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Thanks to the Montana NADE Chapter, *MONTADE* for hosting a fabulous National Training Conference!

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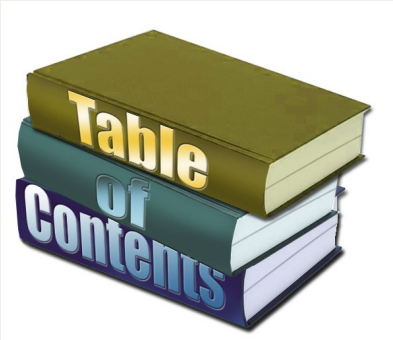


PRESIDENT'S MESSAGE

NADE PRESIDENT, KATE MILLER

Greetings NADE Members,

The 2023 National Training Conference (NTC) took place in Helena, Montana with over 80 members attending in-person and 15 tuning in virtually. The NTC was a huge success, and the Big Sky state boasted the best August weather that I can remember in years. "NADE Roots Run Deep" was this year's theme which really held true as this was the 60th anniversary of NADE. Long-time member and retiree, Anne Graham, also celebrated her 60th year in NADE at this year's NTC in Montana. Amazing!

We were fortunate to have several SSA speakers present in person, including the Assistant Regional Commissioner for Management and Operations Support, Vikash Chhagan. We also met Lucinda Davis from the Office of Disability Determinations (ODD). The Office of Quality Review was well represented by Kasey Torres, who enthusiastically offered to come back again next year. And the Office of Inspector General brought a local Special Agent in Charge from Montana, Jacques Hanson. We also heard from several other SSA speakers who presented virtually.

There were many other educational topics presented as well, including information on telecommunications access programs, vocational rehabilitation programs, audiology and cochlear implants, IMAGEN, and avoiding burn out. We also dug deeper into the cardiac listings, nephrology disorders, and memory loss. You can read more about some of these topics in this edition of the Advocate.

Everyone in attendance was anticipating the announcement of next year's conference location. Unfortunately, the pandemic caused a bit of uncertainty and there were no bids for the next NTC location. The Board acted quickly and created an NTC Planning Committee, which was combined with the Non-Dues Revenue Committee. The NTC Planning Committee is working on finalizing a location for the 2024 NTC and will be recruiting for committee members very soon.

I want to give special thanks to the 2022-2023 Board members who served this past year. Your dedication to the organization is evident and your knowledge is an asset to NADE. I cannot thank you enough for your service and friendship.

Lastly, welcome to our new Board members and new NADE members. The excitement that our newest members offer is truly contagious. I hope we can continue to embrace the unknown in front of us with the same courage and enthusiasm.

I look forward to hearing how NADE can serve you and your chapter this coming year.

Warmest regards,

Kate Miller
Kate.miller@ssa.gov

Office of Disability Policy Updates

Presented by Steven Rollins, Esq., Mary Quatroche, and Jessica Spartana

Steven Rollins, Esq., the Associate Commissioner, Office of Disability Policy (ODP); Mary Quatroche, Director, Office of Vocational, Evaluation and Process Policy (OVEPP); and Jessica Spartana, Branch Chief, Office of Medical Policy (OMP); respectively, honored NADE with a presentation at our conference regarding some recent and upcoming changes from their office. They provided the status of the Occupational Information System (OIS) and the associated occupational data; upcoming changes to the cardiovascular, digestive, musculoskeletal, and skin listings; and upcoming changes in vocational policy.

The OIS project is currently in a holding pattern. The Bureau of Labor Statistics (BLS) began gathering data using its Occupational Requirements Survey (ORS) in 2015 and has completed the final year of the second wave of data collection. As the data was analyzed, it was determined that larger changes to policy would be necessary. For disability adjudicators to use the new OIS, it was determined that five-years of production data from BLS, the Vocational Information tool (VIT), and new regulations and revised subregulatory guidance would be needed. BLS estimated that the final year of Wave 2 data, which will include 5 years of data, will be released in 2024. This includes data regarding basic mental and cognitive work demands. ODP is anticipating it will take at least several months and possibly longer to analyze this data prior to proposing regulation updates.

ODP continues to keep the disability program aligned with contemporary medicine, healthcare systems, technology, and workplace requirements by reviewing and proposing updates to the Listings of Impairments. A final rule published on June 8, 2023, that includes the revised criteria in the Listing of Impairments that we use to evaluate digestive and skin disorders. These changes took effect October 6, 2023. Training materials for these updates, including desk guides and videos on demand (VOD), are available for review in the Training section of the ODP intranet site.

ODP also published a Notice of Proposed Rulemaking (NPRM), Revised Criteria for Evaluating Cardiovascular Disorders, on August 24, 2022. The public comments for this NPRM are currently under review. Regarding the musculoskeletal disorders listings, ODP published a temporary final rule (TFR), which will be effective on October 30, 2023. The TFR extends the flexibility provided in the prior TFR until May 11, 2025, by revising introductory text to the musculoskeletal disorders listings to redefine the "pandemic period" as "the period beginning on April 2, 2021, and ending on May 11, 2025."

Along with updates to the Listing of Impairments, the panel discussed upcoming updates to vocational policy. The vocational expert handbook was updated to address using more common occupations at step 4 and step 5 of sequential evaluation. ODP also formed an intercomponent workgroup tasked with streamlining and clarifying transferable skills assessment (TSA) policy and procedures in the POMS. Workgroup participants included representatives from DDS, Regional Centers for Disability, NCDDD, NDIG, ODD, OQR, and ODP. Between March and September of 2023, the workgroup developed POMS drafts for intercomponent review (eIRD) and considered additional recommendations from the eIRD before ODP finalized the POMS for publication. Updated and new POMS published 9/29/2023:

DI 25015.015: Work Experience as a Vocational Factor
DI 25015.017: Transferability of Skills Assessment Policy
DI 25015.018: Transferability of Skills Assessment Process
DI 25015.019: Transferability of Skills Assessment Documentation

In addition, ODP is considering a new regulation that will reduce the relevant period of work. This will include revisions to the SSA-3368 and SSA-3369. The NPRM published in September 29, 2023 . The proposed rules would reduce the relevant work from 15 years to 5 years. The goal is to publish the final rule by April 2024.

