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RespectAbility

Baby Boomers, Acquired Disabilities & Stay-at-Work Strategies with Jennifer Christian, MD

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 >> Good afternoon and welcome to the RespectAbility webinar for December 13th, 2017. This is actually our last webinar for 2017, so those of you who are with us today, thank you very much for closing out the year with us. We'll be back in January with a lot of exciting new topics and new conversations about disability, employment, education, some of our work in California and New York. We have lots of great things in the pipeline, and so please stay tuned to your in‑box to keep a tab on what's coming up in the world of RespectAbility.

 So today we are kind of shifting focus a little bit, and when we shift focus, we are really talking about new models and new ways of thinking. This webinar series has always been dedicated to providing a platform for you, the people working in the field of disability and employment, self‑advocates, and policy makers to really get a chance to learn innovative ideas, to engage thought leaders on new developments and new models for success and transition. And now actually we are going to be talking with a thought leader about really a new way of thinking about disability, work, getting people to stay at work, getting them to return to work, and really the complex challenges and choices that we face as we age into disability, as we incur a traumatic injury that makes someone a person with a disability or develop a chronic illness, which impacts their ability to stay in the workplace and put their talents to work.

 So, as you saw from the invite, we are going to be speaking today with Jennifer Christian, and she is an M.D. and MPH, a really amazing leader with lots of ideas around new models of work disability prevention. She's given some really serious thought to how to shift the paradigm of SSDI, of disability, of workers' comp, and is very much a field practitioner with an eye and commitment to methodology. One of the first resources that we provided me when we were talking about doing a webinar was this slide here, which talks about how affected people are thrust into a maze. And really, we are dealing with very personal issues, very personal challenges and choices. Think about what happens when somebody's health status changes. I mean, they are suddenly in the emergency room. They may have a traumatic injury. They have to grapple with a new reality. The choices they make will have lasting consequences. The information they get from their doctors is going to shape the course of their lives, the quality of their lives, and when we are dealing with disability, it's very easy to talk about process, but at the end of the day we are in this because we care about people, what choices people make and how they navigate through the system.

 And so this picture is a maze, and it shows on the left health change status, and then throughout the different corridors and pathways, you see specialists physicians, walk‑in clinics, FMLA, SSDI, the whole soup of letters that can be very dehumanizing, but can also empower somebody to get back into the workplace, and at the very end of the maze, the end of the labyrinth is the promise of return to normal rhythm of life. So it's this process, these complexities, and Dr. Christian's approach to these challenges with her new paradigms and models, I highly encourage you to check out in the handouts and the media library, she's worked in partnership with ODEP and the American college of occupational medicine. We'll start with a back and forth of me asking her questions and her talking about some of her ideas and some of her work and life experience. And then we'll have some opportunities for questions. And if it works, the video showing a very personal journey of somebody living with disabilities and changing their outcomes.

 So, as I said, today we are joined by Jennifer Christian, M.D., MPH, FACOEM. She has a great deal of training and expertise, thousands of clients ranging from the private sector, the medical sector, the nonprofit sector, the Department of Labor. She is an amazing leader with a great compassion for these challenges. So I turn it over to you, Jennifer.

 >> Well, thank you very much for asking me to be part of this webinar today, and I hope that what we talk about opens some windows in people's minds into rooms where they haven't really been doing a lot of thinking and creates opportunities for action. That's why I'm here.

 >> Wonderful. So can you just very quickly kind of give us a run through of your educational credentials?

 >> Oh, I have an MD and a master's in public health from the University of Washington. I'm board certified in occupational and environmental medicine. I'm a fellow of the college ‑‑ it calls itself ACOEM, of the American college of occupational and environmental medicine, and over the years I have sort of developed my expertise in the area of leadership. I call myself a self‑appointed envoy between the various sectors of society, and trying really to draw their attention to this problem of needless work disability, and the need to help mitigate the impact of injury and illness on working people's lives and livelihoods.

 Most of my time has been spent as a management consultant kind of person. Our clients have been employers, health care delivery organizations, managed care companies, disability and workers' comp insurers, government agencies. We have done projects for Social Security and for the Air Force, and I have been recently a member of the Stay‑at‑Work/Return‑to‑Work policy collaborative at the US Department of Labor. I haven't been in private practice until this year, December 1 this year. I have entered private practice very part‑time in order to work with people who have had unexpectedly poor outcomes and been left with chronic pain and what I call over‑impairment and over‑disability as a result of the way that the stakeholders have responded to the person who has an injury or illness. I did have a program called Maze-Masters, which we'll talk about a little bit later, in which I did work one‑on‑one with injured workers.

