minimum: Per SSA current practice Preferred: Bachelor's degree with some additional previous training on vocational topics and issues	A. For certification as a mid-level disability examiner (who can adjudicate Class B as well as Class A claims), applicants should have had at least 40 hours of additional formal training and supervised practice covering the following topics: • Classifying (or re-classifying) claims into complexity classes and the claim pathways to which they should be assigned. • Evaluating the adequacy of F/V information contained in medical records and claimant-completed questionnaires. Identifying characteristics of documents that indicate the claimant may be unable to present their own case competently. • Identifying and handling claims in which mental and physical health issues are both present, or in which undeclared mental health issues may be playing a role. • Referring claims for MDAs, and selecting the type of mFV professionals to do an MDA under given circumstances. • Evaluating the adequacy of data contained in an MDA report. Identifying inconsistencies in recommendations and clarifying issues with experts as necessary. • Developing an RFC by extracting and analyzing pertinent information provided by the MDA, the claimant-completed questionnaires, and medical records. • Establishing the causal chain between medical condition and lack of work ability. • Determining the most appropriate method to assess availability of occupations suitable for particular RFCs, especially with regard to persons with light and sedentary work capacity. • Developing credible written claim decisions – the required elements, including portions	At least two years of experience as an SSA DE (or equivalent work experience adjudicating disability claims).

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
	that will be potentially useful to the claimant and elements that can be considered in making the benefits award decision; explicit and logical description of the causal chain; and a writing style that will be credible to claimants and, potentially, an ALJ. • Identifying federal, state, and non-profit resources to which claimants can be referred, and how such information can be provided to claimants within legal and regulatory constraints. This training should conclude with an evaluation process that ensures the person demonstrates in practice the ability to do the above tasks proficiently. B. Ongoing refresher courses every 6 months of 4 to 6 hours covering similar material. C. Periodic reviews by experts of a sampling of their cases, concluding with feedback to the examiner about patterns observed. (It is critical to review a series of cases at the same time, since detecting and correcting systematic weaknesses or patterns of behavior will improve the way that multiple claims are handled in the future. Critiquing the approach taken in a single individual claim file or decision is unlikely to have that impact.)	
SSA Disability Examiners: Advanced level. Can adjudicate claims in all 3 classes (A,B & C).		
Minimum: Bachelor's degree Preferred: Master's degree with some additional previous training on vocational topics and issues	A. For certification as an advanced disability examiner who can adjudicate Class C claims as well as Classes B and A, candidates should have had at least 3 weeks (at least 115 hours) of additional education whose purpose is to gain field experience that will (a) create a deeper understanding of the complex situations with which the claimants with Class C claims are dealing and (b) provide them with personal knowledge of how other participants in the functional and vocational process in the initial adjudication and appeals processes actually evaluate claimant's situations and do their work. At this level, a thorough understanding of how things work in "the outside world" is required in order for the Specialist to tease apart the complex issues in the causal chain and write appropriate decisions for Class C claims. This training will consist of at least the elements described below. Note that the training hours need not be contiguous, and in fact there will be some benefit to spreading them out over time. • 4-6 hours prior to the field experiences enumerated below with an instructor preparing the DE for what they will see and providing them with guidelines for what to look for and how to make the best use of the time • 21 hours (3 days) of onsite observation, experience in a functional rehabilitation environment (e.g., OT, PT) where professionals are working with clients with chronic mental conditions, chronic physical conditions, and conditions in both domains jointly. • 21 hours (3 days) of onsite observation, training and experience in a vocational	At least five years of progressively-more demanding experience as an SSA DE (or equivalent work experience in adjudicating disability claims).

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
	rehabilitation and/or work transition environment (e.g., state DVR, university program, or private firm) where professionals are working with clients with mental conditions, physical conditions, and conditions in both domains jointly, particularly those with sedentary and light work capacity. • 14 hours (2 days) of observation of mFV professional experts as they make initial mFV "triage" decisions in an SSA or similar disability claim intake process and assign the claims to appropriate pathways • 21 hours (3 days) of onsite observation of mFV experts as they conduct MDA appointments and write up MDA reports • 7 hours (1 day) of observation and formal instruction by internal mFV professional experts on how to find, extract, and assess the accuracy and credibility of mFV data in medical records and claimant questionnaires according to its source, context, and content. • 14 hours (2 days) of onsite observations of SSA vocational experts as they evaluate claims and provide expert opinions re: availability of appropriate occupations using a variety of methods. • 14 hours (2 days) of onsite observation and discussion with ALJ's as they evaluate the credibility of claimants and evidence, conduct appellate hearings, and write decisions. • 4-6 hours <u>after</u> the field experience with an instructor debriefing what was learned during the field experiences, and discussing how those insights should be applied in their work. B. Ongoing refresher courses every 6 months of 4 to 6 hours covering similar material. C. Periodic reviews by experts of a sampling of their cases, concluding with feedback to the examiner about patterns observed. (It is critical to review a series of cases at the same time, since detecting and correcting systematic weaknesses or patterns of behavior will improve the way that multiple claims are handled in the future. Critiquing the approach taken in a single individual claim file or decision is unlikely to have that impact.)	
SSA F/V Specialist		
Minimum: Bachelor's degree Preferred: Master's Degree in Vocational	SSA F/V specialists will require an additional 2+ weeks (80 hours) of additional training beyond that of advanced disability examiners. They will also need the portion which is still relevant of previous training that SSA has been offering to SSA vocational specialists. Because SSA F/V specialists will be viewed as first-line resources by DEs, they should have some expertise in all the F/V-related areas (claims triaging, MDA reports, RFC determinations,	At least five years of progressively-more demanding experience as an SSA DE (or

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
Rehabilitation or any degree with major course of study in health, functional rehabilitation, vocational rehabilitation, science, or legal fields	and vocational determinations). Because they will be responsible for day-to-day teaching, coaching and mentoring of certain aspects of the work done by DEs and mFVs, SSA F/V specialists should be trained in the basics of: • educational techniques as well as coaching and mentoring methods, • quality improvement techniques, and • methods for evaluating the quality of individual reports and decisions being made based on those reports in the pertinent content areas, as well as methods for evaluating multiple reports and decisions to determine trends and patterns. Moreover, since it is possible (though not desirable due to their lack of medical training) that SSA F/V specialists will sometimes be called on to serve as "back-up" to mFV expert triagers, they should receive basic training in how to do claim triaging as well. For certification as an SSA F/V specialist, candidates should have all training required for advanced disability examiner (see above) plus: • 21 hours (1 day each) of training and practice in training and quality improvement disciplines: o Basic principles of educational design and methods (should include case studies). o Continuous quality improvement philosophy and methods (should include case studies). o Effective coaching / mentoring techniques (should include role playing). • At least 14 hours of training/supervision/coaching about triaging from an internal mFV professional expert: o How to triage claims, to assign Complexity Class to claims, to assign them to claim pathways, and to decide whether a field MDA is required, and if so, what kind of mFV professional should do it. This should include how to assess retrospectively whether a claims triaging decision was appropriate, as well as identification of circumstances that should trigger re-triaging. o The mFV professional expert providing this training should be familiar with SSA triaging procedure and have had practical experience doing the work. • At least 7 hours of instruction on how to find, extract, and assess the accuracy and credibility of mFV data in medical records and claimant questionnaires according to its source, context, and content. • At least 14 hours of instruction on MDAs: o Quality standards specifying what a high quality MDA report should look like.	equivalent work experience in adjudicating disability claims) plus informal or formal experience in teaching / mentoring others

