DIRECTIONS

Aging with a Disability

RESEARCH TO CLINIC

Page 34

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WE'VE HIT THE "ROARING TWENTIES!!"

Written by: **GERRY DICKERSON, ATP, CRTS®**

It is hard to believe it is the year 2020.

At each of these milestones, I always like to stop and wonder what was and what will be.

What was it like in 1920? I have a pretty good collection of my grandparents' "things," including diaries, postcards, letters, handwritten firsthand accounts, and my memories of their stories and what transpired in their lives during the '20s. I come from a family of savers, especially family history.

It's amazing to see how far we have come in 100 years. It boggles the mind to try and imagine where things will be in another 100 years.

More importantly, where will we be at the end of this year, the end of the next five years, the end of the next decade?

In 2019, the Accessory bill was in the books. A huge thank you to all the folks who were involved in getting this done. Thanks to NRRTS, NCART and all the consumers and clinicians that gave of their time in the effort to get this done.

"COMPANIES ARE MERGING, REHABILITATION ENGINEERING AND TECHNOLOGY CENTERS ARE CLOSING, KEY PEOPLE ARE CHANGING JOBS . . . CHANGE, CHANGE AND MORE CHANGE.

Our energy now turns toward the Separate Benefit Category (SBC). We need everyone to be involved in the push to get the SBC passed. The original bill was introduced to Congress in 2009. Ten years ago! Please get and stay involved. We need everyone to be part of this.

The 2020 Access2CRT Summit is scheduled for March 30-31, 2020, in Washington, D.C. Please visit www.CRTSummit.com to register. Join suppliers, clinicians, manufacturers, consumers, caregivers and friends in advocating for Complex Rehab Technology!

To me, the SBC should be our singular goal for 2020. As always, the NRRTS staff and I are here to help you in your efforts with your legislators. It's really very easy; it just takes time. We are available to help you in any way we can. For some, that might just mean getting over the fear of making that first contact; to others, it may be talking points that drill down the "ask" into a few talking points. Whatever it is, please don't hesitate to ask for help. If we can't help you, we will find someone who can.

Having said all that, now it's time to ask, what can NRRTS do for YOU?

- What do you need from us to make your professional life better?
- Is there an area of interest that you would like us to seek content expert help on and publish in DIRECTIONS?
- Are there funding questions that still make your head spin? Policy questions?
- Questions about disability?
- Questions about challenging interventions? Not only challenging from the equipment end, but also addressing family dynamics, cultural issues, environmental issues and behavioral issues?
- What about funding or policy driven catastrophes? You know what the right thing to do is, but the restraints of funding and policy have you tired up in knots, or "nots."

Our online CEU courses are spectacular in my view and the view of those who have participated, but do they meet YOUR needs? Is there something missing from the curriculum that you would like to see?

Please send your questions, comments, requests and opinions to my email below. At your request, I'll keep it all confidential if you wish.

One last thing, a look back. Can you guess who said it and when? The answer is just below my name.

"Everywhere I go, everyone I talk to is concerned. Translate that to scared.

All over the country, providing rehabilitation technology is changing.

Companies are merging, rehabilitation engineering and technology centers are closing, key people are changing jobs … change, change and more change.

On top of this add changes in funding structures and payment schedules. Even avoiding the politically charged issues surrounding Medicare and Medicaid, there is a perception among most RTSs there will be less money available to provide service to consumers with disabilities."

Here's to a spectacular New Year! Now, please go contact your representative in Congress!!

Gerry

Simon A. Margolis
NRRTS News, Fall 1995

CONTACT THE AUTHOR
Gerry may be reached at GDCRTS@GMAIL.COM

"EVERYWHERE I GO, EVERYONE I TALK TO IS CONCERNED. TRANSLATE THAT TO SCARED."

Gerry Dickerson, ATP, CRTS®, is a 40-plus year veteran of the Durable Medical Equipment and Complex Rehab Technology industries. Dickerson, president of NRRTS, works for National Seating & Mobility in Plainview, New York. Dickerson is the recipient of the NRRTS Simon Margolis Fellow Award and is also a RESNA fellow. He has presented nationally at the RESNA Conference, ISS and the National CRT Conference and is a past board member of NCART.

CEREBRAL PALSY COLORS OUR WORLD

Written by: **ROSA WALSTON LATIMER**

As with life in general, Carol Shrader learned that with a family of five, including two children with cerebral palsy, balance is essential. "Giving my boys every opportunity to develop physically and meet certain milestones was certainly important," Shrader said. "However, I also needed to let Benjamin and Mason discover what drives and motivates them beyond their physical needs. Of all the obstacles that my boys have had to knock down and plow over, there were times when the most significant barriers were the ones that I had to overcome so they could succeed and be their best.

"I WANT TO TELL MOMS TO GET OUT OF THE WAY AND ALLOW YOUR CHILD WITH DISABILITIES TO THRIVE AS A PERSON."

"I want to tell moms to get out of the way and allow your child with disabilities to thrive as a person. We want the best, but we can be so concerned with the expected milestones that we forget to see the beauty in what we have been given in our children. This is what I would want to know if I were a young mom again. If my babies were young again, this is the story I would want to hear."

A dedicated advocate for those with cerebral palsy, Shrader now takes every opportunity to speak and blog (http://theblessingcounter.blogspot.com/) to share the lessons she has learned. She also recently led a NRRTS webinar and co-wrote a children's book, "Helix Holds a Sleepover," with Randal Betz Jr. The book, available from Amazon beginning Feb. 12, 2020, is the second in a series about Helix, a tortoise without the use of his back legs who uses wheels to move around.

"Wade and I married one week after graduating from college and, four years into our marriage, he began medical school at the Pritzker School of Medicine, University of Chicago. I was working full time, working on a master's degree at night, and he was in school full time," Shrader said. "We were also living in an undergraduate student dorm serving as dorm parents. One year into this, for several reasons that made sense at the time, we decided it would be a great time to have a baby." The couple learned a few weeks into their pregnancy that they were having three babies!

At the 19 ½ week mark in her pregnancy, Shrader was put on bed rest in the hospital. "At 28 4/7 weeks, Benjamin, Claire and Mason were born. They all cried and were whisked away to the NICU," she said. "Benjamin was only in the NICU seven weeks and was home before his original due date. He was healthy, grew rapidly and was alert. He interacted with everyone. It was amazing!"

Because of the possibility of seizure activity, Claire was put on meds and was sleeping most of the time. "We thought she was probably going to have some residual effects," Shrader said. "Mason was tiny. He barely weighed two pounds and even though he had a hard time getting off of the ventilator, he did very well."

The Shraders were still serving as dorm parents and brought the three newborns home to their dorm residence. "Who doesn't want the responsibility of three newborns and 80 undergrads?" Shrader said. "Once all three of the babies were home from the NICU, we thought the hard stuff was over; however, the challenges of life with CP were just beginning."

While participating in a physical therapy study on premature babies, Shrader felt positive about her babies hitting expected milestones. "Benjamin was hitting them faster than the other two, and I was all puffed up thinking my firstborn was doing great," she said. "When the physical therapist told me about three months into the study that she suspected that Benjamin had cerebral palsy, I was furious. I called Wade crying, saying that we were quitting the study, and I did not want the physical therapist back in my house. Fortunately, Wade was more rational than me, and we decided that we needed to stay in the study as a way to help other young families. My feelings were hurt that someone would say that my kid had cerebral palsy, but my feelings didn't matter. At six months, Claire could sit up, and the boys could not." Indeed, Benjamin and Mason both had cerebral palsy, a congenital disorder that affects movement and muscle tone.

"At a year, Mason started crawling, Claire started walking, and Benjamin still wasn't rolling over," Shrader said. "I basically had a developmental preschool in my

Wade Shrader with his 1-year-old trio: Mason, Claire and Benjamin.

The Shraders together for Thanksgiving, 2019 – Benjamin (in red), Carol, Claire, Mason, Cate, and Wade.

house and was aware that Claire was hitting milestones, and Mason was hitting the same milestones but delayed. Benjamin was looking at the other two as though to say, 'You know she'll hold you in her lap. I don't know why you are trying to move.' However, at 9 months, Benjamin started talking, and the other two were not. By the time he was a year old, Benjamin was putting words together, but while he excelled with verbal skills, his mobility was not there. He's 22 years old now, and he still can't roll over, but there are many things he can do. He's very creative and his communication skills are awesome!"

"Around the age of 3, Mason was using a walker and trying out crutches. We called the crutches 'power sticks' because we thought crutches was a terrible word for a little boy," Shrader said. "Benjamin was using his little walker, but it would take every ounce of energy he had to put one foot in front of the other. He would arrive at the entrance to preschool exhausted."

> "AT A YEAR, MASON STARTED CRAWLING, CLAIRE STARTED WALKING, AND BENJAMIN STILL WASN'T ROLLING OVER. I BASICALLY HAD A DEVELOPMENTAL PRESCHOOL IN MY HOUSE AND WAS AWARE THAT CLAIRE WAS HITTING MILESTONES, AND MASON WAS HITTING THE SAME MILESTONES BUT DELAYED.

Young Claire, Benjamin, and Mason at Disney World.

CONTINUED ON PAGE 10

CEREBRAL PALSY COLORS OUR WORLD
(CONTINUED FROM PAGE 9)

At this time, the physical therapist began to talk with the Shraders about a wheelchair for Benjamin. "I don't think I was even polite when she first brought up the subject. All of my Southern charm went out the window," Shrader said. "I explained that we weren't even going to use the 'w' word in front of the triplets. I thought the wheelchair would be limiting and would shut down the world for Benjamin. Putting my son in a wheelchair was, to me, a testimony that this was a long-term disability. I was not ready to accept that."

A very young Benjamin, as has happened throughout his life, was able to communicate through his natural humor and help his mother gain new insight into his individual needs. "The PT had been helping Benjamin learn how to move from a stroller to a walker. After they worked and worked at this, finally Benjamin was in the walker, but he was in it backward," Shrader said. "The therapist asked Benjamin what he was going to do. My beautiful, smart little boy looked her and said, 'I guess I'll do the Hokey Pokey and turn myself around.' We all laughed, but I had tears in my eyes. I realized at that moment that this child was smart and funny, and he had been going to church, to school and to playdates exhausted because I was making him walk. His little body was tired."

After this experience, Shrader relented, and, in preparation for kindergarten in the fall, Benjamin got a wheelchair. "So the kid that I thought would shut down if we put him in a wheelchair, now had the whole world open to him," she said. "The wheelchair gave him freedom when I had thought it would remove freedom. Benjamin could now drive from point A to point B and still talk, and talking was the most important thing to him!"

