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NADE

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Inside this issue:

President's Address	2
Presentations from SSA Commissioner's Office	3-5
Presentation from the Office of Disability Determinations	6-7
Presentation from the Office of Disability Policy	8
Changes to the Informal Request for Review Process	9-11
SOAR	12-13
Guest Presenters and Break-Out Sessions	14

President's Address

Greetings NADE Members,

It was wonderful that NADE was able to host an in-person in Burlington, VT. I greatly appreciated being able to catch up with friends and meet new people. It is a unique opportunity to over our shared profession with others who work in the disability field throughout the country. I also want to pay a special thanks to the Green Mountain (Vermont) chapter of NADE for their extensive efforts to host the conference this year. The training that was provided was extremely informative.

At the Vermont conference we were able to offer a virtual option for people to attend some of the conference sessions. This was a new option for a NADE conference, and I'll be honest, I was a tiny bit afraid. It turned out the technology worked out fine and is something we will have to consider for the future. If you are already thinking about the next NADE conference, it will be in Helena, MT.

If you were at the conference, then you are well aware of a major change that occurred at the general assembly meeting. The NADE membership voted to change the number of regions. There will be four regions: Pacific, Midwest, South and North. These new regions will go into place November 1, 2022. This was an important step to make to help control expenditures. I am confident that each chapter will still have strong representation on the NADE board by the new regional directors.

While we look forward to the future, it is important that we develop new leaders within NADE. If you are interested in getting more involved in NADE, now is the perfect time to express your interest. We are currently looking for members to be part of all of our committees. NADE also has a mentoring program. We have a lot of members with valuable experience in NADE, that would love to share their knowledge with others. If you are interested in the mentoring program or would like to be a committee member, please contact your regional director.

I am honored to serve as NADE president and I look forward to this coming year.

Best regards,

Jennifer Nottingham

Jennifer.Nottingham@ssa.gov

Acting Commissioner Dr. Kijakazi Addresses NADE

NADE was honored to have Acting Commissioner Dr. Kilolo Kijakazi address our members by video to open our national conference. She shared that she'd been meeting with members of Congress to press SSA's need for $14.8 billion dollars' funding included in the President's 2023 budget request. That money would help SSA provide the staffing and overtime necessary to reduce DDS backlogs from the pandemic. It would also help modernize our systems and increase online services for claimants.

Dr. Kijakazi reported that due to years of prior inadequate funding, SSA is at its lowest staffing level in 25 years. Budget issues have also slowed progress on Improvements in decision-support tools designed to boost productivity like IMAGEN.

Reducing backlogs is one of Dr. Kijakazi's top priorities is reducing backlogs, she said. Another is to ensure that our programs are fair and equitable. She emphasized the importance of removing barriers to claimants' access to benefits and our services, and the importance of good customer service. She described a new online SSI protective filing tool that allows claimants to answer a few questions, schedule an application interview at a later date, and use the date of that online questionnaire as their protective filing date. This helps claimants start receiving benefits as soon as possible if they're approved.

Dr. Kijakazi described an Equity Action Plan designed to remove barriers that limit claimants' access to SSA programs and services. She cited aged people, children, people with mental illness, people experiencing housing instability and claimants with limited English proficiency as some populations who face barriers to access. Part of the action plan includes increasing collection of race and ethnicity data to help understand whether our programs are equitably serving our applicants and beneficiaries. She referenced 12 new statistical tables on the SSA website reflecting data by race and ethnicity of our beneficiaries.

Transgendered claimants face barriers in access to our benefits and services, too. Dr. Kijakazi mentioned an upcoming change in policy regarding transgendered claimants such that they will no longer have to provide medical or legal documentation of their sex designation when they apply. "We are committed to providing equal opportunity for all," she said.

Effective in November, the fee cap that representatives can charge and collect will increase from $6,000 to $7,200, Dr. Kijakai said. "Our programs are complex, and quality representation helps people navigate them." Quality representation is important for some claimants' access to SSA benefits and services.

In closing, Dr. Kijakazi said, "DDS employees continue to do an outstanding job in supporting our disability program despite the challenges we've experienced and the impacts of the pandemic over the last couple of years. I'm very grateful for all you do each day for the people who need our services. With your hard work and dedication, support from the administration and Congress, I'm confident that we will overcome the challenges we face and improve service delivery. My team and I look forward to continuing our work with NADE, with President Garcia and with President-Elect Nottingham to address your concerns."

Grace Kim Visits NADE Conference

Grace Kim, Acting Assistant Deputy Commissioner for SSA began her remarks at our conference by thanking DDS offices for our outstanding work in meeting the public's needs. She went on to provide interesting statistics about DDS challenges and accomplishments:

ACCOMPLISHMENTS

- One goal this year was to improve customer service by reducing processing time with a focus on aged cases, and we succeeded. DDS surpassed the goal for clearing cases over 180 days old.
- Improving accuracy is always a goal. The top states for initial accuracy were Wyoming, Kansas and Alaska. The top states for accuracy on recon were Kansas, New Mexico, and Wisconsin.
- Improving productivity is another perpetual goal. By week 43, we had completed 1.5 million initial claims, 385,500 recons and 513,000 CDRs nationwide.
- In April, SSA opened field offices (FOs) to in-person visits. By the conference, field offices had served 6.7 million walk-in visitors.

