

# the NADE ADVOCATE



A Publication of the National Association of Disability Examiners

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## SoDADE Hosts Great Plains Regional Conference

by Donna Hilton, Missouri DDS

THEY CAME FROM THE COLORADO Rockies, the rolling terrain of Wyoming, the plains of North Dakota, the wheat fields of Nebraska and the Ozark Plateau of Missouri. Gathering in Sioux Falls, NADE members met to learn more about the disability program and to share case experience with one another at the Great Plains Training Conference on May 1-3, 2002. The conference provided a diversity of topics: childhood asthma, Mental Function Forms, residual function of cancer survivors, depression, attitude and its effect on decision making, managing stress in the workplace, and the impact of disability services on immigrants. NADE President Jeff Price also addressed the conference and outlined the national organization's activities.

Dr. Richard Hosen spoke on Asthma in Childhood. He explained that it is now referred to as reactive airways disease. The epithelium of the lungs becomes irritated and the resulting inflammation causes swelling, tissue spasm, and increased mucous. Air that is inhaled becomes trapped and can not be released. On listening to the patient's chest, a

physician will hear rales, the musical sound of trapped air rattling in the lung. Previously, patients were treated with adrenaline but now bronchodilators are administered. On x-rays this condition shows hyperinflation, hyperlucency, and a flattened diaphragm. To meet the intent of 103.03C2, a patient would have to have been prescribed glucocorticoids by mouth for short courses of 5-7 days. These are given in short course because they suppress the pituitary and adrenal glands. Short courses or tapered dosages allow those glands to restart. Growth impairment can be a side effect of steroid treatment for asthma. Asthmatic symptoms are usually related to home environment, and are worse in adolescents when they have not built up antibodies by exposure to allergens in childhood. As an adult this condition is usually diagnosed as bronchitis and can be seen as either a cough or a wheezing condition.

NADE President Jeff Price greeted the conference attendees and encouraged everyone to become involved actively in their professional organization. He stated, "Your investment of dues is an investment in your future," noting



that NADE is the only effective voice for DDS employees. NADE offers professional certification, quality training, and interaction between disability professionals. He reminded the group that professional development cannot be ignored or one will become a dinosaur in his/her own career. "Just because you're in the car, doesn't mean it's going anywhere," he stated, "the future is in your hands." He outlined activities by the executive board which recently met for the mid-year board meeting in Washington DC. The NADE officers met with the new SSA commissioner. They also visited various disability groups, congressional membership and staff, the SSA Advisory

See *Great Plains* on Page 12

### CELEBRATE NATIONAL DISABILITY PROFESSIONALS WEEK

June 17-21 has been designated as National Disability Professionals Week will be approaching us soon. The two chapters that celebrate NDPW the best will be recognized at the award luncheon at the national conference in Oregon in September.

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**Letters to the Editor** are welcomed and may be selected for inclusion in future issues. Please forward ideas for future *Advocate* topics to the editor or your Regional Publications Representative.

The next issue will be published in **July, 2002.**

All correspondence should be directed through your Regional Representative or directly to the *Advocate* editor **no later than June 15, 2002.**

You may e-mail articles in text format to [drhilton@sofnet.com](mailto:drhilton@sofnet.com)  
Please also forward a hard copy.

**President's Message**

“THE TIMES, THEY ARE A’ CHANGIN’!” Bob Dylan was right! Prototype is over and the Commissioner



has made her initial announcements as to where we will go from here. The claimant conference will be eliminated June 30 and the single decision-maker (SDM) will be rolled out nationally. It will also be expanded to include reconsideration claims. The prototype states will not be going back to reconsideration, however, until the Commissioner decides what she is going to do with this intermediate appeal step. She has promised a decision by the end of the fiscal year. NADE submitted a detailed proposal to the Commissioner (see the March/April issue of the *Advocate* or visit NADE online at [www.nade.org](http://www.nade.org). for details) that, in our opinion, addresses the best interests of the claimant with a claims process that is practical and affordable. Our proposal has been the only one offered for public review and comment, and there have certainly been comments! John F. Kennedy wrote Profiles In Courage fifty years

ago but NADE has written a new chapter to describe how a professional association came together to develop a vision of how best to serve the disabled community and then had the political courage to describe their vision publicly.

“The times, they are a’ changin’!” Ken Nibali, SSA’s Associate Commissioner for Disability since March, 1998 (and Deputy Associate Commissioner for many years prior to that), has announced plans to retire in June. Ken has been a great leader and a great supporter of NADE. He has been willing to speak at our conferences, confer with our Board members on policy issues and listen to our concerns, complaints and ideas. He has served longer in this position than anyone else and has managed to maintain his sense of humor in spite of tremendous pressures. Ken will be remembered for his presentation at last year’s national conference that included his “Top Ten Reasons Why I like Going to NADE Conferences” (Numbers 9, 5 and 2 were especially insightful – “NADE held its 2000 national conference in Puerto Rico!). NADE will miss a good friend and SSA will miss a knowledgeable leader. We extend our “Best Wishes” to Ken as he turns his attention to other pursuits.

*continued on page 3*

**NADE 2002 CALENDAR OF EVENTS:**

<b>Great Plains Regional</b>	<b>Ramada Inn</b>	<b>Sioux Falls, SD</b>	<b>May 1-3</b>
<b>Great Lakes Regional</b>	<b>Battle Creek Inn</b>	<b>Battle Creek, MI</b>	<b>May 9-10</b>
<b>SE/NE/Mid-Atlantic</b>	<b>Hyatt Regency</b>	<b>Louisville, KY</b>	<b>May 7-10</b>
<b>Pacific Regional</b>	<b>Red Lion Inn</b>	<b>Sacramento, CA</b>	<b>May 15-17</b>
<b>National Conference</b>	<b>DoubleTree Hotel</b>	<b>Portland, OR</b>	<b>Sept. 21-27</b>

*The NADE Advocate is the official publication of the National Association of Disability Examiners. It provides a forum for responsible comments concerning the disability process. Official NADE positions are found in the comments by the NADE President and NADE Position Papers.*

**Advocate advertising rates are as follows:**

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1/3 page	\$75.00	\$50.00 per issue
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“The times, they are a’ changin!” They are changing quickly and we all need to stay abreast of what is current and what is not. The best way to do that is to attend a NADE training conference. NADE has sponsored several regional events this year and I hope everyone had an opportunity to attend one of these conferences. Each one offered great value regarding disability training and opportunities to establish lasting friendships with fellow NADE members. Our national training conference will be held in Portland, Oregon September 21-27 and SSA Commissioner Jo Anne Barnhart will headline a great group of speakers for this conference. Many state NADE chapters will hold state training conferences this summer. Visit NADE online to check out dates and locations for these and other exciting events and items of interest.

“The times, they are a’ changin!” Have you heard of accelerated e-dib? If not, you will! Commissioner Barnhart has committed SSA to pursuing full implementation of the electronic disability claims folder by January 1, 2004. Can you hear me now? That is just twenty months away! The paperless claim folder is designed to resolve many of the issues that plague the program, including storage space problems, lost folder problems, folder alignment problems, and much more. The huge outlay of resources necessary to bring this about is expected to be offset by tremendous savings later.

“The times, they are a’ changin!” The Maine and Georgia DDSs are changing administrators as Ann DeWitt in Maine and Shelia Williams in Georgia have retired. NADE extends its “Best Wishes” to each of these very dedicated women who have contributed many years of experience and wisdom to the disability program. NADE has been grateful for their support and we wish each of them well as they divert their attention to the other pursuits that make life interesting.

“The times, they are a’ changin!” How many verses does that song have? These days, it seems to have many. For example, I used to be a good baseball player and there was nothing more I liked better than to smack the ball over the fences. Too bad I only did it twice and once it was a foul. Even so, I liked stepping up to the plate and swinging for the moon. Advancing age and the realization that other players were much better than I, persuaded me to retire from being an active player and turn my attention to coaching and trying to teach younger players the skills I once had (or wish I once had!). Baseball is truly a team sport but many of the skills used in the game are not so apparent. One of these is the sacrifice.

As much as I liked to hit the ball, you can imagine my horror when, on one occasion, my coach signaled to me to lay down a sacrifice bunt! So what if we had a runner on first, the score was tied, it was the last inning, there was one out, and our best hitter was due up next. I wanted to be the hero, to swing for the fences and knock the runner in. But I did as I was instructed and laid down the perfect bunt, sacrificing myself by being thrown out at first base but moving the runner to second. The next batter did hit a line drive into center field, easily scoring the runner from second and we won the game. I was praised for my willingness to sacrifice myself for the good of the team, making it possible for us to win the game. Since then, I have noticed that even major league ballplayers show great respect for their teammates who lay down a sacrifice bunt for the good of the team. It takes courage to put the team ahead of personal goals.

What is the moral of this story? It is membership renewal time and I want every NADE member to know that your membership is important. Yes, I am leading up to asking you to make another sacrifice, to once again choose to invest in your future and sacrifice \$50 (or \$25) for the good of the team. By doing so, you make it possible for your voice to be heard. Every member deserves the credit for making it possible for NADE to offer its vision for a new disability claims process. Every member deserves the credit for making it possible for NADE to be present at the National Dialogue on SSI Childhood Disability. Every member deserves the credit for making it possible for NADE to present testimony before Congress. Every member deserves the credit for making it possible for NADE to meet with the Commissioner to express your concerns. Every member is important! Every member has made it possible for NADE to be the effective advocate that we have become. Yes, I hope you will continue your support by renewing your membership and I hope you will encourage others to do likewise. The game is far from over and it is too early to take our bat and ball and go home.

I would like to express appreciation to the NADE chapters that acted as hosts for this year’s regional training conferences – Arkansas, South Dakota, Kentucky, Michigan, and California. Thank you for your tremendous effort to showcase NADE’s commitment to providing quality training that gives our members a door to an exciting and informed future.

I had the privilege of visiting the Ohio DDS in March and talking with the staff about NADE and what their professional association was doing on their behalf. I want to thank the Ohio Chapter for their invitation and I especially want to thank Kathy Johnson, the Ohio DDS Administrator, for giving her staff administrative leave to attend my presentation. This level of support, not only for NADE but also for staff development training, is much appreciated.