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
	o Grading criteria to use when evaluating quality of MDAs and the method and format for doing so. o What a DE should do if an MDA report is of low quality. o How to provide helpful feedback (that results in improvement in quality) to mFV professional experts who are writing MDA reports. • At least 7 hours of instruction on RFCs: o What an appropriate RFC based on credible evidence looks like, how its derivation from the MDA report and other materials in the claim file should be documented, and what a DE should do if the RFC provided is not credible; • At least 7 hours of instruction on vocational issues: o What an appropriate vocational evaluation will consist of, based on methods currently employed by credible vocational experts (especially methods beyond the DOT and vocational grids). How these evaluations should be documented. o What the generally accepted current job market assessment methods are – and are <u>not</u> – and where a DE should turn for advice when unsure. • At least 14 hours of instruction by an ALJ or similarly-trained legal professional on how to: o Extract and interpret the facts provided in the MDA along with other materials in the claim file. o Make a solid and credible benefits determination. o Write a credible and appropriate decision that provides value to the claimant as well as documents clearly which facts were used as the basis for the opinion and which were not. For each of the training segments above, teaching case examples should be developed, with all students in each class expected to analyze the same batch of cases, compare their analyses with one another, and with the instructor. This process will assure that the approaches being used actually produce similar (consistent) results. (The inventory of case examples should be large enough so that different batches can be put together for each class. This will discourage passing down the "right" answers from one class to another.) Upon completion of the above training, candidates should be given an examination consisting of additional teaching case examples, and demonstrate strong proficiency in evaluating them and making appropriate and specific suggestions to the DE for next steps, and/or to the mFV expert for improvement. Successful completion of this examination should be required before beginning work as an independent SSA F/V specialist. For the first 90 days, a supervisor or	

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
	manager should monitor the work and mentor the new SSA F/V specialist carefully.	
Administrative Law Judges		
n/a	In order to deliver the intended results of the changes recommended in the Core Report, ALJs should receive additional training in key topics. We recommend at least 70 hours of cross-disciplinary training as enumerated below. Some of this material intentionally duplicates that provided to DEs, which will help the entire system function in a consistent and smooth manner. • Basic principles and philosophy of the new mFV approach to evaluating claims, and a discussion of the roles of the disability examiner, mFV experts, and ALJs in the mFV process. o Describe how the DE will develop and document functional and vocational detail, make a preliminary evaluation of what additional information is needed, and then after it has been obtained, assess it for adequacy and credibility. o Introduce terminology and phrases that are unique to the occupationally- and vocationally-oriented professions, including medical terminologies as appropriate. o Discuss methods and tools available for determining availability of suitable occupations, particularly Department of Labor resources such as O*NET and the Occupational Outlook Handbook. o Describe competing paradigms: (a) the biopsychosocial model of disability vs the strictly medical one; (b) the disability prevention paradigm that focuses on achieving an optimal resolution of the claimant's entire life situation in multiple domains vs. the benefits adjudication paradigm that focuses only on claim adjudication decisions. Describe how thorough evaluation of the causal chain and providing value to claimants requires use of both paradigms. o Articulate SSA's intention to provide practical value to SSA claimants beyond prompt and accurate claim benefit decisions. • Overview of the interconnections within the Disability Determination Process from initial determination through ALJ decision. Details as to what each of the participants in the claim adjudication process do, and how the work done by the DE affects the work of the ALJ and vice versa. Presentations from additional experts including: internal mFV experts who triage claims, scheduling staff who find mFV experts to do MDAs, field-based mFV experts who do MDAs, vocational experts who assess availability of appropriate occupations, other ALJ's who evaluate evidence and hold hearings. (It would be best if ALJ's could make site visits to view DE's evaluating claims and making	n/a

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
	adjudication decisions at the DDS, and to sit in on several MDA appointments.) • The legal standard for disability and the causal chain. Detailed review of the Sequential Evaluation Process – particularly steps 4 and 5 and the proper methodology to make vocational assessments. Describe why asking and answering the two questions (1) "What specifically is preventing this person from working?" and (2) "What would be required (have to happen) for this person to return to work [or enter the workforce if not previously employed]" is required in order to explicitly analyze each element in the causal chain, and to provide helpful counsel to claimants regarding any post-determination referrals for vocational or other services • At least 7 hours of instruction on how to find, extract, and assess the accuracy and credibility of mFV data in medical records and claimant questionnaires according to its source, context, and content. • At least 14 hours of instruction on o Quality standards specifying what a high quality MDA report should look like. o Grading criteria to use when evaluating quality of MDAs and the method and format for doing so. o What an ALJ should do if an MDA report is of low quality. • At least 7 hours of instruction on RFCs: o What an appropriate RFC based on credible evidence looks like, and how its derivation from the MDA report and other materials in the claim file should be documented. o What an ALJ should do if the RFC provided is not credible. • At least 7 hours of instruction on vocational issues: o What an appropriate vocational evaluation will consist of, based on methods currently employed by credible vocational experts (especially methods beyond the DOT and vocational grids). How these evaluations should be documented. o What the generally accepted current job market assessment methods are – and are <u>not</u> – and where an ALJ should turn for advice when unsure. • Effective writing for documenting functional limitations in rationales and consultation requests – the purpose and required elements of the decision, its audiences and their needs/expectations. What a good decision/rationale looks like vs. a mediocre vs. a poor one. B. Ongoing refresher courses of 4 to 6 hours covering specific aspects of similar pertinent material, 3 months after hire and every 6 months thereafter.	

Basic Professional Education	Subsequent Preparation	Specific Functional / Vocational / Rehabilitation Experience
	C. Periodic reviews by senior ALJs (who have been made responsible for assuring consistency of decisions) of a sampling of their decisions, concluding with feedback to the ALJ about patterns observed. (It is critical to review a series of cases at the same time, since detecting and correcting systematic weaknesses or patterns of behavior will improve the way that multiple claims are handled in the future. Critiquing the approach taken in a single individual decision is unlikely to have that impact.)	

Table 2 – Recommended Additional Requirements for mFV Providers by Tier of Expertise

TIER	PROFESSION → REQUIREMENTS (A **Y** means the profession is eligible for membership in the Tier and requirements must be met. Shaded cells indicate ineligibility for the Tier.)	Nurse Case Manager	Nurse Practitioner	Occupational Therapist	Physical Therapist	Physician	Psychologist	Social Worker	Voc Rehab Counselor	SSA Disability Examiner	SSA Vocational Specialist
All Tiers, All Providers	• Meets Basic Qualification Requirements shown in Tables 1A and 1B. • Completes SSA-Specific Training - Mandatory task- and role-specific training. (Different for mFV Unit vs. mFV Network.) Also passes a competency test or obtains a certificate.	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Tier I: Practitioners	• There are no additional requirements beyond those in Table 1B.									**Y**	**Y**
Tier II: Experts	• Has completed at least 12 hours of continuing education in functional assessment/disability management and 6 hours annually thereafter in pertinent topics. • In order to do community-based multidimensional assessments (MDAs) provides acceptable quality work samples – examples of MDA reports. • In order to do community-based functional assessments or testing, provides acceptable quality work samples – examples of testing reports.	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y***		
Tier III: Senior Experts	• Meets Tier II requirements. • Either: (a) has had at least 5 years of significant direct involvement at the Tier II level (or equivalent) in disability evaluation and functional or vocational assessment in multiple domains and has produced good quality work products peer reviewed by Tier III experts; or (b) has a PhD in a mFV profession or equivalent AND 10 years of pertinent mFV experience. **AND** • Has had progressive and substantial experience or training in a particular specialty area integrating mental or medical with functional or vocational expertise, or in direction of disability programs.	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**		
Tier IV: Subspecialist Experts	• Meets Tier II and III requirements (including a doctoral degree in the pertinent specialty). • Has attained acknowledged pre-eminence in a particular and relevant subspecialty area combining medical (physical or mental) with functional or vocational expertise, or in direction of disability programs.					**Y**	**Y**				

***** Community-based vocational rehabilitation counselors do community-based MDAs but not specialized functional assessment or testing

Table 3 – Matching mFV Providers with Specific Tasks

The rows of this table show the major task clusters involved in providing functional and vocational expertise, including some tasks not now performed for SSA but which are part of the multidimensional assessment (MDA). (The MDA is described in more detail in Appendix 2. Both the MDA and the task clusters are elaborated upon in the Supplemental Report.) The X's in the table show the typical proficiency level **of the subset of individuals who are mFV Registry-qualified** within each profession at doing each task cluster. (NOTE: The footnotes impose important caveats.)