CHALLENGES

- One challenge this year has been attrition. There's an 18% attrition rate for DDS overall, and 25% for analysts. We are currently at the lowest staffing level of the last 25 years. Employees leave due to feeling overwhelmed by the work or leave for comparable pay in a less complex job.
- Increasing fixed costs and budget constraints required a focus this year on hiring and OT hours versus long-term, supportive solutions for the future.
- CE availability has been a significant challenge for DDS offices across the nation. Claimants often sought telehealth visits only during the first and second years of the pandemic, or didn't seek treatment at all. This has resulted in a much higher demand for CEs this year. Scheduling telehealth CEs requires that we contact the claimant to read them a script, which takes up processing time.

SOLUTIONS

- SSA protected DDS against hiring freezes that other SSA offices were subject to.
- SSA made use of new technologies, including supports for remote work, expanded use of Teams and authorization for a variety of telehealth exams as supports for DDS.

Ms. Kim then opened the floor for questions from the audience.

One NADE member complained that the field offices don't seem to understand as well as they used to what DDS does. She cited an example of DDS needing an SGA determination even though it doesn't affect onset. She pointed out at assistance requests (ARs) are often not addressed until a manager gets involved. She asked Ms. Kim what SSA is doing to address these issues.

Ms. Kim said that she and John Owen, Associate Commissioner for the Office of Disability Determinations, had been talking about the fact that there are fewer meetings with field offices across the country for orientation to DDS work and needs. She agreed that ongoing communication between DDS and the field offices is essential. She and John plan to speak to Regional Directors about ways to streamline ARs and maximize their efficiency. She invited us to identify trends and issues, and committed to bringing those to our Regional Directors to address them in every way possible.

In the meantime, she encouraged analysts to pursue with our administrators reinstating annual meetings with the FOs. She encouraged the use of Requests for Policy Consults (RPCs) to pursue issues related to policy that aren't decisional.

Next, a training supervisor pointed out that changes in policy over the last year have not been fully prepared before they were disseminated. Updates to policy changes have been frequent, and frustrating for trainers. She noted that DDS trainers across the country have had to develop their own training materials on all those changes, and have to re-do them when SSA sends out updates. She asked whether more training materials will be sent to DDS offices.

"We have been sending out new policy and policy changes fast and furious," Ms. Kim said. "We're mindful of how disruptive it is when you're sending out guidance and changes at the last minute. We're planning to revert to pre-pandemic strategies for vetting policy changes." She described plans to create training materials for policy changes in advance of their release.

A member brought up the fact that DDS offices are printing and mailing copies of all our forms to both the representative and the claimant. She pointed out that this is an expensive and time-consuming practice, and asked whether we can put the forms on the claimant's account in SSA.gov. She suggested that they could fill out and submit their forms online at the same time they complete their application for benefits.

Ms Kim said, "SSA is on the same page. We're undertaking a review regarding how to make our forms electronic and available to complete online. That's part of our customer service initiative." She noted that our NADE board had listed this as a priority in their requests on members' behalf at their mid-year meeting.

Another member suggested, "Some states have required staff to stop working remotely and return to the office. DDS would have an easier time retaining people of that requirement was eliminated." She went on to say that telework saves SSA money.

Ms. Kim said that SSA supports telework, but the decision about whether staff should work from home or in the office is a state decision. SSA has provided guidelines that allow states to make telework permanent as long as they put together a plan that satisfies those guidelines.

"When we saw in the newspaper that one state required all state workers to return to the office, we reached out to the decision-makers," she said. "Administrators at that DDS office were able to get an exception."

Ms. Kim closed by acknowledging the significant stressors of the last year and thanking us again for our commitment and determination to serve

Office of Disability Determinations Update

Presented by John Owen and Lucidna Davis

Immediately following Grace Kim's presentation, NADE members heard from John Owen and Lucinda (Luci) Davis, the Associate Commissioner and Deputy Associate Commissioner for the Office of Disability Determinations (ODD), respectively. They expanded on some of Ms. Grace's presentation, shared information on other topics and then opened the session for questions.

Regarding the 25% attrition rate for examiners mentioned earlier in this publication, John noted that DDS surveys show a spike in experienced Disability Examiners leaving the DDS versus traditional attrition, which is usually comprised of retires and new hires who realize the examiner job is not for them. The survey also indicated DDSs have cited pay as a significant factor in examiner retention. States' salaries impact DDSs' ability to attract the right candidates for the examiner position , since states salaries are not commensurate with similar jobs in the private sector in some states, for positions requiring a four-year degree. The survey indicates examiners left for other federal and private sector jobs with greater pay, or jobs with the same pay and lower stress. John indicated the agency recently shared a document that identifies information the states can use to obtain concurrence from SSA for salary increases, following both federal and state guidelines, such as examples for reclassing positions, etc. John, indicated in addition to the guidance provided, SSA stands ready to assist in evaluating any state salary increases. In FY 2022, SSA worked directly with eight states to pursue salary increases, including one that had not had a salary increase in twenty years.