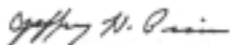
NADE recently provided congressional testimony on “Major Challenges Facing the New Commissioner.” A copy of this testimony can be viewed at NADE’s web site ([www.nade.org](http://www.nade.org)). We identified many challenges that Commissioner Barnhart must deal with, some very quickly. Much of our testimony was directed at NADE’s proposal for a new disability claims process, a proposal that has come under fire from many

other groups, most of whom have a vested interest in maintaining the status quo. NADE is committed to assisting the Commissioner in moving the disability program forward into the 21<sup>st</sup> century and we are firmly convinced that our proposal will help achieve that goal. I strongly urge every member of NADE to communicate with your congressional representatives on this issue. The consequences of the effort to modernize the disability program and the tremendous campaign by the special interests to resist those efforts are enormous!

I would like to remind NADE members and other interested persons that the official views of the National Association of Disability Examiners are communicated via the *NADE Advocate* or are posted on our web site ([www.nade.org](http://www.nade.org)). Other web sites and internet chat exchanges sometimes distribute information about NADE and the disability program. This information is occasionally mistaken as an official statement from NADE. Any information that is communicated by any means, other than our official communication channels, cannot be accepted as representing the official views or opinions of NADE. If there are ever any questions as to whether a specific communication actually represents the views of NADE, please check the official sites.

“The times, they are a’changin!” NADE extends greetings to Mr. Hal Daub, the new Chairman of the Social Security Advisory Board, and to Ms. Dorcas Hardy, a former Commissioner of Social Security, who was recently appointed to serve as a member of this Advisory Board. We look forward to working with these individuals in the years ahead to address the issues critical to the disability program.

Have a great summer and we’ll see you in September (in Portland!).



Jeff Price  
NADE President



**NADE needs your support!  
Renew your membership today.**

**Make plans to attend the  
National Training Conference in  
Portland Oregon September 21 - 27.**

**NADE Thanks  
Dr. Ward Jankus**

**Neuropsychological Associates of Southwest Missouri  
Becker Law Office      and      L & S Associates Inc  
for their continued corporate support.**

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April 22, 2002

The Honorable Jo Anne B. Barnhart, Commissioner  
Social Security Administration  
500 C Street, S.W.  
Suite 850  
Washington, D.C. 20254

Dear Commissioner Barnhart:

The National Association of Disability Examiners (NADE) fully supports the decisions you announced last week during your remarks at the DDS Administrators/SSA Management Forum regarding the future of the disability claims process. NADE is committed to working with you and your staff to devise an effective disability claims process that will be affordable and practical. We believe that expansion of the single decision-maker to all states, the inclusion of reconsideration claims within the SDM process, the elimination of the claimant conference in the prototype states, and reinforcing more contact with the claimant earlier in the process will help provide better service. This has been our primary goal – better service at a better price!

We also support your decision to pursue the accelerated electronic claims folder (e-dib). While our Association does have some concerns about this new technology and the speed at which it is being introduced, we trust these concerns will be adequately addressed as the development of this technology advances and implementation throughout the process occurs. We would very much welcome an opportunity to discuss our concerns with you and your staff to ensure that adequate measures are taken early to address them. It is our intent to act as a partner in the development and implementation of this technology.

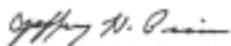
The “sooner-than-expected” availability of the electronic claims folder may alter NADE’s objection, expressed in our original proposal for a new disability claims process, to the DDSs sharing in the application process. Our original recommendation indicated that the intake of the disability claim would be done solely by the Field Office. If this technology becomes available as it is currently projected, our Association may agree that the disability examiner could share in the intake process and assist the claimant in completing the disability application. We would very much like to discuss this matter further with you and Deputy Commissioners Martin Gerry and Linda McMahon. We believe that representatives from the Social Security Field Office should also be included in this discussion.

NADE’s proposal for a new disability claims process was presented to you on February 26, 2002 as a concept as to where we should go once prototype was ended. There have been discussions since then by various groups, some of whom have expressed disagreement with certain portions of NADE’s proposal. This was to be expected. However, I do want to emphasize that NADE’s proposal was an effort to initiate the national dialogue that will assist in providing the necessary information that will enable you and your staff to make the critical decisions that will be needed.

NADE does commend your initial actions regarding the future of the disability claims process and we wish to emphasize our support for you and your staff as you forge ahead, making the responsible decisions that are necessary to lead this Agency. We concur with your view that the public is poorly served by a process that provides ineffective service and service that is more costly than it should be. We also believe the public is poorly served when the Social Security Administration is forced to continue to operate two very distinct disability programs and the availability of the opportunity for a reconsideration decision, for example, can actually depend upon which side of the street you live on. NADE fully supports your actions to bring the Social Security disability program back under one disability claims process.

In the weeks and months ahead, NADE is committed to working with you and your staff to resolve these and other issues. As the professional association representing the dedicated workers who will be charged with these new responsibilities, and on whose shoulders the success of implementation will lay, we trust that our expertise and commitment to working with you and your staff will continue to be appreciated.

Sincerely,



Jeffrey H. Price

cc: Martin Gerry, Deputy Commissioner for Disability and Income Security Programs  
Linda McMahon, Deputy commissioner for Operations  
Bill Gray, Deputy Commissioner for Systems  
Ken Nibali, Associate Commissioner for Disability  
NADE Board of Directors

**STATEMENT  
OF THE  
NATIONAL ASSOCIATION OF DISABILITY EXAMINERS**

**Jeffrey H. Price, President**

**PRESENTED BEFORE THE  
UNITED STATES HOUSE OF REPRESENTATIVES  
COMMITTEE ON WAYS AND MEANS  
SUBCOMMITTEES ON SOCIAL SECURITY AND HUMAN RESOURCES**

**“Challenges Facing the New Commissioner of Social Security”  
May 2, 2002**

The National Association of Disability Examiners (NADE) commends the positive action taken by the Subcommittees on Social Security and Human Resources in holding today’s hearing that directs public and congressional attention to the *“Challenges Facing the New Commissioner of Social Security.”* We appreciate the opportunity to present our perspective on this topic.

NADE is a professional association whose mission is to advance the art and science of disability evaluation. Our membership includes personnel in Social Security’s Central Office and Field Offices, claimant advocates, physicians, attorneys, and many others. However, the majority of our members work in the state Disability Determination Service (DDS) offices and are directly involved in the adjudication of claims for Social Security and Supplemental Security Income (SSI) disability benefits. It is the diversity of our membership, combined with our “hands on” experience, that enables our Association to offer a perspective that is both unique and reflective of a pragmatic realism. Our perspective is also developed with a conscious awareness that none of the challenges facing the new Commissioner exist in a vacuum.

Jo Anne Barnhart has served as the Commissioner of Social Security for six months, having been sworn in on November 8, 2001. We are convinced that her brief tenure thus far, combined with her service as a member of the Social Security Advisory Board, has provided the Commissioner with a keen awareness of many of the challenges she will face, and the urgent necessity to move quickly to address them.

We believe the new Commissioner has already indicated a willingness to make the necessary decisions to move the Agency forward. The new Commissioner provided a capsule summary of the challenges she will face when she outlined her goals for the Agency during her confirmation hearing.

- Improve service to the public
- Strengthen and modernize the Social Security program
- More fully involve SSA’s employees in making decisions

We concur with these broadly stated goals and fully support the Commissioner’s intent to make them a reality. NADE previously provided testimony on the *“Challenges Facing the New Commissioner of Social Security”* before these Subcommittees on March 12, 1998. We stated then that, “We are keenly aware of many of the challenges facing Social Security today, perhaps the greatest of which is restoring and maintaining public confidence.” Time and circumstances have not altered our opinion. We believe the crisis in public confidence is a greater priority, and a greater challenge, today than it was four years ago.

Because of the tremendous impact Social Security and Supplemental Security Income have on our nation’s well being, maintaining America’s confidence in the ability of these two programs to provide at least some guarantee of financial security is of paramount importance. Social Security touches the lives of every American and SSI touches the lives of millions of Americans. For many of these citizens, the benefit payments they receive from these programs are their primary or sole source of income. Therefore, it is critically important that America’s confidence in the promise inherent in these two programs be restored and maintained.

The new Commissioner must recognize that each of the challenges that faces her leadership team detracts from the level of confidence the public has in Social Security. To successfully combat this crisis in public confidence, the Commissioner will have to effectively resolve these issues:

- Solvency of Social Security trust funds
- The need to develop a more efficient disability claims process that is affordable
- SSA's inefficient and ineffective quality assurance process for its disability programs
- The need to eliminate the five-month waiting period for Social Security disability benefits
- The impact of technology on claimant service
- The need to prepare for the impending wave of retirements that face both SSA and the DDSs
- The need for bold leadership to provide direction for a program that has been managed, in large part, by short sighted responses to court decisions and other external pressures
- The need to truly implement the "One SSA" concept throughout the Agency
- The need for adequate resources to deal with the Agency's caseloads
- The need to meet other challenges, including the impact fraud has on the disability program, the need to resolve critical systems issues, and the challenge of ensuring that only the truly disabled are awarded benefit payments and that only those who remain disabled continue to receive these payments

### **Solvency**

There has been extensive public discussion regarding the solvency of Social Security. This has led to a fairly widespread belief, particularly among younger workers, that Social Security will not be available for future retirees. While most of this solvency debate has centered on the status of Social Security's retirement trust fund, it is important that attention also be directed at the disability trust fund, which is projected to become insolvent even earlier. At her confirmation hearing, the new Commissioner asserted, "*Whether they are just beginning their careers or retiring next month, the people of America expect and deserve to know that Social Security will be there when they need it.*" We agree. Partisan politics and "hidden agendas" must be removed from the solvency debate if public confidence is to be restored.

### **NADE's Proposal for A New Disability Claims Process**

We believe that one of the most important challenges facing the new Commissioner is the need for an effective and affordable disability claims process. Any process must necessarily take into consideration the need for fair and timely decisions and the need for the American public to have confidence that only the truly disabled are awarded benefits. NADE is fully supportive of the Commissioner's intent to examine the claims process to determine how to reduce the lengthy time period that many claimants must endure before a favorable decision is made on their claim.