Cate, Mason, Benjamin, and Claire Shrader. The triplets all graduated from their respective colleges within eight days of each other!

Mason, Benjamin, Claire, and Cate Shrader at the 2018 Nemours Gala benefiting the Cerebral Palsy Center at A.I. DuPont Hospital for Children.

"I DON'T WANT TO MAKE IT SOUND AS THOUGH IT IS EASY BECAUSE HE CERTAINLY HAS TO MAKE SURE EVERYTHING IS IN PLACE TO DO WHAT HE WANTS TO DO."

Skip forward to May 2019. That is the month the now young adult Shrader triplets all graduated from their respective colleges within eight days of each other.

Claire graduated magna cum laude from Mississippi College in Clinton with a degree in Spanish, a minor in English, and also completed prerequisites for occupational therapy school. She is currently a teacher's aide at a school for children with complex medical needs in Philadelphia and will start occupational therapy school in the fall.

Mason graduated summa cum laude from Millsaps College in Jackson, Mississippi, with a double major in anthropology and classics (Greek and Latin) and a minor in archeology. He is currently attending Texas Tech University in Lubbock, Texas, pursuing a graduate degree in classical archeology. He is also a teaching assistant. "Mason has been on archeological digs in Mexico and Spain. He's living on his own, travels on his own and so far has done very well," Shrader said. "I don't want to make it sound as though it is easy because he certainly has to make sure everything is in place to do what he wants to do." Mason plans to get his Ph.D. and teach on the college level.

Benjamin graduated magna cum laude with a major in theater with emphasis in dramatic writing and a minor in political science from Belhaven University in Jackson, Mississippi. He is currently volunteering with 2020 political campaigns and was an adviser on disability policy for the Beto O'Rourke campaign until it ended. "Benjamin loves to go to political rallies and likes to be the first one to ask a question," Shrader said. "He will wait on a decision about graduate school or employment until after the 2020 election."

When the triplets were 8 years old, the family of five welcomed one more into their circle. "Cate is an amazing, self-assured young lady," Shrader said. "We all consider her a true gift, a light to all of us. She has always been a champion for her brothers. When she was 4 years old, I, fortunately, caught her fist in time to prevent her from punching a little boy because he said her

Benjamin Shrader with 2020 presidential candidate Beto O'Rourke.

Mason Shrader on an archeological dig in an ancient necropolis off the coast of Spain.

CONTINUED ON PAGE 12

CEREBRAL PALSY COLORS OUR WORLD
(CONTINUED FROM PAGE 11)

brother was weird. I had to reprimand her but wanted to hug her!" At this time, Cate is enjoying her teenage years, playing softball and plans to be a NICU doctor.

Wade Shrader, M.D. is the division chief of cerebral palsy at Nemours A.I. DuPont Hospital for Children in Wilmington, Delaware. After the cerebral palsy diagnosis for Benjamin and Mason, Carol's husband decided to pursue pediatric orthopedics and specialize in the disease. "Wade wanted to be the one that walked families through the experience of living with CP," Shrader said. "He relates so closely with his patients and their families; I am sure there are times when it is difficult to distinguish whether he is the doctor or the daddy."

"OUR LIVES AREN'T PERFECT! LIKE OTHER FAMILIES, WE'VE HAD TEARS AND MOMENTS WE WANTED TO RUN DOWN THE STREET SCREAMING, AND CP HAS DEFINITELY COLORED OUR WORLD, BUT WE HAVE HAD SO MANY BLESSINGS!

"Our lives aren't perfect! Like other families, we've had tears and moments we wanted to run down the street screaming, and CP has definitely colored our world," Shrader said. "But we have had so many blessings! Throughout our life, our faith has remained important to us, and that helps us through difficult times and enables us to thoroughly appreciate the good times."

"I'm so grateful that on that day when 5-year-old Benjamin joked about the Hokey Pokey that I realized he had more to offer than putting two legs on the ground and walking. Benjamin's dreams were not this limiting paradigm that I had - that walking would be the be-all, end-all for him," Shrader said. "Motor skills don't define us. If I could convince our society of anything, it would be that we need to stop defining people by their motor skills, allow them to find what drives them and what motivates them, and do everything we can to encourage that."

CONTACT
Carol may be reached at CAROLLEIGHSMILES@ME.COM

Carol Shrader is mother to young adult triplets, two of whom have cerebral palsy, and she also has a pre-teen daughter. In 2008, her then 11-year-old son created a blog — The Blessing Counter — and encouraged her to write. His willingness to have his story told so that even just one family could find hope in the journey of raising children with cerebral palsy inspires her still.

Shrader is passionate about helping others find the joy in raising their children with cerebral palsy; about helping all children reach their full potential; and knocking down roadblocks that get in the way of just that. Her husband Wade, is a pediatric orthopedic surgeon committed to the medical care of children with cerebral palsy. It is their family's goal to remove helplessness and hopelessness from the diagnosis.

Shrader holds a B.A. in Communication from Mississippi State University.

BENEFITS OF NRRTS REGISTRY

NRRTS offers an impressive lineup of **monthly live webinars,** an extensive **on-demand library of webinars** offering more than 50 courses to fit your schedule, and numerous **CEU article reviews.** All **content is geared toward clinicians and suppliers** working in Complex Rehab Technology (CRT) and Assistive Technology.

DIRECTIONS, the **bimonthly publication of NRRTS,** offers articles **spotlighting consumers, clinicians, manufacturers** and **suppliers of CRT.** A **clinical focus** and **CEU article** are offered in each issue. **DIRECTIONS** has a circulation of over **10,000 readers.**

The NRRTS Website receives more than **6,000 visits** each week. All **current Registrants are listed** on the website by state or province.

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NRRTS works closely with other organizations to **promote** and to **advocate for the CRT Industry.**

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For questions, please contact
Amy Odom at **aodom@nrrts.org** or
Weesie Walker at **wwalker@nrrts.org.**

EFFECTIVELY DELIVERING THE INDUSTRY MESSAGE

Written by: **ROSA WALSTON LATIMER**

John Goetz's first exposure to public policy came while he was working as an intern in the office of U.S. Sen. Bob Corker of Tennessee. The experience gave him a clear career direction. "I began an internship with Sen. Corker soon after I graduated from the University of Tennessee at Chattanooga with a major in political science," Goetz said. "A couple of months after my internship began, they hired me to help with casework. Most people who call a senator's office with casework issues are in distress and need help. I discovered that I enjoyed finding solutions that could make a positive difference in someone's life."

Goetz later became a health care policy staffer for the senator and, during this time, earned his master's degree in public administration from the University of Tennessee at Chattanooga.

"After leaving Sen. Corker's office, I worked for the Tennessee Medicaid agency, where I gained valuable experience as a legislative liaison and performed policy advisement for the long-term services and support division," Goetz said. "My direct involvement in the CRT (Complex Rehab Technology) industry began when I left TennCare to join Permobil as their director of government affairs."

YOU HAVE RECENTLY TAKEN A DIFFERENT APPROACH TO YOUR ADVOCACY WORK. TELL US ABOUT BRIDGE PUBLIC AFFAIRS AND YOUR RESPONSIBILITIES AS A SENIOR VICE PRESIDENT WITH THAT COMPANY.

At the beginning of 2019, I joined with some former colleagues from the U.S. Senate, and together we founded Bridge Public Affairs. We are a multiclient company that works with local, state, national and some international clients on many levels. We've worked with over 30 clients during this first year providing traditional lobbying work, helping with strategic communication and consulting on a variety of issues. I primarily lead with our health care clients. Bridge is like a start-up, and we are always on the move, but that's fun for me. Work is fulfilling for me when I am involved in many things at once.

My decision to be part of Bridge was a very positive choice, especially because it allowed me to continue to work with Permobil on a consultancy basis. I also continue to advocate for coverage, legislation and the users of complex rehab equipment. I am very pleased to maintain my connection with the health care industry in general and with those who depend on it.

> "A COUPLE OF MONTHS AFTER MY INTERNSHIP BEGAN, THEY HIRED ME TO HELP WITH CASEWORK. MOST PEOPLE WHO CALL A SENATOR'S OFFICE WITH CASEWORK ISSUES ARE IN DISTRESS AND NEED HELP. I DISCOVERED THAT I ENJOYED FINDING SOLUTIONS THAT COULD MAKE A POSITIVE DIFFERENCE IN SOMEONE'S LIFE."

In addition to our work assisting clients, Bridge maintains a core principle of supporting charities that are important to our employees. We continue to be involved in public service outside of work, so in recognition of that, our CEO established this policy. The company matches a portion of any donations of time or money that our staff contributes.

WHY IS THIS WORK IMPORTANT TO YOU, AND HOW IS IT ESPECIALLY REWARDING?

The work is rewarding because, ultimately, I am a policy nerd! I enjoy policy matters and searching for workable solutions to a variety of issues. I also enjoy helping people solve problems.

Lobbying is a different route for advocacy that is extremely important. In this role, with my health care background at a state and federal level and also working with a CRT manufacturer, I have a unique perspective to offer. When we face a challenge relating to our industry, a particular argument may sound effective; however, the perspective of an agency might be different. Your message, while well-intentioned, could be way off the mark. Knowing how to properly communicate with congressional or agency staff – any group generally – is an important thing a lobbyist can do. The work I do is very gratifying!

IS THERE SOMETHING ABOUT YOUR PERSONAL LIFE THAT INFLUENCES YOUR WORK?

My father was young when he had a stroke, and I've seen what a person experiences when going through a catastrophic event. I witnessed him going from a productive, successful

John and Whitney Goetz with their sons, Theodore (left) and George.

ABOVE - John and Whitney Goetz and Ann and Brent Wiles. John and Brent are partners at Bridge Public Affairs.

BELOW - George, John, Theodore and Whitney Goetz with Gov. Bill Lee, R-Tenn.

businessman and member of society to someone who, because of a medical situation, is now dependent on public payers. I realize many individuals are in this situation, and I also know that it can happen to anyone, any time. My father is somewhat independent, but to some extent, I am his caregiver.

My sister was adopted from Romania when she was 1 ½ years old. At the time we adopted her, she had never been out of her crib in the orphanage. She has an intellectual disability because of that situation when she was young, and I am also involved with her care. My family is fortunate that, because of my career, we know how to work through problem situations. I know the rules or know where to find the rules if I don't know them. Many do not have this advantage. This is a big motivator for me to continue to work with groups that are trying to help people with disabilities. While I have this new adventure, I am not giving up the personal advocacy work that is very important.

TELL US ABOUT YOUR FAMILY AND WHAT YOU DO WHEN YOU ARE NOT WORKING.