Key: **X** = typically proficient at simple versions or limited portions of the task
XX = typically very proficient at doing simple and moderately complex versions of the task
XXX = typically extremely proficient at all levels of the task

PROVIDER TYPE (assumes provider has specific training and experience that meets eligibility criteria listed elsewhere in this report) → **TASK CLUSTERS** ↓	Physicians	Psychologists	Nurse Practitioners	Social Workers	Nurse Case Managers	Occupational Therapists	Physical Therapists	Voc Rehab Counselors	SSA Vocational Specialists	SSA Disability Examiners
MEDICAL EXPERTISE: 0: Determine Impairments	XXX	XXX[m]	XX	XX[m]	XX	XX	XX[p]			
FUNCTIONAL / VOCATIONAL EXPERTISE:										
1: Assess Situation; Determine What mFV Expertise Is Required	XXX[s]	X	XX	X	XX	XX	X		X	X
2: Establish Medical Restrictions and Functional Limitations	XX	XX[m]	XX	XX[m]	X	XX	XX[p]			
Perform Multidimensional Assessment (MDA)	XX	XX[m]	XX	XX	XX	XX	XX	XX[v]		
3: Assess or Test Functional Limitations / Work Capacity	X	XXX[m]	X	XX[m]	X	XXX	XXX[p]	X		
4: Assess Extent of Vocational Disruption		XX[m]		X	X	XXX	XXX[p]	XXX	X	X
5: Envision Feasible Functional & Vocational Solutions	X-XX[s]	X	X	XX	XX	XXX	XXX[p]	XXX	X	X
6: Assess Availability of Work Opportunities				X		X	X	XXX	X	X
7: Make / Implement a Vocational Plan				X		X	X	XXX		
8: Navigate Healthcare and Social Service Programs	X	X	X	XXX	XX	XX	XX	XXX		X

[m] – For claims with primarily cognitive or mental health diagnoses

[p] – For claims with primarily physical diagnoses

[s] – Level of proficiency is **XXX** for preferred medical specialties only; others are usually **XX** unless specially trained

[v] – For claims with primarily functional/vocational issues

Introduction to Table 4 – Assigning Roles and Responsibilities to mFV Providers Using Claims Complexity Classes and Expertise Tiers

To set the context for describing Table 4, a recap of the other material in this Appendix (see above) will be useful. Tables 1A and 1B describe the minimum basic qualifications required of individuals in the chosen mFV professions in order to be designated by SSA as an mFV provider. Table 2 goes a step further by defining additional qualifications that place these experts into different Tiers, so that mFV experts can be assigned appropriately to cases based on their requirements for different levels of expertise. Neither of these tables provides specific guidance on how to select an mFV expert for use on a specific case, however. Table 3 provides general guidance on this issue, noting the typical proficiency of each mFV profession at key mFV tasks, as described at length in the Supplemental Report. During the triaging process, the mFV tasks that are of most importance to that case are identified, and Table 3 then defines the type(s) of mFV providers that would be best to assign.

Table 4 below adds two important further distinctions to help make appropriate assignments of mFV experts. It introduces the notion that the complexity of the claim should also determine which types and tiers of mFV experts are appropriate to work on that claim, and that mFV experts may play different roles and have different levels of accountability under different circumstances. Together, Tables 3 and 4 form the basis for making assignments of mFV providers to specific cases.

Table 4 directly answers the question "For a claim with a given complexity level, what role can be played (if any) by the professions in each of the Tiers in performing the major tasks to be done for that claim?" The table can also be used indirectly to address the question "What type of mFV experts should I use to do the tasks on a given claim?"

Table 4 packs a lot of information into a very concise format, so understanding its structure and derivation is important. Two sections of explanatory material are presented here before the table itself. The first section provides a narrative description of key mFV processes and of the roles that various mFV providers will play under the recommendations in this report. The second section describes each of the key attributes of the table in detail, providing a foundation for understanding the labels and codes in the table.

Description of Processes / Roles

Below are summary descriptions of the recommended changes to roles, and new roles, for various types of mFV providers. These and other details are summarized in Table 4.

- **SSA's / DDS's Disability Examiners (DEs) and Functional/Vocational Specialists (F/V Specialists)** provide preliminary or limited technical assessments on mFV issues.
    - DEs:
        - Use criteria at initial claim intake and at intervals as prescribed by the claim processing pathways to screen and promptly identify claims that are potentially likely to require mFV input and send them to the mFV Triager for assignment.
        - Use information provided by mFV experts in the MDA as well as the RFC and any vocational assessments to make Step 4 and Step 5 claim determinations.

- F/V Specialists:
    - Work with internal as well as community-based mFV experts to assure that their reports meet quality criteria and reflect an accurate understanding of SSA rules / regulations / laws.
    - Serve as internal experts on SSA statutes / rules / regulations / case law in the functional / vocational arena.
    - Train and support the DEs by serving as their internal technical resource regarding the new functional / vocational evaluation process, including the sequence of events, the roles various participants play, and how to evaluate the adequacy and credibility of MDA reports and outside vocational assessments, and how to extract and use data from MDAs, RFCs, and vocational assessments in the disability determination process.

- **mFV experts in DDS and SSA offices will do the F/V triage**
    - Professionals with a requisite level of both medical / physical and psychological expertise – namely nurse case managers, nurse practitioners, occupational therapists and physicians (including psychiatrists) – are the most appropriate choice to do F/V triage on all types of claims.
    - Psychologists and social workers may do F/V triage for claims where cognitive or mental conditions predominate. In other cases, they must work in conjunction with another medically-trained mFV expert.
    - Physical therapists may do F/V triage for claims where medical / physical conditions predominate. For other claims, they must work in conjunction with another psychologically-trained mFV expert.
    - All mFV experts in DDS and SSA offices must be sufficiently cross-trained to be able to screen for previously unidentified conditions outside their normal clinical domain.
    - The triaging mFV expert(s) will:
        - Re-screen claims that either (a) on initial screening by the DE were deemed unlikely to meet the Listings, or (b) after full evaluation by the DE in Step 3 have already been determined not to meet the Listings, in order to determine the nature / extent of mFV input that will be required by Step 4 and/or 5.
        - Classify those claims by complexity level.
        - Re-evaluate the mFV claim processing pathway previously selected by the DE, and revise if appropriate.
        - Identify the most appropriate type of mFV provider to do (a) the community-based MDA, if applicable; (b) the internal determination of current actual functional capacity as well as RFC; and (c) the internal determination of vocational opportunity, if required. Because research has shown that half of people with serious physical medical conditions also have psychiatric ones, the triager should use criteria established by an interdisciplinary team of mFV experts to determine whether to assign two mFV experts – one with primarily physical and one with primarily mental health focus. It is expected that some Class B claims and most

Class C claims with physical conditions will also need to be evaluated in the mental health domain.

- If an MDA is required, write the request and determine which records will be sent.
- Identify and assign an appropriate individual mFV provider(s) to work on the claim, possibly delegating part of this task to a scheduler.