NADE developed a proposal for a new disability claims process in February of this year and shared this vision with the Commissioner. A copy of this proposal is attached to our statement. What we desired was to use our experience and expertise to describe a way to improve the level of service provided to the claimant. It is appalling that many claimants wait nearly four years before a favorable decision is made on their claim. The major highlights of our proposal include:

- Placing greater emphasis on claimant responsibility
- Expansion of the Single Decision-Maker in the DDS
- Enhancing the current reconsideration to provide a due process hearing for the claimant
- Closing the record after the reconsideration decision
- Allowing Administrative Law Judges to make the legal decisions that they are trained to do
- Eliminating the Appeals Council
- Establishing a Social Security Court to hear appeals of ALJ decisions.

We firmly believe that the decision as to whether a claimant is disabled is a medical decision and should be made by those who are especially trained to make such decisions. There have been arguments presented that hearings conducted at the reconsideration level would violate the Administrative Procedures Act of 1946 and would restrict the claimant's right of appeal. This is not true. In the NADE proposal, claimants retain their full appeal rights guaranteed by law. Our proposal does assert that any appeal to an Administrative Law Judge should be an appeal of the claim that was heard at the DDS level. As long as the record remains open, and subsequent appellate levels are free to make decisions based on evidence that was not presented to the initial adjudicator, the discrepancies in the allowance rates between the different appellate levels will continue and the public's confidence will continue to be undermined. NADE's proposal affords the claimant the right to a hearing much earlier in the claims process than is the current practice. This is important when the timeline for the claimant to receive a hearing can exceed 1000 days!

Those who resist our proposal do not counter with a different proposal of their own. Rather, it is obvious their intent is to maintain the status quo. NADE is concerned that many who have expressed opposition to our proposal have a vested interest in maintaining the current system without significant changes. But, when the claimant now must wait 1000 days for a hearing, do we want to maintain that status quo? Our emphatic answer would be "No!" It is our assertion that the status quo won't go anymore! It is time to move the disability program into the 21<sup>st</sup> century!

NADE believes that truly disabled citizens should be awarded benefits and that those who are not disabled should not receive benefits, regardless of the claims process used. NADE supports the goal that disability claimants who should be allowed are allowed as early in the process as possible. Our proposal attempts to do something about it and to do so in a constructive way.

### **Quality Assurance**

Another challenge is SSA's Quality Assurance process. In a study conducted recently, the same case was adjudicated in different parts of the country, at different levels, including the Disability Determination Service, the Office of Hearings and Appeals, and the Disability Quality Branch in SSA's regional offices. The decisions rendered by these components varied widely, providing emphasis on the fact that there are widespread disparities between states and regions and between the DDSs and Administrative Law Judges. These disparities underscore the lack of a comprehensive quality review process that offers clear, consistent, and nationally uniform feedback. NADE has pointed out problems inherent in the current process and we have offered to assist any effort to design a more effective process. We are pleased to see the new SSA Commissioner has initiated efforts to reform the quality assurance process and we are hopeful that a new system can be designed and implemented that will address our concerns.

We believe it is essential that the new Commissioner should immediately address the problems with the QA process and the misguided perception that allowance rates reflect either accuracy or quality. Accurate decisions do not always mean allowance decisions. Sometimes, the answer is, "No," but that does not mean the decision is any less accurate.

We believe Administrative Law Judges can, and should be, limited to issuing legal decisions as to whether the DDSs correctly applied the law and that Administrative Law Judges should not be allowed to continue issuing new medical decisions for which they have little or no training. The availability of a hearing at the reconsideration level should increase the DDS allowance rate while affording the claimant the right to a hearing much earlier in the process. Restricting the hearings before Administrative Law Judges to only matters of law should substantially lower their allowance rate. These actions would effectively reduce the gap between the allowance rates of the DDSs and Administrative Law Judges and help restore public confidence in the program while improving the level of service provided to the claimant.

### **Decline in Institutional Knowledge at SSA and DDS**

The impending retirement wave at SSA and in the DDSs presents a significant challenge to the new Commissioner and one that must be addressed immediately. This expected decline in institutional knowledge would come at a time when the experience level in the DDSs is already severely diminished due to frequent staff turnover in recent years. Major challenges lie ahead as the bulk of institutional knowledge in the disability program retires, only to be replaced by less experienced personnel who will lack the opportunity to be mentored by knowledgeable persons. SSA has declared its intent to be an "Employer of Choice," with a highly trained workforce and a work environment that attracts the most highly qualified job applicants. This commitment also requires that SSA address the same fundamental issues for the DDSs, including those of salary and training.

### **Impact of Technology on Claimant Service**

SSA has acted in recent years to utilize advances in technology to improve the level of service offered to those seeking assistance. Unfortunately, these efforts have not always had the desired result and, in some cases, have had the opposite effect. We believe that this is especially true for disability claims. Because of the complexity of the disability application process, we believe that most applicants would benefit greatly from having access to personal assistance. Yet, the level of expertise within SSA's field offices has declined along with the actual number of employees available to provide assistance. This has had an adverse affect on the quality of the application received in the DDS, reducing our ability to move forward quickly with processing these claims. The Commissioner has announced her goal to have the electronic disability claims folder fully operational in the field offices and DDSs by January 1, 2004. We believe this is an ambitious goal for an Agency that has struggled for the past ten years with developing an electronic folder. NADE is encouraged by the Commissioner's commitment to advancing this goal and we support this effort. However, we caution the Subcommittees that the expected costs will be significant and will either be taken from other components already experiencing financial strain, or must be provided as new money. It will be unfair to expect the level of service that has been provided to be maintained if needed funds are diverted to other projects.

### **Elimination of the Five Month Waiting Period**

There is growing concern that the disability program is not fair in requiring disabled citizens to complete a five-month waiting period before they can begin to receive benefit payments. This waiting period has caused many claimants and their families to suffer severe economic and emotional hardship. NADE prepared a position paper on this issue in 1999 and the Executive Summary is attached to our statement today. The entire paper can be seen at [www.nade.org](http://www.nade.org). We commend Congress for legislation passed, and subsequently signed into law, in December, 2000, that eliminated the waiting period for a small portion of the disabled community – those who suffer from Amyotrophic Lateral Sclerosis, or Lou Gehrig's Disease. Subsequent legislation that would eliminate the waiting period for all claimants has yet to receive favorable action. The challenge we are presented with today is the need to recognize the human suffering caused by the waiting period and to eliminate this "eternal" wait, or at least limit its impact by significantly reducing its timeframe. Disabled citizens should be treated with compassion, dignity and honor.

### **Other Challenges**

- The challenge to examine the current relevance of SSA's definition of disability.
- The challenge to revise the medical listings with attention as to how new and/or revised listings will impact on administrative and program costs.
- The challenge to find a replacement for the Dictionary of Occupational Titles.
- The challenge of dealing with increased instances of fraud.
- The challenge of providing effective service to non-English speaking claimants.
- The challenge of implementing the "One SSA" concept.
- The challenge surrounding the medical improvement review standard (MIRS) and its impact on program costs.

NADE has expertise in many of these areas. For example, we have suggested that a claimant's privilege to continue receiving benefit payments during their appeal should be revoked when the basis for the proposed cessation of benefits was the claimant's own failure to cooperate. Also, the need to show medical improvement before ceasing benefits should be examined in light of the new advances in medical and rehabilitation technology. At the very least, a new exception to MIRS should be created to allow the cessation of benefits when the current assessment of the impairment(s) concludes that it is non-severe, or even non-existent, but the prior claim folder cannot be located, making it impossible to demonstrate that medical improvement has occurred.

### **Conclusion**

In its September, 2000 report, the Social Security Advisory Board reported that, "...in recent decades, disability policy has come to resemble a mosaic, pieced together in response to court decisions and other external pressures, rather than the result of a well-thought out concept of how the programs should be operating... Policy and administrative capacity are dramatically out of alignment in the sense that new and binding rules of adjudication frequently cannot be implemented in a reasonable manner, particularly in view of the resources that are currently available." NADE concurs with this observation. We believe the Commissioner must provide more definitive input into the development of disability policy and that this policy must reflect pragmatic reality. It is critical that the Commissioner should recognize that more direct guidance and administrative oversight from SSA's top levels of management is needed. We believe it is equally important that the Commissioner be given the support necessary to make the appropriate changes that

will recommit the Agency to its primary purposes of stewardship and service. The administration of the disability program presently requires about two-thirds of SSA's operating budget (\$8 billion in FY 2002-2003). To continue to allow the disability program to operate as described in the report from the Social Security Advisory Board would be a violation of the mission of SSA. That mission, clearly stated, is: **"To promote the economic security of the nation's people through compassionate and vigilant leadership in shaping and managing America's social security programs."**

The new Commissioner will be significantly challenged by the need for greater emphasis on the demand for vigilant leadership. At her confirmation hearing, the new Commissioner asserted, *"I do not seek to manage the status quo."* NADE agrees that managing the status quo is no longer a viable option. While we do not support change for the sake of change, we recognize that there a need for increased vigilance in the leadership of the Social Security Administration. No other agency has a greater impact on the quality of life in this nation and the American public will judge the ability of their government to meet their needs almost solely by the quality of service provided by SSA. We reiterate the point we made earlier in our statement that **maintaining America's confidence in the ability of Social Security and SSI to provide at least some guarantee of financial security is of paramount importance.** Social Security can and must do better in fulfilling its promise to America and NADE stands ready, willing, and able to assist the new Commissioner in fulfilling that promise.

**Regional Conference Coverage**

## **Asthma In Childhood**

*by Laura Cassens, Texas Association of Disability Examiners*

THE SWADE REGIONAL CONFERENCE IN Little Rock, Arkansas had a presentation by Dr. James Magee on asthma. Dr Magee works at the Arkansas Children's Hospital. Dr Magee began by asking why do we treat diseases? The answer is to basically make improvements in the quality of life and to prevent complications from the disease. In addition, the number one goal for treating children with asthma is for them to live a normal childhood including participating in physical education and sports.

Asthma is a chronic disease which requires routine follow up. Asthma is an inflammation of the airway obstructing the airflow, which is irreversible. The most common symptoms include coughing, wheezing, and shortness of breath. Seventeen to 18 million Americans have asthma, and 5.6 million of these people are below the age of 18. Every year 7000 people die from asthma. The goals of treating asthma are to prevent the chronic symptoms, allow a normal life, prevent exacerbations and airway scarring, and maintain normal pulmonary functions.