The panel also discussed ODP's FY24 goals which include updating training materials for vocational specialists and telehealth consultative examinations (CEs), completing a post-implementation study on failure to cooperate policy updates, publishing an occupational information SSR to bridge the gap until OIS is implemented, and expanding HIT to bring on additional providers.

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

Kasey Torres, Division Director, ARO, OQR, Division of Disability Quality

By: Michelle Wade, MI DDS

Kasey discussed the way DQB reviews are completed. Generally, a case is reviewed backwards. The 831 is reviewed, then age and RBC. The goal is not to re-adjudicate, but rather to support the DDSs with policy. This tends to evolve over time. There are several types of DQB pulls. The initial QA sample is random and used to measure site accuracy and includes 70 allowances and 70 denials per quarter per state. The QA sample also includes reconsideration and CDR, but these are not used to measure site accuracy. Other controlled samples include Pre-Effectuation and Targeted Denial Reviews, or PER and TDR. PER reviews include 50% Title II Initial and Reconsideration Allowances and 50% Title XVI Adult only claims. The TDR sample is Commissioner directed and includes reconsideration denials and is based on workload goals.

Kasey provided information about accomplishments for FY23 and upcoming tasks for FY24. He provided statistics for accuracy of Title II pre-effectuation returns (4.5%), Title XVI pre-effectuation returns (3.6%), Targeted Denial Returns (15.9%). He said that the national QA accuracy is at 97.4%, Reconsideration QA accuracy at 93.4%, and CDR national accuracy at 96.5%. He indicated that CDR cessation quality is dropping, primarily due to medical documentation errors.

The top 5 deficiencies were identified as Group II Decisional, Group I Medical Documentation (RFC), Group I Impairment Severity, Group I Vocational Documentation (Work Hx) and Group II Documentation (Evidence of Work Activity

This past year, DQB has migrated to a new case processing system, QRCPS, has split work related deficiencies from the FO to the DDS, analyzed CE concerns and has trained three separate OQR/DDS cadres. They have done advanced training with all QR staff, expanded training and immersion training to DDS, implemented innovative hiring methods and tend to hire a lot from DDS. An OHO cadre has been trained to adjudicate and DDQ does all the training for DQB.

In FY24, they are hoping to add more immersion training sessions for any DDS that wants it. FY24 will also see MC/PC quality certification, an analysis of FTC policy, national program leader training, expansion of immersion training, and policy changes of Skin and Digestive Disorder listings.

Kasey stated that DQB is just like DDS; it is made up of everyday people in production all dealing with the same issues that DDS deals with on a daily basis.

CDI PRESENTATION

By: Amber Barnes, AZ

NADE welcomed back members of SSA Office of Inspector General (OIG), which oversees the Cooperative Disability Investigations (CDI) program. Kevin Huse, Deputy Assistant Inspector General for Investigations, and Jacque Hansen, Assistant Special Agent in Charge. OIG shared their mission and overview and CDI case reviews.

CDI investigates fraud in SSA's disability program. There are 50 CDI units covering all 50 states as well as US territories. There number of units have doubled from 2015 to 2022. There are three divisions, Western, Midwestern, and Eastern. A CDI unit is compromised of members from OIG, SSA, DDS, and a law enforcement partner.

In 2022, OIG closed over 1.200 CDI cases that resulted in denials/cessations. This resulted in approximately $66 million in SSA savings and $85 million in non-SSA savings. Since inception, CDI has saved $4.3 billion in SSA funds and $3.4 Billion in non-SSA funds. .

SSA OIG then shared two CDI case reviews. During the case reviews, SSA-OIG shared some of their investigative techniques. This included use and review of social media, yelp reviews, GPS trackers, geo fences, weather reports, and Medicaid and SNAP records. After the case reviews were presented, SSA/OIG answered questions from the audience.

2023 NADE CONFERENCE-NEW MEMBER ORIENTATION

By: Reagan Lederman, NV DDS

On 8/14/2023, we welcomed new attendees to the 2023 NADE Conference. We had a great turn out with about 25 attendees. 2022/23 President Jennifer Nottingham led the welcome and highlighted what to look forward to. The main message was to CONNECT. We all want to share innovative ideas and likely have similar experiences. The 2023 conference and NADE in general gives you a voice. She encouraged attendance and participation in the General Assembly meeting. Several veterans spoke about their longevity and experiences with DDS and NADE.

Terri, from Wisconsin, stated she has been with NADE since 1981/1982 and they did not have an active chapter. She reminded us that the more you get involved the more you will grow. Todd started in 2000 and joined NADE right away. He noted it is an eye-opening experience and it will be great information.

Anne our long-time veteran, shared that she started in 1962 and has been to 35 conferences. She has only missed two. Mostly she enjoys meeting new people and interacting with them. She especially enjoys the medical information. She encouraged us to take what we learn back to our DDS offices and make them so jealous that they want to join NADE.

We all went around and introduced ourselves and our DDS locations. We were well represented within the different regions. Jennifer reminded us that SSA looks to NADE for input and feedback. She shared that the changes to step 4/5 Vocational policies came from NADE recommendation. She advised we are the voices that advocate for this change and since we are the ones handing things day-to-day, WE are the best source for input.

WELCOME NEW MEMBERS!!!!!

Hearing Loss

By: Reagan Lederman, NV DDS

Dr. Katherine Lynch, AuD, CCC-A from the School for the Deaf and Blind in Montana gave a presentation on Hearing loss. She began with "Audiology 101" and walked through the anatomy of the ear and how we hear. She explained there are three classifications of hearing loss: conductive, sensorineural, and mixed (combined conductive and sensorineural). She explained that hearing loss is rated on a scale from mild to profound and that amplification and hearing technologies are designed based on your degree of hearing loss.