To further address hiring and retention issues, SSA convene a workgroup, including representatives from DDS, regional offices, the Office of Budget, the Office of General Counsel, and the Office of Disability Determinations. The workgroup identified recommendations that are both short- and long-term solutions—with no idea considered too big or too small. The workgroup identified four main focus areas: Improving business processes, marketing, reviewing the examiner position, and training.

John also acknowledged the impact the current suitability process is having with onboarding new hires, with the current process taking as much as nine weeks to complete. John indicated SSA recognizes that candidates are leaving for other jobs while awaiting clearance to work at DDS. The Office of Personnel is working on solutions to expedite the credentialling process. SSA is also working on national mentorship programs to improve morale and an effort to create additional training materials that would be available for all DDSs. The goal is to develop training that can be accessed virtually and on demand. We are also looking at how we can incorporate DCPS training into the core examiner training materials. The workgroup is also developing a video that can be used to market the Disability Examiner position, to assist applicants understand what an examiner does when they apply for the position. The goal is to attract the right candidates and improve marketing in that regard."

John discussed the outlook for FY 2023. We are seeing historic high levels of initial cases pending this FY, recently hitting 907,000. Pre-pandemic, that number was around 650,00 per year. Some states are facing significant challenges in meeting processing goals due to staffing issues, so ODD asked other states to exceed the goals. Capacity challenges will continue, until the DDSs are able to increase their hiring.

Luci then spoke about DCPS rollout, stating that 49 of 52 states and territories are using DCPS exclusively for case processing—with only a few hundred cases still pending in legacy that were previously receipted. DCPS will soon be available at federal sites, with an associated user function (AUF) to provide assistance to state DDSs.

She asked NADE participants for feedback about DCPS. One NADE member said that the ability to see all the tasks needed for one claim would help. Another said having the remarks and follow-ups visible on the

the same page has been of tremendous help.

John and Luci finished their virtual visit by talking about Presumptive Disability, stating, Presumptive Disability (PD) benefits are critical for our most vulnerable claimants. This year, we released best practices for assessing cases for PD, and encouraged each DDS to apply PD when the evidence is insufficient to make a final determination but enough to suggest an allowance is probably, following PD policy guidance. SSA has seen a modest gains in the use of PD, with the national PD rate average between 12 and 14 percent—although the percentage varies greatly by state. The executives then asked for some feedback, asking if there are any particular barriers and successes in making PD determinations.

One member remarked that the administration required that they go through their entire caseload looking for cases that could qualify for PD. That had only happened once, she said, but suggested that requiring that on a regular basis would help.

One barrier suggested by another member was the quick turn-around time from Medical Consultants, which is great for productivity, but makes applying PD impractical.

The variety of case type examiners field each day makes applying PD easy to forget, a member said, because so few are eligible. In a caseload with Title II, Title XVI, CDR, DS, DWB and DC cases, for example, only a few are even eligible. As we hop from one case to another, remembering to check that possibility is tough. She suggested a pop-up in DCPS to alert the examiner that the case had potential for PD.

As usual, members enjoyed Grace, John and Luci’s participation in the training conference, and the collegial spirit and openness to our suggestions and feedback. Each of the executives expressed their appreciation for the work of NADE, the hosts and organizers of the training conference, and the work NADE members do on behalf of SSA in support of the SSA disability programs, indicating they too enjoyed the discussion and meeting firsthand with those on the front lines in the DDSs.

Office of Disability Policy Updates

Presented by Steven Rollins, Esq. and Ben Gurga

Steven Rollins, Esq. and Ben Gurga, the Acting Associate Commissioner and Acting Deputy Associate Commissioner of the Office of Disability Policy (ODP) respectively, honored NADE with a presentation at our conference regarding some recent and upcoming changes from their office.

They described upcoming changes in the cardiac, digestive and skin listings due to changes in medicine, and changes in the genitourinary listing. Regarding the latter, historically providers have used different values for the eGFR for African Americans and Caucasians. In 2021, the Kidney Foundation and The National Academy of Nephrology promoted use of the same values for both. Use of the same values is medically sound and unbiased.

They announced that changes to simplify the 454 form are in the works. They solicited feedback and received more than 100 responses from advocacy groups. Members on the Hill also passed on their constituents' concerns. Some comments they received were that the form is too long and the burden to gather information is too high. OPD created a CDR discovery group to develop an i454 to simplify and streamline the process. They conducted testing with beneficiaries and claimants' representatives for usability and solicited their feedback. It's currently in the approval process. It may be released by the end of this calendar year.

ODP released 12 new CAL conditions on August 15th. These were solicited from the public and vetted by doctors. Training in the new CAL conditions was set to begin on August 18th.

At this point, Steven and Ben opened the floor to questions. One member asked about a replacement for the DOT. Steven said ODP is working on this daily; it is a high priority. He referred members to https://www.ssa.gov/disabilityresearch/occupational_info_systems.html for progress reports on the project..

Another member asked about revising the 3369 work history form now rather than waiting for the revision of the DOT. She suggested that SSA could revise the work history again after the DOT revision is complete. Steven said that revisions to the form must go through a significant regulatory process, and that work on enhancements to the form is ongoing. He emphasized that ODP hears NADE's concerns about the form.