 >> Gotcha. Well, moving ahead to the next slide, it gives you the sense that, you know, Jennifer has a lot of ‑‑ as the slide's title says, many years, many chairs, and many perspectives, from being an emergency room physician to working in a primary care clinic, medical director, medical officer, and in a bunch of different states. She's really traversed the nation in terms of looking at best practices, and so we'll talk through all of these things, and with a particular focus on a couple of key questions. And so that first key question, you know, when you work in disability, there's always some reason or motivation why somebody cares about the issue and works on it.

 So, Jennifer, how did you first get interested in the issue of preventing needless work disability.

 >> You know, I don't personally have a disability, and nobody in my family does, so it is peculiar that I have gotten so interested. There are two particular incidents that I can remember and can't forget. One is that I had a pretty conventional medical education, and then I moved to Maine, and I was at a medical conference, and somebody showed a slide that showed how the likelihood of someone ever going back to work fell with every passing week or month that they were away from work, and when I looked at that chart, I got a pang in my heart, because I realized I had been hurting people, because I wasn't paying attention to the passage of time. And we have our number one motto in medicine, we call it the first precept of medicine, is first, do no harm. And at my ‑‑ basically, I'm not interested in forms. I joke that I have an allergy to forms, and I would always put the forms on to my desk because I didn't know how to answer them, and I thought it wasn't really my business. It was adminis‑trivia, I called it. I had been harming people with my attitude about forms, and it is typical of how medical training makes doctors think about the issue of disability. I then, after I saw that chart and I had this pang in my heart, I then went to work. At that time I worked at naval ship builders, and that was really my first job in occupational medicine as a ‑‑ taking care of people, and I started seeing men, because it was primarily men, men who had been out of work for years on a workers' compensation injury, and I saw they were basically faint hulks of who they used to be. They had kind of turned into whining people who just kept talking about what they couldn't do, and I just felt like that was wrong, because all that they had had at the beginning was a back strain, and most people who have a back strain get better and stay at work. Most of them actually really don't even go to the doctor, and I started seeing a righteous anger, why is this happening, why are these people having such terrible outcomes. And I guess that's just fueled me ever since then, is whenever I see a person who could have had a better outcome but didn't, and I see that it's due to the way that they managed the situation and the system interacted with them, the response they got from all of the other stakeholders when they developed their injury or illness, that that has caused and wrecked their lives, I just have a lot of compassion for them.

 >> Gotcha. And it sounds like you've learned a lot from the people you've worked with over the years. So then it parlays into my second question that I have on the docket, is how does the focus of your work differ from that of typical organizations that advocate for employment of people with disabilities.

 >> The people that I have compassion for are people who don't yet have the label disability, that they fall between the cracks of all of our safety net programs, because they don't identify themselves as disabled, nor do have they warranted the label disabled yet. They are just somebody who hurt their shoulder yesterday or lifted something too heavy and their back hurts, or have gotten some depression or some anxiety, and they are just defining themselves as a regular person who happens to currently have an injury or an illness, so that's a big difference in how my work differs.

 And the second thing is that I'm talking about from the moment of onset of the injury or illness in a working person. I haven't ‑‑ I don't feel a call. My mission isn't people who were born with a disability or children or really old people, because my specialty is occupational medicine, I have a commitment to working people who are trying to work, trying to stay in the workforce, who want to have and keep a livelihood and want to avoid ‑‑ actually, they may not want to avoid a future on disability benefits, but I want to avoid it for them. I think the best and happiest lives for human beings is to be fully participating in society at the highest level that you can.

 >> Wonderful. So I think that you sort of answered what was going to be my next question about why are you so committed to this issue.

 >> I think the short answer is that I'm some form of crazy.

 >> [Laughter].

 >> Because I think in America, and actually probably all around the world, oftentimes the people who really drive change, who are really committed to something, they are for some reason, they are more passionate about it than anybody else. And it just happens to be it's my fate. I was called to it, and I have just given myself to it.

 >> You definitely ‑‑ you need to have a certain intensity of spirit to really succeed in this, and I mean, obviously, you know, the audience for this webinar are people on our mailing list who care about disability in one form or another, but, you know, oftentimes this specific angle of work disability, of, you know, becoming over-disabled due to the way systems work and way medicine works, I'm really curious. Why do you think we should pay attention to this particular issue and this particular perspective of or paradigm about disability?

 >> There are kind of two reasons that I see. One is I don't think most people have really looked at it this way, but roughly half the people now entering SSDI, half of the people being awarded benefits each year, roughly, are people who started out with common, everyday health conditions. They are not people with spinal cord injuries, schizophrenia, or congenital malformations. They are people who the nature of their condition is some of the most common everyday human health problems that normally do not result in the loss of livelihood and permanent incapacitation. So they ‑‑ something has changed. Part of it is court decisions have changed about the way the common law has evolved around on how deal with pain, but we actually, if you have been reading a newspaper, what you have figured out, America is managing pain wrong these days.

