PART C – Decision under Appeal

The decision under appeal is the Ministry of Social Development and Social Innovation (the ministry) reconsideration decision dated February 2, 2017 which found that the appellant did not meet three of the five statutory requirements of Section 2 of the *Employment and Assistance for Persons with Disabilities Act* for designation as a person with disabilities (PWD). The ministry found that the appellant met the age requirement and that his impairment is likely to continue for at least two years. However, the ministry was not satisfied the evidence establishes that:

- the appellant has a severe physical or mental impairment;
- the appellant's daily living activities (DLA) are, in the opinion of a prescribed professional, directly and significantly restricted either continuously or periodically for extended periods; and,
- as a result of these restrictions, the appellant requires the significant help or supervision of another person, the use of an assistive device, or the services of an assistance animal to perform DLA.

PART D – Relevant Legislation

Employment and Assistance for Persons with Disabilities Act (EAPWDA), Section 2

Employment and Assistance for Persons with Disabilities Regulation (EAPWDR), Section 2

PART E – Summary of Facts

With the consent of both parties, the hearing was conducted as a written hearing, pursuant to section 22(3)(b) of the *Employment and Assistance Act*.

The evidence before the ministry at the time of the reconsideration decision included the appellant's Persons With Disabilities (PWD) Application comprised of the appellant's information and self-report dated July 7, 2016, a physician report (PR) and an assessor report (AR) both dated July 26, 2016 and completed by a physician who is a specialist in internal medicine (internist) who has known the appellant since April 2016.

The evidence also included the following documents:

1) Outpatient clinic notes by the internist dated April 21, 2016, June 6, 2016, and July 11, 2016;
2) Outpatient clinic note for cardiologist dated May 5, 2016; and,
3) Request for Reconsideration dated January 5, 2017.

Diagnoses

In the PR, the GP diagnosed the appellant with chronic fatigue syndrome (CFS) and Postural Orthostatic Tachycardia Syndrome (POTS), both with an onset in 2016. Asked to describe the mental or physical impairments that impact the appellant's ability to manage daily living activities (DLA), the internist left this section of the AR incomplete.

Physical Impairment

In the PR and AR, the internist reported:

- The appellant does not require any prostheses or aids for his impairment.
- In terms of functional skills, the appellant can walk 2 to 4 blocks unaided on a flat surface, climb 2 to 5 stairs unaided, lift 2 to 7 kg. (5 to 15 lbs) and remain seated 2 to 3 hours. The internist noted with respect to all of these activities: "not consistent or predictable."
- In the additional comments to the PR, "no evidence of secondary gain. Doing everything to improve his condition."
- The appellant is assessed as being independent in all areas of mobility and physical ability, specifically: walking indoors, walking outdoors, climbing stairs, standing, and lifting. There is no assessment for carrying and holding. The internist commented that "ME [Myalgic Encephalomyelitis]/CFS is now known as SEID: Systemic Exertion Intolerance Disease. His energy is not consistent or reliable. Although he can do these activities independently, he cannot do them for long or predictably.
- In the section of the AR relating to assistance provided, none of the listed assistive devices are indicated as applicable by the internist.
- In the additional comments, the appellant "has an activity tolerance of about 30%, i.e. 3 hours "unable" during the day (not necessarily consecutive)."

In the appellant's self-report, he wrote:

- He has been diagnosed with ME/CFS and POTS. CFS/ME causes any physical exertion to make him "crash." Simply daily activities are severely affected by this condition.
- POTS directly affects his heart rate and causes his BPM [beats per minute] to rise significantly upon standing or exerting any energy.
- He gets extremely light-headed and dizzy after a very short amount of exercise.

In the Outpatient clinic note dated May 5, 2016, the cardiologist wrote:

- The appellant's diagnoses include a structurally normal heart, no evidence of coronary artery anomaly or coronary artery disease on CT, and there was previous suspicion of supracristal

ventricular septal defect but none was shown on testing
- The appellant "remains a diagnostic conundrum."