Medications used for long term control include corticosteroids, cromolyn, nedocromil, long acting B2 agonists, methylxanthines, leukotriene modifiers, and combination therapy. Quick relief control of asthma includes using short acting B2 agonists and anticholinergic agents. Treatment for quick relief with Albuterol should only be used as needed. Using greater than two canisters per month would be a risk factor for death. Atrovent is very useful for acute exacerbations and has few side effects. Anti-inflammatory agents used include Intal, Tilade, and Corticosteroids. Inhaled steroids (Prednisone) is the most effective long term treatment for asthma and is the first choice in all hospitalization visits.

Treatment of the children with asthma is done according to a chart classification.

<b>Step</b>	<b>Day Symptoms</b>	<b>Night Symptoms</b>	<b>PEF/FEV1</b>	<b>FEF .50</b>
4 – severe persistent	continuous	frequently	<60%	<50%
3 – moderate persistent	daily	>1/week	60-80%	50-70%
2 – mild persistent	>2/week	>2/month	>= 80%	>70%
1 – mild intermittent	<2/week	<2/month	>80%	>70%

The treating doctor finds the category that the child fits into (at least two circled) and adjusts the medication accordingly. Daily control is needed for persistent asthma. An asthma action plan is completed in writing for the patient and information is provided of when and how to seek medical treatment when needed.

In conclusion, the doctor pointed out that asthma is a disease that can be controlled with proper treatment. Nearly all children who have asthma should be able to lead normal lives including playing outside and playing sports.

## Organ Donation - The Gift of Life

by Veronica Monsivais, Texas DDS

SINCE THE 1950s HUNDREDS OF ill and injured people have received new hope through organ and tissue transplants. With today's advances in medical transplant technology, tissue matching and immunology, organ and tissue transplants have become a widely accepted method of medical treatment.

There is still a critical shortage of organs and tissues available. Each year thousands of children and adults get a second chance at life through transplants, yet thousands more die while waiting for their chance.

Any person can be a donor, from a newborn to the elderly. Some guidelines do exist for organ donations but most tissues and bone have fewer restrictions. Certain diseases and other medical conditions can also be a factor but everyone can be considered as a donor. Being an organ and tissue donor is an unselfish act that can touch the lives of many people.

You can start by signing the back of your driver's license to designate that you want to be a donor. However, you need to discuss your wishes with your family and next-of-kin. In many states, the next-of-kin must still approve any organ and tissue recovery. Only when someone is declared "brain dead" can they be considered for organ donation. Brain death is the medical criteria a person must meet in order to be considered for organ and tissue donation. Brain dead means that there is no blood flow or oxygen to the brain, and it is no longer functioning in any capacity. Brain death occurs in approximately only 10 percent of all deaths. Once brain death occurs the organs can be maintained for a short time by mechanical support. Brain death must happen in a hospital where machines are available to support the organs.

The most frequently transplanted organs are the kidneys. Other organs and tissues can be donated too. The heart, lungs, pancreas, corneas, bone, skin and valves can all be donated for transplants.

The National Transplant Act of 1984 makes it illegal to buy or sell organs in the U.S. Donations is considered to be the ultimate humanitarian gift. There is a federal law that states that all hospitals must discuss organ and tissue donation options with the family of every patient when death is imminent. Family discussions, before a tragic accident, can make such a decision much easier for the family. Most religions support organ and tissue donation on the basis that it is a gift of life from one human to another.

Below are some facts about transplantation in the U.S. from the Arkansas Regional Organ Recovery Agency, based on statistics as of August 31, 2001.

### Patients waiting for a...

**kidney transplant – 50,003**  
**liver transplant – 18,414**  
**pancreas transplant – 1,158**  
**pancreas islet cell – 194**  
**kidney-pancreas transplant – 2,497**  
**intestine transplant – 177**  
**heart transplant – 4,171**  
**heart-lung transplant – 214**  
**lung transplant – 3,741**

Each day, 10 people die waiting to receive an organ transplant. Every 18 minutes, a new name is added to the organ transplant waiting list. Yet, one donor can save the lives of more than 50 people.

Though less widely publicized than organ transplantation, tissue transplantation is one of the great success stories of modern medicine. Tissue donations affect about a half-million people in the U.S. each year. Donated musculoskeletal tissue can be used to replace bone, tendons and ligaments lost to cancer, trauma, arthritis and other conditions. Severe burn victims often need skin transplants. Heart valves can replace damaged ones. Patients with coronary artery disease often need veins and arteries to reestablish blood circulation. A transplanted cornea means vision is restored.

Unlike organ donation, tissue donation is possible in both cases of brain death or cardiac death and doesn't need mechanical support. This greatly increases the number of circumstances under which tissue donation is an option. Tissue transplants are not subject to rejection and don't require life-long drug therapies. Often there is minimal recuperation and rehabilitation time required.

Families do not know who receives the organs. This information is confidential but the family is told what tissues and organs were transplanted. The donor organization in your area can usually arrange correspondence between donor families and recipients if both parties agree.

Upon completion of the donation, the body is restored to its natural appearance. Donation of tissues and organs is accomplished usually within a few hours. Donations can dramatically change and improve the quality of life for many individuals—and may even save their lives. There are more than 60,000 people in the U.S. waiting on a transplant. Make the decision to become a donor, it may save the life of someone you know and love.



**Give the Gift of Life.**  
**Sign a donor card today!**



*Great Plains, from page 1*

Board, and the Office of Management and Budget. President Price noted that the NADE website has added membership renewal by credit card. Members were provided copies of the written NADE testimony presented to the House Subcommittee on Social Security and Human Resources on May 2, 2002.

In an interesting team approach, Richard Gunn Ph.D. and Cheryl Buchkoski Ph.D. presented "Form Follows Function." They explained that it takes the total picture of the claimant to be able to complete a mental assessment form adequately. Sources to consider in the file include: psychiatric and psychological files, the claimant's own ADL (activities of daily living) descriptions, third party ADL information, employer and teacher contacts, and treatment current and past. Dr. Gunn took the group through the DSM-IV axes and described the various components. He noted that the GAF (global assessment of functioning) score is often the least understood. It is two scales in one: symptom severity and psychosocial function. Using PTSD as an example, they cautioned the audience "don't superimpose your attitude of what should be traumatic." An event to one person may be manageable, while to another person it is devastating. They discussed PTSD symptoms of avoidance and numbing vs. increased arousal, and how to assess function from the various components of information.

Kevin Whittle M.D. discussed the Residual Function of Cancer Survivors. He reported that more cancer patients are living longer. Cancer continues to be treated through surgery, radiation

therapy and chemotherapy. Surgery is used most often in cases where the malignancy can be easily excised and as an adjunct treatment after other therapies have been used. Radiation is being used as an external beam and as implants. Chemotherapy can be curative, palliative or as a precursor to surgery, such as in cases of breast and colon cancer. Depending on the type of cancer, side effects can include loss of taste, loss of smell, peripheral neuropathy, ataxia, and fatigue. Many patients will be limited to 20 pounds of lifting due to their residuals from treatment. Some examples he gave were abdominal wall herniation after colon surgery and complications from prostate surgery. Breast cancer, if extensive, can require surgical removal of lymph glands under the arm and lead to lymphedema which causes problems with fine motor skills and overhead reaching.

In a break out session, everyone divided up into four groups to discuss some "hot" topics that people might have differing views on. The facilitators, all psychologists with the South Dakota DDS, each led a group in identifying how opinions are formed and how they can impact you in a work setting as a decision-maker. It was a unique approach to how we make decisions.

"Fiction and Fact from Fred's Almanac" was an enlightening presentation by Fred Entwistle, MD on how to distinguish between diagnosis and symptoms. As a rehabilitation specialist, Dr. Entwistle is trained in making objective assessments of disability and identifying symptom magnification. When a patient states he is unable to do anything, he looks for

evidence of muscle atrophy to confirm the allegation. He assesses range of motion to determine if it is consistent with the ADL information. Most patients with fibromyalgia need to be active as a method of treatment for their impairment. On the other hand, he noted that not everyone has the same pain response and the claimant's report must be given credibility if the objective findings are consistent. He stated that it often takes neurological deficits 18 months to two years for recovery.

Just when we were getting tired of sitting in our seats, in walked Tonya Schoenfelder to lead us in stretches that can be done in the workplace. She gave us instructions to get enough sleep, drink plenty of water (12-16 glasses per day), and we are now fully trained in desk aerobics! She warned that caffeine acts as a dehydrator in your body, so for every ounce of caffeine you consume, you should replace it with that same amount of water.

Leah Kreykes of the Lutheran Social Services and Marilyn Eberhart of OMS International raised our awareness of conditions in other parts of the world. Refugees who come to our country as immigrants face a host of challenges such as learning the language and currency, adapting to a new climate and community, and often simple lifestyle changes such as using a stove and having electricity.

As a part of the conference the Great Plains Region met as a delegation and elected Sharon Belt (MO) as the regional director. Sherry Sheely Blythe (CO) served the region as director for the previous four years and the Great Plains region thanks her for the time and leadership she has provided in her tenure. Gabe Barajas (WY) was elected regional President-elect but will step up as current regional president due to the election of Belt as regional director. Denise Eschenbaum (CO) was elected secretary and Ella Timm (SD) still has another year of her two-year term as treasurer to complete. Thanks to South Dakota for their hospitality and the excellent training experience.