 >> Yeah.

 >> So the people who are entering Social Security are people who have had painful conditions that have been mismanaged in one way or another or responded to inappropriately by the worker or by the other people around them, and so that's one big reason why we should pay attention to these issues.

 And I think the other issue is a lot of people are suffering who wouldn't otherwise need to.

 >> Yeah. And I mean I would add to that, you know, the fact that ‑‑ I think that, you know, it ties very clearly into a lot of the negative stereotypes and stigmas that are out there in terms of what is or isn't disability. The Washington Post has recently done a series of articles featuring folks in Appalachia and Kentucky who are on SSDI or SSI, and there are a lot of leaders in the community who pushed back on those portrayals, because they felt they were unfairly perpetuating the stereotype that the social safety net is only for people who ruin their back, but that these are very real issues, and this is a process where a lot of people ‑‑ we are talking millions of Americans who may not think of themselves as people with disabilities, as you say, but are experiencing these issues and are part of the same system that we work on, so thank you for that.

 >> And also, anybody who does have ‑‑ we are going to have a slide that talks about classic catastrophes or classic disabilities, but the government is interested in reducing inflow on to SSDI and protecting the economic well‑being of the country.

 >> Oh, yeah.

 >> And two things are true, is it makes a lot of sense not to have people on SSDI who could have had a better future, and when we did a project for Social Security, what we saw that was one of the like saddest and weirdest things about the SSDI application process is the question is never asked, is this remediable? Could this person, through some process, get better enough so that they could work again? It's never even asked.

 And the second thing is that the economic engine of America depends on having as many people as possible pushing that economic engine forward, and as a society, we have to have kind of like the right proportion of people being dependent and those being productive and generating the dollars that support the other ones. So in the interest of the country, as in the long term, we really want to have everybody working who could.

 >> Absolutely. And it's interesting that, you know, as economic conditions continue and we reach, you know, the full employment, unquote, the employers are looking, like we need more talent, we need more and more people, which means that companies by necessity are going to have to grapple more with workers' comp and worker disability and talent pools that they haven't tapped into yet.

 Shifting back to the last question, can you explain why these outcomes have happened, and as policy makers and practitioners what can we do to prevent those bad outcomes from occurring.

 >> Okay, so when a person who has been able to work develops a new injury or illness or their existing problems worsen so that it's unclear whether or not they are able to do their job, that starts a clock, and there are important decisions that are going to be made by the worker themselves, by their doctor, by their employer, by their claims payer, if there is one, and if those decisions aren't optimal, if the right things don't happen, that person may end up as a creeping catastrophe, which we are going to talk more about. But their small initial problem, their normal run of the mill back pain can become chronic pain and can become disabling back pain, so it is the way event unfurl or unfold immediately after the onset of an episode that are going to have a powerful impact, the most powerful impact on how it turns out. In fact, there are quite a few scientific studies that show that from the time of onset of a condition that is disrupting work to 12 weeks, it's in that first 12 weeks that the most important things are happening, because it's during that period that everyone is coming up with strategies for how they are going to deal with this disruption. So we are going to walk through a slide together in a few minutes that shows in detail what I'm talking about, but it is the response of the other stakeholders to the injured or ill person, and it's also the way the injured or ill person themselves responds that's going to drive these situations in either a good or a bad outcome.

 So, obviously what can be done about them is to try and make the right stuff happen instead of the wrong stuff.

 >> And make sure people get good information so that they make informed choices. So ‑‑

 >> Yes. And they need more than information. They need guidance. They need ‑‑ and I actually just wrote a ‑‑ I run a list serve called the work, fitness and disability round table, which is a multistakeholder LISTSERV. And a lot of the work that I do is multistakeholder, because these issues are not contained in one sector. When people ask about my work, I say that I work in the gap between health care, employment, and insurance, and no one sector owns the Stay‑at‑Work/Return‑to‑Work process entirely, which is why we have to work in a multistakeholder way.

 >> Absolutely. So now is one of our kind of ‑‑ I wanted to make sure I set some time aside for our audience to ask some questions, and there's two ways that you can do that. Either you can type a question in the chat box on the bottom left of your screen, or, Virginia, can you explain how to ask a question by phone?

 >> Participants who have called in on the phone can indicate they would like to speak by pressing 7 pound on their telephone keypad. That's 7, followed by the pound sign, on their telephone keypad to indicate they would like to ask a question.

 >> All right. We'll give anybody joining us by phone a chance to do that. But from the chat box, we have a question from Alan who is asking about the difference between sports medicine and workplace medicine, and really what are some of the differences and some of the different approaches to those.