Conductive hearing is caused by problems in the outer and or middle ear. Sound cannot be conducted properly to the cochlea. This is the type of hearing loss that you will get if you perforate your ear drum (a reminder not to use Q-tips). Sensorineural is damage to hair cells or malformation of cochlear structures. This is usually caused by old age or noise exposure.

Audiograms focus on measuring the frequencies that make up speech. Bone conduction assists with determining whether it is conductive, sensorineural or both. Normal hearing in adults is usually up to 20db HL and then increases as loss occurs. Profound hearing loss will be in the ranges of 90-120 dB HL.

Dr. Lynch then went in to sharing the type of amplification and hearing devices. There were several types which she brought in person as well. Most commonly are behind the ear, in the ear, bone anchored and, of course, cochlear implant. She explained that there are two types of cochlear implants the traditional and off the ear. To be a candidate for cochlear implants we look at word recognition ability, essentially difficulty understanding sentences in best aided conditions. Candidates also will need medical clearance and typically MRI/C imaging, physical and even psychological exams. She advised once an individual has a cochlear implant, they should attend rehab so the individual's brain can learn to interpret the electric signals to understand what they are hearing.

Dr. Lynch shared about implications of hearing loss in the workplace. She explained that someone with hearing aids or cochlear implants will always have hearing loss. Effectiveness of the device will depend on early identification and device use, participation in rehab, the hours per day the individual wears the hearing device, the cause of their hearing loss, and the cognition of the individual. Individuals with hearing devices will have follow up assessments to determine the success of the device. Some are subjective reports, but they can also conduct a sentence/word recognition test.

She shared that even with device use there will still be background noise, and this should be considered when assessing work conditions for those with hearing loss. These can include cubicles, AC/HVAC systems, and street traffic. She said the best placement for an individual is to sit far away from the noise with their back to the noise. Individuals can also use Bluetooth devices, amplified phones, and other assistive listening devices that will allow the speaker's voice to be directed to the device for better hearing.

Lastly, she took questions from our group. Two questions brought up really addressed some of the issues that we face as disability examiners. We brought up concerns regarding the HINT. She said the problem with the test is that it has a ceiling affect, it is never going to show improvement. She said a better test is the AzBio which is a speech recognition in noise test. We expressed concerns with those no longer using their cochlear implants. She explained that after five (5) years the device becomes obsolete and out of warranty with expensive replacement/repair costs. Additionally, it can be overwhelming for an individual to do the rehab and train their brain, which results in less use of the device.

Montana Telecommunications Access Program (MTAP)

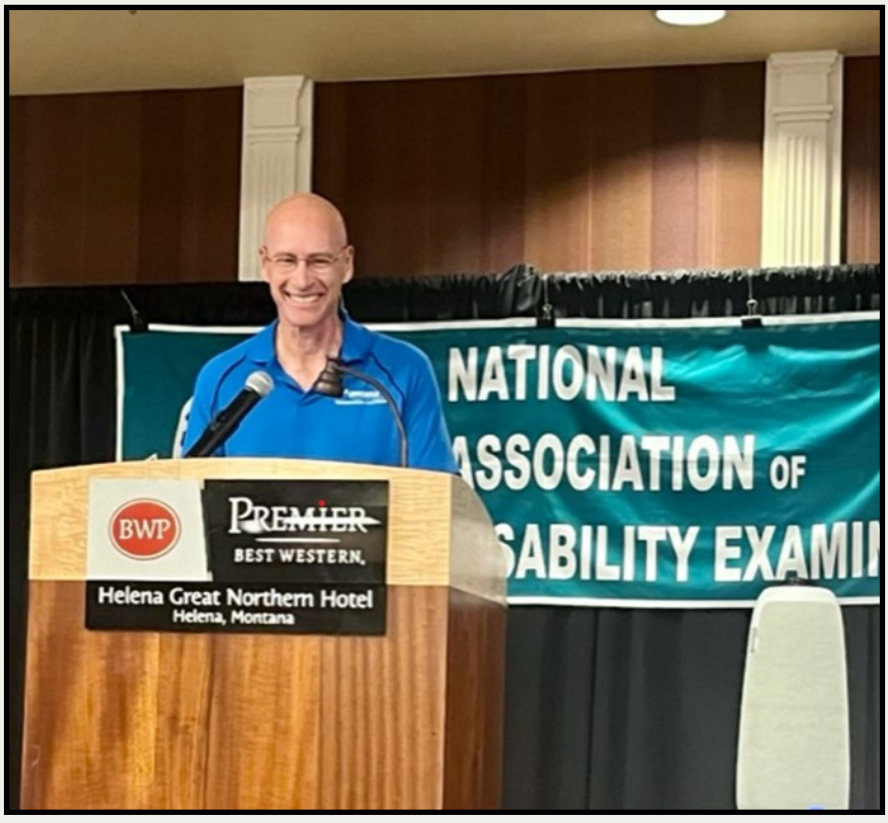
By: Kate Miller, MT DDS

Michael Bouchard from MTAP shared how smart devices are helping people with hearing impairments. A typical telephone volume is 15 decibels (db.), where MTAP phones can get up to 55 db. Bouchard said that 47 states have a program like MTAP. To qualify for the program individuals must make less than 250% of the federal poverty level. The candidate must also have a land line or qualify for a smart device with internet and/or cell capabilities in their area.

Bouchard also discussed the many different types of technology including a caption telephone, text telephone, a smart device, and relay. The variety of phones available these days can offer people with disabilities a range of options. Bigger phones, a built-in flasher, enabled talk-back, and captioned phones are just a few examples of some of the features. There are even phones that offer "call by picture" or text. Bouchard said technology has come so far from the first TTY (text telephone typewriter) that transmitted code through copper wire to a hand-held phone.