Whitney and I have been married for seven years. We are both from Tennessee, but we met in Washington, D.C., when we were both working for Corker. We were the new folks in the office and started hanging out together, but we weren't sure what the dating policy was. However, our Chief of Staff and Corker were both very supportive of our relationship. Now Whitney is director of Human Resources for the Tennessee Department of Treasury. We have two sons: George, 3 years old, and Teddy, 1 year old. With the boys and our careers, we are quite busy!

What do we do for fun? I go to bed early whenever I can! We enjoy just hanging out as a family and being outdoors together. Before George and Teddy, Whitney and I enjoyed traveling. We both grew up traveling with our families, and that is something we want to do with our kids, too, when they are older.

CONTINUED ON PAGE 16

EFFECTIVELY DELIVERING ...
(CONTINUED FROM PAGE 15)

I believe traveling opens your eyes to many things and gives you more of a global perspective.

IS THERE A PARTICULAR ISSUE ON WHICH YOU BELIEVE OUR INDUSTRY SHOULD PUT ITS FOCUS?

While we've made great strides in many areas through the years, I believe we have some things on the horizon that need our attention. Personally, I am concerned about some of the Medicare policies that have come out regarding CRT manual wheelchairs. I think this is something that we need to focus on to determine what can be done. This isn't just an accessories issue or the upgrade/titanium issue. There has been some hint that more policies are coming that could result in more cuts. As is often the case, continuing to have the same approach to a problem will not necessarily get positive results.

"PERSONALLY, I AM CONCERNED ABOUT SOME OF THE MEDICARE POLICIES THAT HAVE COME OUT REGARDING CRT MANUAL WHEELCHAIRS. I THINK THIS IS SOMETHING THAT WE NEED TO FOCUS ON TO DETERMINE WHAT CAN BE DONE. THIS ISN'T JUST AN ACCESSORIES ISSUE OR THE UPGRADE/TITANIUM ISSUE."

I am pleased to continue to direct Permobil's government affairs and serve as their representative on the NCART legislative committee. I am optimistic that the broader spectrum of my work at Bridge Public Works will be a positive influence on my perspective of the CRT industry.

YOUR LIFE IS FULL NOW WITH A YOUNG FAMILY AND YOUR WORK AT BRIDGES, BUT WHERE DO YOU SEE YOURSELF PROFESSIONALLY IN THE FUTURE?

Of course, you never know what will happen. I'm excited to be part of this adventure and to be part of an outstanding team. There is some apprehension working in a new company, but I'm with people I've known for a long time and who share my values and goals. That reduces anxiety.

John Goetz on tour at Permobil with Rick Haynes senior vice president of human resources; Todd Walling senior vice president of sales, and Rep. John Rose, R-Tenn.

John Goetz and Brent Wiles of Bridge Public Affairs participating in a charity golf tournament.

Whitney and John Goetz at Bristol Motor Speedway, Bristol, Tennessee

ONE THING YOU CAN BE SURE OF IS THAT WHATEVER I DO IN THE FUTURE, I WILL STILL BE INVOLVED IN ADVOCACY FOR THE HEALTH CARE INDUSTRY AND THE PEOPLE IT SERVES.

Long term, I see myself at some point going back into public service. I love health care policy and specifically like policy work. One of the most rewarding parts of my work at TennCare was the CHOICES program. We focused on making sure that people with disabilities, or who were elderly, could remain in the community and in their home if they could be safely served. Appropriate CRT is a big part of accomplishing this. I can see a future working in the public policy arena to help people who need assistance to achieve the most independent living circumstances possible. One thing you can be sure of is that whatever I do in the future, I will still be involved in advocacy for the health care industry and the people it serves.

CONTACT
John may be reached at JOHN@BRIDGEPUBLICAFFAIRS.COM

Prior to joining the Bridge team, John Goetz served for nearly three years as director of government affairs for Permobil. Before joining Permobil, Goetz served as legislative liaison to Tennessee's Medicaid agency, TennCare, serving as the liaison between the agency and the General Assembly. There, he advocated on behalf of the governor's agenda and provided policy counsel for the Long-Term Services and Supports (LTSS) division within TennCare. He also served as acting public information officer when the program faced major challenges due to federal litigation, thereby gaining notable experience explaining detailed health policy issues to the media and other key audiences. Prior to TennCare, Goetz served as U.S. Sen. Bob Corker's legislative aide for health care policy. In addition to serving as a senior staff member for the Senate Special Committee on Aging, where Corker served as ranking member, Goetz worked on several provider and insurance issues to help assist Tennessee businesses navigate federal health policy. Significantly, he also provided policy guidance to Corker surrounding the contentious implementation of President Obama's Affordable Care Act (ACA).

Goetz earned a bachelor's degree in political science and a master's in public administration from the University of Tennessee at Chattanooga.

JAN FURUMASU

GIVING GUIDANCE AND SHARING EXPERIENCE

Written by: **ROSA WALSTON LATIMER**

The entire four-decade career of Jan Furumasu, BSPT, ATP, has unfolded at Rancho Los Amigos National Rehabilitation Center in Downey, California. The facility, founded over 125 years ago, has been recognized as an international leader in rehabilitation medicine and clinical research. Through the years, Jan continues to be motivated by her patients and the positive experience of working with a dedicated team of professionals. "The staff at Rancho Los Amigos is patient-oriented and passionate about their clients," Furumasu said. "There is a prevailing good spirit and positive energy among all of the therapists, nurses, physicians and engineers. Working in this atmosphere has been a positive influence on my individual growth as a physical therapist."

While the positive atmosphere of care at Rancho Los Amigos has remained constant, many other facets of the industry have changed during Furumasu's career. "When I first began there were only Everest & Jennings wheelchairs in two sizes – 16-by-16 inches or 18-by-16 inches. The equipment and technology available to us now have had a significant impact on treatment for our patients. Our services have gone from a medical model to a patient model, and now it is mostly insurance-driven," Furumasu said. "At one time, our patients stayed until they were independent. Now the insurance company dictates how long a patient can stay in rehab. Insurance-driven health care can be very frustrating, especially when a patient needs access to specialty care and expertise that isn't always allowed by the insurance company."

"My experience in college as a gymnast and gymnastics coach drew me to the field of physical therapy," Furumasu said. "I did my student affiliation at Rancho Los Amigos in 1978 in pediatrics and was hired the next year on the adult Spinal Injury service. In 1982, I returned to pediatrics. At that time, we had 18 pediatric and adult specialty outpatient clinics, and I worked with the medical team in one or two different clinics each day. During this time, I was exposed to many different diagnoses, treating adults and children with a variety of injuries, including spinal and brain injuries as well as patients with cerebral palsy and muscle diseases."

> "THROUGH THIS EXPERIENCE, I WAS EXPOSED TO VERY PROFESSIONAL, ETHICAL SUPPLIERS WHO PUT THE PATIENTS' NEEDS FIRST. THEIR EXPERIENCE AND POSITIVE INFLUENCE HAS A DIRECT IMPACT ON A PATIENT'S OUTCOME."

After eight years in pediatrics, Furumasu started working with the Assistive Technology Center at Rancho Los Amigos, focusing on seating and mobility, where she still works. "I also consult with the California State Department of Rehab, working with the mobility team serving clients that are either going to school or are employed and the goal may be to drive a van to become independent," she said.

"Since Rancho Los Amigos is also a center for clinical research and has a rehabilitation engineering research lab, I have had the opportunity to work on three, five-year pediatric power mobility grants," Furumasu said. "I also completed two years on a custom ultra-light wheelchair configuration grant. I am very fortunate to have had a wide range of experiences during my career." She is also very involved in special events and fundraisers held annually at the facility. "We have a festival or special day for each of our services such as Spinal Injury Games or Pediatric Carnival, and I help coordinate the participation and support of manufacturers and suppliers."

Furumasu has been a part of NRRTS from the beginning of the organization. "When Simon Margolis first began to organize NRRTS, he wanted some input from a clinician and asked me to serve on the board during the first year," she said. "Through this experience, I was exposed to very professional, ethical suppliers who put the patients' needs first. Their experience and positive influence has a direct impact on a patient's outcome. Working within this industry can be a struggle. It is important to have this professional organization as a support system." Furumasu is currently a member of the Clinician Task Force and RESNA.

She is energized by mentoring therapists who are at the beginning of their careers. "Sharing experience and guiding someone new to this field is very important to me," she said. "Rehab isn't for everyone. You have to be a team player, but the work is gratifying, and there is never a dull moment. If you are a 'people' person, the rewards double! I like to mentor the young 'uns!"

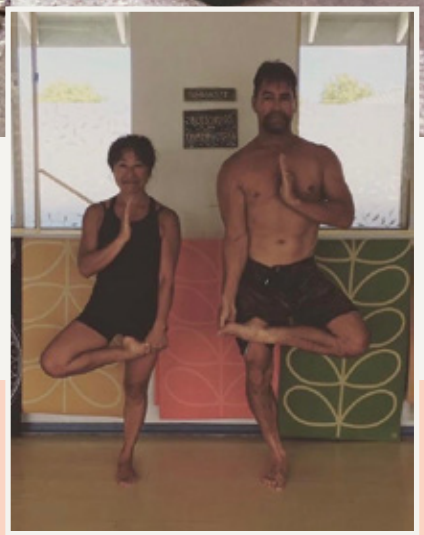
For over a dozen years, Furumasu assisted Wheels for Humanity and then Global Mobility to organize day trips to Mexico to distribute wheelchairs and to provide some intense, hands-on training and experience. "Wheelchairs for Humanity collected the wheelchairs. We would put together a crew of therapists and suppliers and deliver as many as 150 wheelchairs across the Tijuana and Mexicali border," Furumasu said. "Those trips provided valuable teaching

ABOVE: Rancho Los Amigos National Rehabilitation Center, Downey, California

LEFT: Jan Furumasu hiking in a slot canyon in Zion National Park, Utah.

experiences helping newer therapists identify the appropriate solution for each patient. These day trips provided exposure to many different situations in a short time.

"Throughout my career, day in and day out, working with my patients keeps me engaged," Furumasu said. "Each person is amazing. I am always inspired by the way they live their lives and pursue their goals while dealing with a disability. The grants for providing early powered mobility to young kids and networking with many clinicians nationally and internationally have been especially rewarding. The kids are adorable and to see the light in their eyes when they realize they can move around independently – that is the best!"



ABOVE: Jan Furumasu with a 4-month-old participant in a 1994 powered wheelchair study.

RIGHT: Jan Furumasu and her husband, Jeff Lewis.

CONTACT

Jan may be reached at JFURUMASU@DHS.LACOUNTY.GOV OR JFURUMASU@GMAIL.COM.