 >> Alan, you're exactly right. There is quite a different sort of spirit in sports medicine than in workplace medicine. Anybody who is playing a sport is presumably doing it because they want to, and anybody in sports medicine is trying to help the person do the thing that they want to do, which is play sports. People sometimes have mixed feelings about work. I think we have done, unfortunately, a lot more studies about how work hurts people in my specialty, in occupational and environmental medicine, there's a heck of a lot more research on how work can hurt people than there is awareness of the research showing that work is really part of a ‑‑ an important and vital part of a healthy and happy human life. So workers' compensation in particular has kind of a sleazy reputation, and people get taught when they enter a workers' comp claim, they sort of enter the culture of workers' compensation, and that's a fast track to a ruined life, is to really get into that work comp cultural.

 >> Gotcha. Wonderful. Virginia, do we have any phone questions?

 >> No phone questions yet. Again, that's 7 pound on your telephone keypad to ask a question on the phone.

 >> All right. Well, then we are going to keep moving on, and we had a video that we wanted to show, so fingers crossed the technology will work.

 Jennifer, can you explain why this video is interesting and what we should look for?

 >> Okay. This is a video of a person who you'll see starts off very disabled. Look at the look on his face as he walks in the door, and you're going to watch how he undisables himself.

 >> Interesting.

 >> You can run the video.

 >> There we go.

 (Video playing.)

 >> It does have sound. I don't hear any.

 >> You'll be hearing the sound through your computer outlets, if you have logged in.

 >> There's the look on his face that I'm talking about.

 (Video playing.)

 >> I have lost so much weight that if I don't hold these up, they will fall, and I'm not going to do that right now. But I'm really pleased with this. And I just want to share this with everyone. Thanks a lot.

 (Music playing.)

 >> Here's where I'm at now.

 Just because I can't do it today doesn't mean that I'm not going to be able to it someday.

 >> One, two, three, four.

 (Music playing.)

 >> He doesn't have his knee braces on anymore.

 >> Wow. You know, I think from time to time when we are really working on these issues, it's important to keep that lesson in mind, to never give up and kind of the boundaries that have to be pushed sometime to help somebody improve their quality of life, so thank you very much very sharing that, Jennifer.

 So are there any other key takeaways that you would want people to reflect on from the video?

 >> Well, I use it when I teach doctors. I teach a course called getting difficult cases unstuck, strategies for stalled recovery and prolonged work disability. And I show that video, and I have shown it now for several years, and generally speaking there are a lot of people sort of crying by the end, and the part that I think is overlooked is that this guy, DDP, who, by the way, he's a real character. He is a former world heavy weight wrestler. He has come up with a program. But what he is doing is he is believing that something better is possible. And so when Arthur had a little spark in him somewhere that thought maybe something better was possible, but he couldn't find anyone who would really believe that with him and move him forward into it, and that is what he needed. So that's one thing.

 The other thing I ask the doctors after they watch that video is how many diagnoses do you think Arthur had, how many medicines do you think he was on, and what the hell good had that done him.

 >> Right.

 >> And so this is really a case of a guy who becomes self‑empowered. He wasn't at the beginning, though. That is the important part, is that you get a lot of negative messages. I think he'd gotten messages about how he had no more cartilage left in his knees, and he got messages from the armed forces about how he had sacrificed himself for the country and now he's disabled, and in our work with the Air Force, that's what we see, that someone has impaired themselves a lot in working for the country and they graduate them out of the Air Force without a focus on how they can have the best possible life going forward. What all of the conversation about when you leave the Air Force is about how to maximize your benefits. So we have got to get the focus on how to have the best possible life despite what's happened to you. That's where we have to have the focus be.

 >> Absolutely. And it's interesting because of how different the VA system is than the civilian disability system. The civilian SSDI is very binary, whereas the VA you graduate to the different percentages of disability, yet the fact of the matter is it's very often an escalator. A veteran may leave with a 35% disable, but that disability goes up and up as they pursue more services and get additional diagnoses.

 >> Yeah, and they are all coaching each other and getting coaching on how to maximize the benefits. I don't object at all to the idea that somebody wants to survive economically. But we are having a conversation only about money. We are not having the conversation about how to have the best possible life as a human being.

 The first time that I ever talked on Capitol Hill, I happened to say, which brought the room to the standstill, that money is kind of a consolation prize because you didn't really get what you wanted out of life.

 >> It's interesting, because one of the new appointees to the EEOC is lieutenant colonel gauge, who lost a leg in Iraq.

 But we are off track and I want to talk about what you have done over the years.

 >> And we do have a question on the phone.

 >> Oh, wonderful. Sorry about that. Please join us. What was your question?

 >> Hello. I'm here.

 >> Marilyn ‑‑

 >> Can you hear me?

 >> Yes, we can.