A third member advocated for improved organization of the Q&As in PolicyNet. Steven suggested that we share our suggestions with our Regional Directors, but solicited ideas from the floor. The member suggested that the Q&As could be organized by topic, by date, or in categories by condition. She suggested that the Q&As could be incorporated into the listings. Steven found those suggestions valuable and expressed gratitude.

Another member bought up the circumstance when representatives file for reconsideration without contacting the claimant, and submit a blank 3441. There was different guidance about how to handle this depending on the region. She asked for policy guidance from ODP. Steven expressed interest in the issue and committed to collaborating with ODD in this regard. *Note that shortly after the conference, nationwide policy regarding blank 3441 forms was disseminated.*

NADE appreciates ODP's commitment to collaboration with our members and the time Steven and Ben took to share news from their office.

Changes to the Informal Resolution Request Process

By Sara Winn

Kasey Torres, Division Director of ARO, OQR, Division of Disability Quality spoke to NADE about the Informal Resolution Request (IRR) started as a result of an audit recommendation by Government Accountability Office (GAO). Prior to the GAO audit, every Disability Quality Branch (DQB) handled IRR's very differently. To streamline the process, the Office of Disability Policy (ODP) created an IRR tool that allows the Disability Determinations office (DDS) to submit an IRR before it goes to RPC. However, ODP does not own the IRR process or policy. The IRR policy is GN 04440 in POMS.

DDS can submit for IRR any cited Group 1 deficiency, Group 2 deficiency, or technical corrective action (TCA), in a fully electronic case. Cases in which the DDS disagrees with the deficiency type cited, otherwise known as "wrong deficiency cited" must first be submitted thru IRR before they can be reviewed by RPC. The DDS cannot use Probability of Reversal (POR) as the basis of the IRR for a documentation deficiency and they cannot use Substitution of Judgment (SOJ) as the basis for an IRR for a decisional deficiency. The DDS is not required to perform any development actions requested on the SSA-1774 or Request for Corrective Action, prior to submitting an IRR. IRR will not accept a review request on a subsequent return, closed cases, with the exception of Group 2 deficiencies routed directly to the FO. IRR must be submitted with 20 days of the deficiency citation. Once submitted through the web- based tool, the IRR is assigned to the OQR staff member who was not involved in the initial return. The reviewing component has 14 days to respond.

When the DDS receives an IRR response that does not answer the questions submitted, or if the language appears like a canned response, they should inform the Regional Office (RO) or Office of Disability Determination (ODD). They will engage Division of Disability Quality (DDQ) and we will give the feedback to the DQB immediately. As of 7/31/22 (FY to date) there were 1,434 IRR's submitted. There were 41 still open with 1,399 closed. The average processing time is 6 days. The affirmation rate is 51% which closely mirrors the RPC percentage. About 19% of IRR's are changed to a different deficiency, and in about 25% errors are rescinded. The data shows that he most rescinded deficiency by the DQB's is the medical decisional. Cases that are affirmed at IRR can then be submitted for RPC review. One primary focus is the IRR's that were affirmed but later rescinded at RPC. This helps to learn and opportunities to streamline the process even further.

OPCA/ODP Presentation on Requests for Program Consultations

Jennifer Pecora is the Division Director of the Office of Policy Consultation and Analysis, or OPCA, in the office of Disability Policy, or ODP.

She was a member of NADE for many years, an adjudicator for the DDS office in Maryland, and served on the board of her local chapter, MADE. She's hosted some and attended many NADE conferences over the years.

"I learned so much (at conferences) about medical impairments and the program," she said. "But most of all I enjoyed meeting people from all over the country and sharing information and ideas. My involvement in NADE made me a more proficient adjudicator and enabled me to do my job better!"

With her was Kasey Torres, the Division Director in the Division of Disability Quality (DDQ), in the Office of Quality Review (OQR).

Ms. Pecora presented at the conference a very helpful and informative report about the Request for Program Consultation or RPC. She generously provided The Advocate with a copy, below. It's edited for space; no other changes have been made to her original.

What is RPC?

RPC is a process administered by ODP for resolving differences of opinions between adjudicating and quality reviewing components concerning disability determinations. Its objectives are:

- To provide a policy-supported resolution to case-specific questions concerning application of disability policy and procedures;
- To provide an objective and transparent process to resolve policy disputes;
- To improve the accuracy and consistency of disability determinations and quality reviews; and
- To identify trends, policy and procedural issues requiring clarification or training.

What rules apply to RPC? What is the current RPC process?

The RPC process only applies to certified electronic folders (CEF) and includes review of initial, reconsideration, and continuing disability review determinations. When a DDS disagrees with a deficiency citation, they can submit an RPC. They may, before submitting a case for RPC, attempt to resolve the deficiency via the Informal Resolution Request (IRR) process with OQR. The DDS must attempt IRR prior to submitting an RPC.

The DDS should submit a case for RPC as soon as possible, but no later than 30 calendar days from the date of receipt of a deficiency. If more than 30 calendar days have elapsed since the OQR return, the DDS must obtain permission from the regional Center for Disability prior to submitting the case for RPC. If the case had an IRR, the 30-day calendar count begins when OQR responds to the IRR.

The DDS is not required to perform any documentation actions directed by OQR prior to submitting the case for RPC.