In the Outpatient clinic note dated June 6, 2016, the internist wrote the appellant meets the diagnostic criteria for CFS and POTS.

In the Outpatient clinic note dated July 11, 2016, the internist wrote the appellant's activity tolerance is about 3 to 4 hours during the day inside the home. This translates to about 2 hours outside the home and an activity tolerance of about 35%.

Mental Impairment

In the PR and AR, the internist reported:

- The appellant has no difficulties with communication.
- The appellant has significant deficits with cognitive and emotional function in the areas of executive, memory, and perceptual psychomotor. The internist wrote "cognitive symptoms 'brain fog.'"
- The appellant has a good ability to communicate with hearing, satisfactory ability with speaking, and poor ability with reading and writing, with a comment: "cognitive symptoms- 'brain fog.'"
- There is no indication whether there are daily impacts to the appellant's cognitive and emotional functioning.
- The appellant is independent and requires no support or supervision in all areas of social functioning, specifically: making appropriate social decisions, developing and maintaining relationships, interacting appropriately with others, dealing appropriately with unexpected demands, and securing assistance from others.
- The appellant has good functioning in both his immediate and extended social networks.

In the Outpatient clinic note dated April 21, 2016, the internist wrote that the appellant's past medical history includes depression and anxiety.

In his self-report, the appellant did not refer to any cognitive symptoms.

Daily Living Activities (DLA)

In the PR and the AR, the internist reported:

- The appellant has not been prescribed any medication and/or treatment that interfere with his ability to perform DLA.
- The appellant is independent with walking indoors and walking outdoors.
- The appellant is independent with all of the assessed tasks of the medications DLA, including filling/refilling prescriptions, taking as directed, and safe handling and storage.
- For the personal care DLA the appellant is independent with the tasks of transfers in/out of bed and transfers on/off of chair, and takes significantly longer than typical with dressing, grooming, bathing, toileting, feeding self and regulate diet. There is no explanation or description provided by the internist.
- For the basic housekeeping DLA, the appellant requires continuous assistance from another person with laundry and basic housekeeping. There is no explanation or description provided by the internist.
- Regarding the shopping DLA, the appellant is independent with most tasks (reading prices and labels, making appropriate choices, and paying for purchases), and requires periodic assistance from another person with the tasks of going to and from stores and carrying purchases home. There is no explanation or description provided by the internist.

- For the meals DLA, the appellant requires continuous assistance from another person with the tasks of meal planning, food preparation, and cooking. He is independent with safe storage of food. There is no explanation or description provided by the internist.
- The appellant requires periodic assistance from another person with all tasks of the pay rent and bills DLA, including budgeting and banking. There is no explanation or description provided by the internist.
- Regarding the transportation DLA, the appellant is independent with getting in and out of a vehicle and using transit schedules and arranging transportation. The appellant requires periodic assistance from another person with using public transit. There is no explanation or description provided by the internist.

In his self-report, the appellant wrote that CFS/ME causes any physical exertion to make him "crash". Simple daily activities are severely affected by CFS/ME.

Need for Help

With respect to the assistance provided by other people, the internist reported that the appellant receives help from his family. In the section of the AR for identifying assistance provided through the use of assistive devices, the internist did not indicate any of the listed items as being required by the appellant.

Additional information

In his Notice of Appeal dated February 14, 2017, the appellant expressed his disagreement with the ministry's reconsideration decision and wrote that he was denied his reconsideration request by the ministry for a lack of supporting documents, although he did hand these in. The ministry processed them one day late and they were not considered. He is disabled.