- **Internal mFV experts who are also medical or mental health practitioners will use all available information, including results of MDAs, to determine RFC (residual functional capacity) and estimate current actual functional capacity (CAFC) and interpret any disparities.**
  - mFV experts who are physicians, psychologists, nurse practitioners, and clinical social workers will determine RFC/CAFC.
    - mFV experts who are psychologists and clinical social workers will determine RFC/CFP only for primarily cognitive or mental claims, and will provide technical input to medically-trained mFV experts for claims with primary medical/physical diagnoses.
    - mFV experts who are nurse case managers, occupational therapists, and physical therapists can provide technical input on functional issues.

- **Internal mFV experts who are vocational rehabilitation counselors, employment specialists, vocational evaluators, or professionals in very similar fields will make the Step 5 determination of availability of occupations that claimants can perform for claims in Complexity Classes B and C.**

- **Vocational Experts who testify in SSA hearings will be vocational rehabilitation counselors, employment specialists, vocational evaluators, or professionals in very similar fields who meet the criteria for community-based mFV experts.**

- **Community-based mFV experts of all types will perform MDAs** on claims that have been appropriately selected for them by the internal mFV expert who does the mFV triage. All mFV experts who do MDAs should be sufficiently cross-trained to be able to screen for previously unidentified conditions and evaluate minor contributing conditions outside their normal clinical domain.

  Tier II Experts

  - Tier II mFV experts who are nurse case managers, nurse practitioners, occupational therapists, physical therapists, physicians, psychologists, social workers, and vocational rehabilitation counselors will do MDAs on Class B claims.
    - Tier II physical therapists will do MDAs only on primarily musculoskeletal claims or will provide technical input to a more broadly medically-trained or psychologically-trained mFV expert.
    - Tier II psychologists will do MDAs only on primarily cognitive or mental claims, or will work in conjunction with a medically-trained mFV expert.
    - Tier II vocational rehabilitation counselors will do MDAs only on claims where functional/vocational issues are the primary ones needing clarification.

Tier III Experts

- Tier III senior mFV experts who are nurse case managers, nurse practitioners, occupational therapists, physical therapists, physicians, psychologists, social workers, and vocational rehabilitation counselors will perform MDAs on Class B and C claims with exceptions as described below. At their discretion, they can seek input from Tier IV subspecialists on MDAs for class C claims.

    - Tier III psychologists will do MDAs only on primarily cognitive or mental claims, or will work in conjunction with a medically-trained mFV expert.

    - Tier III social workers will do MDAs on all types of Class B claims. For Class C claims, Tier III social workers will do MDAs only on primarily mental claims, or will work in conjunction with a medically-trained mFV expert.

    - Tier III physical therapists will do MDAs on all types of Class B claims. For Class C claims, Tier III physical therapists will do MDAs only on primarily musculoskeletal claims or will provide technical input to a more broadly medically-trained or psychologically-trained mFV expert.

Tier IV Experts

- Tier IV subspecialist mFV experts who are physicians and psychologists will occasionally need to provide definitive evaluation and assessment of specific issues in MDAs on selected Class C claims.

    - Tier IV psychologists will do MDAs only on primarily cognitive or mental claims, or will work in conjunction with a medically-trained mFV expert.

Detailed Description of Table 4 Attributes

Overview

At a high level, the **rows** of the Table contain all of the types and tiers of mFV providers, grouped by tiers. The **columns** contain general roles to be played by mFV providers at different times in the claim process, as well as different levels of claim complexity. Each individual cell in the table contains codes indicating the responsibilities that the mFV expert in that row can have in the general role and claim complexity type in that column. To illustrate this, look at the third row in the Tier II section of Table 4. The four cells in that row indicate that a Tier II occupational therapist in the mFV Unit can independently triage claims in all claim classes, can provide technical consulting on both Class A and B claims, and provide limited or preliminary assessments on Class C claims. A Tier II occupational therapist in the mFV Network can independently perform MDAs or functional testing.

Descriptions of each of the key distinctions drawn in the table follow.

General Role Categories

In the table, roles are split into two general categories reflecting different stages of the claim process: (1) initial assessment, triaging, and assignment of resources, and (2) providing the substantive support on the disability determination. The project's expert panel agreed that the level of mFV expertise required to do the triage task does not need to vary by claim complexity level (though it does vary with the type of medical condition), so there is only one column for the first role category. For the second category, three columns are used, one for each of the three claim complexity levels, which are described in detail later.

Affiliations With SSA

mFV experts can have one of two affiliations with SSA, referred to in Table 4 as being members of the mFV Unit or the mFV Network.

> The mFV **Unit** consists of mFV Providers who are SSA or DDS employees, as well as mFV Experts under contract to SSA or the DDSs who are used as internal consultants in the disability determination process.
>
> The mFV **Network** consists of community-based mFV Experts who provide independent, fee-based services on individual cases on specific request, especially MDAs and functional testing.

In many cases, the responsibilities assigned to a given row of the table vary based on whether the mFV Expert is in the mFV Unit or the mFV Network.

Responsibilities and Accountability Levels

The table differentiates between three different responsibilities that can be assigned to mFV experts, each reflecting a different level of accountability. These are represented by a code in the cells of the table, as indicated here:

R/S (Responsible / Sign-off) The most accountable role for an mFV expert is to be responsible for a functional or vocational assessment on a claim and sign-off on a report or opinion, regardless of whether the experts are used internally as consultants to the DDSs or SSA (i.e. they are members of the "mFV Unit") or they provide independent field-based services (i.e. they are members of the "mFV Network").

TC (Technical Contributor) In some cases, providers in Tiers below the accountable one can serve as technical contributors or advisors to the accountable expert.

L/P (Limited / Preliminary) In other cases, mFV providers can provide limited or preliminary assessment services to support mFV experts who take on the higher level of accountability.

Nature of Conditions Claimed

Footnotes in some cells in the table limit the role that an mFV expert can play to claim situations in which the expert has adequate expertise. Four different limitations are indicated: (m) confines an mFV expert to claims with predominantly mental conditions, (p) to claims with predominantly physical conditions, (v) to claims where the major issues are vocational, and (s) to claims within the expert's medical specialty area. (See the Key in the table.)

Claim Complexity Levels

Finally, the table differentiates among three levels of claim complexity. Claims that **obviously do not or seem unlikely to meet the Medical Listings in Step 3, and which therefore need mFV expertise** during adjudication, should be divided into three Complexity Classes according to the level of mFV expertise required to adequately evaluate the claim:

Class A: Straightforward mFV Issues Includes some claims that may initially qualify for the Quick Decision Determination process (QDD) but end up being passed through to the regular process, as well as some that are handled from the outset in the regular disability determination process. Examples might include stable congenital conditions, severe

head injury, uniformly and rapidly fatal conditions, paraplegia or quadriplegia, and traumatic injuries from which full recovery is the norm.

Class B: Mid-Range mFV Issues Examples might include conditions that vary in severity (and impact on function) such as anorexia nervosa, schizophrenia, asthma, arthritis, multiple sclerosis and heart disease; mixed mental and physical diagnoses such as lung disease and depression.

Class C: Difficult mFV Issues Examples might include self-reported illnesses such as depression and anxiety, migraine headaches, chronic musculoskeletal pain (e.g., back, neck, hand, widely diffuse) in the absence of demonstrable and causative pathology; chronic fatigue syndrome; mild to moderate head injury.