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*The Nebraska Chapter received the Regional Presidents' Award and Doug Willman was honored with the regional Earl B. Thomas Award for outstanding administrator. The Nebraska delegation, from left: Dr. Linda Schmechel, Alden Peterson, Jill Larrew, Tricia Samuelson, Gina Fountain, Anne Pettit, Bill Allen, and Shari Bratt.*

**2002 Great Plains Award Winners**

<b>Rookie of the Year:</b>	<b>Barnest Patton II (Missouri)</b>
<b>Director's Award:</b>	<b>Bonita Mackendanz (Missouri)</b>
<b>Charles O Blalock:</b>	<b>Nancy Muser (Missouri)</b>
<b>NADE Award:</b>	<b>Sheila Beggs (Missouri)</b>
<b>John Gordon Award:</b>	<b>Deborah Iser (Missouri)</b>
<b>Lewis Buckingham Award:</b>	<b>Lyle Larson (South Dakota)</b>
<b>Earl B Thomas Award:</b>	<b>Doug Willman (Nebraska)</b>
<b>President's Award:</b>	<b>Nebraska Unit of Disability Examiners</b>

## Maine Says Goodbye

by Lynn Murray-DeBlois, Maine DDS

A SUPPORTER OF NADE. A supporter of the DDS and it's workers. An advocate for fair pay and work practices for her employees. A gardener. A dictator. A mediator. A wife, mother and grandmother. An outspoken person. These are some of the qualities and jobs of our director. She is adding a new one shortly, a retired state employee and retired Director of the Maine Disability Determination Services.

Ann DeWitt, retiring Director of the Maine DDS, began her college career at Colby College getting a BA in Physics. She went on to get her Masters in Public Administration from the University of Maine at Orono. She taught Physics in the Waterville, Maine area. In September 1970 she was hired as a Disability Claims Examiner. In January 1972, she began a Unit Supervisor. In October 1973, she went on to Assistant Director and in August 1976, she took over the reigns of the Maine DDS. She will be leaving this position on May 1, 2002 to enter into another phase of life, retirement.

**A supporter of the DDS and its workers.** Ann, while overseeing the DDS, has always had the professional welfare of her employees at the top of her list. She has been outspoken in equal pay for DDS employees and fair workloads. I attended a Managers Forum with Ann in Boston in 1994. All through the Forum, she was vocal about her DDS and their abilities and their needs. Her ability to direct people to her view and provoke lively discussion impressed me. While not always the popular favorite during these conversations, you felt what she had to say. She has been and will always be, a defender of the Maine DDS and its people.

**A supporter of NADE.** Ann has been a member of NADE since the mid 1970s and a member of McADE since its inception. She has supported sending members to conferences to gain knowledge and associate with other state's members. She has supported the local chapter of NADE, McADE, in it's fundraising endeavors and community work.

**An advocate for fair pay and work practices for her employees.** The Maine DDS has been trying to get a pay upgrade with the start of the SDM. While we haven't been successful as of yet, she has stood behind us and written letters in support of this upgrade.

**A gardener.** State office buildings do not always have the best landscaping. One of our employees started a rock garden at the front of our building. This was added to and maintained by some of the staff, including Ann. When this employee passed away, she helped us get a plaque for the rock garden in his memory. During the spring and through the summer, you will always see Ann out in the garden pulling weeds, spreading mulch and planting perennials. (After her retirement, we have thought of offering her a job as a part time gardener to keep our garden up to her standards!)

**An outspoken person.** When Ann has felt strongly about something, people know it. She has lobbied for many years to bring passenger rail service back to Maine. She has written numerous letters to Congress throughout the years advocating for this. It has finally become a reality and she has already taken her first trip on the train!



Ann DeWitt

**A ruler and a mediator.** At the same time being a staunch supporter of her employees, she always took no guff. Her employees also know where she stands on issues, both in- and outside the DDS. While some may not have always agreed with her, respect was given to her commitment to her practices. However, she was always willing to listen to opposing views, discuss changes and even modify decisions at times.

**A wife, mother and grandmother.** Ann is married to Charlie DeWitt. She has three children, John, Charlie and Laura. She has numerous grandchildren, which are her delight. A refrigerator outside of her office is busy with pictures of her children and grandchildren. She is eager to share tales of the grandchildren and accomplishments of her children.

With an era ending, Ann will always be remembered for her personality, her caring for her employees and her energy regarding the direction of the Social Security Disability program. The Maine DDS wishes to express our gratitude to her for leadership throughout the years.

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## Health Notes For Mind And Body

by Donna Hilton, Publications Director

*"Optimism is good for your life and pessimism is bad for your health."  
Michael Craig Miller, editor-in-chief, Harvard Mental Health Letter*

AS THE BABY BOOMER GENERATION ages, we become more aware of the issues of aging and maintaining good health. In the past we were able to keep a watchful eye on our girth as we worked those 9.09 obesity listing cases. However, since Social Security dumped that listing, we have had no guard dog to remind us to watch that waistline. Logically we ought to be able to blame this weight gain on the Social Security Administration, but being dutiful government employees we will take the rap! As summer approaches, we will be more aware of waists, thighs, etc., so I have collected some reminders to help you along.

### Health Notes for Longer Healthy Living:

1. Don't smoke – not only does it clog your arteries and lungs, but it makes more wrinkles!
2. Watch your weight – scales may make you cry, and mirrors never lie. Exercise – Move it to lose it. Every single diet I've read always includes "get regular exercise." It appears you are able to satisfy your taste buds and eat what you want as long as you burn the same number of calories off as you take in. Walking is the easiest exercise on your body and you can do it anywhere, and inexpensively! Fitness trainers recommend adding resistance training to your exercise program. (That means lifting weights – does not refer to perfecting your obstinacy skills.)
3. Eat right – There's always a catch! It's all about balance and eating the right kind of fat. Retrain those taste buds.



Learn to love chicken, tuna, lean meat, high fiber grains and legumes (oatmeal, brown rice, whole wheat bread, lentils, and chick-peas), vegetables and fruit. Consume small amounts of healthy fats such as olive oil, avocados, nuts, olives, and fatty fish (like salmon).

4. Drink 12-16 glasses of water a day. If you consume liquids that contain caffeine, you must drink a corresponding amount of water to offset the dehydrating effect of caffeine. Same goes for alcohol - It also has a dehydrating effect on the body.

5. Take a daily multivitamin. Older folks may need to also take a calcium supplement or pop a Tums XR, which also helps contain those over productive stomach acids causing GERD (gastroesophageal reflux disease) symptoms. Younger women planning to have children should consider folic-acid supplements, which are thought to reduce birth defects in babies.

6. Get 6-8 hours of sleep a night. (You cannot doze at your desk to make up the difference. It doesn't have the same effect!)

7. Take good care of your teeth. Untreated dental conditions can have serious effect on your overall health, and have known to cause serious bone and heart problems. Dental decay is a major factor in poor nutrition.



8. Learn to be hopeful and resilient. Maintain meaningful relationships. People who are upbeat and happy live longer. To grouches, it only seems longer! Manage expectations and confront problems.

9. Get an annual physical, especially once you turn 50. Prevention is far less expensive than treating medical conditions once they occur. The body is a complicated chemical and electrical system that requires ongoing regular maintenance.

Top 10 Chronic illnesses according to the Newsweek Fall Special issue, 2001 :

1. Arthritis
2. Hypertension
3. Heart disease
4. Hearing impairment
5. Cataracts
6. Bone/postural problems
7. Chronic sinusitis
8. Diabetes
9. Tinnitus
10. Visual impairment

Whether you are a boomer, a generation Xer, or somewhere in-between, good health is not something to take for granted. Most of us can not afford a personal trainer and chef, so it is up to each of us to make our health a priority. Good luck with your summer program of healthy living!



**Candidate Profiles**

## Jane Bradley for CCP Chair

HELLO, I AM JANE BRADLEY from Illinois and am the current Council of Chapter Presidents Chairperson. I would like the opportunity to serve in this position for another year.

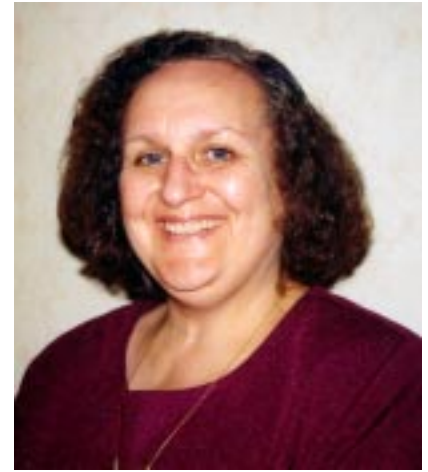
If re-elected, I will continue to keep all Chapter Presidents informed on any information pertaining to the State Presidents and changes to the Chapter Services Handbook which is currently being updated. I will continue to represent the Chapter Presidents on the National Board in a positive manner.

I have been active in NADE since 1989 when I first joined our organization. I attended my first National Conference in Springfield, IL that year. I accepted a one year board position in our local IADE Chapter. I became active in the local Chapter events and started accepting the offices of Secretary/Treasurer, President Elect and President, at which

time I also sat on our Regional Board. I have been Vice President on the Great Lakes Regional Board and for 4 years was the President of the Great Lakes Region. Currently, I am the Illinois State President.

For the last several years, I have been a part of the NADE Publication Committee. During the last year and a half I chaired the three day Great Lakes Regional Training Conference in Springfield, IL and assisted with our State Training Conferences.

I have been with the Illinois DDS since April 1985 where I started as a Trainee and then became an Adjudicator I, doing initial cases. Currently, I am an Adjudicator II processing initial, reconsideration and CDR claims. At times I am an acting supervisor in our unit.



My work ethic is one of getting the job done in the best possible manner and in the shortest amount of time. I take time to explain things to our customers and am available to answer questions and help fellow Adjudicators. I believe in the importance of our NADE Organization and am committed to our profession.

Thank you for your consideration and support for the Council of Chapter Presidents Chair for the coming year.

## Lyle Larson for Treasurer

I WOULD LIKE TO TAKE this opportunity to submit my name in nomination for the office of treasurer of NADE for FY 2003.

During the past seven years I have had the privilege of serving as NADE Treasurer and I would like to continue to serve in that position for FY 2003. I have performed the duties of Treasurer as required by the NADE by-laws and have been an active and positive voice on the NADE Board.

I have worked for the DDS in South Dakota since March 1974 and have had several different positions within the agency including examiner, supervisor, and hearing officer. I have been a NADE member since 1989 and served as President and Treasurer of SoDADE.

The platform provided by NADE for disability employees is recognized as a valuable source of information at many levels. NADE is well respected in Congress and is asked on a regular basis to provide testimony on important issues relating to disability evaluation and program direction.