Jan Furumasu, PT, ATP, is a physical therapist who has worked at Rancho Los Amigos National Rehabilitation Center since 1979. She is currently an instructor working in the Seating Center and the Center for Applied Rehabilitation Technology (CART), evaluating seating, mobility and assistive technology needs. She is also a consultant for the pediatric inpatient service and the adult spinal injury pressure ulcerr management service. Since 1990, she has worked on three nationally funded research projects investigating cognitive readiness for powered mobility in young children.The Department of Defense recently funded a grant on custom wheelchair configuration. She has published and presented extensively in areas including pediatric powered mobility, seating, mobility, gait and patients with muscle diseases. Furumasu was the recipient of the Excellence in Clinical Teaching Award in 1994 and the Amistad Lifetime Achievement Award at Rancho Los Amigos National Rehabilitation Center in 2008.

ARTHRITIS IN ADULTS WITH CEREBRAL PALSY

Written by: **MICHELLE L. LANGE, OTR/L, ABDA, ATP/SMS**

According to the Arthritis Foundation, "over 50 million Americans have arthritis, making it the number one cause of disability in the country." Arthritis technically refers to over 100 types of joint diseases, though the most common type is osteoarthritis, which affects approximately 31 million people in the United States. Arthritis is more common in women and much more common in people who have other chronic conditions, such as heart disease, diabetes and obesity.

Arthritis is much more prevalent in people with cerebral palsy. A study by Peterson, et al. (2015) found that joint pain was present in 43.6% of people with cerebral palsy compared to 28% in all others. The study also found the arthritis incidence at 31.4% in people with this diagnosis compared to 17.4% in others. Joint pain and arthritis were linked to a decrease in function, particularly in mobility.

People with cerebral palsy are also much more likely to develop arthritis at a younger age in comparison with the rest of the population (Whitney, et al., 2018). The authors state that individuals with cerebral palsy are at increased risk for chronic disease due to excessive sedentary behaviors and malnutrition. The study included adults between the ages of 18 and 30 years. Adults with cerebral palsy, GMFCS levels IV-V, had a higher prevalence of osteoarthritis (7.7%) compared to those at levels I-III (3.1%). More striking was the rate of osteopenia/osteoporosis at 58.6% for those at levels IV-V and 29.1% at levels I-III. The authors state that children with cerebral palsy have an underdeveloped musculoskeletal system and that mobility deficits lead "to a progressive loss of mechanical loading, which is an essential stimulus for musculoskeletal growth and maintenance."

> "ARTHRITIS IS MORE COMMON IN WOMEN AND MUCH MORE COMMON IN PEOPLE WHO HAVE OTHER CHRONIC CONDITIONS, SUCH AS HEART DISEASE, DIABETES, AND OBESITY."

An abundance of research from the related field of ergonomic seating has found that constrained sitting contributes to arthritis, inflamed tendons and tendon sheaths, chronic joint degeneration, muscle pain and tissue damage (Lueder, 2004). Much of ergonomic seating design centers around providing movement to reduce this risk.

People with cerebral palsy are at increased risk of arthritis. This research should inform our seating and mobility practices. It is critical to provide weightbearing (i.e., standers, gait trainers) as well as to provide movement within sedentary seated postures (i.e., dynamic seating) as much as possible and appropriate.

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Michelle Lange is an occupational therapist with over 30 years of experience and has been in private practice, Access to Independence, for over 10 years. She is a well-respected lecturer, both nationally and internationally and has authored numerous texts, chapters and articles. She is the co-editor of Seating and Wheeled Mobility: a clinical resource guide, editor of Fundamentals in Assistive Technology, Fourth Edition, NRRTS Continuing Education Curriculum Coordinator and Clinical Editor of NRRTS Directions magazine. Lange is a RESNA Fellow and member of the Clinician Task Force. She is a certified ATP, certified SMS and is a Senior Disability Analyst of the ABDA.

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LESSON LEARNED IN THE FIELD

Written by: **ROSA WALSTON LATIMER**

Dave Nix, ATP, CRTS®, has been a NRRTS Registrant since 1999 and is currently serving as an At-Large Director on the NRRTS Board of Directors. "I've always appreciated the work that NRRTS does and decided that it was time that I start giving back to the organization," Nix said. "Through my work with the board, I look forward to learning how I can help future ATPs and hopefully make a difference for them, especially in the area of reimbursement."

DAVE, YOU'VE WORKED IN THIS INDUSTRY FOR OVER 40 YEARS. TELL US HOW YOU GOT STARTED.

I began in 1975 when I was in high school in Tampa, Florida, working for my uncle who managed a complex rehab branch. I continued in this kind of work through college, sometimes focusing more on traditional DME. In the mid-1990s, I spent five years in home health nursing but returned to complex rehab, and I've been doing it ever since.

YOU HAVE RECENTLY TRANSITIONED FROM OWNING A COMPLEX REHAB BUSINESS. WOULD YOU TELL US ABOUT THAT?

Mike Oliver and I have been friends for many years and began working together in 1999 for Med South. In 2001 we purchased that company and operated as Alabama Wheelchair Specialists until 2017 when we sold to National Seating & Mobility.

The transition from owning a business to being an ATP with National Seating & Mobility in the north central Alabama area has been a good experience for me. Mike and I had enjoyed eight or nine years of good business growth with reasonable payments from insurance companies and payers. However, the last four or five years before we sold the company were very difficult, mostly due to not being able to withstand insurance denials and non-payments. I believe, unfortunately, this is not an unusual experience for small businesses in our industry.

The change has been positive for me. Now I have a much closer connection with clients. I still can't lay my head on a pillow at night knowing all of my work is done, but I have more time for my clients since I no longer have the administrative responsibilities of owning a business.

Now that I am a part of National Seating & Mobility, I realize that the company has a great deal of respect for their ATPs and the service we provide. For example, we are allowed to make decisions about the best product for a client without any pressure to use a particular product just because it is less expensive. This attitude enables me to focus entirely on my clients and how to best meet their needs.

WHAT STANDS OUT TO YOU AS A WAY THE BUSINESS HAS CHANGED DURING YOUR CAREER?

Technology has come a long way, so now there are products offered "off the shelf" that previously required fabrication. I believe that's one of the most significant changes in seating and positioning. Also, not just the technology, but the entire field of study has evolved. We have learned so much about how children and adults change when they are in a seated posture for extended periods. Now we know what kind of technology or interventions are necessary to prohibit more erosion of structural deformities. That knowledge translates to more efficient service to our clients.

LOOKING BACK, DO YOU HAVE AN IDEA OF WHAT YOU MIGHT HAVE CHOSEN AS A CAREER IF YOU HADN'T STAYED IN COMPLEX REHAB?

Do you mean since I didn't make it as a rock and roll star? I've been playing music since I was a kid and still play with a buddy of mine, but we haven't made it to the "big stage!" Seriously, I probably would have chosen something relating to physical therapy. Early on, I read a book, "Your Career in Physical Therapy," and that is where I was headed before I started having some success in this industry.

TELL US MORE ABOUT YOUR MUSIC. WHAT ELSE DO YOU DO WHEN YOU HAVE FREE TIME?

I play guitar and harmonica, and I sing. My buddy, Alan Corley, who also plays guitar and sings, and I have been performing together for about 25 years. We got very creative with the name of our duo - we call ourselves "Dave and Alan." We play a variety of music, including the blues, acoustic singer/songwriter style of music and covers of groups such as the Beatles and the Eagles. We perform at corporate gigs, wedding receptions and small dinner clubs and play regularly at a local restaurant.

I have three sisters and, although we don't live close to each other, we spend time together with our dad as much as possible. We're a very close-knit family.

I spend much of my free time with my church family at Christ Fellowship. We planted this church in 2012, but many of us attended church together years before that, and I have a close relationship with the other church members. We meet in small groups once a week to study, pray or play Bingo with the residents at a retirement community. Since I don't have children, I very much enjoy the fellowship with these families, and these friends are an important part of my life.

Dave Nix, ATP, CRTS® (left) with a wheelchair recipient in Suceava, Romania

Dave Nix helps prepare a wheelchair for distribution during a trip to Jordan

Dylan (left) and Dallas Moore with Dave Nix, ATP, CRTS®, with National Seating & Mobility

Musicians Dave Nix and Alan Corley

Dave Nix with his sisters, Deanna Easterday (back), Donna Cummings and Debbie Pea (left to right front) and dad, Charles Nix

WHAT POSITIVE EXPERIENCES HAVE YOU HAD THAT DEVELOPED FROM YOUR WORK AS AN ATP?

I have developed a passion for helping with the distribution of wheelchairs in other countries. That's how I like to spend my vacation time, and I think if I ever retire, I will devote even more time helping in this way. I've been to Northern Iraq, Jordan, Guatemala and Romania working with ministries such as Wheels for the World, a project sponsored by the nonprofit organization, Joni & Friends (www.joniandfriends.org). This work is very rewarding. Many people work together to coordinate the entire process. The wheelchairs arrive ahead of our team, and we work directly with those who need help. I've seen many individuals gratefully accept equipment that probably would have ended up in the dumpster at my previous business. When someone receives even a standard, folding wheelchair that will change their life, the joy and appreciation are the same in any language.

My involvement in these projects has enlarged my vision and helps me realize that I am not the center of the world. There are so many people that need this help, and it does my heart good to have a small part in that.

TO CLOSE THIS INTERVIEW, WOULD YOU TELL US AN IMPORTANT LESSON YOU'VE LEARNED IN THE FIELD? PERHAPS SOMETHING YOUR PATIENTS TAUGHT YOU?

Through my experience of serving patients for many years, I've learned it is essential to always speak to the patient directly. Many times when I meet someone, I'm not sure of his level of cognition or where he is developmentally. However, I've learned that every patient likes personal interaction. They want me to look at them and to ask permission before I place my hands on them to move them around in their seating system.

This need for personal attention and human interaction is genuine even if a patient seems to be very far away into themselves, and I don't know how much he is hearing or comprehending. Early in my career, I would stand above a young patient and talk to the parents. Now I make sure that I interact with the child in some way. When I have an adult patient with perhaps a severe head injury, it may be necessary to communicate primarily with a spouse or parents; however, I try to always intentionally include the patient even when there may not be any response.

I have come to realize that I can't always see the beauty in my patients in the way that God sees their beauty. I must look closely and give each patient respect and individual attention so that I can be more compassionate.

CONTACT THE AUTHOR

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Dave Nix, ATP, CRTS®, has been a NRTTS Registrant since 1999 and is currently serving as an At-Large Director on the NRRTS Board of Directors. Nix works for National Seating & Mobility in Pelham, Alabama.