 >> Okay. I'm sorry. Anyway, I got on this webinar, and I couldn't get into the webinar, but on the phone, but I applaud the doctor's work in this area, highly. I know for myself, I was ‑‑ I have been working since I was 15 years old, and, you know, I went through the whole step of getting education, actually, as an older person, not a traditional age student, and I worked somewhere for 20 years and ended up being diagnosed with fibromyalgia, also issues with my spine and IBS, and within that period of time, which was a really quick period of time, actually, I ended up being depressed, and then severely depressed, and I came back, you know, full knowledge, I'm back in the workplace. I love my job, and part of it was teaching. The other part was being a specialist in a specific area, in academia, and, you know, I can tell you that, you know, trying to find a job and for ten years still has been very deflating. But, you know, you're a certain age, and it's true, you know, women and men hit a certain kind of, what do they call it, the glass ceiling, and then people don't want to hire you, and it doesn't matter if you go through the whole process. I didn't get the employment ‑‑

 >> Can I just interrupt for a minute?

 >> Yeah, sure, hon.

 >> Do you have a question?

 >> My question is how do people ‑‑ because you're saying, go from being ‑‑ having this certain injury, or whatever, and continually thinking about being positive, beyond hope, actually action oriented, and having people help them. Because I'm a big advocate ‑‑

 >> Well, actually, that is one of the places where the system is weak right now.

 >> Right, right.

 >> And that's part of why I decided to go into the particular kind of private practice that I went into ‑‑

 >> Okay, all right.

 >> ‑‑ is because people have been encouraged to think a particular way.

 >> Right.

 >> And they have or have not received the kind of support they need, and I was actually asked by a pain medicine doctor the other day to help him with a guy who'd been turned down for everything, and I said, I think the kindest thing that you can tell that person is they are on their own, because when we teach people that the system should take care of them and the system fails to take care of them, and you've advocated the best you can. You have gotten in touch with the best advocates you can, nothing works, the best thing to do is focus on creating the best life that you can with the resources that you have.

 It would be way better if we had more people who were able to do what I'm going to be trying to do in my private practice. We should get ahead here and talk a little bit about Maze-Masters, but you with your diagnoses, fibromyalgia, and whatever else you said, there are some clinicians in America, and I met a medical hypnotist the other day, that can help people with fibromyalgia feel a lot better, but that knowledge isn't percolating down to the front line medicine right now.

 Can I answer the question about what does Webility do? We don't work with individuals. We are working at the system change level. Our tagline is that we are a positive change for workers' comp and disability benefits systems. Our clients are organizations, you know, agencies, corporations, health care delivery organizations, and it is through that work that I think I actually personally feel like I'm having the biggest influence, is that's how I got to be on the Stay‑at‑Work/Return‑to‑Work policy collaborative to start drawing attention to the people with these needs and predicaments.

 >> Gotcha. Wonderful. Thank you, Marilyn. So let's move on to our next question after that.

 So you mentioned it, Maze-Masters, and I would like you to talk about its approach and how this idea developed, because I think this is a resource and a website that you should take a look at.

 >> Well, Maze-Masters was, I actually to be truthfully, the impulse to develop Maze-Masters was sort of revenge. I had been spending 20 years trying to get employers and payers, meaning insurance companies, to start paying attention to making sure that the right thing happened early in episodes, because as I said that first 12 weeks has such a powerful impact, and they just really haven't been willing, it seemed like, to listen to me or pay attention or spend money on our consulting services to make something happen. So I decided I'm going to have revenge on you. I'm going to get you where I know you're hurting. I'm going to go to the back end of episodes where people's lives have been hurting, and you the insurer or payer have been spending more than a hundred thousand or 250 or $500,000 on people, and I'm going to offer you a service, and I'm going to help you. I tried to do something good for those people, so I set out to say what has to happen when somebody has already had all of the unfortunate things happen, what has to happen in order to change the trajectory or the pathway of that person's life from down to up? And I didn't really know the answer, but we started getting referrals. It actually for me, as I'm the chief salesperson for Webility, it was the easiest sale I ever made, because these workers' comp insurers, we primarily were working with them, we knew they were hurting, and they didn't have any other solutions for what they call failed cases or what they often call train wrecks, somebody whose life has become a train wreck. So we started getting all of these referrals, and I started meeting the people. And because I had been doing file reviews for people with complicated chronic low back pain, with fibromyalgia, with chronic fatigue syndrome, there were parts of the country with either no access to expert medical care or where there is access it's to weird medical care, and so I said I wanted to be able to deliver this service in any place in the country, and I don't want to have a medical license to do it, because I can't afford 50 different medical licenses, so we are going to do this as a nonmedical program. We realized if we took an education approach and a health coaching approach, that was the ground rules. We were going to make a difference in people's lives. When we started meeting the people, and we started finding out who they really were and what their situations were and kind of like what had happened and started figuring out what we had to do to undo the damage, the main thing that we had to do was to strengthen the person, that often through lack of information, through lack of skills, through lack of awareness of kind of how the world works and how the system works and what the options are, they were in a deeper hole than they needed to be, and that by strengthen them and their skills, we could help them crawl back out. And so that's what Maze-Masters is about.