Table 4 – Assigning Roles and Responsibilities to mFV Providers Using Claims Complexity Classes and Expertise Tiers

Key: **R/S** – Responsible/sign-off **TC** – Technical contributor **L/P** – Limited or preliminary assessment
^{m} – For primarily cognitive or **mental** conditions ^{v} – For claims with primarily **vocational** issues
^{p} – For claims with primarily **physical** conditions ^{s} – In **specialty** area only

CLAIM COMPLEXITY CLASS →		**ALL CLAIM CLASSES**	**CLASS A** **Straightforward mFV Issues**	**CLASS B** **Mid-Range mFV Issues**	**CLASS C** **Difficult mFV Issues**

GENERAL ROLES →
 	
 EXPERTISE TIER ↓
		• Do preliminary evaluation of claims needing mFV input
		• Classify claim by complexity
		• Select mFV processing pathway
		• Select mFV Expert(s)
			• Provide assistance to DE process as an internal consultant (i.e. member of the mFV **Unit**) **on F/V issues** such **as assessing and determining medical restrictions, functional limitations, functional capacity and making a vocational assessment**
			OR
			• Provide independent field-based services (i.e. member of the mFV Network):
			  • Multi-dimensional assessments (MDAs)
			  • Functional testing		

		RESPONSIBILITY mFV PROVIDER CAN HAVE (see key above)			
Tier I – mFV PRACTITIONERS					
	Disability Claims Examiners		L/P in Unit	L/P in Unit	
	Vocational Specialist		L/P in Unit	L/P in Unit	
Tier II – mFV EXPERTS					
	Nurse Case Managers	R/S	TC in Unit	TC in Unit R/S in Network	L/P in Unit
	Nurse Practitioners	R/S	R/S in Unit	TC^{p} in Unit R/S in Network	L/P in Unit
	Occupational Therapists	R/S	TC in Unit	TC in Unit R/S in Network	L/P in Unit
	Physical Therapists	R/S^{p}	TC^{b} in Unit	TC in Unit R/S^{p} in Network	L/P in Unit
	Physicians	R/S	R/S in Unit	R/S in Unit R/S in Network	L/P in Unit
	Psychologists	TC or R/S^{m}	TC or R/S^{m} in Unit	TC or R/S^{m} in Unit R/S^{m} in Network	L/P^{m} in Unit
	Social Workers	TC or R/S^{m}	TC or R/S^{m} in Unit	TC^{m} in Unit R/S^{m} in Network	L/P^{m} in Unit
	Vocational Rehabilitation Counselors, etc.	L/P	R/S^{v} in Unit R/S^{v} as VE in Network	R/S^{v} in Unit R/S^{v} in Network as MDA / VE	L/P in Unit

Key: **R/S** – Responsible/sign-off **TC** – Technical contributor **L/P** – Limited or preliminary assessment
[m] – For primarily cognitive or **mental** conditions [v] – For claims with primarily **vocational** issues
[p] – For claims with primarily **physical** conditions [s] – In **specialty** area only

CLAIM COMPLEXITY CLASS →		**ALL CLAIM CLASSES**	**CLASS A** **Straightforward mFV Issues**	**CLASS B** **Mid-Range mFV Issues**	**CLASS C** **Difficult mFV Issues**

GENERAL ROLES →
 EXPERTISE TIER ↓
		• Do preliminary evaluation of claims needing mFV input
		• Classify claim by complexity
		• Select mFV processing pathway
		• Select mFV Expert(s)
			• Provide assistance to DE process as an internal consultant (i.e. member of the mFV **Unit**) **on F/V issues** such **as assessing and determining medical restrictions, functional limitations, functional capacity and making a vocational assessment**
			OR
			• Provide independent field-based services (i.e. member of the mFV Network):
			  • Multi-dimensional assessments (MDAs)
			  • Functional testing		

		RESPONSIBILITY mFV PROVIDER CAN HAVE (see key above)			
Tier III – SENIOR mFV EXPERTS					
	Nurse Case Managers	R/S		TC in Unit R/S in Network	TC in Unit R/S in Network
	Nurse Practitioners	R/S		TC in Unit R/S in Network	TC in Unit R/S in Network
	Occupational Therapists	R/S		TC in Unit R/S in Network	TC in Unit R/S in Network
	Physical Therapists	R/S		TC in Unit R/S in Network	TC in Unit R/S[p] in Network
	Physicians	R/S		R/S in Unit R/S in Network	R/S in Unit R/S in Network
	Psychologists	TC - R/S[m]		TC or R/S[m] in Unit R/S[m] in Network	TC or R/S[m] in Unit R/S[m] in Network
	Social Workers	TC - R/S[m]		TC in Unit R/S in Network	TC in Unit R/S[m] in Network
	Vocational Rehabilitation Counselors, etc.	TC		TC[v] in Unit R/S[v] in Network as MDA / VE	TC[v] in Unit R/S[v] in Network as MDA / VE
Tier IV – SUBSPECIALIST mFV EXPERTS					
	Physicians			R/S[s] in Unit R/S[s] in Network	R/S[s] in Unit R/S[s] in Network
	Psychologists			TC or R/S[ms] Unit R/S[ms] in Network	TC or R/S[ms] Unit R/S[ms] in Network

Appendix 2: Multi-Dimensional Assessments (MDAs)

This appendix provides additional information about the multi-dimensional assessments (MDAs) recommended in section D.3, above, of the Core Report. An even more extensive description is included in the Supplemental Report, Part I.

The material in this Appendix covers three topics:

1. How the F/V triage and the MDA option can fit into SSA's sequential disability determination process;

2. What happens during the MDA evaluation sessions; and

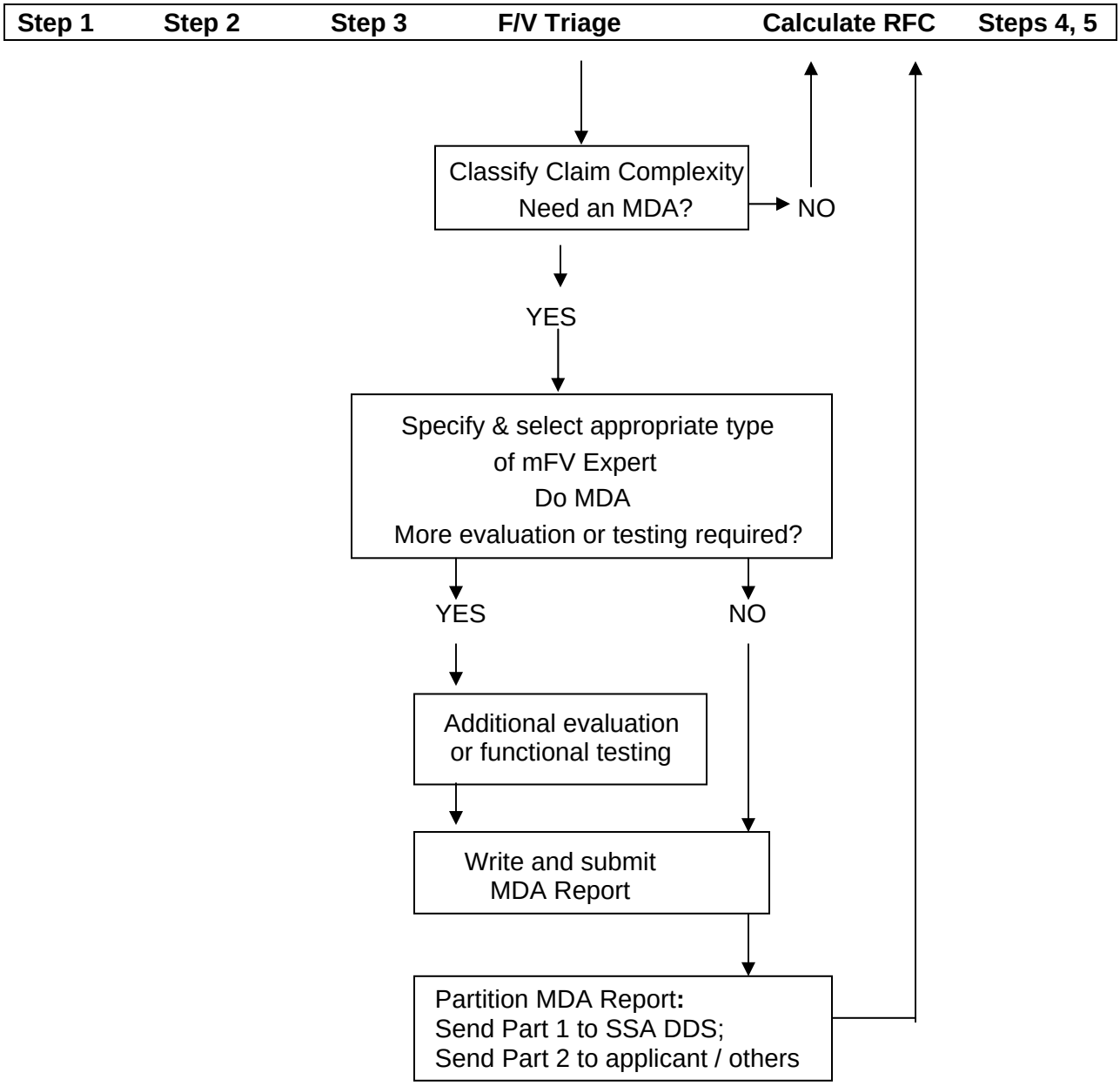
3. What an MDA report consists of and how it can be used by adjudicators.