Prior to the hearing, the appellant provided the following additional documents:

1) Outpatient clinic notes dated September 27, 2016 and December 15, 2016 in which the internist wrote:
    - The appellant stated that his anxiety is much worse.
    - The appellant's activity tolerance is very low. He only has 1 to 2 hours before he goes into post-exertional malaise.
    - He needs consistent help with his DLA. There is no way he could work at any job even part-time.
2) Outpatient clinic notes dated January 12, 2017 in which the respirologist wrote:
    - The appellant's problems include CFS, Fibromyalgia (FM), POTS, exercise intolerance and depression/anxiety.
    - In summary, although the appellant may carry the diagnosis of CFS and FM, he clearly has an abnormal cardiac response to exercise and needs follow up with cardiologist.
3) Letter dated January 24, 2017 in which the internist wrote:
    - The appellant is completely disabled and cannot work at ANY job. [emphasis included]
    - The appellant has an activity tolerance of about 10 to 20%. Activity tolerance is based on a normal of 10 "usable" hours in a day. It is based on what patients can accomplish WITHOUT [emphasis included] precipitating post-exertional malaise (i.e. "crashing").
    - This is an average as available energy is not consistent or reliable. At an activity tolerance of 30% patients are not usually able to complete their ADL without modifications, limitations, or assistance.
    - The appellant is home-bound and often [in bed]. If he does more than 1 to 2 hours of activity outside the home, he suffers significant post-exertional malaise and worsening symptoms.

- The appellant has severe cognitive symptoms that affect his short-term memory, concentration, and information processing.
- The appellant has limitations that require assistance with his DLA and he remains severely restricted.

4) Letter dated January 5, 2017 in which the appellant wrote:
   - In late August of 2015 he became extremely sick and weak and progressively for almost 2 years all of his medical conditions have caused his level of activity and ability to work to become almost non-existent.
   - He has been diagnosed with ME/CFS, FM, and POTS and each of these plays a role in his daily life and they each come with their own limitation.
   - Throughout the day, he needs to think ahead about what tasks he can accomplish within his energy for that day.
   - He spends almost 90% of his day bed-bound and the other portion of the day attempting to make meals for himself, or do the pacing exercises prescribed by his doctor.
   - If he pushes his body beyond its tolerance level for that day, the consequences are something he can pay for potentially weeks.
   - When he remains standing or does too many activities in a day, it leaves his body and his brain exhausted. His muscles stay sore for weeks on end if he attempts to carry too many groceries.
   - His brain will end up so tired at the end of the day that he is not capable of processing information.
   - He deals with these symptoms every day and they are severe.
   - Pain related to FM is also a huge part of his daily life. When he does any activity involving lifting, moving, stretching, or bending, he suffers prolonged muscle and joint pain afterwards.
   - With POTS, when he performs an activity, his heart rate sharply increases. This causes him to experience blackness in his vision, light-headedness, and shortness of breath.
   - The impact these conditions have on his ability to work is huge.
   - There has been an impact on his social abilities. For almost 2 years, he has been unable to attend a gathering with family or friends.

Prior to the hearing, the ministry provided a letter dated March 8, 2017 for its submission on the appeal, relying on the reconsideration decision. The ministry noted that had the appellant's reconsideration information been submitted within the time limit permitted, the ministry would have taken the additional information into consideration and a different decision may have been made as a result. The panel considered the information from the ministry as part of argument, as discussed in Part F- Reasons for Panel Decision.

Admissibility of Additional Information

The ministry did not object to the admissibility of the appellant's additional documents. The panel considered the information in the Outpatient clinic notes and the letters from the internist and from the appellant as being in support of, and tending to corroborate, the impact from medical conditions referred to in the PWD application and the supporting documentation, which were before the ministry at reconsideration. Therefore, the panel admitted the documents in accordance with Section 22(4)(b) of the *Employment and Assistance Act.*

PART F – Reasons for Panel Decision

The issue on appeal is whether the ministry's reconsideration decision, which found that the appellant is not eligible for designation as a PWD, was reasonably supported by the evidence or was a reasonable application of the applicable enactment in the circumstances of the appellant. The ministry found that the evidence does not establish that the appellant has a severe mental or physical impairment and that his DLA are, in the opinion of a prescribed professional, directly and significantly restricted either continuously or periodically for extended periods. Also, as a result of those restrictions, it could not be determined that the appellant requires the significant help or supervision of another person, the use of an assistive device, or the services of an assistance animal to perform DLA.