 My new private practice is I'm going to do medical care for people who have chronic pain or are on medications. They may not have had the right diagnosis. They may not have had access to the right medical care, and I'll do other things in the medical practice, but Maze-Masters is a part of my new practice.

 >> Very interesting, and I'm always very curious to see new models that are leaving aside traditional licensing schemes, and I think you have got a very interesting approach to some complex challenges, but there's a term that you have used quite a few times, and I would like to walk you through it step by step. You talk about craving catastrophes and kind of the process involved. What do you mean, and how can these types of catastrophes be prevented?

 >> Phillip, I thought I had a slide that combined creeping catastrophes ‑‑ classic catastrophes and creeping catastrophes. The idea of a creeping catastrophe is it looks like a common health problem at the beginning. It looks like a sort of a little nothing, like a back ache or a little bout of depression, right, and that's different from the classic catastrophes, which really look serious on day one. In the classic catastrophes, you have an obvious immediate or imminent anatomical or functional destruction of some tissue or a multisystem insult, and it's often a clearly irreversible loss, whereas the creeping catastrophes, the depression and the low back pain, as I said, most often people get better, and the classic catastrophes can be congenital. They can be some sort of devastating illness or major trauma, and the creeping catastrophes as I said are musculoskeletal pain, anxiety and depression, and the people who have some sort of catastrophic event on day one often get much more support and encouragement for the fullest possible recovery. I have gotten to know a little bit Jennifer, the deputy assistant secretary of labor, and she's quadriplegic. She talked about waking up the day after her injury, she woke up in a devastated environment where people knew and wanted her to have the best possible quality of life. Whereas when people have a little bit of back pain or depression, people don't leap in. They just barely notice what's happening. So in the creeping catastrophes, for some reason the recovery stalls. Nothing seems to work, and they seem to have more distress and more sickness than there is actual evidence of disease in terms of tissue pathology, and they get desperate, and because they really are trying to get better, and their desperation drives a search for ever more expensive and ever more destructive measures. They keep thinking the solution is medical, and unfortunately the medical system is designed to give you more treatment whether or not it's actually the right thing for you to get, and the medical system is also designed to give you more diagnoses, whether or not that's helpful for you, and so these people that end up on SSDI go downhill overtime. Their lives have been ruined, and they end up leaving the workforce and staying on disability, and really this is preventable over‑impairment and worklessness.

 >> Got you. Very interesting. And you have a very involved and very clearly articulated chart that you want to walk us through step by step.

 >> Yes. The main thing with this chart to notice is that down the middle of the chart, we are going to go through it in more detail, but the big picture is there's a series of events unfolding over time down the middle of this chart, and the way each one of these issues is handled, the way each one of those moments turns out is going to drive this person's situation towards a good outcome on the left, and if it isn't handled that way, it will drive it to the right. And so the more unfortunate things happen, the more likely it is that you're going to end up with a really bad outcome on the right‑hand side, and the more things turn out the way you hope they will, the more likely you are to have a good outcome on the left.

 So, at each point, there's kind of a Y in the road. So, as we start here, and this is ‑‑ we are using as an example a common musculoskeletal condition, like low back pain, and the symptoms are usually pain, weakness, swelling, spasm, decreased function, and in reality 80‑90% of these things usually resolve rapidly and rarely cause job loss. So what are the things that drive it to become chronic? And I do want to say that science says that there is no correlation between how serious your back pain is and the functional outcome. And there is no correlation between the way your MRI looks and your level of function. There are people who have no symptoms whatsoever who have horrible looking MRIs, and there are people for whom you can find no pathology on an MRI who are ‑‑ view themselves as completely disabled. So we are going to walk down here, and the first thing is at the moment when the episode begins ‑‑ uh‑oh, I have to cough. Hold on. I have a cough drop, and I'm doing what I can, but I do have a cold or something.