In addition, Appendix 3 contains a number of detailed hypothetical case examples showing the kind of results MDAs will generate, and how they will support the disability determination process.

How the MDA Fits In

The diagram below shows where the new elements (F/V triage and MDA) occur during the sequence of events during the determination process. The F/V triage is performed as soon as it is clear that a claim will reach Step 4 and before the RFC (which is used in Steps 4 and 5) is determined. If an MDA is needed, the results will be available to the internal mFV expert who will determine the RFC.

How the MDA Will Fit Into the Sequential Disability Determination Process



What Happens During the MDA Sessions

The MDA will be completed during one or two sessions totaling 1-1/2 to 2 hours. Once the appropriate type of mFV expert for a particular case has been specified by the F/V Triager at the DDS, MDA administrative staff at the DDS (or a contractor) will use a database of available mFV experts to select the one to do the MDA and then make contact with both the mFV expert and the applicant / beneficiary to arrange a face to face appointment. (This same staff will receive and distribute the MDA reports after the MDA is completed, as described below.) If a face-to-face appointment is not feasible, a video appointment can be scheduled instead, and failing that, a telephone appointment can be made. **The panel recommends very strongly that face-to-face appointments be used.** Making the appointment scheduling process user-friendly for applicants is critical, with an emphasis on courtesy, clear instructions, convenient locations, transportation and hours – but also with clear and significant consequences for no-shows.

In general, a community-based mFV expert located a geographically reasonable distance from the applicant/ beneficiary will be chosen to do the MDA. The mFV expert will receive a referral from the DDS that lists the key issues of concern that led to the MDA request along with copies of the application materials received to date and any other appropriate items from the applicant's file. The mFV expert will conduct the initial MDA session, request additional CE or detailed functional testing if needed, carefully document all findings, use their professional judgment to analyze the results, meet with the applicant / beneficiary for a second session by telephone if indicated, and write a two-part report (one part for SSA, and the other optional part for the applicant / beneficiary.) If a claim decision is appealed, the mFV expert who performed an MDA in that case may be called on to testify.

The structure of the first MDA session is as follows. The mFV expert will spend some time orienting the applicant / beneficiary to what is going to happen, creating a comfortable environment and establishing rapport. The mFV expert will follow a structured format prescribed by SSA (and developed by mFV experts with extensive experience in administering similar screening and assessment processes). The expert will use an interview guide to elicit information from the applicant/beneficiary, observe and document the applicant / beneficiary's appearance and behavior, and select and administer simple screening functional tests (standardized questions, survey instruments, or prescribed simple physical maneuvers on a list approved by SSA) during the MDA in an attempt to resolve any issues at hand. If open issues still remain, the mFV expert can decide that further evaluation or testing by another expert is indicated.

In general, mFV experts doing MDAs will be expected to conduct themselves like professional, neutral and observant evaluators, unbiased as to the facts or the outcome, but courteous, authentic, and empowering. They need to be committed both to the applicant / beneficiary's highest possible level of self-sufficiency and fullest possible participation in life, and to upholding SSA's duty under the law to the public trust.

MDA Session Content – More Details

During the interview the mFV expert will employ interviewing skills to elicit information (expanding on certain issues as their professional judgment suggests) from the applicant/beneficiary that will:

– Clarify the applicant/beneficiary's current status in multiple domains of life (medical, physical, mental, socio-economic, environmental and personal). Examples include education, skills, aptitudes, transportation, access to specific needed, services, and also includes past experiences, family values, cultural beliefs, personal desires, intentions, and goals.

– Explicitly identify specific barriers to function or employability and their source.

– Identify any previous efforts made by the applicant / beneficiary to overcome those barriers, the results, and reasons for any inaction.

– When feasible, identify possible future strategies or techniques to remove each barrier.

The mFV expert will also observe the applicant / beneficiary's function and behavior in spontaneous activities and social interactions before, during and after the formal interview, with particular regard to the consistency of the relationship between medical impairments and functional ability, and make note of key details such as eye contact, affect and social skills, intelligibility of speech, distractibility, level of engagement, thought process, presence of alcohol on breath, pain behavior, fidgeting, grooming, balance, use of adaptive equipment, and so on.

Based on all the information gathered and the mFV expert's professional judgment, the mFV expert will then evaluate the availability, accessibility, duration, cost and likelihood of success of any potential strategies or techniques for removing barriers in this particular case.

Lastly, where feasible, appropriate and welcomed by the applicant / beneficiary, the mFV expert will counsel the applicant / beneficiary in a general way about realistic potential solutions to problems and ways to remove or get around barriers to employability, and lay out a potential approach and timeline for doing so. The mFV expert will also ask the applicant / beneficiary for their reaction and what they intend to or want to do with these results. If the applicant / beneficiary requests or agrees, the mFV expert can refer to public sector or non-profit agencies for services. (If additional testing or evaluation is required, the mFV expert will offer the applicant / beneficiary a second telephonic appointment to discuss the findings and recommendations that he/she will make after the results of that further evaluation is available.)

What an MDA Report Consists of and How it Will Be Used

Data gathered during the MDA will be recorded on "smart" worksheets that should be developed by SSA. For an example, see the SCID (Structured Clinical Interview for DSM-IV Axis I Disorders). The MDA report will be prepared by the mFV expert using a template and specifications provided by SSA to document and analyze results and make findings and recommendations. The report will document the applicant / beneficiary's current functional status in domains in which key barriers to employability often exist (medical, physical, mental, socio-economic, environmental, perceptions), will document results of observation and testing along with the applicant's behavior and comments; explicitly address issues related to the causal chain (medical condition leading to impairments leading to effect on ability to work) and consistency of findings; and identify specific barriers to work in any life domain.

The mFV expert's report will include professional opinions as to whether (a) the limitations on function reported by the applicant have been understated or overstated; (b) other limitations that are often associated with this medical situation are present but the applicant has failed to mention them; (c) other medical conditions may be present that have not been claimed, but are

having an impact on the applicant's functioning or ability to apply for benefits effectively; (d) the claimed functional limitations are present, but are not due to a pathological process; or (e) the previously-claimed limitations are inconsistent with the applicant's report during the interview or behavior during the interview. In addition, the mFV expert will also opine as to what specifically is preventing the applicant from working today and what would be required (have to happen) for the applicant to return to work or enter the workforce if not previously employed.

The report will also, when feasible, lay out in Part 2 a general strategy for removal of barriers to employability, including examples of potential solutions and a timeline; and when appropriate, suggest options for needed services.

The report of the MDA will be partitioned, with Part 1 – all information about the applicant / beneficiary's current situation – available to the adjudicator, but not the information in Part 2 about potential future solutions, strategies to remove barriers to employability that have been identified, or the expert's assessment of the likelihood of success of these strategies.