Lastly, he talked about the Relay System, which came out in the 60's. He said the relay is a third party that bridges communication between people who are deaf/hard of hearing or have a speech impairment. There is now an internet-based relay service, captioned telephone service, and video relay service that goes to a sign language interpreter.

Bouchard said there is always a TTY operator available, just call 7-1-1. It's available 24 hours a day, 7 days a week.



Railroad Retirement Board

By Jennifer Nottingham, Nevada DDS

Arturo Cardenas, the Deputy Commissioner for Disability, Retirement Policy and Operations for the U.S. Railroad Retirement Board presented at the NADE 2023 Training Conference. Legislation from the 1930s led to the establishment of a Railroad Retirement system. This system administers benefits for railroad employees and their families. The Railroad Retirement Board consists of three members representing labor, management and a chairperson. Each of the Board members has an equal voice and is term limited. The Railroad Retirement Board adjudicates decisions for disability, retirement, unemployment, survivor benefits and sickness (short-term disability). The short-term disability program is important if a medical impairment affects the safety of themselves or others, given the nature of the industry.

While it is separate, the Railroad Retirement Board works collaboratively with the Social Security Admiistration. Their office follows the exact same regulations as SSA and body systems with their applicants, except the vocational rules. Instead, they consider if the person can work in their own industry, not across the economy. An individual may be found disabled and able to get another job. It is also possible for someone to be eligible for railroad and Social Security retirement.

Although they use the same regulations as Social Security, there are no electronic applications. They take most applications on paper in their field offices. People cannot go online to apply or change their information. The Railroad Retirement Board is working toward IT modernization. They anticipate a lot of challenges to get online applications because any new technology will need to work with the existing old-er applications.

The structure for railroad claims is different. Their field offices do the development of the claim and send the claim with records to the examiner. The disability examiner will review the records, and if additional evidence is needed the field office will obtain it. Quality reviews for all their components are completed by SSA's Chicago DPB office. Traditionally, the disability examiners were based out of their headquarters in Chicago but are now able to be based out of any of the Railroad Retirement Board regional offices.

It was great to learn more about railroad claims from someone familiar with the Social Security disability program.

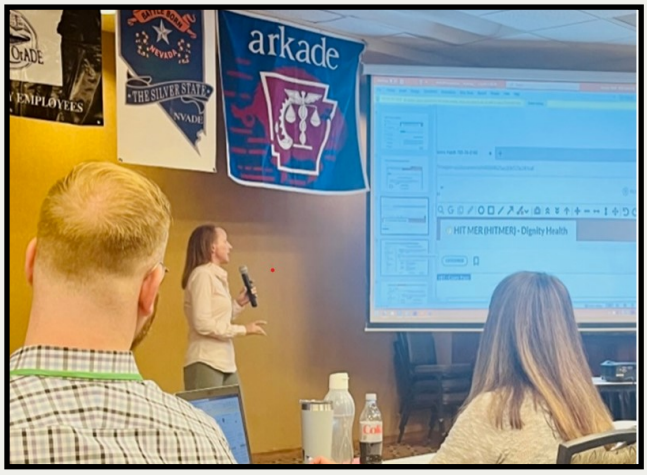


IMAGEN: An Adjudicator's Perspective

By Julie Kujath, NV DDS

Julie Kujath, Disability Adjudicator with Nevada DDS, presented a basic overview of IMAGEN and discussed the processing of claims in this new system. IMAGEN is Intelligent Medical-Language Analysis Generation. Due to the public nature of the NADE training conference, the presentation could not include actually using IMAGEN as there is no testing environment and it requires use of claimant information, including Personal Identifiable Information (PII) which cannot be shared with the public.

Despite these limitations, screen shots were shared with PII redacted, showing attendees images of IMAGEN in use. Access to IMAGEN through DCPS Workload Summary Quick Links and Case Quick Links was shown. Julie discussed the different side panel views including Contents, Claimant Overview, Case Notes, Bookmarks and An-notations, Documents, Quick Links, and Exit Case. This was followed by a demonstration of ways to view medical evidence (MER). IMAGEN is able to sort evidence by Date, Document, Document then Date, Relevance, and Relevance then date. When looking at MER by date, the results can be interchanged between Oldest First and Newest First in either Document or Relevance views.

The toolbar and other features at the top of IMAGEN when viewing MER was discussed. The user is able to jump throughout a document by page number, or between different sections of the MER using hyperlinks (e.g. to Encounters, labs, etc.). There are hyperlinks at the top that allow you to jump between different documents within the same case. The toolbar at the top has the ability to highlight a word, then search documents for that word. You can highlight a word and click on the Google icon to automatically search the highlighted word on Google. There are ways to copy text from documents in IMAGEN and post to bookmarks or other operating systems. There are many ways to annotate documents with shapes, lines, and paint brush. They are continuing to add features as some are still missing, such as the highlighter feature. There are arrows to move within a document and between documents. There are buttons to zoom in and out in a document, along with aligning the document to margins. There are also ways to rotate the page, by 90 degree turns or 180 degree turns.

Different options were shown on how to create a bookmark in IMAGEN, such as using the icon at the top of the page to make a page bookmark or by right clicking and hitting the bookmark icon in the right click options. There is an option to highlight text and propagate into a bookmark. The right click box options were discussed. Additionally, there is a link in the toolbar for the BMI calculator which includes the ability to create a bookmark directly from the BMI calculations for documentation purposes.

Basic search options of IMAGEN were discussed. IMAGEN has the ability to search by word, or searches based on each case's impairments and allegations. There is a filter tool that allows for even more search capabilities. You are able to search a date range, by body system, or content types (e.g. Sections or diagnostic reports).