 So at the moment when there's the onset of this, we are going to say this is a person with low back pain, some people come into this situation with added risks as a result of their experience in life or who they are or their makeup, such as they come in with inaccurate beliefs about the meaning of back pain. They come in with unhelpful attitudes and expectations, with fear or anger or passivity, and they have accompanying other significant medical or psychiatric conditions. They may have substance abuse. They may have a high A score. I don't know how many of you have heard of this, but there has been a lot of work done between Kaiser Permanente and the Centers for Disease Control and now a whole bunch of other work done on the impact of childhood experiences on adult health status. And they have found out that if people have had four different kinds of bad things happen to them when they were kids, meaning that they, for example, had somebody in their family in jail, that they watched a man beat their mother regularly, if there was somebody in the family with a mental illness or suicide, if there's somebody in their family with alcoholism or drug abuse, if they themselves were sexually, physically, or emotionally abused or neglected, those are the ten things that are on an A score. If they have had at least four of those things, that's the strongest predictor we have for adult health status. So having had a very difficult childhood predisposes people to a bad outcome when something happens to them as an adult, overage, you perceive yourself as not very capable, displacement, job issues, hidden agendas, meaning they have an axe to grind or something of that sort, all of those things drive towards a poor outcome unless acknowledged or managed. That's the second thing, does the worker receive prompt services that identify and mitigate those added risks, as well as the ability to restore and function and work.

 How are we doing? Is this okay? Is this tracking for you?

 >> Absolutely. And I would just add to that as we go from step number two to step number three, kind of an unrecognized element of it is our language barriers. We live in an America that is much more diverse and has larger populations who come to this country and ESL students or English may not be their first language, making sure that you get credible accurate health information is only going to become more important. That's just a side note as to how this intersects with immigration and other populations.

 >> You're totally right. Culture should be in there. It isn't just we need to get the information, but we need to understand what their health beliefs are. I did some work with Mexican peasants, basically, coming to southern California when I was an intern, and my advisor specialized in Mexican folk beliefs. And they don't understand the principle of medicines, how to take medications, so it gets into low health literacy and a language barrier and can be really very tricky.

 Step number three, we are hoping that the person got appropriate health care, but the other item is did they get sound medical advice and guidance about activity that permits and encourages medically appropriate work. Most doctors have never had any training whatsoever in how to give that advice, and so they basically totally make up the answers, and so people will be kept away from work. They think they can never do their job again, because the doctor just took a wild guess about what it is that they are or are not able to do, and the employer takes that as the revealed truth, and it becomes etched in stone.

 And then step number four is how it reflects the importance of getting somebody back into productive activity soon, instead of having them sitting on the couch worrying that they won't be able to work again. So keeping them in the normal rhythm of life right from the start, by temporarily adjusting job demands, fixing a safety or ergonomic problem in work, or making accommodations early on are really important, because if people keep thinking of themselves as a person who can work, even though they have to modify what they are doing, that is a very important belief for the person to have.

 Do you want to go ahead to the next one?

 >> Yep. And in the next slide we jump to five, six, and then there's a gap in terms of whether recovery is prolonged in step seven.

 >> And then in step five, it is tremendously important, whether the worker accurately appraises the situation and copes successfully with the challenges, and if they may need some help doing that, they may need help accurately appraising the situation, and they may need help figuring out how to cope successfully. There are normal life interruptions which are usually ignored. They are not often taught how to manage the situation. They get the idea that the pill and the doctor are supposed to manage the health symptoms. They don't know how to manage the health benefits situation. They don't even talk to their employer, which is the wrong move. So professional support can make a big difference.

 And then mother nature is partly going to help us decide whether the worker enjoys a rapid and full recovery of function by that 12‑week mark. Some kinds of conditions you're not going to do it, because you have conservative care and then you have to wait for surgery. So sometimes things get prolonged for medical reasons, but there is also very good science now that some conditions become chronic because steps one through five didn't work out right. Chronic pain is not always caused by the medical thing itself. It is caused by the interaction of the medical thing and all of those things in steps one through five.

 >> Gotcha.

 >> So, for some people, their recovery is prolonged, and their condition becomes chronic, and now we are starting to say again, now we are at the worker, did they overcome their pain‑related distress, discouragement, are they able to accept their loss, or are they going to keep looking for a solution. People in Maze-Masters had basically been holding their breath for three or four years for a medical miracle, and we asked them what is the probable almost certain future that you are dealing with, and they didn't want to see that it was that they weren't going to get better. So this is about adapting to the situation, and they may need to have a new view of themselves and what their future is going to look like, and they may need support to do that internal work.

 >> All right. Very interesting. So then moving on to, you know, part number four with steps eight, nine, and ten.

 >> So now would be steps seven, eight, nine, and ten. Now we are dealing with people that you are more familiar with, that they may have made reasonable accommodations or corrections, whatever it is at work, and now they have a chronic condition and they are able to stay there, cope successfully with flare‑ups and periods of uneven job demand, and an important one here is the worker aware of how much better it is for them to keep fighting the good fight and stay at work, instead of giving up and going on disability benefits. So steps seven, eight, nine and ten you're more familiar with, not so much step seven. It seems to me when I have looked at the disability literature, a lot of what we are talking about here in steps one through seven is internal transformations in the way that the person sees themselves and what's possible, and that's where I think a tremendous amount of power is sitting.