The RPC process starts when RPC accepts a DDS submission electronically processed through eRPC indicating why the DDS does not agree with the deficiency. The RPC technical expert assigns the case to one of seven RPC reviewers who serve as ODP's representative on the RPC panel. In preparation for the RPC panel discussion, the ODP representative reviews the case facts,

all disagreements, all medical and vocational evidence, all related policy, and, if needed consults with medical or policy experts. ODD and OQR panel members also review the entire case. After completing their review, the ODP representative schedules the case for panel discussion.

The panel discussion begins with the ODP panel member presenting the case facts, adjudicating and reviewing components case actions, and the policy issues raised in the cited deficiency and RPC submission. The panel members then discuss the case in detail, addressing all policy issues identified in the case. All panelists focus on the correct application of policy. The goal is to reach consensus, but it is not required, as a majority rules.

If the DDS's original determination can be reasonably supported by policy, the panel affirms the original case action(s) and rescinds the deficiency. If policy does not support the original determination, but does support the OQR Deficiency, then the panel affirms the OQR Deficiency. If policy supports neither the original case determination nor the OQR deficiency, then the panel members consider what the appropriate policy-based solution should be - and the resolution reflects that finding.

How does RPC impact DDS accuracy?

The biggest impact for DDS quality would be in QA cases, if the RPC Panel finds that the DDS actions were reasonable and supported by policy, the deficiency is rescinded. The RPC process can positively impact the DDS quality average and participation is encouraged.

How does RPC impact policy?

"The RPC process shifts the focus from 'error detection', a 'gotcha' mentality, to identifying policy issues that are misunderstood, unclear, or difficult to follow," Ms. Pecora said. Once RPC identifies a policy issue, that information is shared with the divisions within ODP that are responsible for those policies, and they use the information to improve the policy and provide clarification. The Step 4/5 expedient is an example of a policy change that came out of the RPC process.

As of July, the RPC had received 600 RPC submissions for 2022. Of those, RPC affirmed the OQR's finding of deficiency in 47% of the cases reviewed. They rescinded the deficiency in 31% of cases, and changed the deficiency type in 17% and 5% were excluded from the RPC process.

Ms. Pecora invited DDS offices to make use of the RPC website's http://rpc.ssahost.ba.ssa.gov Management Information Dashboards to assess quality issues. The data there is displayed in a variety of ways – pie charts, bar graphs, etc. The data can be filtered in different ways, too, including timelines. The RPC website also contains links to ODP training resources,

The Office of Strategic Learning and Workforce Development (OSLWD) website, http://humanresources.ba.ssa.gov/oslwd/oslwd-home has VODs on RPC Mock Panel Discussions and a Tour of eRPC for anyone to review.

SOAR: Opportunities for Collaboration

By Jennifer Nottingham

At the NADE National Training Conference in Burlington, VT, we were fortunate to have a presentation on SSI/SSDI Outreach, Access, and Recovery (SOAR). The Substance Abuse and Mental Health Services Administration (SAMHSA) funds the SOAR Technical Assistance (TA) Center. Abigail Kirkman shared information about the SOAR program and is currently the assistant director of the SAMHSA SOAR TA Center at Policy Research Associates.

SOAR is a model for assisting eligible individuals to apply for Social Security Administration (SSA) disability benefits. The model is used for individuals who are experiencing or are at risk of homelessness and have a serious mental illness, co-occurring substance use disorder, or other physical disabilities to help them overcome barriers to access disability benefits. These populations may have impediments to their access to benefits.

For example, someone who is homeless or is at risk of homelessness may have challenges in communicating with SSA and the Disability Determination Service (DDS) office by phone or mail if they do not have a reliable address or access to a phone. The individual's symptoms can potentially interfere with their ability to navigate a complex symptom. The SOAR program can help remove those barriers.

SOAR case workers take the web-based SOAR Online Course to learn how to effectively gather documentation and submit a complete and thorough SSI/SSDI application. They serve as the appointed representative on the claim and play a crucial role in communication with SSA . When interviewing the claimant, the SOAR case workers ask open-ended questions. This helps in getting more information about all potential conditions, functional limitations, and treatment history. They also collect and submit medical records, which may include collaborating with local medical providers. The SOAR representatives write a Medical Summary Report (MSR) to submit with the claim. The MSR provides an overview of the claimant's medical treatment history and describes any functional limitations that stem from each psychiatric or medical impairment. The MSR is then signed by an acceptable medical source.

The MSR has detailed information about the claimant's personal history, their education and occupational history. Information is provided on substance use history, physical health and psychiatric history. It includes a summary and contact information. Since it is signed by an acceptable medical source, the MSR is considered medical evidence. The functional information included in the MSR can be used in lieu of an adult function report.

The SOAR model is used in 50 states and the District of Columbia. The SOAR TA Center designates state-specific liaisons dedicating to supporting SOAR growth and success. Most states have a SOAR state team lead and local leads that work together to implement and support SOAR. The SOAR TA Center helps facilitate collaboration between the state leads, local leads, SSA and the DDS. The SOAR TA provides ongoing support to the local SOAR providers. There are newsletters, individual technical assistance, bi-monthly webinars, monthly SOAR lunch calls, and a resource library with a broad range of guides and infographics to assist those in the SOAR community. SOAR providers track disability applications and outcomes in the Online Application Tracking (OAT) program. Through OAT, the SOAR TA Center is able to track successes and challenges in each state. Ms. Kirkman shared actions that some states and DDS's have taken to improve the success of the SOAR program.