The criteria for being designated as a PWD are set out in Section 2 of the EAPWDA as follows:

Persons with disabilities

2 (1) In this section:

"assistive device" means a device designed to enable a person to perform a daily living activity that, because of a severe mental or physical impairment, the person is unable to perform;

"daily living activity" has the prescribed meaning;

"prescribed professional" has the prescribed meaning.

(2) The minister may designate a person who has reached 18 years of age as a person with disabilities for the purposes of this Act if the minister is satisfied that the person is in a prescribed class of persons or that the person has a severe mental or physical impairment that

(a) in the opinion of a medical practitioner or nurse practitioner is likely to continue for at least 2 years, and

(b) in the opinion of a prescribed professional

(i) directly and significantly restricts the person's ability to perform daily living activities either

(A) continuously, or

(B) periodically for extended periods, and

(ii) as a result of those restrictions, the person requires help to perform those activities.

(3) For the purposes of subsection (2),

(a) a person who has a severe mental impairment includes a person with a mental disorder, and

(b) a person requires help in relation to a daily living activity if, in order to perform it, the person requires

(i) an assistive device,

(ii) the significant help or supervision of another person, or

(iii) the services of an assistance animal.

(4) The minister may rescind a designation under subsection (2).

The EAPWDR provides as follows:

Definitions for Act

2 (1) For the purposes of the Act and this regulation, **"daily living activities"** ,

(a) in relation to a person who has a severe physical impairment or a severe mental impairment, means the following activities:

(i) prepare own meals;

(ii) manage personal finances;

(iii) shop for personal needs;

(iv) use public or personal transportation facilities;

(v) perform housework to maintain the person's place of residence in acceptable sanitary condition;

(vi) move about indoors and outdoors;

(vii) perform personal hygiene and self care;

(viii) manage personal medication, and

(b) in relation to a person who has a severe mental impairment, includes the following activities:

(i) make decisions about personal activities, care or finances;

(ii) relate to, communicate or interact with others effectively.

(2) For the purposes of the Act, "**prescribed professional**" means a person who is

(a) authorized under an enactment to practise the profession of

(i) medical practitioner,

(ii) registered psychologist,

(iii) registered nurse or registered psychiatric nurse,

(iv) occupational therapist,

(v) physical therapist,

(vi) social worker,

(vii) chiropractor, or

(viii) nurse practitioner, or

(b) acting in the course of the person's employment as a school psychologist by

(i) an authority, as that term is defined in section 1 (1) of the Independent School Act, or

(ii) a board or a francophone education authority, as those terms are defined in section 1 (1) of the School Act,

if qualifications in psychology are a condition of such employment.

Part 1.1 — Persons with Disabilities

Alternative grounds for designation under section 2 of Act

2.1 The following classes of persons are prescribed for the purposes of section 2 (2) [persons with disabilities] of the Act:

(a) a person who is enrolled in Plan P (Palliative Care) under the Drug Plans Regulation, B.C. Reg. 73/2015;

(b) a person who has at any time been determined to be eligible to be the subject of payments made through the Ministry of Children and Family Development's At Home Program;

(c) a person who has at any time been determined by Community Living British Columbia to be eligible to receive community living support under the Community Living Authority Act;

(d) a person whose family has at any time been determined by Community Living British Columbia to be eligible to receive community living support under the Community Living Authority Act to assist that family in caring for the person;

(e) a person who is considered to be disabled under section 42 (2) of the Canada Pension Plan (Canada).