CEU Sesson Details

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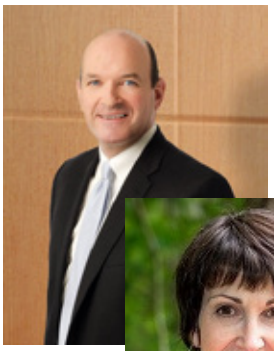
$199 per attendee



"New Developments Impacting CRT and Advocacy"
Speakers Peter Thomas and Rita Stanley .1 CEU

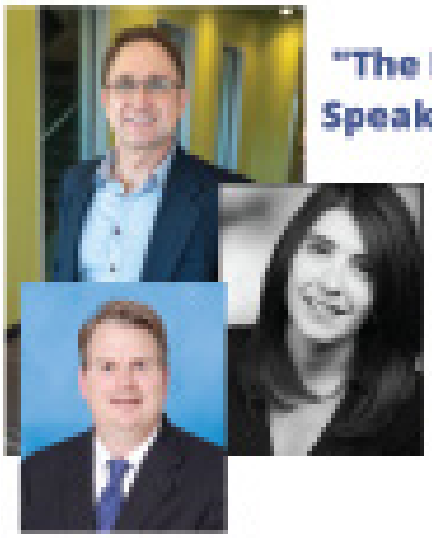
In the world of CRT provision, it is easy to focus on the issues at hand, but let's not take our eyes off the future. This presentation will provide information to guide efforts to influence positive change and increase access to technology. Understanding the decision in Alzar v. Alina will identify the possible impact in regulatory changes. How will Medicare establish reimbursement for new items and items without fee schedules?

"Medicaid Managed Care: CRT Issues and Advocacy"
Speakers John Goetz and Marge Gustas .1 CEU

As states move towards Medicaid Managed Care Organizations (MCO), issues around CRT access are increasing. It is important to understand how MCO's are structured and what their obligations are to follow Medicaid policy. Having the right tools and information will enable a better strategy for addressing issues. This session will provide an overview of MCO's including how to find information specific to each state.

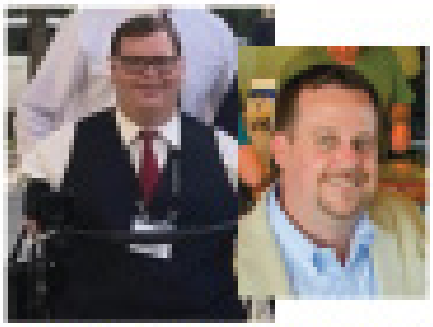
"Dealing with Difficult CRT Situations"
Speaker Jill Sparacio, OTR/L, ATP/SMS, ABDA .1 CEU

In our industry, professionals are expected to interact with a variety of personalities. Difficulty and frustration in dealing with others can occur. This session will focus on identifying issues that can cause conflict as well as providing the tools necessary for successful resolution. Anecdotal case examples will be highlighted to demonstrate how conflict and potentially difficult situations can be defused.



"The HOT Topics of CRT Funding"
Speakers Dan Fedor, Seth Johnson, Claudia Amortegui .1 CEU

Medicare coverage policy is a complex issue (no pun intended) for CRT. This panel will cover funding topics that are at the forefront of issues surrounding the coverage and payment for certain services. By understanding these issues, suppliers, clinicians and consumers can make informed decisions.



"ADVOCACY- Game Plan for a Winning Strategy"
Speakers Kyle Romano and John Miller .1 CEU

Advocacy is the only way to bring awareness and initiate change for current issues surrounding access to CRT (Complex Rehab Technology). Knowing where to start, how to express the problems and when to follow up is the key to success. Kyle and John will share a proven game plan that will ensure understanding and support for necessary legislation. This presentation also explains how everyone can be involved in advocating for CRT to bring about needed changes to policies.

"Going to the Hill: Everything You Need to Know to be a CRT Advocate"
Speakers Weesie Walker, ATP/SMS, Don Clayback, Cathy Carver, PT, ATP/SMS .1 CEU

Coverage for Complex Rehab Technology is determined by various agencies, laws and policies. This session will prepare participants to meet face to face with their Members of Congress and their staff. Understanding the issues is key to educating Congress about access to CRT. Given the short time to "present your case", this session will go step by step on getting the most out of the meeting. Participants will understand the obligation to continue advocating from home.

Visit www.crtsummit.com for more information

WELCOME TO 2020

Written by: **DON CLAYBACK, EXECUTIVE DIRECTOR OF NCART**

The Complex Rehab Technology (CRT) world had some very good news in 2019, and we're looking forward to continued progress. Sincere thanks to everyone who participated in some way in CRT advocacy last year. Now let's review some important updates and get 2020 off to a strong start.

ATTEND THE NATIONAL CRT CONFERENCE

If you haven't done so yet, now's the time to get your organization signed up to attend the 2020 Access2CRT Summit being held in Arlington, Virginia, March 30-31. This is the annual CRT conference that focuses on delivering the important CRT message to Congress to secure needed changes to improve access.

Hosted jointly by NCART and NRRTS, this two-day event offers a wide range of benefits for CRT suppliers, manufacturers, consumers, clinicians and others. It includes excellent education, advocacy and networking opportunities. Most importantly, it allows us to meet with hundreds of Members of Congress to ensure that CRT access initiatives get addressed. And new this year, continuing education credit will be available for attendees.

We're thrilled with all the CRT community accomplished in 2019 and are excited to see even more progress in the year ahead. There's no doubt the Congressional visits and follow up from our past conferences played a major role in the successes we've had to date. However, continuing to be present on Capitol Hill is vital to making needed further changes a reality.

The planning committee has put together a great program of excellent speakers, and it promises to be an informative and productive two days. So don't delay, visit www.CRTsummit.com to get all the details and sign up to be part of the team promoting and securing protection for CRT access.

2019 LEGISLATION PROTECTS CRT MANUAL WHEELCHAIRS

As reported, we ended 2019 with success on a major improvement for CRT access. On Dec. 20, the President signed into law HR 1865 that includes significant protections for complex rehab manual wheelchairs and related accessories within the Medicare program. This is a great win resulting from the collective and persistent advocacy from the CRT community.

The bill includes provisions to permanently exempt complex rehab

manual wheelchairs and accessories from inclusion in the Medicare Competitive Bidding Program (CBP). This mirrors the protection obtained for complex rehab power wheelchairs back in 2008. Additionally, there is an 18-month suspension in the current inappropriate application of CBP payment rates to complex rehab power wheelchairs accessories. This suspension is effective Jan. 1, 2020, to June 30, 2021. This time period allows for further discussions to achieve a permanent resolution.

Our sincere thanks to our CRT champions Reps. John Larson, D-Conn., and Lee Zeldin, R-N.Y., and Sens. Bob Casey, D-Pa., and Rob Portman, R-Ohio, for their leadership and hard work. We're also grateful to the Energy and Commerce Committee Chair Frank Pallone, D-N.J., and Ranking Member Greg Walden, R-Ore., Ways and Means Committee Chair Richie Neal Neal, D-Mass., and Ranking Member Kevin Brady, R-Texas, and Senate Finance Committee Chair Chuck Grassley, R-Iowa, and Ranking Member Ron Wyden, D-Ore.

This shows when the CRT community comes together things can get done. Recognition and thanks to the ITEM Coalition, United Spinal Association, NCIL, National Multiple Sclerosis Society, Christopher and Dana Reeve Foundation, Paralyzed Veterans of America, Spina Bifida Association, Clinician Task Force, RESNA, Abilities Expo, APTA, AOTA, and all the other consumer, disability and medical professional organizations who invested their time in educating and advocating. Thanks also to the dedicated consumer advocates, our NCART members, and to our industry partners NRRTS, US Rehab, AA Homecare and the state associations for their significant contributions.

In summary, thanks to everyone who played a part. It wasn't quick, and it wasn't easy, but everyone's outreach and persistence paid off.

SUSPENSION OF CUTS TO CRT MANUAL WHEELCHAIR ACCESSORIES

As a follow up to the passage of HR 1865, on Jan. 15, the Centers for Medicare and Medicaid Services (CMS) released "initial" instructions regarding the 18-month suspension in Medicare's application of CBP payment rates to complex rehab manual wheelchair accessories.

You can find the link to the CMS instructions in the blog posting at www.ncart.us, but here are the highlights:

- CMS identifies the manual wheelchair bases impacted: "complex rehab manual wheelchairs" (defined as HCPCS codes E1161 and K0005) and "certain manual wheelchairs" (defined as HCPCS codes E1235, E1236, E1237, E1238, and K0008).

- The new rates are effective Jan. 1, but "it is unlikely that changes to the Medicare claims processing system can be implemented sooner than July 1, 2020, and possibly later."

CONTINUED ON PAGE 28

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WELCOME TO 2020
(CONTINUED FROM PAGE 27)

- For now, providers should continue to bill accessories as they have been doing and claims will continue to be paid at the CBP adjusted rates.

- Once the claims processing systems are updated, "payment at the full fee schedule amounts for claims submitted for these items with dates of service on or after Jan. 1, 2020, will be available retroactively."

- CMS indicated additional information, including a list of HCPCS codes for accessories affected, as well as further instructions regarding the submission and processing of claims, will be provided in the coming months.

We've been in contact with CMS and a joint workgroup of CRT stakeholders will be developing questions and suggestions. Our comments will include finalizing the system changes ASAP, adding the pediatric size tilt-in-space wheelchair codes and streamlining the process of securing retroactive payments. We'll be sharing updates as we receive additional details.

2020 CRT FEDERAL PRIORITIES

As mentioned, it's very important to thank your Members of Congress and staff for their support and action at the end of last year. We will be sharing more details on our federal priorities for 2020, but these items are top on the list for continued advocacy:

- Obtain Medicare policy change to permanently stop the application of CBP payment rates to complex rehab manual wheelchair accessories — The Jan. 1 suspension noted above provides temporary relief, but we need a change to the policy just like there was for complex rehab power wheelchair accessories in 2017 to make this permanent.

- Pass the Medicare Separate Benefit Category legislation — This has been a long-time focus of the CRT community in order to provide true recognition of the

specialized nature of CRT and that the people, products and process are much different than standard Durable Medical Equipment. The bill will provide improved coding, coverage, safeguards, and payment.

• Secure Medicare coverage for power wheelchair seat elevation and standing — There have been ongoing discussions and meetings with CMS over the past two years requesting this needed change. A wealth of information has been shared identifying the policy and medical reasons that support this coverage change, and we need CMS to approve the request.

NCART NEEDS SUPPORT

NCART is exclusively focused on CRT advocacy at the federal and state levels. We bring together dedicated providers, manufacturers, consumers, clinicians and others to protect access and have a proven record of leading and collaborating to deliver the CRT message and secure needed policy changes. But more NCART members are needed to keep up the good fight.