The MDA report will provide adjudicators with additional information that provides a richer context and more solid basis for (a) determining the causal association (or lack thereof) between the applicant / beneficiary's medical condition(s), impairment, residual functional capacity, and ability to work, (b) assessing the credibility of the applicant / beneficiary's claim, and (c) explicitly differentiating between factors that do and do not constitute the legal basis for a benefit award.

The community-based mFV experts who perform MDAs will be required to take training in how to do them and be expected to periodically present their work to groups of other mFVs in order to foster continuing professional development of the mFV expert network. The MDA reports will be subjected to quality control audits, and mFV experts will receive feedback about the aggregate quality of their work. The database of quality control audit results, mFV expert performance, and the impact of MDAs on claim acceptances and denials will be used to drive program and training program refinements.

For concrete examples that illustrate the way the MDA works and the type of impact it will have, see the Appendix 3 (next), Hypothetical Case Examples. Part 1 of the Supplemental Report also provides further general information about MDAs.

Appendix 3: Hypothetical Case Examples: How mFV Triage and MDAs Will Work

The table below uses a set of hypothetical case examples to show how an "mFV Triager" will assign claim complexity classes, determine whether an MDA is required, and if so determine the kind of mFV expert(s) to do it. It also shows the additional information that can be gathered during the face-to-face MDA process, and the resultant outcomes including possible opportunities for follow-up action identified.

The "mFV Triager" is a member of SSA's internal mFV unit who has been given the responsibility for doing the triage work. In making these decisions, the mFV Triager uses a combination of SSA's criteria for claim classification and for mFV provider selection (which will be fleshed out more completely by SSA based on the general descriptions laid out in the Core and Supplementary Reports from this project).

Name	*Information the SSA application process has already gathered before triage is done*	*Triage Results (See Table 4):* *1. Complexity Class* *2. MDA? Yes or No* *3. Who will do the MDA?*	*Additional information gathered by the mFV expert in the course of the MDA*	*Possible Opportunity*
Becky	**Age:** 14 **Status:** New applicant for SSI **Geography:** Lives in Baltimore, MD **Claimed Medical Conditions:** Recently diagnosed with Laurence-Moon syndrome, a degenerative genetic syndrome **Education:** Special education. **Work History:** N/A	Complexity Class A No MDA needed now due to young age and low likelihood of future capability for gainful employment above SGA An MDA might still be a useful option because it could help her start planning for supported or sheltered employment in the future.	n/a	Rapid claim decision

Name	*Information the SSA application process has already gathered before triage is done*	*Triage Results (See Table 4):* *1. Complexity Class* *2. MDA? Yes or No* *3. Who will do the MDA?*	*Additional information gathered by the mFV expert in the course of the MDA*	*Possible Opportunity*
Victor	**Age:** 53 **Status:** New applicant for SSDI **Geography:** Boston metropolitan area (population 2.5 million) **Claimed Medical Conditions:** Recent diagnosis of metastatic lung cancer with documented rapid progression of disease despite treatment. **Education**: PhD – psychology **Work History:** 30 years of private clinical practice	Complexity Class A No MDA needed due to poor medical prognosis; death appears likely in the near future	n/a	Rapid claim decision
Mike	**Age:** 48 **Status:** On SSDI x 1 year (allowed at hearing) **Geography:** Flint, MI (pop 120,000) **Claimed Medical Conditions:** Post-traumatic leg pain and foot drop following work-related accident and tibia fracture. **Education:** High school graduate - unskilled **Work History:** 20 years in auto assembly plant as a painter, parts man.	Complexity Class B MDA required because of limited and stable nature of impairment, likely good future work capacity with rehabilitation and adaptive equipment Triager will assign any Tier II mFV expert to do the MDA, but an OT would be ideal	Workers' comp insurer is paying benefits. Mike had a prior episode of disability but went back to work despite this problem. He went back on disability when layoff loomed. Recently divorced; dull normal intelligence; good mechanical aptitude; has a hobby of small appliance repair. He likes to work and says he could probably find a job if he could get around better. Observation of leg reveals deformity and impaired standing / walking. Functional screening reveals he is functionally illiterate.	Evaluate availability of occupations for illiterate unskilled workers in his area. Refer for orthotic services to get foot brace; refer for assistance in finding small appliance repair or similar; refer for literacy services.

Name	*Information the SSA application process has already gathered before triage is done*	*Triage Results (See Table 4):* *1. Complexity Class* *2. MDA? Yes or No* *3. Who will do the MDA?*	*Additional information gathered by the mFV expert in the course of the MDA*	*Possible Opportunity*
Rosie	**Age:** 44 **Status:** New applicant for SSDI **Geography:** El Campo, TX (Pop 10,000) **Claimed Medical Conditions:** Major depression / anxiety for 6 months. This is the 3rd episode. Still being treated by family doctor. Compliant with treatment but poor response to date. **Education:** High school graduate **Work History:** 15 years as a housewife, 9 years in real estate sales.	Complexity Class B MDA required due to diagnosis with self-report features, good likelihood of substantial residual functional capacity and future improvement with treatment Triager will assign a Tier II or III mFV expert who is also a psychiatrist, psychologist, or social worker	Average intelligence. No private disability insurance; recently separated; empty nest, bored. Lives in largest town in sparsely settled area. Her mother became alcoholic in middle age. Alcohol noted on breath during morning appointment; visible tremor. Admits > 8 ounces of alcohol per day; having had a drink this morning; and prior treatment for alcoholism. Possible additional medical conditions identified during MDA: Active alcoholism	Deny or delay benefits decision until evaluation done for active alcoholism. Request records and refer for CE. Inform treating source and refer to alcoholism diagnostic and treatment program. Explore interest in benefits of RTW.

Name	*Information the SSA application process has already gathered before triage is done*	*Triage Results (See Table 4):* *1. Complexity Class* *2. MDA? Yes or No* *3. Who will do the MDA?*	*Additional information gathered by the mFV expert in the course of the MDA*	*Possible Opportunity*
Pete	**Age:** 41 **Status:** New applicant for SSDI **Geography:** Rayland, WV (pop <500) **Claimed Medical Conditions:** Bulging lumbar disc; osteoarthritis of the spine. Modest x-ray findings. **Education:** Some high school - unskilled **Work History:** 20 years in coal mines	Complexity Class C MDA required due to self-report features of this diagnosis and good likelihood of residual work capacity. The triager will assign a Tier III mFV expert to do this MDA due to rural location, low education and prior work history. An OT, PT, social worker or vocational rehabilitation counselor would be preferred.	Average IQ. 20 minutes to nearest store; 1 hour to nearest large town with a doctor; enjoys working with people but can't imagine trying a new kind of job. Grossly obese, short of breath with mild exertion. Partial amputation of thumb and forefinger on dominant hand not mentioned on claim forms. Dexterity screening test done by mFV expert. Possible additional conditions uncovered during MDA: Major loss of hand dexterity due to amputated digits, sleep apnea, obesity, severe deconditioning.	Award benefits based on new facts now available. Refer for social services and/or voc rehab intervention to develop future life plan and connect with resources, including GED/adult education programs. Refer for treatment of sleep apnea, weight loss and fitness program.