Severe Physical Impairment

In the reconsideration decision, the ministry was not satisfied that the information provided establishes a severe physical impairment. The ministry noted the internist reported that the appellant does not require an aid for his impairment and his functional physical skills, assessed in the middle/high end of the scale, are accomplished “unaided,” or without the assistance of another person, an assistive device, or an assistance animal. The ministry also noted that the internist assessed the appellant as being independent with mobility and physical ability. The ministry

acknowledged that the internist reported that the appellant's functional skills are "not consistent or predictable" and that, with respect to his mobility and physical ability, "his energy is not consistent or reliable" and "although he can do these activities independently, he cannot do them for long," and the ministry concluded that the assessments by the internist speak to a moderate rather than to a severe physical impairment.

A diagnosis of a serious medical condition does not in itself determine PWD eligibility or establish a severe impairment. An "impairment" is a medical condition that results in restrictions to a person's ability to function independently or effectively or for a reasonable duration. To assess the severity of an impairment, the ministry must consider the nature of the impairment and the extent of its impact on daily functioning. In making its determination the ministry must consider all the relevant evidence, including that of the appellant. However, the legislation is clear that the fundamental basis for the analysis is the evidence from a "prescribed professional" – in this case, the internist.

Therefore, the ministry reasonably considered the impacts of the appellant's diagnosed medical conditions on his daily functioning. In the PR, the internist diagnosed the appellant with CFS and POTS, both with an onset in 2016, and assessed the appellant as able to walk 2 to 4 blocks unaided, climb 2 to 5 steps unaided, lift 5 to 15 lbs. and remain seated for 2 to 3 hours, being independent with walking indoors and outdoors, climbing stairs, standing and lifting. In terms of the appellant's abilities being "not consistent or predictable" or his energy being "not consistent or reliable," when examining the impact on DLA, the ministry referred to the internist's comment that the appellant "has an activity tolerance of about 30%, i.e. 3 hours "unable" during the day (not necessarily consecutive)" and concluded that there is not sufficient evidence of a significant impact to the appellant's functioning. The Outpatient clinic note completed by the internist at the same time in July 2016 indicated that the appellant's activity tolerance is about 3 to 4 hours during the day inside the home, and this translates to about 2 hours outside the home and an activity tolerance of about 35%. The panel finds that the ministry was reasonable to conclude that 3 to 4 hours each day inside the home or 2 hours each day outside the home with an ability to independently walk 2 to 4 blocks unaided, climb 2 to 5 steps unaided, lift 5 to 15 lbs. and remain seated for 2 to 3 hours is more in keeping with a moderate than a severe physical impairment. In his self-report, the appellant wrote that his medical conditions cause any physical exertion to make him "crash," although the appellant did not provide information to define 'physical exertion' in his case or his physical functioning after a "crash," and there was no indication by the internist or the appellant that he requires or uses an aid for his impairment, such as a cane or walker, to assist following a "crash."

For the ministry to be "satisfied" that an impairment is severe, the panel considers it reasonable for the ministry to expect that the information provided by the medical practitioner and prescribed professional presents a comprehensive overview of the nature and extent of the impacts of the medical conditions on daily functioning, including by providing the explanations, descriptions or examples in the spaces provided in the PR and in the AR forms.

Additional information was provided by the appellant on the appeal, including a letter dated January 24, 2017 in which the internist wrote that the appellant is completely disabled and cannot work at ANY job. [emphasis included] The appellant also wrote in his letter dated January 5, 2017 that progressively for almost 2 years all of his medical conditions have caused his level of activity and ability to work to become almost non-existent, and the impact on his ability to work is "huge." In the additional submissions, both the internist and the appellant placed an emphasis on the impact to the appellant's ability to work and the panel notes that employability is not a consideration for eligibility for PWD designation as it is not a criterion in section 2(2) of the EAPWDA nor is it listed among the prescribed daily living activities in section 2 of the EAPWDR.