 >> Absolutely.

 >> So just in terms of creeping catastrophes, in terms of big picture things here, ACEs, the average childhood experiences are a major root accuse of both subjective illness and organic disease, and it's really been unacknowledged. I don't know if anybody except me and some of the people who have read what I do who are asking people to calculate their ACE score, but in our Maze-Masters program, we did ask people to calculate their ACE scores, and generally north of six, seven, eight, and nine. We had a person with an ACE score of nine in our program, and we say that kind of child, if your parents were so busy being whatever they were, drug addicts, mentally ill, in jail, beating each other up, they weren't teaching the kid how to ‑‑ they weren't a role model for how to deal with the up and is downs of life, and what I realized by working one‑on‑one with the people with these high ACE scores is they had a profound information and skill deficit, and that's a lot of why our program focused so much on strengthening the person so they could cope with what life had dealt them.

 >> Very interesting. Well, I'll certainly have to look more into that issue and steps ahead. And I think you've definitely covered the creeping catastrophe kind of challenge very clearly, and so as kind of my final question, you've mentioned your policy work before. You've talked about the collaborative. But I'm really curious about your ideas around SSDI and potential improvements to that program. So we have some slides that you previously put together for some proposals that you have about home and health services and community, so can you walk us through those?

 >> Okay. The committee for responsible federal budget held a competition of ideas, and so we submitted an idea, which was accepted and became part of their book of proposed solutions that went forward to the congress, and I am completely happy to say that they picked up our idea, and there is $50 million in the president's budget for this coming year to start a demonstration project on at least a piece of what we proposed. We proposed a community‑focused health and work service. I had two guys, one from the United Kingdom and one from the state of Washington, who went in there with me to write a proposal, and what we proposed was a service that would provide extra support during the first 12 weeks of an episode, exact thing that we have been talking about in this entire talk, which is that first period right after onset of a health care condition that is getting in the way of work, that the health and work service would be able to step in and provide support at the request of the employer, of the insurer, of the affected worker, or of their doctor, with expertise in the stay at work or return to work process.

 >> Gotcha.

 >> Next slide.

 So we said how to avoid needless impairment and work disability is to minimize residual impairment and maximize preservation and recovery of functions that are affected by that condition of improving access and reducing delays in care, by increasing the effectiveness of treatment, there's way too little discussion of the treatment that you're getting and paying attention to function, willingness to cope with what life has dealt them, and to arrange workplace. This health and work service would focus on one, two, and three. Go ahead.

 >> Gotcha. All right. So then there's six key distinctions in this proposal.

 >> Yes. We tried to get people really realizing that work disability is a different issue than impairment disability. Having a diagnosis doesn't mean that you can't work, and work disability occurs whether or not a person has a disability. So, for example, if I go to the dentist this afternoon, because I have a medical problem with my teeth, I am work disabled this afternoon, even though I don't have a long‑term diagnosis. And common health conditions, as I said, are now causing half or the underlying reason or the inciting event that starts now half of people entering SSDI on that path. So the idea of potentially avoidable ‑‑ this idea of things that happen after the onset of the condition, which worsen the functional outcome, we just haven't paid anywhere near enough attention to that, and most of the discussion in disability circles has been about people are irrevocable losses. Our immediate response is so important, and the definition of early intervention in Social Security was like six months after you got on to SSDI. Well, that is long after the horse is out of the barn, so we are talking about getting involved while the person and the people around them are shaping their strategy for how to manage the future.

 And functional recovery versus functional restoration is recovering the rhythm of life, recovering the ability and function to participate in life as fast as possible, because jobs are lost at the speed of life, not at the speed of bureaucracy, and it is early events, expectations, and concerns that are key.

 >> Absolutely. All right. Well, I don't have any final questions. Do we have ‑‑ we don't have any questions in the chat box. So I am going to wrap up our program for today. Thank you, Jennifer Christian, M.D., for being with us today. Thank you so much for talking about your perspective, your passion. You answered a lot of really interesting questions. I thought we had some good back and forth and some really interesting perspectives on cutting‑edge challenges and new models of thinking around disability and life. I thank you very much for joining us today.

 For our audience, I wish you a very warm happy holiday, depending on what holiday you celebrate, from Festivus to Hanukkah to Christmas or New Year's, anything in between. I hope you have a wonderful set of holidays, and we look forward to picking up with you in the new year. A copy the PowerPoints will be on our website soon, along with the great handouts from Jennifer Christian's work. So from the ever growing RespectAbility family to you, happy holidays, happy new year, and we look forward to talking to you later. Good‑bye.