Information and bookmarks can be exported in IMAGEN and used, or it can be exported to a Word document for use. When exporting, IMAGEN can export all of the bookmarks created, or just the new ones created in the most recent session. Bookmarks can also be sorted by source or date. The bookmarks can also be edited to user preference on what is included (i.e. source, note, category, date). The exported information can be used to easily cut and paste the information that is most adequate for the final FOFAE assessment.

While limitations with presenting IMAGEN publicly are present, any NADE member or chapter that wishes to have a training in house should reach out to NADE. It is possible to do a training while working in IMAGEN within the DDS. If anyone working in the DDS is interested in an active IMAGEN training, please reach out to Julie Kujath, Julie.kujath@ssa.gov

TRIBAL RELATIONS

Melissa Williamson, AL DDS

Lesa Evers with the Montana Department of Health and Human Services (DPHHS) spoke to the conference attendees about her role as the Tribal Relations Manager. In this role, she works with the 8 tribal governing bodies, assisting them to gain access to services that the DPHHS agency provides such as Medicaid and public health. Ms. Evers stated that the first and probably most important thing in her job was to remember that each tribe is unique. As a Native American herself, she understands that each tribe has different beliefs, traditions, and ways of communicating, but also understands the difficulty of being able to obtain goods and services while living on the reservation.

Individuals living on the reservation have difficulties navigating public services that require appointments and applications with dead-lines due to communication service and transportation issues. An individual may have no phone access or only has a “pay as you go” phone. They may have no transportation of their own, having to rely on others or on tribal transportation. There are often shared mailboxes for multiple homes, which leads to lost or misplaced/delayed mail. Access to the internet is variable, in areas it exists to a degree and in others it doesn’t exist at all. Groceries are often purchased at a local convenience store, or it requires an hour or more drive to a town that borders the reservation to go to a traditional grocery store.

Native Americans continue to distrust the federal government and continue to teach this to their children. They may feel vulnerable or unsure when requesting federal resources of any type or providing information to the federal government. Ms. Evers reported that the most recent national census indicated that Native Americans make up 7% of the population in Montana. However, she said that she never believes that this number is correct. She went on to explain that the Native Americans often live in multigenerational homes and that they do not want to admit that there may be up to 10 or 15 people living in one dwelling. She also stated that based on a review of the 2013 death records, Indians in Montana die 20 years earlier than non-Indian residents.

In Montana, there are 8 sovereign tribal governing bodies and 7 reservations: Blackfeet Reservation, Crow Reservation, Flathead Reservation, Fort Belknap Reservation, Fort Peck Reservation, Northern Cheyenne Reservation, Rocky Boy’s Reservation, and Little Shell Chippewa Tribe. Ms. Evers explained that these are very large reservations, for example the Crow Reservation covers approximately 2.2 million acres. Sixty percent of the Native Americans in Montana live on the reservation with forty percent living off the reservation. Those living off the reservation are considered “urbanized Indians”.

Ms. Evers explained that the main health system for all Native Americans is the Indian Health System (IHS). This was created via treaties between the Native Americans and the federal government to provide health care to all Native Americans. Although the IHS was created to help treat them, there are still difficulties obtaining the medical treatment and care that is required. There is only one full-service IHS hospital in Montana on one of the reservations. The IHS operates other lower-level hospitals and clinics on other reservations offering a limited range of care services. Ms. Evers provided this example: She indicates that you can go to the Tribal Health clinic in Browning, Montana to see a dentist. This clinic opens at 8am. There is a line that forms around 6-7am each morning. When they open, they may indicate that they will only be able to see 8 people that day. At that point, everyone else in line is told to come back and try the following day. It could be days before someone is able to be treated.

There are also Tribal Health programs located on some of the reservations. This is health care that has been created by that specific tribe's governing body and the services vary based on each individual tribe. Tribes can contract with the federal government to run all or part of their Tribal Health program. Two tribes have entered into these contracts and developed their own health care programs for their tribal members.

Urban Indian Organization are available that treat individuals living in the larger cities throughout Montana. Ms. Evers noted that this is a good resource for those who are urbanized Indians as they can more easily access treatment at these clinics versus going to the reservation. However, there is an issue when it comes to getting prescriptions. If you do not have access to obtaining prescriptions through a local pharmacy in the city (with the use of health insurance, Medicaid, etc.), then you have to go back to your reservation to obtain your prescriptions. This again leads to significant travel just to obtain medication.

Overall, it’s important to recognize that Native Americans are often hesitant to ask for assistance in the first place. They also have multiple barriers to obtain goods and services, and are often required to travel great distances to do so. These same barriers affect their ability to respond to requests for information or action by the often short deadlines government agencies set. It’s also important to recognize the delays and challenges that they encounter in trying to obtain medical treatment and navigating the IHS, and getting transportation to appointments. Ms. Evers pointed out that all of this information is important not only for her department, but for anyone who works in agencies where they may provide services for Native Americans.

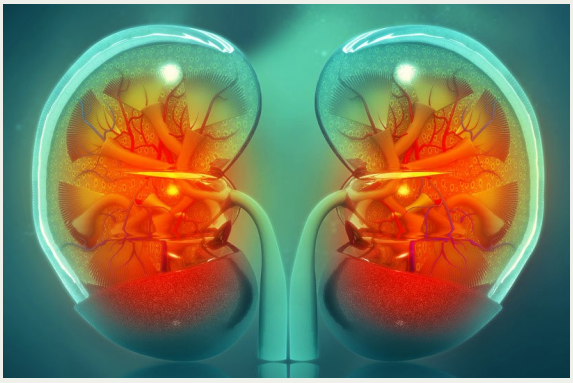
Kidney Disease

Trish Chaplin, Midwest Regional Director, MO DDS

The study of the kidneys, otherwise known as nephrology, as reported by Gwendolyn Pincomb, MD, PhD, is important to the overall health of the human body as the kidneys are vital organs necessary to maintain balance. The primary role of the kidneys is to excrete waste products. The kidneys help to address excessive fluids such as water, glucose, hormones, and metabolic substances (which as oxidation products and acids, electrolytes, minerals, potential toxins and phosphorus in food and water for defense and repair. Four primary substances (water, essential electrolytes, proteins, metabolic substances) are still needed by the body. The kidneys are master conservationist and recycler requiring optimal balance to keep a healthy body.