SSI/SSDI benefits can mean more than just an income for beneficiaries. They can provide access to health

care and treatment support services. They can increase access to housing, education, and employment opportunities and reduce the number of incarcerations and hospitalizations in a community. They allow health care providers to recoup costs. Local governments can recoup costs of public assistance. Cash benefits are spent in communities, providing a boost to the local economy.

The presentation was helpful in sharing the benefits of the SOAR model. For more information see https://soarworks.samhsa.gov.

OIG/CDID Presentation

By Amber Barnes

NADE was joined by Mr. Don Jefferson, Mr. Conor Washington, and Mr. Mike Gibson from the Office of the Inspector General, Cooperative Disability Investigations Division. They discussed the history of the CDI program, nationwide coverage of the CDI program, program achievements, roles and responsibilities of CDI, and the referral guideline process.

In 1997, SSA and SSA OIG established the Cooperative Disability Investigations Program, aimed at pooling federal, state, and local resources to combat fraud. The CDI program now has 49 units in 47 states, Puerto Rico, Guam, American Samoa, Northern Mariana Islands, and the US Virgin Islands. CDI units consist of team members from SSA OIG, SSA, DDS, and a law enforcement agency. CDI's mission is to obtain evidence of material fact to resolve questions of fraud or similar fault in SSA's disability programs. Since inception, the CDI program has saved $4.3 Billion in SSA monies, and $3.4 Billion in non-SSA monies, totaling $7.7 Billion.

The CDI program investigates both Title II and Title XVI cases, at all levels of adjudication. They investigate false statements, feigning impairments, concealing work, concealing medical improvements, inconsistent statements and facts, facilitators, and unreported Workmen's Compensation benefits. These investigations can lead to criminal prosecutions, civil prosecutions, administrative sanctions, denials, cessations, adverse re-openings, or approvals.

NADE thanks Mr. Jefferson, Mr. Washington, and Mr. Gibson for sharing their time at the 2022 NTC, and we look forward to hosting them any time they can join us.

LONG-HAUL COVID SYNDROME

Presented by J. Scott Pritchard, DO

Dr. Pritchard is the lead Medical Consultant for Oregon's DDS, a Diplomate of the American Board of Professional Disability Consultants and the NADE Medical Consultant Chair.

COVID-19 was named from (Co)rona (Vi)rus (ID) identified in 2019. Long COVID is defined as a spectrum of new, recurrent or ongoing health problems experienced four or more weeks after initial infection according to the CDC. It was recently added to the list of conditions protected by the Americans with Disabilities Act (ADA). It can affect people of all ages, but is more common between age 35 and 69, and women are more vulnerable than men. The risk of long COVID is 50 percent less in people who are fully vaccinated.

COVID – 19 attacks the body at the cellular level. The virus targets the mitochondria and disrupts their normal function, hijacking it for viral replication. During the hijack phase, the cell's anti-viral signaling and immune responses are decreased, inflammatory responses increase. The end result is loss of mitochondrial integrity and cell death. The body's ability to produce energy at the cellular level is decreased.

What causes symptoms of Long COVID? There can be persistent viral replication after the major symptoms have abated. There could be viral remnants in the system, not replicating but causing chronic inflammation. Some people may have acquired autoimmune diseases. Other symptoms can be related to organ damage sustained during the acute infection. Post-hospital or ICU syndromes can be an issue. Others may have a dysregulated gut microbiome as a result of their acute COVID infection potentially leading to reactivation of latent viruses already in their system, for example, Epstein-Barr.

The characteristic symptoms of Long COVID include post-exertional fatigue, pain with breathing, brain fog, tachycardia or heart palpitations, GI issues, headaches, hair loss, nerve issues, sleep disruption and loss of smell Fatigue is the hallmark symptom, characterized by increased physical or mental exertion on a "good day" followed by severe exhaustion requiring several days or weeks to recover. It can occur from minimal physical activity like bathing. Onset of post-exertional fatigue can be delayed for 12 to 72 hours. For more symptoms and syndromes associated with Long COVID, please visit Dr. Pritchard's PowerPoint presentation at https://www.nade.org/nade-news/conferences/.

SSA sent DDS offices around the country an emergency message with guidance of how to establish Long COVID as an impairment. In order to qualify, a claimant must have medical record of a positive viral test for SARS-COV-2. Home tests are not adequate to establish impairment. They must have a secondary test confirming the presence of the virus, like a chest x-ray. They must have been diagnosed with the condition, with signs consistent with COVID as part of their diagnosis, like a fever or cough. COVID-19 as a stand-alone impairment cannot meet a listing. We cannot equal listing 3.14 with COVID-19. If fatigue is pervasive and severe, Dr. Pritchard encouraged analysts to

Mental Health in the Transgender Community
Presented by A. Evan Eyler, MD

By Michelle Wade

Dr. Eyler helped found a transgender health program in 1995 and has worked in trans clinical care since that time. Dr. Eyler has co-written several books and co-authored multiple American Psychiatric Association practice guidelines.