While we made good progress in 2019, there is still much work ahead. If your organization provides or manufactures CRT, are you a member of NCART? If so, thanks very much for your support. If not, please join to enable us to continue our important advocacy. For more information visit the membership area of our website at www.ncart.us or email me to set up a conversation.

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Don Clayback is executive director of NCART. NCART is national organization of Complex Rehab Technology (CRT) providers and manufacturers focused on ensuring individuals with disabilities have appropriate access to these products and services. In this role, he has responsibility for monitoring, analyzing, reporting and influencing legislative and regulatory activities. Clayback has more than 30 years of experience in the CRT and Home Medical Equipment industries as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences.

YEAR IN REVIEW FOR CTF

THE CLINICIAN TASK FORCE REORGANIZES AND DEMONSTRATES AN ACTIVE YEAR OF ADVOCACY AND RESPONSIVENESS

Written by: **AMBER L. WARD, MS, OTR/L, BCPR, ATP/SMS, FAOTA**

The CTF had an amazing year of growth and change, and we would like to share some of that with you.

BY THE NUMBERS: Membership has grown from 41 to 77, comprised of 42 physical therapists, 15 occupational therapists, and 15 of these are from the Complex Rehab Technology (CRT) industry (meaning they are employed by a manufacturer or supplier). We actively engaged many of these members and were able to fund work tasks due to generous donors to the organization.

LEADERSHIP: We added Lorri Bernhardt, PT, to the executive board, as Cathy Carver transitioned to the executive director position, a two-year appointment. Penny Powers rotated off the board March and Mike Babinec began his term. This year, we celebrate a long history of active membership and leadership by Jill Monger, PT, as she rotates off in December, and the membership selected Erin Michael, PT, to fill that position. We are thankful for the wonderful support of our administrator, Margaret Kennedy, who joined our team in December 2018. We have updated our website, upgraded our communications, data management, record keeping and logo, as well as enlarged our social media presence.

STATEMENTS FROM NEWEST MEMBERS: "I am honored to have joined the Clinician Task Force. I know my voice will be heard at the national level, and I can team with other clinicians that are focused on improving outcomes, advocacy and helping people get the equipment they truly need. I have wanted to help change policies for many years, and I see this as a possibility with this group!" Nicole Laberge, PT, ATP, Minneapolis, Minnesota.

JILL HAS A UNIQUE COMBINATION OF BUSINESS ACUMEN PLUS KNOWLEDGE AND SKILLS RELATED TO IDENTIFYING AND MEETING THE MEDICAL AND FUNCTIONAL GOALS OF PEOPLE WITH DISABILITIES.

JILL MONGER: "It is my privilege to recognize and honor Jill Monger PT, MS, ATP, for 15 years of volunteer leadership and service with the CTF. A founding member of the CTF dating back to our organizational meeting in May 2004, Jill has served continuously on the executive board since its inception, donating countless hours and passionate effort. A worker, not a lurker, Jill's clinical expertise and depth of understanding where policy and CRT practice interfaces with the consumer has informed CTF strategy and activities. I am grateful to have had the opportunity to serve with my colleague and friend!" Laura Cohen Ph.D., PT, ATP/SMS

"Jill has brought invaluable knowledge, compassion and commitment to efforts to improve access to CRT. Jill doesn't merely seek ways of obtaining products for her clients, she takes bold steps to create solutions that ensure clinicians have the skills to evaluate clients requiring wheeled mobility and seating, ensure therapy services are adequately covered and reimbursed, and to improve supplier's ability to provide a full range of products and all the related services. Jill has a unique combination of business acumen plus knowledge and skills related to identifying and meeting the medical and functional goals of people with disabilities. While she has worked tirelessly and deserves recognition and gratitude for her efforts on behalf of the CTF, I have no doubt she will continue fighting for the rights of people with disabilities and the stakeholders involved in improving access to CRT. If this makes Jill sound a bit like "Wonder Woman," well … she is, and I am grateful for her passion, dedication and friendship!" Rita Stanley, vice president of government relations for Sunrise Medical.

ACTION FROM 2019 AND PLANS FOR 2020: The updated CTF mission: to provide clinical based expertise to inform and promote public policy, best practices and positive outcomes regarding people with disabilities who require Complex Rehab Technology (CRT) products and related services.

FOUR AREAS OF FOCUS:

1. FEDERAL: This group assisted with the passing of the recent CRT bill related to manual wheelchair accessories. In 2019, CTF members identified clinicians in Oregon and California for visits to Members of Congress on key committees. A consumer-focused video was made for therapists, suppliers and others to show new consumers to advocacy their involvement is critical. Two more

videos are in process; one focuses on educating physical and occupational therapy students on getting involved in advocacy early in their careers; the second one has the supplier in mind to provide a tool to use in the field with consumers.

We partnered with the ITEM Coalition in signing letters to the Centers for Medicare and Medicaid Services (CMS) that affected access, and we sent a member to a meeting with CMS to provide clinical expertise and evidence-based articles supporting standing and seat elevation.

CTF members were invited to be and serve on the Access2CRT Summit Planning Committee giving input on programming, providing CEUs and marketing to engage more clinicians and consumers.

We sent a member to United Spinal Association's annual "Roll On Capitol Hill" to continue to provide clinician support and voice on The Hill for bills that affect our consumers using CRT.

CMS issued the DMEPOS Proposed Rule this year, and Laura Cohen and Mike Babinec wrote an excellent response letter written and helped APTA write a response as well.

2. MEDICARE: This work group has been busy this year and has big plans for 2020. In 2019, the CTF with RESNA updated the RESNA Position on the Application of Seat-Elevation Devices for Power Wheelchair Users Literature Update (2019). Jill Monger represented our organization last fall at the PDAC meeting to give the clinical voice on why people with certain disabilities need CRT. This group is beginning work on a thorough and robust paper for standing and plan to have a comprehensive paper published in the next 12 to 18 months. We will then partner with RESNA to update its Position Paper on Standing Wheelchairs.

CONTINUED ON PAGE 32

YEAR IN REVIEW FOR CTF
(CONTINUED FROM PAGE 31)

3. MEDICAID: We have a work group that serves to work on state issues related to Medicaid. Issues have arisen in several states on the use of outside consultant therapists hired by a company who is directly contracted with a state managed care organization (MCO). This has affected access to appropriate CRT and resulted in a loss of mobility, function and independence for many who need CRT. We are actively working in California, Michigan, Pennsylvania and several other states as we collect case examples the impact this process has on the provision of equipment.

4. EDUCATION: This group has an education focus in two areas: one is the novice clinician to the seating and wheeled mobility practice; the other group is focused on quality student education for physical and occupation therapists. Currently, the novice clinician group is evaluating CRT education currently available and plans to offer a listing in 2020 with impartial recommendations on focus topics for each.

The Clinician Task Force is a group of "Hall of Famers" with many gifts and talents. Members have written articles for DIRECTIONS magazine and provided very informative webinars for NRRTS and other groups. Others have given expertise in support of the Unite4CRT movement and/or will attend the Abilities Expos in 2020 to continue to engage consumers and therapists in advocacy.

WHAT OTHERS ARE SAYING ABOUT THE CTF:

"Last year (2019) was another active year for CRT access and it was very encouraging to see the growth and increased involvement of the CTF. The CTF is ideally suited to bring CRT experienced therapists together to ensure the important clinical voice is heard regarding CRT policies, safeguards and access. Glad to have them engaged as we enter 2020." — Don Clayback, executive director, NCART.

"The CTF has made great strides in several areas. The number of participating clinicians has grown significantly. This offers an opportunity for CTF members to work in more local areas on CRT Issues. The CTF has produced many informative videos that explain what the CRT issues are and how they affect the consumer. This effort will raise awareness and bring more advocacy action. The CTF has supported,

"LAST YEAR (2019) WAS ANOTHER ACTIVE YEAR FOR CRT ACCESS AND IT WAS VERY ENCOURAGING TO SEE THE GROWTH AND INCREASED INVOLVEMENT OF THE CTF. THE CTF IS IDEALLY SUITED TO BRING CRT EXPERIENCED THERAPISTS TOGETHER TO ENSURE THE IMPORTANT CLINICAL VOICE IS HEARD REGARDING CRT POLICIES, SAFEGUARDS, AND ACCESS. GLAD TO HAVE THEM ENGAGED AS WE ENTER 2020."

promoted and participated in the Unite4CRT townhall meetings. The CTF also supports NRRTS by presenting numerous webinars and writing CEU articles for DIRECTIONS. This collaboration shows that together we can make a difference." - Weesie Walker, executive director, NRRTS.

"At RESNA we are so pleased to see the new energy and enthusiasm that is so noticeable at the CTF. The leaders of our two organizations are now meeting monthly. We are collaborating on some initiatives related to progress with position papers and other efforts to influence

public policy. It is great to see the remarkable growth in CTF membership and the development of committees to focus member's energies. We look forward to continued partnership in 2020 and invite you help us celebrate RESNA's 40th anniversary." - Mary Ellen Buning, director, RESNA

FINALLY: What an honor and privilege it is for each of us to serve on the CTF. Just know that no matter where you turn, we will be your clinical voice, offering integrity and expertise. See you in 2020!

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Amber Ward has been a treating occupational therapist for 25+ years; 10 years in inpatient rehabilitation and 15-plus years as full time occupational therapy coordinator with persons with amyotrophic lateral sclerosis (ALS) and muscular dystrophies. She has treated a wide variety of patients of all ages and functional levels. She currently is an adjunct professor at the for the occupational therapy assistant and Master of Occupational Therapy programs at Cabarrus College of Health Sciences in addition to working in the clinic. She received the RESNA Assistive Technology Professional certification in 2004, the Seating and Wheeled Mobility certification in 2014, and became AOTA board certified in physical rehabilitation in 2010. She manages the seating clinic at the Neurosciences Institute Neurology in Charlotte, North Carolina. Ward is involved with multiple research projects and is the author of two peer-reviewed journal articles about power wheelchairs with persons with ALS.

Aging with a Disability

RESEARCH TO CLINIC

Written by: **SUSAN JOHNSON TAYLOR, OTR/L, ISWP CERTIFIED**

NRRTS THANKS NUMOTION FOR SPONSORING THIS ARTICLE.