NADE will continue to be challenged even more in the coming years with all of the technology and changes that are planned. NADE has taken a strong pro-active position on issues that affect the program and our profession. There will be additional challenges for NADE over the next few years. There is constant pressure to do more and more with fewer resources and NADE needs to make certain the States are given the resources to do a quality job. I look



forward to the opportunity to take an active and positive role in effecting the outcome of the many proposed changes in the year ahead.

If elected, I will continue to strive to be an active voice for all. I seek your support for the office of Treasurer of NADE.

## Candidate Profiles

### Terri Klubertanz for President

I WOULD LIKE TO TAKE this opportunity to formally announce my candidacy for the position of President-elect of NADE for the 2002-2003 year. I have had the privilege of serving as the Great Lakes Regional Director for the last five years and feel that my national Board experience and my many years of service to the NADE organization have helped to prepare me for the role of the NADE president.

I have worked in the DDS for 22 years in a variety of positions. As an examiner, I adjudicated all levels and types of cases. I have supervised initial, reconsideration and CDR adjudicators and served as supervisor of the Full Process Model and Disability Claims Manager projects in our office. I currently supervise the Quality and Special Projects unit. My staff are involved in quality review activities, as well as developing new procedures and processes, performing program research and serving as technical experts and resources for the rest of the agency. In addition, I coordinate all of the special workloads, including totalization, ALS, EXR and the current Special Title II workload, as well as several special state workloads. In my current capacity, I also serve as the Medicaid liaison between our Bureau and other state components and am called

upon to conduct or coordinate orientations and training sessions about the disability evaluation process to outside interest groups.

I have been a member of NADE since 1981 and have always been extremely active in our professional organization. Before taking on the Great Lakes regional director position five years ago, I served in every single office at both the local and regional level of NADE. I have served as chair or co-chair of several regional conference planning committees, as well as other local, regional and national committees. When I first joined NADE in 1981, our local chapter was inactive with no presiding officers. I assisted in "jump-starting" the chapter again, and became the first president of the re-activated chapter, serving as President for several years, before taking the position of Secretary of the Great Lakes region. I have won several local and regional awards for my service to NADE, and am most proud to have received NADE's supervisor of the year, the John Gordon award, in 1996. I believe my experiences at every level of NADE have provided me with the background and skills necessary to take on the crucial role of the president of a national association.



I believe that my diverse work background and NADE experiences have given me a broad perspective of the issues facing the disability program and of the challenges we face as disability professionals in the upcoming years. NADE is well respected as an organization and I am committed to continue to promote that respect, as well as the professionalism and skill of our members. As current regional director for the Great Lakes region, I have been an active participant in all Board meetings bringing forth the concerns and issues of the members of the Great Lakes region. If elected president, I will continue to strive to be an active voice for all and to represent the interest of all members.

For these reasons, I am asking for your support of my candidacy for NADE president-elect. Thank you for your consideration.

### Publications Grants Available

**Publications grants of up to \$50 are available by contacting the Publications Director and submitting copies of receipts of publication expenses for chapter newsletters. Deadline for applications is September 1, 2002.**

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**Candidate Profiles**

## Shari Bratt for NADE Secretary

IT IS WITH PLEASURE THAT I announce my candidacy for NADE Secretary. I am fortunate to have the support of my Administrator for this endeavor. Since elected to this position in 1997, I have fulfilled the charges of my office by recording the minutes of NADE business meetings and Delegate assemblies. I have also been responsible for maintaining and dispensing NADE stationery. Minutes of all meetings are distributed in a timely fashion after the meetings conclude.

As a member of NADE for the past 18 years, I have watched NADE's membership grow and its involvement in the political arena expand. NADE serves as a strong voice on disability issues which affect our careers and the lives of the claimants we work with. The energetic leadership of this organization has long been a source of pride. I have always felt that my membership in NADE has provided an excellent opportunity for continuing education and awareness of disability program issues and challenges we all face.

I have been active in NADE at the local, regional, and national levels since I joined the organization. I started working at the Nebraska DDS in 1983 as an Examiner, and currently work as a Hearing Officer. I served as the local Chapter president from 1990-1999, and have helped plan local and regional conferences. I have chaired regional committees, such as Awards and Nominations. I am currently President of the Great Plains Region. The Charles O. Blalock award was presented to me by my region in 1991, 1993, 1994, and 1997. In 1999 and in 2001, I was honored to receive the regional Lewis Buckingham award.

On a national level, I have served on the Publications Committee since 1989 as a contributor to the Advocate. In 1996, I had the pleasure of presenting the awards program in my capacity as Awards Committee Chair at the national training conference in Chicago, Illinois. I am a charter member of the Council of Chapter Presidents. As a delegate to numerous regional and national conferences, I have



had the opportunity to meet and talk to many of you regarding our profession and the challenges we face.

I am privileged to be a NADE member, and my continuous involvement at local, regional and national levels speaks to my commitment to the organization and its goals. I wish to be of continued service to NADE, and if re-elected, will strive to be a positive voice on the Board. It is for the reasons that I respectfully request your consideration of and support for my candidacy as NADE Secretary.



**NADE welcomes and extends  
congratulations to Hal Daub  
on his appointment of  
Chairman of SSA Advisory  
Board.**

**2002 SWADE AWARD WINNERS**

Membership Award:	BRADE ( Baton Rouge Chapter)
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The SWADE Award:	Susan McClure (Arkansas)
SWADE Director's Award:	Cathy Davis (Texas)
Charles Blalock Award:	Christa Royer (Shreveport LA)
SWADE President's Award:	TADE (Texas Chapter)

## Electronic Medical Information

by Barbara Young, Director of Government Services, IMA

ELECTRONIC DISABILITY REPORTING INC. (EDR) is pleased to make electronic medical information available to DDSs for the processing of Disability cases.

EDR will work with any DDS to provide an electronic data interchange for ordering and receipt of all medical information—both consultative examinations (CEs) and medical evidence of record (MER).

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The web-enabled EDR application provides a uniform interface for your CE providers and MER sources. Encryption and Secure Socket Layer (SSL) technology provide both security and authentication of the electronic medical information, as well as an audit trail of claimant contacts, MER and CE appointment status. EDR is IWS/LANAS 400 compatible and HIPAA compliant.

The key members of the EDR team worked closely with the New York DDS as co-developers of the electronic data exchange project that the NY DDS uses to order electronic CEs from all its providers. EDR has worked hard to bring together private resources to make electronic medical information available to any DDS interested in speeding caseloads and decreasing turnaround times in the absence of substantial new staff or financial resources. With EDR, you pay-as you go, no multi-year bud-

getary commitments to develop costly new software and systems. Moreover, EDR is solely focused on providing electronic medical information to the Disability program.

EDR is ready to work with you today to build a website for your DDS to order and receive medical information via a secure, Virtual Private Network (VPN). This application will go with your existing legacy software, eliminating the need for costly staff retraining. And EDR will help you implement the “paperless case folder” by handling your scanning and imaging needs as well.

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**NADE extends congratulations to  
Dorcus Hardy, former SSA  
Commissioner, upon her appointment to  
the SSA Advisory Board.**

## Highlights Of Recent OIG Cases

### **Prison And Restitution Ordered In Social Security Number (SSN) Fraud Investigation**

A Michigan man was sentenced to 18 months prison with 2 years supervised release. He was also ordered to pay restitution in the amount of \$266,114 to six different financial institutions and private business enterprises. The subject pled guilty to false use of an SSN and false statements to a financial institution. From 1995 through 1997, the defendant misused SSNs to establish credit. He secured a credit card, obtained home loans, received construction loans to build properties, and purchased vehicles—all through providing false information during the application process. His fraud scheme victimized First Security Bank, American Honda Finance Corporation, Principal Residential Mortgage, Desert First Credit Union, Bank of Utah, and Calvary Investments.

### **Stiff Sentenced Handed Down For SSN Fraud Involving Banks, Credit Card Companies And IRS**

A defendant from Phoenix, Arizona was sentenced to 30 months incarceration in the Bureau of Prisons, 5 years supervised release, and restitution to the victims (8 Banks and 7 Credit Card Agencies) in the amount of \$157,840. The defendant was found guilty by a trial jury of using an SSN that was assigned based upon false information, mail fraud, access device fraud, false statements, wire fraud and bank fraud. In a separate criminal proceeding, the defendant was also convicted of filing false claims for tax refunds and was sentenced to 4 years incarceration. The defendant fraudulently obtained an SSN that he used to acquire lines of credit from various banks and credit card agencies. The defendant subsequently defaulted on all lines of credit he obtained fraudulently. This investigation was initiated based upon information received by the U.S. Secret Service and the U.S. Attorney's Office in Phoenix, Arizona.

### **Disability Fraud Uncovered By Referral from Private Investigator**

A New York man pled guilty to theft of government funds and was sentenced to 4 months incarceration, 4 months home confinement, 3 years supervised release, and required to wear an electronic monitoring device. He was ordered to pay \$70,422 restitution to SSA and a \$100 special assessment fee. The investigation determined that the man started receiving social security disability in 1978 while he worked under another name and SSN until April 2001. SSA's loss was \$172,665. While SSA lost \$172,665, the restitution imposed by the court was limited to the benefits paid during the last 5 years. This investigation was initiated based upon information received from a private investigation firm.

### **Man Ordered To Pay SSA Over \$87,000 Restitution In Disability Fraud Case**

An individual was sentenced in U.S. District Court, District of Kansas (Kansas City), to 3 months home confinement, 5 years probation and ordered to pay \$87,125 in restitution to SSA. Investigation was initiated based on an allegation that the man failed to report his income while drawing title II disability benefits. The man claimed that he was only receiving "royalties" from a computer program he had written being utilized by a few doctors' offices. Investigation revealed he was working for the doctors as an office manager and was also consulting. All of his wages and fees were paid directly to a company he created and the company's bank account was used to pay his personal living expenses.

### **Iowa Woman Ordered To Pay Over \$129,000 Restitution in Multiple Benefits Scam**

Investigation revealed that a Steamboat Rock, Iowa woman used an alias and a fraudulently obtained SSN in order to receive SSI payments, Medicaid benefits, and subsidized housing assistance.