In this discussion, Dr. Eyler presented a more detailed discussion of some of the differences between gender identity, gender expression, transgender, and non-binary. Gender identity is described as an intrinsic sense of being a specific gender. Gender expression includes characteristics of personality, appearance and behavior more typically seen in a specific gender. Transgender is varying of sex assigned at birth and non-binary individuals do not identify exclusively as a man or woman and may define their gender identify and experience outside those of typical gender norms. Non-binary is fluid and or called agender. It was discussed that in a 2/2022 Gallup Poll, 7.1% identify as other than the sex they were born as. Other terms within the non-binary population include: queer, gender non-conforming, genderfluid, genderqueer, androgynous, agender, demigirl, demiboy, genderflux and bigender.

Gender dysphoria is distress caused by a discrepancy between how a person feels on the inside vs. how they appear on the outside. This often results in a person wishing to transition to the opposite sex including use of pronouns, appearance, and expectations. There are several areas of functioning that are identified within the transgender community, including socialization/adaptation, lifestyle concerns, and use of hormones that may have variable emotional response. For some, therapy may be helpful and medical monitoring is needed.

Trans, or "gender-creative" adolescents may or may not mature into transgender adults, however for many, it is not immediately apparent. The process of puberty will however continue unless suppressed and can often be very distressing. The practice of providing puberty blockers, in essence, puts a pause on puberty to allow sufficient time for additional maturity in cognitive and emotional areas, before determining if medical treatment is needed, or started. The practice of puberty suppression is becoming illegal in many states.

There are many areas of health risks/illnesses seen across the LGBTQ+ population, including substance abuse, depression, suicide, smoking, STDs, and severe obesity. Additionally, adolescents within the population may have early experiences of discrimination or abuse that negatively impact them in their adult life and functioning. As a group, trans people have a variety of health disparities that are relative to cis-gender peers. They often face discrimination and violence in their society, from family, at school or work, by homeless shelters, doctors, emergency rooms, judges, landlords and police officers.

When evaluating a disability claim that includes someone within the trans community, Dr. Eyler provided several recommendations:

- Have an attitude of acceptance
- When appropriate, state that the agency has a policy of non-discrimination
- Inquire about, and use, preferred pronouns, and name, and if you make a mistake, apologize and move on.
- Remember that youth and young adults lack life experience.
- Support decisions regarding gender expression and transition and recognize the complexity.

- Oppose stereotypes
- Remain informed and keep learning- this area is rapidly evolving.
- Remember that trans/nonbinary individuals-
    - May have effects of a difficult youth
    - May be experiencing minority stress or barriers to care
    - May be at higher risk for poor health outcomes

Resources- The World Professional Association for Transgender Health (https://WPATH.org), The Trevor Project (www.thetrevorproject.org), https://transequality.org/issues/us-trans-survey, Endocrine Society (www.endocrine.org)

Food Insecurity in the United States

Presented by David H. Holden, PhD

Dr. David Holden is a professor and Gillespie Distinguished Scholar of Nutrition and Hospitality Management at the University of Mississippi. He's also the Director of Office of Food and Nutrition Security at the university. He currently studies food insecurity in rural US communities, and has studied the same worldwide.

Food insecurity is defined as uncertainty about food supply. Food insecurity is caused by issues of :

- Availability - is there healthy food available in stores or gardens?
- Access - can people afford the food that's available? Can they grow food in their terrain?
- Utilization - can people cook the food?

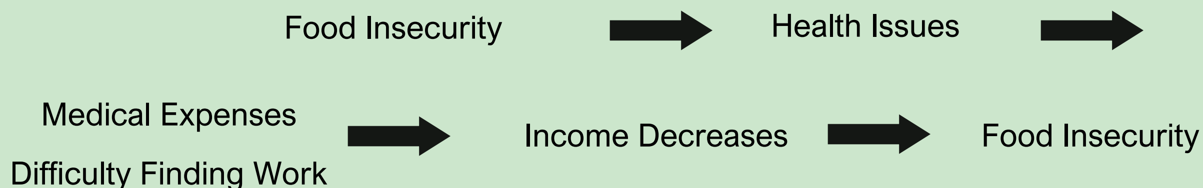
Food Insecurity affected 13.8 million Americans, or ten percent of the families surveyed in 2020. Most reported issues of access: they didn't have sufficient funds to buy food. They depend on food assistance programs, skip meals, and rely on cheap foods with little nutritive value. They often are forced to make trade-offs, like paying their utility bills instead of eating. Many will try to provide their own access by hunting, fishing, gardening and Dumpster diving.

People who live in areas with high housing costs are at risk for food insecurity, as are those who are under-employed. Households with children, single parents, people who live alone, people with mental illness and people of color are also at high risk.

People living in the southern regions of the U.S. are above the national average for food insecurity according to studies. New Mexico, Texas, Oklahoma, Louisiana, Alabama, Mississippi and Tennessee are at greater risk. The west coast is below the national average for food insecurity; New Hampshire residents have the lowest risk for food insecurity in the country.