Although the internist wrote that the appellant has an activity tolerance of about 10 to 20%, which is based on what patients can accomplish WITHOUT [emphasis included] precipitating post-exertional malaise (i.e. "crashing"), the internist wrote that this is an average as "available energy is not consistent or reliable." The internist made this point as well in the PR and the AR that the appellant's physical abilities are "not consistent or predictable" and his energy is "not consistent or reliable." Given an opportunity to update his assessment of the appellant's physical abilities, there was no detail provided in the internist's letter of the appellant's physical functioning after a "crash," whether he is capable of any mobility or physical ability, or whether he could perform some of these activities, such as walking indoors, with the aid of a cane or walker. The internist wrote that If the appellant does more than 1 to 2 hours of activity outside the home, he suffers significant post-exertional malaise and worsening symptoms, and the appellant wrote in his letter that throughout the day he needs to think ahead about what tasks he can accomplish within his energy for that day.

While the ministry wrote in its letter on appeal that a different decision may have been made upon considering the additional information provided, the panel finds that the ministry reasonably determined that the assessments of completely independent physical functioning within a moderate range of functional skill limitations as set out in the PR and the AR was insufficient evidence of a severe physical impairment, especially in the absence of additional specific information from the medical practitioner to alter these previous assessments and given the appellant's stated ability to pace himself to avoid precipitating post-exertional malaise.

As discussed in more detail in these reasons for decision under the heading "Restrictions in the Ability to Perform DLA", the evidence indicates that the limitations to the appellant's physical functioning have not directly and significantly restricted his ability to perform his DLA either continuously or for extended periods, as required by the EAPWDA

Given the focus on employability in the additional information provided and a lack of detail regarding the appellant's level of physical functioning during a "crash" and how often he precipitates post-exertional malaise, the panel finds that the ministry reasonably determined that there is not sufficient evidence to establish that the appellant has a severe physical impairment under Section 2(2) of the EAPWDA.

Severe Mental Impairment

In the reconsideration decision, the ministry was not satisfied that the information provided was sufficient evidence of a severe mental impairment. The ministry noted that the internist reported significant deficits with cognitive and emotional functioning in the areas of executive, memory, perceptual psychomotor and wrote "cognitive symptoms- brain fog;" however, the internist did not provide an assessment of the degree that these deficits impact the appellant's daily functioning. The ministry pointed out that the internist indicated that the appellant does not have any difficulties with communication yet his abilities to communicate through reading and writing are "poor" due to "brain fog." The ministry also wrote that the internist assessed the appellant as being independent in all aspects of his social functioning and that he has good functioning in both his immediate and extended social networks.

The panel notes that the internist did not diagnose a medical condition within the 'mental disorders' category of the PR; however, there was a reference in the in the Outpatient clinic note dated April 21, 2016, to the fact that the appellant's past medical history includes depression and anxiety and, in the Outpatient clinic note dated December 15, 2016, the internist wrote that the appellant stated that "his anxiety is much worse." Although the internist reported in the PR that the appellant has significant deficits to cognitive and emotional functioning in the areas of executive, memory and perceptual psychomotor, this is attributed to "cognitive symptoms, 'brain fog'" as a result of the diagnosed

conditions of CFS and POTS. The panel finds that the ministry reasonably noted the lack of sufficient evidence of a severe mental impairment in part due to the absence of an assessment in the AR of the degree to which the appellant's mental impairment or brain injury restricts or impacts his daily functioning, particularly given the variability ascribed to the appellant's physical functioning as a result of CFS and POTS.