She also used another alias and SSN to conceal her ownership of a second home. Investigation found she fraudulently obtained \$14,879 in housing subsidies, \$51,747 in SSI payments, and \$62,900 in Medicaid benefits. She pled guilty to one count of Title 42, USC Section 1383a(a)(3), fraudulent receipt of SSI payments, and was sentenced to serve 3 years probation. She was also ordered to pay full restitution, totaling \$129,526, to the affected agencies. This investigation was opened after the Iowa Department of Human Services reported they suspected she was using multiple SSNs.

### **Multiple Benefit Investigation Results in \$132,000 Restitution**

The United States Attorney's Office, Southern Judicial District of Ohio, Columbus Docket agreed to prosecute a package of cases involving fraud against SSA and other related State and federal programs. Included were Medicare, Medicaid, Workers Compensation, housing assistance, and Aid to Dependent Children (ADC). Targeted cases, investigated jointly by the SSA OIG and the Postal Inspection Service, were projected to exceed \$1,000,000 in fraudulently obtained benefits.

One prosecution in this effort resulted from a referral by the Columbus Ohio East District Office after an anonymous source reported an individual attempted to have false invoices prepared for submission to SSA. Investigation disclosed the subject was married throughout the entire time she received benefits from April 1990 through November 2000. Her husband was gainfully employed earning in excess of \$45,000 per year with company provided health insurance. As a result of her failure to report her marriage and her husband's income she received Supplemental Security Income, ADC, and Medicaid benefits totaling \$132,527. She pled guilty in U.S. District Court to a one count Information charging her with violation of 42 USC 408(a)(4) "Concealing or Failing to Report an Event Affecting Benefit Payments" and was sentenced to 8 months

incarceration, followed by 3 years supervised probation. The court also ordered total restitution of \$132,527, including \$48,120 to SSA and \$84,407 to the Ohio Department of Jobs and Family Services.

**Representative Payee Sentenced and Ordered To Pay Over \$71,000 Restitution**

From 1984 to 1999, a Michigan representative payee made repeated false statements to SSA regarding the household income and living arrangements with her husband. As a result of these statements, she caused continued SSI benefits to be made to her on behalf of her son, when in fact she was not eligible to receive such benefits. She pled guilty in U.S. District Court for the Eastern District of Michigan to one count of 18 U.S.C. 134-Mail Fraud. She was later sentenced to 3 years probation and home confinement for 150 days and ordered to repay \$71,517 to SSA.

**Former SSA Employee and 4 Co-Conspirators Defrauded Banks of Over \$300,000**

This case was identified as the result of a national project to identify SSA employees who are illegally accessing the SSA database to obtain and release information to individuals to commit program and credit card fraud. Also, the Spartanburg, South Carolina SSA Office advised the Atlanta Field Division of an anonymous call alleging that an employee in the Spartanburg Office was committing SSN and credit card fraud.

The investigation determined that an SSA Service Representative, a 20-year employee, accessed the SSA computer system to obtain SSN information that she released to several individuals to commit credit card fraud. Approximately 61 credit cards accounts were affected, which caused losses to Citibank and FirstUSA in amounts exceeding \$300,000. The employee and

four co-conspirators were charged in an indictment with Conspiracy, Computer Fraud, and Aiding and Abetting. Subsequently, the employee and two co-conspirators were arrested. Arrest warrants remain outstanding for the remaining two co-conspirators. It is believed that the two individuals have left the country.


The employee and the two arrested co-conspirators pleaded guilty to conspiracy and the remaining charges were dismissed. The employee was sentenced to eight months incarceration, 3 years supervised release, and ordered to perform 250 hours of community service. She was terminated from her position at SSA. One co-conspirator was sentenced to 10 months incarceration and 3 years supervised release. Also, a deportation order was issued prohibiting the individual from returning to the United States. The other co-conspirator was sentenced to 6 months home confinement and 3 years supervised release. Each defendant was ordered to pay restitution to SSA of \$3,854 to cover the cost of the investigation.

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## Cognitive Deterioration from Chemotherapy and Radiation: The Responsibility of the Psychological Consultant and the Examiner

by Michael Schneider, Psy.D & William Jamieson, Ph.D

*This article was co-written by New Hampshire DDS Medical Consultants based on research they have done in conjunction with a Dartmouth Hitchcock Medical Center psychologist regarding cognitive impairments as a result of chemo and radiation treatment.*

IN A RECENT PRESENTATION TO the New Hampshire DDS sponsored by NADE in NH, Gary Schwartz, M.D. of Dartmouth Hitchcock Medical Center discussed the treatment of breast cancer. He mentioned some studies that were done that suggest decreased cognitive functioning in patients who have had chemotherapy as part of the treatment for breast cancer. It seemed to us as psychological consultants that we need to be aware of the possibility of cognitive deterioration resulting from either chemotherapy or radiation utilized to treat any form of cancer. As consultants and examiners we need to be sensitive to claimant's allegations of problems with thinking, attention and memory as possibly related to their experience of treatment with chemotherapy or radiation. This article will review some of the studies that have been completed with both children and adults who have had either chemotherapy or radiation and for whom cognitive deterioration was an issue.

Recently, in Cancer Investigation, Drs. Saykin & Ahles reviewed a number of studies showing cognitive effects from standard-dose chemotherapy in patients with cancer. Although problems alleged by patients will vary, some of the most common areas of difficulty reported are concentration, memory, ability to be focused or organized, and working with numbers. The problems are usually subtle and difficult to pick up on a mental status examination and even with more formal testing. Sometimes nobody but the patient notices the problems. There are studies that go back as far as 1980 but it appears that the earlier studies are inconsistently supportive of the hypothesis that there is deterioration as a result of chemotherapy. The inconsistencies are probably due to difficulties in the methodology of the studies and differences in study populations.

More recent studies utilizing formal neuro-psychological testing have supported the relationship between standard-dose chemotherapy and cognitive dysfunction. In one study following 30 small-cell lung cancer patients following treatment with chemo-

therapy, 95 percent of patients demonstrated cognitive impairment as compared to published norms, especially in the areas of verbal memory and frontal lobe functioning. A possible shortcoming of this particular study, however, is that the psychological testing took place relatively shortly after chemotherapy was completed. Therefore, the patients may have been experiencing acute effects of the therapy itself. In a different study that evaluated 28 women an average of six months post-treatment with various chemicals, 75 percent of patients scored > 2 standard deviations below the norm on one or more of the neuropsychological measures. Measures of memory and concentration were most commonly affected. Drs. Saykin & Ahles point out, however, that using the published normative samples as opposed to clinically matched samples is somewhat problematic.

The authors of the article cite such a study. Breast-cancer patients an average of two years post-treatment were randomized to high-dose chemotherapy plus tamoxifen or standard-dose therapy plus tamoxifen. There was a control group of patients who were treated with local therapy only (surgery plus local radiotherapy). Patients utilizing high dose treatment were more likely to demonstrate cognitive impairment, however, a greater number of patients in standard-dose treatment demonstrated cognitive impairment as compared to the local therapy group.

Saykin & Ahles point out that it is not possible to identify which chemotherapy agents are responsible for producing the cognitive deficits, largely because chemotherapy regimens nearly always include multiple agents. It is possible that there are a variety of agents or combinations of agents responsible for the effects on cognition. The research data is consistent regarding the notion that the cognitive deficits that have been identified are relatively subtle. Although the difference between the controls and the clinical subjects was statistically significant in many of the studies, the relative differences are fairly small and sometimes only a small number of

processes are affected. On the other hand, when qualitative data is collected it does indicate that the subtle effects can have an important impact on the patient's quality of life generally and on meeting career and educational goals specifically. There are other studies, however, that do not show a significant impact on the quality of life scores and correlation with performance on neuropsychological tests. The authors give some potential reasons for the discrepancy in results such as it may be that general quality of life measures do not assess the specific areas affected by the cognitive problems experienced by cancer survivors. Another explanation may relate to the type of data gathered by quantitative instruments vs. qualitative instruments. For example, someone who survived cancer and completes a quantitative questionnaire may report that they are working in the same profession post-treatment as pretreatment. When patients respond in a more elaborate way on qualitative instruments, however, they may report such things as having taken a less demanding position or some other adjustments in their job that suggests some deterioration in their functioning.

There are certain factors that influence cognitive functioning. These factors must be taken into consideration when conducting studies that look at cognitive deterioration following chemotherapy or radiation. Intelligence and educational level influence scores on neuropsychological tests; therefore, comparisons between groups of patients treated with systematic chemotherapy and cancer patients treated with local therapy or healthy controls must either match on IQ and education or, less desirably, covary their effects in the analyses. There is also data that indicates that higher IQ and educational level may reduce the negative neurocognitive impact to the brain. This concept, however, has not been directly examined in a cancer population.

In a recently published study in the *Journal of Clinical Oncology*, Drs. Ahles, Saykin et al studied the neuropsychological

impact of standard-dose systematic chemotherapy in long-term survivors of breast cancer and lymphoma. In this study, the survivors had to have been a minimum of five years past diagnosis, receiving no cancer treatment except tamoxifen, disease-free, > 18 years of age when diagnosed, and fluent in and able to read English. The neuropsychological testing occurred approximately two years after treatment. Thus, this study does not suffer from the confounding effects of acute treatment effects and any cognitive deterioration seen at this point in time may be viewed as long-term and irreversible. Another positive aspect of this particular study was the fact that 85 percent of the patients received only one type of chemotherapy regimen. The median number of cycles of chemotherapy within a regimen was 6. A significant but low correlation was found between the number of cycles and the mean of the neuropsychological main scores, indicating that more cycles of chemotherapy was associated with lower neuropsychological performance. A comparison of those patients having taken tamoxifen compared with those who had not, revealed no significant differences on any of the neuropsychological domain scores.

The cognitive deficits seen in this study were identified in survivors of approximately 10 years duration. The deficits that are measured after two years apparently persist long after treatment and may persist indefinitely. Age or educational level did not affect the differences in cognitive functioning. Depression, anxiety, and fatigue were also evaluated and not found to be confounders in the study.