The USDA cites poor nutrition as a leading cause of illness in the United States, associated with more than 500,000 million deaths per year. It's linked with increased risk of obesity, diabetes, and heart disease (www.usda.gov/nutrition-security). Dr. Holden added that food insecurity can contribute to or exacerbate ambulatory issues, vision issues, and cognitive and mental health issues. It causes illness, fatigue and stress.

Dr. Holden described a vicious circle as follows:



The New American Experience

Presented by Thato Ratsebe

By Marjorie Garcia

Born in Botswana Africa, Ms. Ratsebe came to the United States in 2001 to attend college in Vermont. Although she returned to Africa after graduating, she returned to VT and is the current Associate Director and Program Manager for the Association of Africans Living in Vermont (AALV). Her presentation addressed the experience of new American refugees.

A refugee is a person who has been forced to leave their country to escape war, persecution, or natural disaster. They will be relocated with little or no advance preparation or notice. They usually arrive without family or friends in the country they are arriving in, and without any more than the personal possessions they could carry while fleeing. The AALV works to lessen their turmoil and ease their transition into a new country by offering a variety of integration services aimed at helping a refugee become independent in their new community. Some of these services include case management, job training/placement, access to public benefits, immigration assistance, and access to farm or youth programs. First, though, the AALV case manager will help the refugee find a place to live.

Teaching English as a second language is not a priority of the AALV since most language skills are developed adequately through work. Instead, the AALV team will assist refugees with reading mail, banking, applying for benefits (including SSA), enrolling in school, making medical appointments, navigating complex systems, locating appropriate trauma counseling, and supplying interpreters. The current AALV project team is fluent in no less than 16 African languages and will train interpreters for a variety of paid assignments, including the interpretation of medical terminology and how to interact with medical personnel.

As much as the AALV has accomplished, they continue to face significant challenges. These challenges have increased with the recent and continuing public health emergency (PHE). As a result of the PHE, there is less housing available, jobs were lost and not regained as businesses closed or reduced services, and some job training has paused. Some refugees are still in need of medical waivers and/or disability determinations. All these programs contribute to the resettlement goal: assisting a refugee to be a healthy, productive, and independent community member or New American.

If you would like help, or learn more about the AALV or similar programs, visit your state or federal websites. You'll find various refugee services available in your state, as well as information about how you can help. The U.S. Refugee Resettlement Program – an Overview | The Administration for Children and Families (hhs.gov)

Break-Out Session with Medical Professional Relations Officers

By Kate Miller

Vermont welcomed a break-out session for Medical Professional Relations Officers (MPROs) topics at this year's training conference. Attendees discussed a wide range of issues affecting MPROs and CE units.

The largest issue discussed was problems with recruitment and retention of mental health CE providers. Several states reported aging vendors and the shortage of licensed psychologists. One MPRO indicated most of their providers were over 60 years old and could retire at any moment.

There was a general agreement that it is increasingly difficult to recruit psychologists that can perform testing. DDSs are getting creative with their recruitment approach and focusing their efforts heavily on promoting the telehealth option and building relationships with behavioral health APRNs. The biggest reason providers said they choose not to work for the DDS is that their own patient caseloads are too high, and/or the DDS pay is too low.

The group also discussed other topics: DCPS issues interfacing with ERE; providers using old technology; biases inserted into CE reports; a dearth of HIT providers in rural states; and benefits of having biweekly MPRO regional calls.

The MPROs want to thank the Vermont DDS for hosting this break-out session and providing another avenue to collaborate and help navigate through some of these challenges together.

From The Editor

It's been my privilege to edit The Advocate for the past one and a half years. It was a longer term than anyone expected due to COVID; all of NADE's Board members served longer terms because we couldn't hold elections in 2020.

It's been an especially hard couple of years for all of us with the pandemic, natural disasters, unprecedented political unrest. Add to that the introduction of DCPS and the many, many changes brought about by the pandemic, like consultative examiners retiring en masse, the implementation of video exams and all the new protocols that came along, then changed, then changed again.

NADE has stood strong through it all. Our commitment to each other and the people serve kept us strong. I'm proud of all our members. I urge everyone to use this time of struggle as a recruiting point: nothing can stop us.

I'm especially proud to have served as Communication Director under Marjorie Garcia, our Past President. She was tireless in her commitment to NADE. She faced all the same obstacles and challenges we faced at our day jobs, plus all the obstacles and challenges that came with being president during COVID in her personal time. So did all of our officers, obviously, but as editor of The Advocate, we worked closely together. Marjorie was a model of patience, grace and strength during her term of office. She made my job easier.

It's not a hard job, though, and I'd encourage anyone who loves writing to submit your name for appointment to this post. It's a great credential for those who hope to earn money as writers, and for people seeking promotion in their DDS offices. And, if you love writing like I do, it's a chance to write something aside from Findings of Fact and Evidence (FOFAEs)! You learn a lot about NADE and the work we're doing to improve DDS processes and access for claimants. It's invigorating to get the word out through The Advocate.

I'd also encourage people to submit articles for the publication. I know we're all tired and write all day, but every article you submit inspires other members to contribute. It's an opportunity to build and strengthen our community. Everyone wants to know what's going on in your state. Everyone wants to see pictures of our extended NADE family.

Plus, it'll make Sara Winn's term as Communication Director easier. Welcome back, Sara!

Fondly,

Korin Gary

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