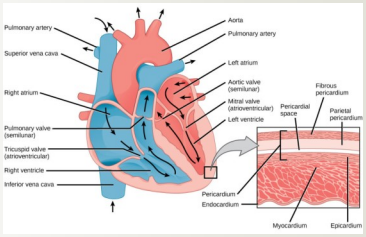
Kidney disease is often associated with anemia as well as high blood pressure. Advance kidney disease, most commonly known as chronic kidney disease (CKD) can lead to kidney dialysis which can cause difficulty of breathing, strength, and adaptability of cardiovascular system to accommodate work/stressful conditions, neurological functioning for accurate sensation, steady manual dexterity and ambulation, cognitive function and endurance, wound/bone repair, and growth/development in children.

People who have advanced kidney disease often have blood pressure that fluctuates making it difficult for them to perform any heavy jobs if not at listing level, also any environmental factors such as machines, scaffolds, ladders and such could cause their blood pressure to lower causing a heart attack or stroke. It is always best to reach out to these claimants alleging kidney disease for their symptoms to obtain additional information regarding their impairments as individuals may vary and allowances may still be supported. In dialysis and transplant cases, we know we can only give an onset the date dialysis began or the date of the transplant. Most often, people with the most severe CKD have creatinine =>2, chronic proteinuria of 2-3 grams or more or microhematuria. People with kidney disease will have albumin that is either too low or too high which will cause loss of urine. Also, people with kidney disease require heavy use of diuretics which can cause quite significant fatigue leading to impaired functioning.



To evaluate cases prior to the date of dialysis or transplant, it is important to look at the medical evidence showing creatinine, chronic acid/base or electrolyte disorders and check the laboratory reports for albumin in both blood and urine. Often consider weight bearing, upright postures, sustainability of work activities as well as environmental conditions and hazards with the residual functional capacity for any onset prior to the listing onset date. Claimants with CKD may have manipulation limitations with upper extremities. Some may also have hearing limitations or retinal pathology which often parallels with kidney disease. As noted above, claimants would often require cold/heat, chemical hazards and other workplace hazards related to their medications. What is the future for renal care? Research is still underway regarding regenerating and wearable artificial kidneys.

The Cardiac Listings: Unlocking the Mysteries of the Echocardiogram



By: Julie Kujath, NV DDS

Dr. J. Scott Pritchard, DO spoke on the cardiac body system and heart failure specifically. Heart failure is considered an epidemic. Reportedly, 6.2 million individuals have heart failure and 85.6 million people have some type of cardiovascular disease. There are 550-650,000 new cases of cardiovascular disease a year. It is estimated that 30.2 million dollars was spent to treat heart related illnesses in 2022.

The heart is a complex organ system composed of a muscle, electrical system, valves, coronary arteries, chambers, and much more. Heart failure is a syndrome of ventricular dysfunction. In medical records, heart failure is often abbreviated: HFrEF, for heart failure reduced ejection fraction; and HFpEF, for heart failure preserved ejection fraction. It can affect either the left or right ventricles or both. Although often associated with respiratory "congestion" type symptoms, individuals with right ventricular (RV) failure have little or no respiratory symptoms or findings. Heart failure is often defined as diastolic or systolic depending on cause and presentation.

Stages of heart failure are established by the American College of Cardiology (ACC) in stages A through D. Stage A is a high risk to develop heart failure. This can involve being diagnosed with high blood pressure, coronary artery disease, diabetes mellitus (DM), or a family history for HF. Stage B is asymptomatic LVSD and can include a previous myocardial infarction (MI), valvular disease, or a period of heart failure. Stage C is symptomatic LVSD. Stage D is refractory/end-stage heart failure. Patients in stage D heart failure have symptoms at rest despite therapy.

The New York Heart Association (NYHA) classifies heart failure is classes I through IV. NYHA Class I, the patient is asymptomatic, no limitations. NYHA Class II, there are slight limitations with mild symptoms. NYHA Class III, there are moderate limitations and symptoms with minimal activities. NYHA Class IV, there are symptoms at rest.

For individuals with systolic heart failure, the heart is weakened and cannot pump blood adequately. Left ventricular systolic dysfunction (LVSD) combined with HFrEF is often caused by inflammation, acute and chronic ischemia (MI/cardiomyopathy), idiopathic, familial cardiomyopathy, toxins-drugs/alcohol, valvular disease, or Tako Tsubo and is one of the most common types of heart failure. The symptoms of LVSD are dyspnea, orthopnea, paroxysmal nocturnal dyspnea, fatigue, anxiety, and cough. Clinical findings can include: increased neck vein distention (JVD), increase in heart/respiratory rates, decreased breath sounds/rales, gallop rhythms at S3 or S4, unexplained weight gain, red frothy sputum, sitting upright with air hunger, abnormal labs or Echocardiogram.

Echocardiogram (Echo) is used for visualizing heart structures and documenting how the heart is working. An echo can document increased left ventricle size, sometimes noted as LViD. Normal LV size is usually < 6.0 CM (60 mm). Echo can document LV ejection fraction (LVEF). LVEF >50% is normal. LVEF is calculated by measuring the LV when filled with 100% capacity, then measuring after the LV contraction that forces blood up into the aorta, and the amount of blood that remains in the ventricle.

For individuals with diastolic heart failure, the heart develops stiff and thick chambers, reducing the heart's ability to fill. Diastolic dysfunction is a heart failure with preserved EF. This type of heart failure is hallmarked by a normal or elevated LVEF. This syndrome can be caused by chronic hypertension/concentric hypertrophy, infiltrative disorders (i.e. amyloidosis), DM, or advanced kidney failure.