Considering the two "social functioning" DLA that are specific to mental impairment – make decisions about personal activities, care or finances (decision making), and relate to, communicate or interact with others effectively (relate effectively), the panel finds that the ministry reasonably concluded that there is insufficient evidence to establish that the appellant is significantly restricted. Regarding the 'decision making' DLA, the internist reported in the AR that the appellant independently manages almost all decision-making components of DLA, specifically: personal care (regulate diet- takes him longer), shopping (making appropriate choices and paying for purchases), meals (safe storage of food), medications (taking as directed and safe handling and storage), and transportation (using transit schedules and arranging transportation). For the task of meal planning, the internist assessed the need for continuous assistance from another person, without providing an explanation or description of his need for assistance in this task. For the tasks of budgeting and pay rent and bills, the internist assessed the need for periodic assistance from another person and did not include an explanation or description of how often or for how long the appellant requires assistance in order to determine that the assistance is required periodically for extended periods of time. The internist indicated in the AR that the appellant is independent in his ability to make appropriate social decisions.

Regarding the DLA of 'relating effectively', the internist reported in the AR that the appellant is independent in his ability to develop and maintain relationships and interact appropriately with others and he has good functioning in his immediate social network (family, friends) and his extended social network (neighborhood contacts, acquaintances, storekeepers, public officials, etc.). The internist reported that the appellant has no difficulties with communication and assessed him as having a good/satisfactory ability to communicate with speaking and hearing and a poor ability with reading and writing due to "cognitive symptoms- 'brain fog'," and it is not clear whether these symptoms are constant or variable as are the physical impacts to CFS and POTS.

The appellant did not refer to any cognitive symptoms in his self-report and, in his letter provided on the appeal, wrote that his brain will end up so tired at the end of the day that he is not capable of processing information and that there is also an impact to his social abilities since, for almost 2 years, he has been unable to attend a gathering with family or friends. With an opportunity to update his assessments of daily cognitive and emotional and social functioning in the January 24, 2017 letter, the internist wrote that the appellant has severe cognitive symptoms that affect his short-term memory, concentration, and information processing.

Given the lack of evidence of significant impacts to the appellant's cognitive, emotional and social functioning due to CFS and POTS, and absence of a definitive diagnosis of depression and anxiety in the PR and a description of the resulting impacts, and a the panel finds that the ministry reasonably determined that a severe mental impairment was not established under Section 2(2) of the EAPWDA.

Restrictions in the ability to perform DLA

In the reconsideration decision, the ministry was not satisfied that the appellant has a severe physical or mental impairment that, in the opinion of the prescribed professional, directly and significantly restricts DLA either continuously or periodically for extended periods of time.

According to the legislation, Section 2(2)(b) of the EAPWDA, the ministry must assess direct and

significant restrictions to DLA in consideration of the opinion of a prescribed professional, in this case the appellant's internist. This does not mean that the other evidence is not factored in as required to provide clarification of the professional evidence, but the legislative language makes it clear that a prescribed professional's evidence is fundamental to the ministry's determination as to whether it is "satisfied." Therefore, the prescribed professional completing the assessments has the opportunity to indicate which, if any, DLA are significantly restricted by the appellant's impairments either continuously or periodically for extended periods.

In the reconsideration decision, the ministry reviewed the information provided in the PR and noted that the internist reported that the appellant has not been prescribed medication and /or treatments that interfere with his ability to perform DLA. The ministry also reviewed the information provided in the AR and noted that while there was an assessment of the need for continuous assistance with some tasks of DLA, including laundry and basic housekeeping, meal planning, food preparation and cooking, there was no explanation by the internist of the reason for this level of assistance given the appellant's level of independent functioning for some hours each day. In the absence of an explanation or description by the internist to indicate whether this assessment for the need for continuous assistance with these tasks is when the appellant has "crashed" or why these tasks could not be performed within the window of tolerated activity each day for which the appellant paces himself, the panel finds that the ministry's conclusion with respect to these tasks of DLA is reasonable.