CEU ARTICLE REVIEW

CLINICAL PERSPECTIVE - CEU ARTICLE

INTRODUCTION

We use research information to assist in informing our clinical practices. We must extrapolate facts and information from studies that are relevant to evaluation for, and intervention with, seating and wheeled mobility. Information can be a double-edged sword. A marquee in Colorado Springs reads, "We are drowning in information but starving for wisdom." Upon further investigation, the quote was found to be by Edward Osborn Wilson and is completed with, "The world henceforth will be run by synthesizers, people able to put together the right information at the right time, think critically about it, and make important choices wisely" (Brainyquote.com). This is a two-pronged issue — information and wisdom, and the balance of the two. The wisdom comes from our cumulative experiences with our clients that we can integrate into our practices. The information comes from research and other literature. One cannot be employed without the other. The stories of our clients, combined with our professional responsibility to stay current in our fields, allow us to guide our clients toward choices that are wise for them. Then, like the title of Dr. Seuss's book, "Oh,The PlacesYou'll Go!" If you work in the field of complex rehab technology (CRT), you need to be aware of the affects that aging can have on those with disabilities. This is true whether you are a professional who primarily works with adults or children. Hopefully, information that is learned from those who are aging can help inform therapy practices in children.

The information around aging with a disability applies to both those who acquired a disability or who were born with disabilities. Signs of aging can show up quite early relative to those who do not have a disability. For example, if someone acquired a spinal cord injury at age 16 years, they may be only 36 years old 20 years post injury but could have difficulties more common in people who are chronologically older. For persons who have had a disability since birth, their age equals the time "post-injury." It amounts to the same thing: living a certain amount of time with a physical disability can change the way one functions and is able to participate (Taylor, 2017).

REHABILITATION AND ITS RELATIONSHIP TO DISABILITY OVER TIME

Life expectancy increased from about 47 to 77 years of age between 1900 and 2000. As recently as 1945, the life expectancy of an able-bodied person was 55 years, while life expectancy was only two years following a spinal cord injury. Nowadays, the life expectancy of most individuals with acquired disabilities is 85% of those without physical disability. It is estimated that about 12 million people in the United States are disabled (Kemp and Mosqueda, 2004).

Until about 1945 (WWII), no organized rehabilitation existed. During the 1940's, rehabilitation was "born" as a profession

to re-integrate those who had sustained injuries in the war back into society. During that era, the prevalent attitude was that one could overcome anything if one tried hard enough. Society was not set up for those with disabilities, so people were encouraged to "fit in" and be productive in society (Kemp and Mosqueda, 2004).

The 1960s and early 1970s saw the rise of the disability rights movement, which paralleled other human rights movements of the same era. These movements drove the idea that access to society literally become accessible. The passage of the Americans with Disabilities Act (ADA) in 1991 was a first step in this process. At the same time, due to improvements in emergency care, more people were surviving serious accidents and incidents. Into the 1970s and early 1980s, large numbers of people with disabilities were living into middle and older ages, and it became clear that signs of early aging were evident and could not be ignored. Many clients did not anticipate these changes, and many clients were, and continue to be, caught off guard by the changes that they experienced. The first large group to experience these functional changes were those who had been living with the effects of polio. These clients were taught that hard work would overcome all and that one must rely on oneself. Their lives had revolved around exerting huge efforts on a daily basis, as if one had to run a marathon every day. The attitude was "Use or Lose it" (Taylor, 2017).

Beginning in the 1980s-'90s, studies of the physical, psychological and sociological aspects of aging with a disability revealed some troubling trends. From the late 1990s through the present, enough relevant information has become available to incorporate into everyday clinical practice.

What is the scope of the issues? Begin with the perceptions of those who are living with a disability. A recent study by Molton and Yorkston (2017) gathered 49 adults between the ages of 45 and 80. Diagnoses included muscular dystrophy, multiple sclerosis, post-polio syndrome and spinal cord injury. They conducted a focus group with the theme of what successful aging looked like to them. The researchers came up with four areas:

1. Resilience and adaptability: The interviewees defined this as having a positive outlook and being able to adapt to changes.

2. Autonomy and choice: Maintaining control over life decisions such as what kinds of adaptive equipment to use.

3. Social connectedness: Strong relationships and being able to share experiences with peers.

4. Physical health and access to health care: Being able to maintain physical wellness to continue to participate in desired activities. Not only having access but also having health care professionals who understand their disability.

CONTINUED ON PAGE 36

(CONTINUED FROM PAGE 35)

Similar findings were revealed in a longitudinal study of individuals with spinal cord injuries that was carried out by James Krause. (Krause, et al., 2015).

THE AGING PROCESS

Theory in the field of aging delineates several different types of aging (Rowe and Kahn, 1998):

- Successful: These are people who have what we would call "good genes." Little change in function is noted until the early to mid-70s, with no chronic disease to limit function.
- Usual: This type is defined as positive or neutral genes that are revealed in a neutral or slightly negative environment. Although there may be some disease, this does not impair the individual's ability to function.
- Pathologic: These people are at serious risk of major functional limitations with severely limited independence.

It is not well understood how each person's genetics/lifestyle choices/experiences and the presence of a disability intersect (Rowe and Kahn, 1998). It was once thought that after rehab, the client would go out into the working environment with few changes: it is now known that functioning over time is quite a dynamic process.

A MEANS TO UNDERSTAND

The International Classification of Functioning (WHO, 2002) provides an internationally accepted common language and standard for describing function and disability (see Figure 1). Of course, this is how we conduct a seating and mobility evaluation. We examine impairments to body structures and functions and how these affect the client's ability to complete activities that allow them to participate. We ask and observe about environmental issues as well as factors that are unique to that client. The end result for the clinical team is to collaborate with the client on equipment and strategies that ultimately allow them to participate. First, common impairments that lead to secondary conditions will be overviewed.

SECONDARY CONDITIONS THAT EFFECT SEATING AND MOBILITY CHOICES

Secondary conditions form the basis of what needs to be understood and screened at a seating and mobility appointment. It is imperative that wheelchair seating and mobility professionals understand an individual client's diagnoses and impairments and the effects that aging can have on activity and participation. Many of the studies that will be presented, and similar studies, are directly related to factors that should be screened during a seating and mobility evaluation. Much of the studies are centered on people with spinal cord injury, with a more recent increase in studies on people with cerebral palsy.

FIGURE 1 The International Classification of Functioning

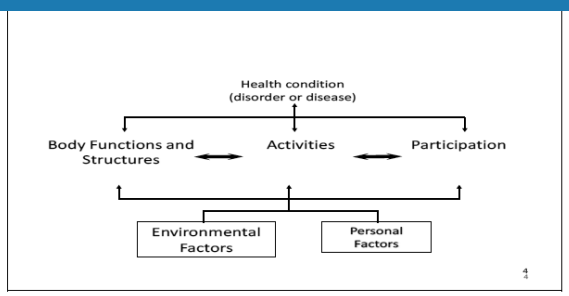

Figure 1: Interactions between the components of ICF (WHO 2001:18)

Sometimes clients just need new equipment and sometimes they are having an issue that effects their positioning and/or mobility with the current equipment. Clients often seek seating professionals for four areas of concern:

- Pain
- Fatigue
- New weakness
- New or recurring pressure injuries

Often, these symptoms have reached a point where the client can no longer ignore them. It has been noted by clients to seating professionals that pain, fatigue and weakness can be insidious; changing function here and there over time until the client has cut their life down to the "necessities" (Taylor, 2017), often giving up social aspects of life in order to maintain activities of daily living and other functional skills. Social aspects of one's life are hardly disposable. Many clients have related to this therapist that they didn't even realize how much they had given up until someone questioned them about it. Remember that social connectedness has been identified in many studies as one of the most important quality of life contributors.

PAIN

Musculoskeletal changes are the most obvious external signs of aging and are particularly affected by aging with a disability. A University of Washington study looked at 1,877 individuals with longstanding disabilities including Spinal cord injury, neuromuscular disease, post-polio syndrome and multiple sclerosis for prevalence and impact of pain. The researchers found that of several secondary conditions including pain, spasticity, fatigue, weakness and imbalance, the most common was pain - 25% to 33% of individuals rated their pain as severe. These symptoms can have a profound effect on quality of life and the ability to participate (Molton, et al., 2014). The researchers found that the degree to which these secondary conditions

interfere with activities varies widely and is based on the person's life context and environmental demands (Molton, et al., 2014).

As one can appreciate, the incidence of pain in those aging with cerebral palsy may be significant after years of functioning with joints that are mal-aligned or not well formed and/or in postures and using movements that lead to these orthopedic issues. The odds are higher in those who display more physical impairments (Whitney, et al., 2018). Soft tissue limitations leading to joint deformity over time can also increase pain and discomfort.

In older studies, Andersson and Mattson found that 79% of individuals with varied types of cerebral palsy had pain that was primarily in the hips, back and shoulders (Anderson, et al., 2001). Vogtle states that 67% of clients with cerebral palsy had one or more pain sites and identified back, hip and lower extremities as the biggest pain sources (Vogtle, 2009). Haak, et al. state that while there is not a huge amount of objective information on adults aging with cerebral palsy, anecdotal reports do indicate that many clients feel the effects of aging in their 20s, with decreasing function, increased spasticity and, if walking, decreased balance (Haak, et al., 2009).

In the study by Whitney, et al. (2018), the researchers introduce that over the past few decades, the "global disease burden" has shifted from premature death to many years lived with a disability, and from the prevalence of communicable diseases to non-communicable diseases. For this study, they included two broad areas: musculoskeletal morbidity (osteopenia, osteoporosis, osteoarthritis and rheumatoid arthritis) and cardiometabolic morbidity (stroke, hypertension and cardiovascular problems that can include peripheral artery disease and heart failure). They looked at prevalence of non-communicable diseases in a sample of 452 people with cerebral palsy and 448 people without without the diagnosis, ages 18 to 30 years. The researchers found higher rates of these musculoskeletal and cardiometabolic issues in people with disabilities: 51% of participants had non-communicable diseases who scored at levels I-III on the Gross Motor Function Classification System, and 49% scored at levels IV and V. These musculoskeletal and cardiovascular conditions have the ability to greatly impact physical function. Whitney et al. also stated that by age 40 to 60 years, 60% of adults with cerebral palsy have multiple secondary conditions — this is 1.5 to 2.9 times higher than the general population.

The American Academy of CP and Developmental Medicine (www.AACPDM.org) has a Lifespan Committee on Adult Care and Aging. There has been a pointed effort on their part to identify issues in those aging with cerebral palsy as well as directing research efforts and topics to better understand changes that can occur over the lifespan. As stated previously, this knowledge needs to inform practices with children as necessary.

In spinal cord injury, there is an increase in upper extremity pain, decreased strength due to atrophy, and an increased risk for fractures (Hitzig, et al., 2010). The most frequently reported pain in this population occurs at the shoulder and wrist. The longer someone has been injured, the more common this becomes as increased physical demands and overuse of certain muscle groups intersect. This varies according to the individual: some people naturally have better joint integrity than others. Incidence of upper extremity pain in people with spinal cord injuries is between 30 and 70 percent (Sie, 1992, 2001; Pentland, 1994; Klingbeil, 2004).