Pulmonary hypertension (PAH), commonly called Cor Pulmonale, is when there is increased right ventricular size or pressure of any cardiac or lung related cause. This differs from the traditional diagnosis that reflected only non-cardiac etiologies for increased pulmonary artery pressures. PAH is defined by a mean pulmonary artery pressure (PAP) that is >25 mm Hg at rest, provided that left atrial pressure <15 mm Hg and pulmonary vascular resistance (PVR) <3 Wood units. Normal mean PAP is about 15 mmHg. Within a heart with PAH, the right heart becomes larger, left heart becomes smaller, and heart wall muscle becomes enlarged. PAH can be caused by morbid obesity, diastolic dysfunction, OSA, COPD, anorexic drugs (Fen-phen), HIV, valvular heart disease, interstitial fibrosis, or familial. Symptoms of PAH include fatigue not attributable to any other cause, dyspnea upon exertion, syncope or near syncope, cyanosis, LE edema, anasarca/ascites, or chest pain. Testing used to make PAH diagnosis include chest X-ray showing enlarged pulmonary arteries, echo, six minute walk test, arterial blood gases, right heart catheterization, or spirometry. Survival rate is poor for individuals with persistent elevations of PAP and poor functional class. Severe cardiac dysfunctions can require a mechanical circulatory support or ventricular assist device (VAD). These are LVADs, RVADs, biVADs. Use of VAD for 90 days meets the requirements of the CAL condition, equating the cardiac transplant listing and is becoming a higher frequency of VAD use as there are few organ donations to meet the demand.

When addressing heart failure in disability adjudication, it is important to remember that the 4.02B1 criterion does represent an extreme functional limitation. While the description may be consistent with NYHA Class IV, evidence is needed to support these extreme functional limitations rather than simply a citation of a NYHA classification. Also, 4.02A1 specifies an EF of 30% or less during a period of stability. Therefore, you may have to consider purchasing an echo to assess baseline LV functioning during a period of stability to determine if listing 4.02 is met, unless the claim can be favorably decided based on the other evidence in file.

Work & Life Balance

Sara Winn, LA DDS

Alli Wright, PsyD spoke to use about the importance of a work life balance and shared her 15 most important tips to achieve this. Work life balance is not so much as splitting time between work and play at 50/50. It is more about not being consumed by work or having worrying work thoughts while at play. Some benefits of good work/life balance are: reduced stress, better mental and physical health, able to be present and focus, better relationships, and increased creative thinking and production.

One major aspect of achieving work/life balance is to give up guilt. Dr Wright gave 15 tips to achieve this: 1) Viewing relaxation as a necessity or an investment. 2) Think about colleagues and set expectations, it is important to not perpetuate being always "on" or "available". 3) Invest in recovery to avoid "burnout". 4) Take it slow, don't rush through important things. 5) Separate feelings from identity-some feel that not proving dedication can undermine performance. 6) Ditch scarcity and focus on accomplishments. 7) Don't make it hard to go back to work after off time. 8) Set expectations and make sure that your team knows your expectations to not have to continue to put out small fires. 9) Eliminate distractions and update your space or redefine your space. 10) Enforce boundaries. 11) Invest in emotional wellness (yoga or walk). 12) Connect with coworkers. 13) Invest time in something you love. 14) Practice cognitively stimulating exercises daily (puzzles, cooking class, language class, etc). 15) Cultivate an attitude of gratitude.

For better work/life balance it is important to embrace your creative side, listen to audio books, grow something, or take dance or cooking classes. Invest in self care, get 7-9 hours of sleep per night. Switch off electronics and phone and go for walk and be in the moment. Find humor in things, laughing boosts the immune system.

HIT Overview and Outreach

April Bass, ODD

Benefits of partnering with HIT:

> Faster MER receipt – average of 2 minutes

> Standardized format

> Automated HIT MER payment from SSA ($15)

* Saves the state money

> Decision Support

* Uses business rules by identifying key words and emphasizing listings the impairment might meet

Health Information Technology MI - In FY23 to date (Oct 22-Aug 11, 2023):

Nearly 757,000 cases adjudicated contained at least one piece of HIT MER

Average case processing time for cases with HIT MER is 165 days compared to 188 days for cases without HIT MER

Average case processing time for cases with HIT MER ONLY is 121 days

> When HIT is the only MER in file case processing time averages 67 days quicker

14.6% of the medical evidence comes through HIT

> 42,000 more HIT documents than FY22

> 26,000 more ERE documents than FY22

ODD now includes HIT and ERE information quarterly in the MPRO Newsletter (now known as the EEAS Express)

HIT is expanding

> Total MER volume (all channels – paper scan, fax, ERE, HIT) has increased by 13% when compared to FY22

> HIT MER volume is 27% higher when compared to FY22

> Onboarding three high volume HIT Partners

Cerner

Veradigm

MedVirginia-Konza

Requirements for HIT expansion:

> Source must be willing to share substance abuse and behavioral notes

> Must have at least 6 months work of data to share

> Their system must be compatible with SSAs

>Some sources do not meet our criteria

*SSA does not connect with third party copy services such as CIOX

* Onboarding and outreach are determined by yearly budget for SSA and prospective partners

The inception of the Health IT was supported by the 2009 America Reinvestment Act funding which allowed SSA to help vendors pay the cost of upgrading the electronic systems to be able to interoperate with SSA. Since that funding is no longer available through the Act, vendors are financially responsible for their own infrastructure upgrades.

HIT Referrals:

> The DDS can refer a facility or network for HIT consideration by channeling referrals up the line through the regional HIT coordinators

> SSA negotiates with organizations due to complexity and requirements

HIT Contd…….