Name	*Information the SSA application process has already gathered before triage is done*	*Triage Results (See Table 4):* *1. Complexity Class* *2. MDA? Yes or No* *3. Who will do the MDA?*	*Additional information gathered by the mFV expert in the course of the MDA*	*Possible Opportunity*
Nancy	**Age:** 45 **Status:** New applicant for SSDI **Geography:** Wahpeton, ND (pop 10,000) **Claimed Medical Conditions:** Asthma, Diabetes, Hypertension, Venous Stasis Ulcers, Obesity **Education:** 8th grade education **Work History:** 20 years as cafeteria worker, housecleaner, day care worker.	Complexity Class C MDA required due to multiple diagnoses and good likelihood of substantial residual work capacity now or in the future. The triager will assign 2 mFV experts – a medical professional and a social worker – to do the MDA due to (a) multiple diagnoses and (b) rural area, low education, etc.	Above average intelligence; learning disability with limited literacy; history of domestic violence, abusive and alcoholic spouse; lives on a farm, nearest doctor is ½ hour away, car has been repossessed. Non-compliant with medical treatment due to poor understanding of her conditions. Additional medical conditions identified during MDA: depression Says she could work if she could "get motivated again." Social and transportation problems need attention; lack of education, medication non-compliance and depression all need to be addressed	Arrange CE re: depression. Award or deny benefits based on full review of all facts once available. Refer for medical and social services case management interventions. Report to authorities re: possible domestic violence per state law requirements.

Name	*Information the SSA application process has already gathered before triage is done*	*Triage Results (See Table 4):* *1. Complexity Class* *2. MDA? Yes or No* *3. Who will do the MDA?*	*Additional information gathered by the mFV expert in the course of the MDA*	*Possible Opportunity*
Gerard	**Age:** 29 **Status:** New applicant for SSI **Geography:** Bronx, NY (pop >10 million) **Claimed Medical Conditions:** Closed head injury x 6 months in auto accident. Not hospitalized. Few medical records; some ER visits requesting Oxycontin for headache. **Education:** Some high school - unskilled **Work History:** Too few quarters of employment to qualify for SSD	Complexity Class C MDA required due to diagnosis depending on self-report and unclear extent of current or future work capacity. Triager will assign a Tier III mFV neurologist, psychiatrist, psychologist or social worker to do the MDA. The Tier III mFV expert may decide to call in a Tier IV physician or psychologist with expertise in this area.	Interview reveals that he seems to have average intellectual ability, has been on and off welfare most of his life, mentions a history of narcotics abuse and a criminal record, and says he does not want to work. His story about the auto accident is non-credible – details are inconsistent during the interview and the mechanism of injury is inadequate to cause the problems claimed. Observation and screening tests done during MDA show minimal/no brain-related symptoms and fresh needle tracks. Additional conditions identified during MDA: Possible anti-social personality disorder, active substance abuse.	Depending on other facts available, deny SSI or obtain CE re: additional diagnoses; investigate criminal record and medical record of prior narcotics abuse; refer for other appropriate services.

Name	*Information the SSA application process has already gathered before triage is done*	*Triage Results (See Table 4):* *1. Complexity Class* *2. MDA? Yes or No* *3. Who will do the MDA?*	*Additional information gathered by the mFV expert in the course of the MDA*	*Possible Opportunity*
Tikola	**Age:** 52 **Status:** New applicant for SSI **Geography:** Franklin, LA (pop 8,000) **Claimed Medical Conditions:** Fibromyalgia, Chronic Fatigue Syndrome, Lupus Erythematosis. Chronic pain and problems with concentration & memory. Treating source: local family physician. **Education:** College graduate (Myanmar / Burma) **Work History:** None in the US; worked 15 years as a schoolteacher in Myanmar.	Complexity Class C MDA required by nature of diagnosis with major self-report aspects and likelihood of residual work capacity. Triager will assign Tier III mFV expert with expertise in medical as well as psychological issues (physician, nurse case manager, nurse practitioner, OT). The mFV expert may call on a Tier IV physician mFV expert with special expertise with these diagnoses.	Recent immigrant. Has green card; lives with cousin. Non-English speaking; above average IQ; loves teaching. Additional conditions identified during MDA: Possible PTSD, depression, adjustment disorder, somatization. More physical ability to function than reported but significant psychiatric impairment. Mental health treatment should restore her confidence in her ability to function.	Award benefits for a limited period; then re-evaluate. Refer to mental health provider for diagnostic evaluation and treatment. Connect with a social worker – find a way to learn English, get a job.

Appendix 4: Availability of mFV Experts – Preliminary Estimates

Table 5 on the following page shows preliminary estimates of the number of individuals in each profession who are likely to be able to qualify as mFV experts if they so choose, along with a rough indication of prevailing earning levels. The columns in the table include for each profession:

Total Professionals Available: the estimated total number of professionals in the profession, with some comments on their geographic availability, based on national data.

Size of Potential mFV Subset: a preliminary estimate of the number of persons within the group above that are likely to have enough mFV expertise to qualify for the mFV Registry, based on a combination of available data and of estimates made by the expert panel and project staff based on their personal knowledge.

Median Income: median income for individuals in the mFV subset when available, or for the profession as a whole.

More descriptive information about each profession can be found in the Supplemental Report.

Table 5 – Availability of mFV Experts – Preliminary Estimates

TYPE OF PROFESSION	TOTAL PROFESSIONALS AVAILABLE	SIZE OF POTENTIAL mFV SUBSET	MEDIAN INCOME
Certified Nurse Case Managers and Rehabilitation Nurses	o Available in many areas o 100,000 total	o 20% specialize in disability or workers' comp o 20-30,000 estimated	o Median salary $57,000
Nurse Practitioners	o Available in many areas, especially urban/rural o 58,000 employed	o 5% may specialize in disability or workers' comp o 3,000 estimated	o Median salary $75,000 with the middle 50% between $69- $80,000
Occupational Therapists	o Available in most areas o 90,000 jobs (many part-timers)	o 15% or more may specialize in disability or workers' comp o 15,000 estimated	o Median income $59,100 with the middle 50% between $45- $67,000
Physical Therapists	o Available in most areas o 155,000 jobs (many part-timers)	o 20% may specialize in disability or workers' comp o 30,000 estimated maximum	o Median income $65,300 with the middle 50% between $50- $72,000
Physicians	o Primary care specialties available in most areas; preferred specialties are more likely to be in urban areas or towns with industrial plants o Estimated 500,000 in direct clinical practice o Estimated 17,000 in the 3 preferred specialties combined	o 80% of 7,000 in occupational med = 5600 o 60% of 6800 PM&R (physiatrists) = 4100 o 10% of 3300 rheumatologists = 300 o Total 10,000 between all 3 specialties	o Median income varies by specialty o Primary care, occ med & PM&R $150-200,000 base salary + incentives /yr o Most surgical specialties > $250-300,000/yr
Psychologists	o Available in most areas o 150,000 psychologists; 93,000 have doctorates o 40% self-employed	o <2% specialize in disability or workers' comp o 2,000 estimated	o Median income for all doctoral level psychologists is $72,000 and for master's level is $55,000.
Social Workers	o Available in most areas o 500,000 total, with 235,000 SWs with mental health training / experience	o 2% or less of mental health SWs now specialize in disability or workers' comp o 2,200 estimated	o Median income for BSWs is $33,628, MSWs is $46,845 and DWSs is $58,390.
Vocational Rehabilitation Counselors	o Available in most areas o Total 131,000 rehabilitation counselors	o 100% specialize in workers' comp or disability o 131,000	o Median income $28,000 with middle 50% between $22-$36,000
Totals	824,000	218,200	
Estimated Total Available to SSA (Assuming roughly 20% are able / willing to provide some service to SSA)			**44,000**

Appendix 5: Project Participants

(Only primary affiliations are shown.)

Project Director

Jennifer Christian, MD, MPH, FACOEM – Physician (Occupational Medicine)
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Expert Panel

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Rosalind Joffe, MEd – Chronic Illness Coach, Consultant
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Kenneth Mitchell, PhD – Vocational Rehabilitation
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William Molmen, JD – Researcher, Lawyer, Economist
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Robert "Bobby" Silverstein, JD – Disability Policy
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*** Pamela Warren, PhD – Clinical Psychology**
Clinical Psychologist, Faculty – University of Illinois

***** *= panelists unable to attend the two day panel meeting, but who participated in other project activities*

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