The ministry reviewed the internist's assessment for the need for periodic assistance from another person with some tasks of DLA, including those of shopping, paying rent and bills and transportation, and reasonably concluded that without a description of the frequency and duration of these periods, the ministry was not satisfied that this assessment in these tasks represents a significant restriction. The ministry referred to the internist's comment that the appellant "has an activity tolerance of about 30%, i.e. 3 hours "unable" during the day (not necessarily consecutive)" and concluded that there is not sufficient evidence of a significant impact to the appellant's functioning and the panel finds that this is reasonable given the appellant's independent level of functioning during the useable hours of the day. The ministry also considered the internist's assessment that the appellant takes significantly longer than typical with several tasks of the personal care DLA and reasonably noted a lack of a description of how much longer than typical it takes the appellant to manage these activities. There is also no explanation provided as to whether the appellant takes longer only after he has "crashed" or also during his useable hours during the day.

As previously discussed regarding the degree of physical impairment for the 'move about indoors and outdoors' DLA, the appellant is assessed by the internist as independent and able to walk 2 to 4 blocks unaided, noting that this is "not consistent or predictable," but lacking a clear picture of the appellant's abilities at other times. As previously discussed with respect to the severity of the mental impairment, considering the two "social functioning" DLA that are specific to mental impairment – 'decision making' and 'relate effectively,' the panel found the ministry was reasonable to conclude that there was insufficient evidence that the appellant is significantly restricted with either.

While the ministry wrote in its letter on appeal that a different decision may have been made upon considering the additional information provided, the panel finds that the ministry reasonably determined that there was insufficient detail from the prescribed professional to establish that the appellant has a severe physical or mental impairment that directly and significantly restricts his DLA either continuously or periodically for extended periods of time. In the additional letters from the internist and the appellant, emphasis was placed on the impact to the appellant's ability to work, as previously discussed. While the internist wrote in his letter that the appellant has an activity tolerance of about 10 to 20%, there was no additional assessment provided regarding the appellant's ability to

perform specific DLA within the window of available time each day, which is a different consideration than the appellant's ability to work at a job on a regular basis. In his letter, the appellant wrote that he spends almost 90% of his day bed-bound and the other portion of the day attempting to make meals or to do the pacing exercises prescribed by his doctor; however, the appellant does not explain whether he is bed-bound when he "crashes" or how often his activity level precipitates post-exertional malaise.

Given the focus on employability in the additional information provided, and a lack of detail regarding the degree of restriction with specific tasks of DLA or the frequency that the appellant's post-exertional malaise is triggered, the panel finds that the ministry reasonably determined that there was insufficient evidence from a prescribed professional of significant restrictions. Therefore, the panel finds that the ministry reasonably concluded that the evidence is insufficient to show that the appellant's overall ability to perform his DLA is significantly restricted either continuously or periodically for extended periods, pursuant to Section 2(2)(b)(i) of the EAPWDA.

Help to perform DLA

In the reconsideration decision, the ministry held that, as it has not been established that DLA are significantly restricted, it cannot be determined that significant help is required. Section 2(2)(b)(ii) of the EAPWDA requires that, as a result of being directly and significantly restricted in the ability to perform DLA either continuously or periodically for extended periods, a person must also require help to perform those activities. That is, the establishment of direct and significant restrictions under section 2(2)(b)(i) is a precondition of meeting the need for help criterion. Help is defined in subsection (3) as the requirement for an assistive device, the significant help or supervision of another person, or the services of an assistance animal in order to perform a DLA.

While the internist indicated that the appellant receives help from family, as the ministry reasonably determined that direct and significant restrictions in the appellant's ability to perform DLA have not been established, the panel finds that the ministry also reasonably concluded that, under section 2(2)(b)(ii) of the EAPWDA, it cannot be determined that the appellant requires help to perform DLA.

Conclusion

The panel finds that the ministry's reconsideration decision, which determined that the appellant was not eligible for PWD designation pursuant to Section 2(2) of the EAPWDA, was reasonably supported by the evidence. The panel therefore confirms the ministry's decision. The appellant's appeal, therefore, is not successful.