Record Volume and Image Suppression

- SSA ran a pilot with 5 HIT partners
  - Identified 40 images providing no adjudicative value; such as:
    - After Visit Summary (patient care instructions)
    - Clinical consent
    - Nurse notes
  - The pilot yielded positive feedback
    - Reduces processing time
    - MER can be reviewed quicker
    - Takes less time to open the HIT MER document because the file is not so large
- Rollout for image suppression (TBD)

Questions/Answers:

- IHS records
  - Criteria doesn't always trickle down to all components in IHS; looking to see what info they can provide.
  - IHS is actively working with their organizations to provide more meaningful evidence to fulfill our adjudicatory requirements.
- VA records – SSA is having ongoing discussions with the VA
  - VA is receiving increased funding to provide SSA records from the separate VA clinics
- User Trigger (UT) Application
  - When HIT MER is requested outside of DCPS, the UT request does not propagate to the case activities.
  - We are working with the DCPS Team to "bake" some HIT functionality (and ERE functionality) into DCPS, but there is no timeline.
  - SSA plans to reach out through the regions to determine UT application training and HIT refresher needs.
- ERE Modernization:
  - Multiyear process beginning in 2024
  - Aim is to bake ERE into DCPS and to use the same infrastructure platform.
- Where should the DDS route concerns for situations such as no patient match, but MER is subsequently obtained traditionally?
  - Patient not found is usually trigged by an algorithm problem on the partner side.
  - Send HIT partner name and claimant SSN (partner cannot pull by DCPS claim number) to your supervisor (or MPRO) who can contact the regional HIT liaison.

NADE AWARDS

AND THE AWARDS GOES TO……

President's Award-

THADE, NC DDS

Frank Barclay Award–

Ebony Grissett-South Carolina DDS

NADE AWARDS CTD...

Marty Blum Award-

Allyse Lee, Oregon DDS

Medical Consultant Award

Dr J. Scott Pritchard, Oregon DDS

Charles O. Blalock Award

Kerry Fuller, Oregon DDS

NADE AWARDS CTD….

DDS Professional of the Year
-Dr Winifred Ju, Oregon DDS

Lewis Buckingham Award-
Jennifer Pounds, NC DDS

John Goodman Award
(Supervisor of the Year)-
Marcia Golden, NC DDS

NADE AWARDS CTD……

Earl B Thomas Award-
Jacqueline “Jacki” Russell, NC DDS

Directors Award
(Support Staff)-
Crystal Bach, SD DDS

Recognition Award-
MT DDS

NADE Committee Duties:

Awards:

When serving on this committee, the committee members will assist in reviewing the award nominees and voting for the most deserving nominee for each award category via email and send back to the award chair.

CDIU:

These committee members should be someone who works within the CDI. The committee chair will ask about input regarding issues and concerns related to the CDIU. This information will then be shared with the NADE Board.

Constitution , Bylaws, &Strategic Planning:

These committee members will help the committee chair in reviewing regional and state chapter constitutions & bylaws to ensure compliance with the national constitution & bylaws.

Elections & Credentials:

These committee members help the committee chair with election of officers for the national conference.

Hearing Officer:

These committee members should be a hearing officer. The committee chair with ask about input regarding issues and concerns related to hearing officers. This information will then be shared with the NADE Board.

Medical Consultant:

This committee member should be a MC or PC. The committee chair with ask about input regarding issues and concerns related to being a MC/PC. This information will then be shared with the NADE Board.

National Disability Professionals Week (NDPW):

The committee chair with ask for votes for the chapter who has best idea for NDPW theme. They are also responsible for voting on which chapter hosts the best theme week for NDPW.

GET INVOLVED CTD……

Non-Dues Revenue:

These committee members work with the chair for any new ideas for non-dues revenue items to sell to the membership. They work on planning the National Training Conference.

Organ Donation/Transplant:

These committee members vote on the chapter who host the best organ donation/transplant presentation for their chapter in the month of April.

Professional Development:

These committee members help assist the committee chair with reviewing any applications (as needed) for certification and re-certification to ensure that all requirements have been met.

Professional Relations Officer:

These committee members should be a Professional Relations Officer. The committee chair will ask about input regarding issues and concerns related to the PRO position. This information will then be shared with the NADE Board/SSA.

Retirees:

These committee members should be retired NADE members. The committee chair will ask for any input from the retired members about any issues they would like to see addressed related to NADE. The committee chair will then bring this to the NADE Board.

Support Staff:

These committee members should be support staff members. The committee chair will ask for any input from the support staff members about any issues they would like to see addressed related their positions as support staff. The committee chair will then bring this to the NADE Board.

2023 –2024 Committee Chairs

Awards	Melvin Carr	melvin.carr@ssa.gov
CDIU	Jennifer Carles	jennifer.carles@ssa.gov
Constitution, Bylaws, & Strategic Planning	Tonya Scott	tonya.scott@ssa.gov
Elections & Credentials	OPEN	
Hearings Office	Buffie Raynor	buffie.raynor@ssa.gov
Medical Consultant	J. Scott Pritchard,	J.scott.prtichard.do@ssa.gov
National Disability Professionals Week	Marcia Golden	marcia golden@ssa.gov
Non-Dues revenue	Julie Kujath	julie.kuhath@ssa.gov
Organ Donation/Transplant	Emile Reafs	emile.reafs!@ssa.gov
Professional development	Amber Barnes	amber.barnes@ssa.gov
Professional Relations officer	Keith Hearnsberger, EdD	keith.hearnsberger@ssa.gov
Retirees	Terri klubertanz	NADEretirees@gmail.com
Support Staff	Crystal Bach	cryssteve@yahoo.com

Please email Kate Miller to volunteer to be a committee member!

NADE needs YOU!

A Note From the Editor:

Thanks to everyone who wrote an article for our Conference Edition of the Advocate! Special thanks to Rhea Novak and Kate Miller for editing and reviewing each article!

EXCITING NEWS!!!! 2024 National Training Conference will be Oklahoma City in August 2024. Stay Tuned for more details….

Submit your articles to:

sara.b.winn@ssa.gov