In the case of children, there is a substantial body of clinical evidence indicating that cranial radiation therapy, whether as a primary treatment for brain tumor, or as prophylactic treatment in cases of leukemia, can have severe long-term effects on brain functioning. These effects include decline in full-scale IQ, and neurobehavioral alterations. At least one study describes a poor quality of life for children surviving for a long time after radiation treatment for malignant brain tumor. The most severe sequelae are neurocognitive disorders, which are associated with neurobehavioral alterations, often involving academic and social failure. These effects persist, despite the fact that treatment protocols have been continuously refined to

try to reduce this negative impact. Another study reported that 17 percent of 150 subjects had a moderate to severe level of impairment on long-term follow-up. A recent review of studies including almost 2000 children concluded that there were dose and age related factors involved in neuropsychological impairment, with children younger than age six being more vulnerable to even low dose treatment, but with higher dose treatment presenting a substantial risk even for older children. There is also some evidence for long-term effects of chemotherapy on cognition, with methotrexate by itself possibly responsible for cognitive impairment, which can be even more severe in association with radiotherapy.

For adults, other than anecdotal or single case reports, there is little evidence in the literature prior to 1995 regarding the long-term effects of cranial radiation on brain functioning. However, recent studies have consistently shown neurocognitive effects in a significant proportion of long-term survivors. For example, a recent study evaluating 19 patients reported that 80 percent of these patients showed impaired memory, with two patients experiencing brain necrosis with dementia, three patients with brain atrophy. Other difficulties ranged from decreased visual motor speed, frontal lobe executive dysfunction, and decrease in fine motor coordination, and were related to the total dose of radiation, but not to the volume of brain irradiated or to chemotherapy treatment. In another study of 160 patients, with a mean follow-up time of seven years post treatment, those that had had postoperative irradiation performed significantly more poorly in cognitive tests. The authors conclude that postoperative radiotherapy poses a significant risk of long-term cognitive impairment. Both studies report primary effects on the brain's white matter, typically resulting in most notable effects involving decreased processing speed and impaired working memory.

All of the studies of radiation therapy effects indicate that there is a considerable range of long term cognitive effects, and, on the positive side, that newer radiological techniques have resulted in a decrease in deleterious effects. Nevertheless, the issue of possible long-term cognitive impairment secondary to cranial radiation, whether for primary brain tumor or used prophylactically, needs to be carefully considered in any dis-

ability claims involving such a history. The role of chemotherapy in possible long-term cognitive impairment in all cancer survivors, not only breast cancer patients, should also be carefully considered. While it can probably be assumed that a severe level of neuropsychologically measured impairment (for example, in neuropsychological testing) represents a disabling condition, mild to moderate levels require careful assessment of functional, work-related issues, primarily in terms of concentration, memory, and pace. These functional issues are not always directly addressed in the clinical literature, or, for that matter, in neuropsychological reports.

The major limitation to many of the studies is the fact that there is often a lack of pretreatment assessment of cognitive functioning. There is no way to know whether or not the differences seen could be due to preexisting cognitive limitations. For example, some of the subjects may have had learning disabilities that affected their scores. The design of the studies does not always allow one to identify people who may have scored below the norm on certain neuropsychological tests before treatment and who may have been unaffected by the chemotherapy or radiation.

As psychological consultants and examiners we need to understand that it is entirely possible for any cancer survivor to experience cognitive deficits following chemotherapy or radiation therapy. Generally, the cognitive deficits found tend to be fairly subtle, but they may be measurable with neuro-psychological testing. It is also quite likely that significant qualitative changes in function may be evident even in the face of relatively benign quantitative scores. Claimants alleging problems with memory or concentration status post chemotherapy or radiation are probably credible and we will need to evaluate the degree of the impairment. Whether or not a full neuro-psychological battery should be ordered will remain a judgment to be made by the psychological consultant on a case-by-case basis. Psychologists evaluating these kinds of claims need to understand that although the scores obtained by claimants may not appear to be highly discrepant, the degree of functional impairment may be quite significant and disabling.

## Arthritis Impacts Most Americans

by Joseph Cataldo, MD, NADE in NH Member and DDS Medical Consultant



FROM FEBRUARY THROUGH MARCH OF 2002, during the noon lunch hour, Dr. Cataldo led three "Q&A" NADE in NH sponsored panel discussions on the spinal cord, related spinal column disorders and arthritis. This article is based on some of the information, which was presented at those MC training sessions sponsored by our New Hampshire chapter.

Over 40 million Americans have arthritis. Seventy-five percent of adults over age 65 have arthritis of the knees. Most frequent cause of disability in the United States is lower back pain, which will affect 80 percent of all Americans at some time in their life. Not all arthritis is visible and when patients are first examined, there may be no visible inflammation (synovitis) with the most common complaints being pain in the hands, lower back and hips, and of course, the knees. Arthritis costs us 50 billion dollars a year.

There are three main types of arthritis:

### 1. RHEUMATOID ARTHRITIS (R.A.)

may be confused with the arthritis associated with Systemic Lupus Erythematosus or other connective disorders. Diagnosis may include positive blood tests for Rheumatoid Factor and Anti-Nuclear Antibody but these may be sero-negative in some inflammations.

### 2. GOUTY ARTHRITIS

is most common in men between the ages of 30-45 years old. Urates found elevated in the blood are diagnostic and it is increased in African-Americans.

### 3. OSTEOARTHRITIS

is the most common type of arthritis and is called "wear and tear" arthritis. Age, obesity, previous trauma to a joint and being female contribute to the many factors in the etiology of this disease. Patients usually complain of morning stiffness and pain with walking, standing or climbing.

The sedimentation rate and/or the C-reactive Protein tests are common indicators of inflammation. Additionally, the history, clinical examination and possibly x-rays all assist in the diagnosis.

There are pharmacological treatments for all of the above but I insist that the #1 method of treatment is to reverse "de-conditioning." This is especially true with low back pain that is not discogenic. It is estimated that only 1 in

200 people with back pain have a serious condition. The problem there is usually a strained muscle usually due to de-conditioning.

Today, many clinicians are referring patients to Physical Therapy for strengthening and stretching. Weight loss and a solid exercise program help immeasurably. "Strong Muscles Protect Bone." Differential diagnoses must include Fibromyalgia but this is usually accompanied by "trigger point" pain, sleep disturbances, and fatigue. Fibromyalgia is more common in women.

The examination of a patient is most important. Synovitis, decreased range of motion and pain are tools used in diagnosing arthritis.



Some common signs used in testing are Tinels, Phalens, Spurling, Soto-Hall, and Patricks (sometimes called the **FABERE** sign from the acronym: **F**lexion, **A**bduction **E**xternal **R**otation and **E**xtension).

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NADE  
P.O. Box 4188  
Frankfort, Kentucky 40603

As to the pharmacological treatment of arthritis, it is recommended that the first line of treatment should be Acetaminophen (Tylenol). NSAIDS (non-steroidal anti-inflammatory drugs) are a good second line of defense. Some NSAIDS are safer than others such as the COX-2 inhibitors. Celebrex and Vioxx and newer ones are on the market today. Incidentally, we spend almost 3 billion dollars a year on these two COX-2 inhibitors alone.

Topical analgesics usually contain Methyl Salicylate or Capsaicin.

In the realm of alternative medicine, we must include Glucosamine and Chondroitin. Clinical studies have shown the efficacy of these two items.

Most importantly, let us not forget **CONDITIONING** such as moderate walking and stretching of the muscles and **EDUCATION**—use the mind to control the body.

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**NADE extends congratulations to  
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for Disability, on his upcoming  
retirement from SSA.  
Enjoy the golf course, Ken!**

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(Please print name, title & designation as desired on your Membership Certificate)

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NADE's membership year runs from July 1st through June 30th each year. Your membership will expire on the June 30th following your join date.

Exception: All new memberships received between January through June will receive an expiration date of June 30th of the following year. NADE does not prorate dues.

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**Regional Conference  
Coverage**

## Humor In The Workplace

by Alan McCorkle, TADE President-Elect

ONE OF THE FINAL SESSIONS presented at the recent SWADE Conference was entitled Humor In The Workplace. Mickey Quattlebaum spoke at length about the benefits of maintaining a sense of humor during the workday. According to Ms. Quattlebaum, a child laughs 300 times a day. An adult may laugh 15 times a day, if that. Few of these occasions to laugh occur at work.

What causes people to lose the inclination to laugh as often as they become adults? While there are numerous factors, which can contribute to this, several specific factors were discussed:

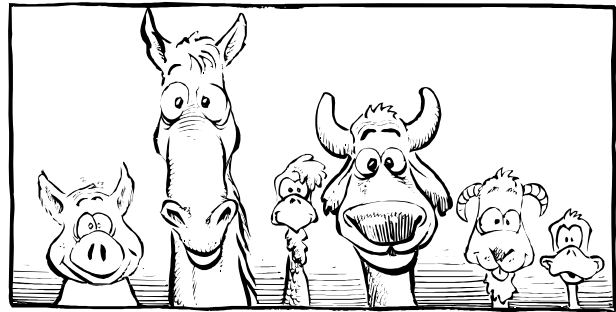
- job change. It's likely you will have three to five careers and ten job changes in your lifetime, many involuntary;
- technology. The high speed of technical innovation can contribute to increased stress on the job.
- confusion about what is politically correct. We think someone may take it the wrong way. We risk rejection.
- not seeing humor in everyday situations.
- not being able to laugh at self. Fear of being fired or ridiculed.

Ms. Quattlebaum listed four types of people:

- People who make things happen;
- People who think they make things happen;
- People who watch things happen; and
- People who wonder what happened.

She used this humorous list to introduce the Humor C.H.I.P.:

- C** - connect with people through use of humor;
- H** - health. Laughter is good for you;
- I** - inspiration. People can be moved to greater pleasure at work by humor;
- P** - perspective. Seeing the humor in a situation can reduce stress.



She offered the following regarding humor at work:

- Take your job seriously...and yourself lightly. With such a perspective, humor can help us survive-and thrive-at work;
- Jest for the health of it. Laughter enhances respiration and circulation, oxygenates the blood, suppresses the stress-related hormones in the brain and activates the immune system;
- Concerning stress and burn-out-by using humor, we can prevent a "hardening of the attitudes";
- "A smile is the shortest distance between two people."
- If you put humor into the environment, it may filter into people's awareness and even become contagious;
- Use humor as a tool rather than as a weapon. Use the AT&T test: is the humor Appropriate, Timely and Tasteful?

She finished by stating that humor is a delightful and powerful way to open doors, minds and hearts.

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