In 1992, Sie looked at 239 people with spinal cord injuries who were an average of 12 years post injury: 55% of those with tetraplegia had upper extremity pain and 65% had shoulder pain: 64% of those with paraplegia had upper extremity pain, mostly shoulder and carpal tunnel pain (Sie, 1992). The Pentland study in 1994 demonstrated similar results. She found that 58% to 60% of males with paraplegia had shoulder pain that was related to time since injury, rather than age (Pentland, 1994). It should be noted that the same types of overuse syndromes of the upper extremities have been identified in clients with spina bifida (Klingbeil, et al., 2004).

One has to keep in mind that an increase in pain and contractures, especially in the shoulder, can lead to a dramatic decrease in function. Even a small decrease in range of motion can impact activities of daily living, such as pulling a shirt over one's head or propelling a wheelchair (Taylor, 2017).

Traumatic brain injury (TBI) survivors also have an increased prevalence of arthritis, as studied by Colantonio, et al. The authors speculated that the mechanism of injury, which included motor vehicle crashes, can lead to multiple injuries as well as prevalence of heterotopic ossification, both of which can lead to arthritic changes. Of 286 clients with moderate to severe traumatic brain injury, 30% identified arthritis as a major problem, as compared to 15% of the general United States population (Colantonio, et al., 2004).

FATIGUE

As interfering as pain can be, fatigue can also greatly impact one's ability to perform activities that allow participation. Fatigue in the general population is reported at 15% to 20%. Fatigue that interferes with the performance of activities of daily living is three times higher in populations with disabilities versus those who have no disabilities. There are several types of fatigue: central, peripheral and mental.

CONTINUED ON PAGE 38

(CONTINUED FROM PAGE 37)

- Central: characterized by exhaustion and a lack of energy.
- Peripheral: characterized by actual muscle weakness.
- Mental: an inability to focus on a task or stay alert.

Fatigue is insidious: clients report giving up a little here and a little there until their activities consist of the basics necessary to function day to day. As previously stated, clients report they give up "extras," like social activities to have the energy needed to, for example, transfer and dress.

Cook, et al. looked at 1,836 people in Washington State using the Patient Reported Outcome Measurement Information System. They found that not only did individuals with a disability have a greater risk for fatigue, but this risk increased with age (Cook, et al., 2011).

Another University of Washington study looked at 1,877 individuals with longstanding disabilities including Spinal cord injuries, neuromuscular disease, post-polio syndrome and multiple sclerosis for prevalence and impact of pain. (Molton, et al., 2014). Rates of pain and pain interference were compared to sample of adults without disabilities. Those with disabilities did not experience an age-related decrease in pain and pain impact that those without disabilities experienced after retirement age. Individuals with disabilities reported elevated pain and pain impacts that were significantly higher. They concluded that pain interference with function does not seem to depend on severity for those with the studied disabilities. The researchers discussed that basic tasks, such as moving and toileting continue throughout retirement, whereas those without disabilities were able to decrease activities that caused them pain issues. (Molton,I, et al. ,2014). This can point the clinical team to ask questions regarding not only rating pain but also describing its effects on function and participation.

In a three-year study by Oude Lansink, et al. (2019), researchers found that 41% of adults with bilateral cerebral palsy rated themselves as severely fatigued. The overriding conclusion was that once adults with the disease reported fatigue, it was unlikely to change over time. The researchers state that health care providers need to understand the factors associated with changes in fatigue in order to provide surveillance, prevention and management beginning in younger life

FUNCTIONAL IMPAIRMENT SYNDROME

In 2001, Thompson and Yakura suggested a "functional impairment syndrome" after studying a group of clients that had developed a constellation of symptoms including pain, fatigue and weakness. The Rehabilitation Research and Training Center at Rancho Los Amigos studied over 600 people with varied diagnoses who complained of these symptoms. They concluded that these symptoms occurred as a syndrome and usually predicted and led to major changes in function (Thompson and Yakura, 2001).

SKIN INTEGRITY/ PRESSURE INJURIES

Another area impacted by aging is skin integrity. This area has been studied in people who have spinal cord injuries, but not as much in those with other diagnoses. Clinically, clients often are surprised that they have developed impaired skin integrity after having no pressure problems for many years. As one with a spinal cord injury ages, sweating and fat decrease and the capillary walls grow thinner and are more prone to rupture. This can lead to decreased sitting tolerance and increased need for pressure relief (or development of the habit of shifting weight), as well as the need for protective equipment (Shea, et al., 2013). One can surmise that these findings also affect others with insensate skin, such as those with spina bifida.

Chen, et al., looked at 3,361 people from the spinal cord injury database. The sample included about the same number of those with tetraplegia and with paraplegia. This review showed that the incidence of pressure injuries was steady for about the first 10 years post injury, with an increase in incidence noted at about 15 years post injury. By 20 years post injury, there was a 30% increase
(Chen, et al., 2005).

EVALUATION: HOW CAN THIS INFORMATION AFFECT OUR INTERVENTIONS?

"The Universe is made up of stories, not atoms" (Muriel Rukeyser, 1913-1980). Indeed, client's stories help us to understand their experiences and who they are so that, at the end of the evaluation, we can respectfully make professional suggestions. We need to listen carefully.

The ICF model (International Classification of Functioning, Disability and Health) should be used to perform seating and mobility evaluations. Assessing impairments and impact on activities and participation is done with specific questions and observations. We often hear, "I just want the same thing I have now." While it is tempting to simply duplicate equipment, the purpose of a professional is to assess a situation and provide professional advice. As previously mentioned, some clients have not really thought about the day-to-day of how their function may have changed, or that there are interventions and/or equipment that could mitigate the effects of secondary conditions. In a study by Thompson, et al., 78% of 54 clients with a functional decline had new equipment prescribed after assessment, whereas only 10% of these same clients thought new equipment was needed prior to the assessment (Thompson and Yakura, 2001).

INTERVIEW

The process of evaluating a client aging with a disability is the same as in any other seating and mobility evaluation: interview, hands-on mat evaluation, observation, functional evaluation and use of trial equipment to meet the client's goals. The clinician must LOOK, LISTEN AND FEEL. Listening is paramount. No one knows the client's function like the client and/or caregiver does. The clinician should assist clients in anticipating and identifying changes due to aging with a disability based on common problems that have been identified by research and anecdotal experience of the clinician in working with others (Taylor, 2017). The clinical team needs to "read the room," including not only the client's face and body language but also caregivers, if applicable. The success of an intervention depends upon everyone understanding and accepting the results of the evaluation.

Several primary open-ended questions for the client aging with a disability include "Why are you here?" "Is this a routine visit or is there a special problem?" "Is there an ongoing problem that has reached a critical stage?" Many times, symptoms of secondary conditions have gotten so bad that the client comes into clinic hoping to address these issues. Medical history, including diagnoses and onset of the primary diagnosis, as well as secondary diagnoses is collected. Surgical history, including skin and musculoskeletal procedures, as well as neurological interventions such as a Baclofen pump is reviewed. History of and current pressure injuries are discussed. Another area to explore are falls. There is a higher incidence of falls from both clients who are still fully or partially ambulatory (although impaired) as well as falls during transfers. Molton and Matsuda (2016) suggest that questions about types of falls, when they occur and whether they are associated with injuries are important. This can inform if and when equipment and techniques are safe and functional.

EQUIPMENT HISTORY

Obviously, the clinician and supplier need to determine the age of the equipment. Often, the equipment that the client is using is no longer available, so exact replacement is impossible. Even if it is to be an "exact" replacement, the equipment will feel different to the client (being new versus the wear and tear of older equipment) and this must be discussed. Also, it may be that the client's current funding is more restrictive than the funding previously used. Observe the current equipment and how it is used. For example; does he require back canes at a certain height to "hook" their arms around for balance? Observe the wear patterns of parts, as that can provide information about how the client sits and functions on their chairs and seating. For example, deep wear marks on the fabric of one side of the back support may indicate clients is sitting asymmetrically. The supplier also focuses on measurements of the existing equipment.

LIFESTYLE (CONTEXT) AND ENVIRONMENTAL FACTORS

Just as with any other seating evaluation, strategies the client and caregiver use for activities of daily living are discussed with an emphasis on where and how the chair and seating are used. It is very easy to get in the way of function with equipment when the details of how the client functions are not understood. This includes any of the client's environments, including home and work. If the client/caregiver have their own van or car, it is necessary to trial any equipment with this vehicle.

FUNCTIONAL EVALUATION

The clinician should observe as many transfers as possible; independent, assisted or dependent, to view what methods and what parts of the wheelchair are used and, as mentioned previously, if they are safe.

In these areas, the clinician should probe for details to determine if skill performance has changed over time, such as change in abilities or in performing a task that was once routine. Remember, some of these changes are insidious and happen over a long period of time.

MAT EVALUATION

In addition to the way a mat evaluation is typically performed, it is necessary to elicit client feedback on how hands-on support from the clinician affects the posture and ability to balance from head/neck through the trunk and pelvis. One can learn a lot from just observing how someone sits and moves, with and without support. For example, people become so used to sitting and moving in a certain way that they may not realize that the compensatory movements to which they have grown accustomed can affect pain and level of fatigue. The level of support needed can increase as the client ages, so increasing the support may not have been brought up to the client previously. While introducing hands-on support during the mat evaluation, the clinician must elicit client feedback on how much support is too much and pay close attention to the amount of pressure required to achieve and maintain a posture. This is a good time to ensure that the postural goals of the client ("I just want to sit straight again … ") are realistic in terms of what can be tolerated and what support equipment

CONTINUED ON PAGE 40

(CONTINUED FROM PAGE 39)

can provide. Nonverbal cues from the client, such as a concerned facial expression, can tell the clinician that the level of support applied may be too aggressive.

TRIAL EQUIPMENT

Trial equipment is, of course, necessary in all evaluations. Even if replacement equipment is being recommended, styles and the features of the equipment change over the years. As indicated above, this must be included in the conversation. Any postural intervention must be tried with the client, specifically with the client performing functional skills such as transferring, propelling the wheelchair, accessing controls on a power wheelchair, or accessing vehicle controls. Often, clients don't realize how much effort they have been putting into balancing and functioning until adequate support is provided (Taylor, 2017).

Based on client feedback over the years, it can be a relief to the client to have someone who is aware of the issues around aging with a disability actually listen and understand that changes are very difficult. The clinical team should remember that change is difficult for anyone, particularly someone who totally relies upon the functional environment of a wheelchair and seating. Many clients are also relieved to hear that these are common problems and that solutions are possible. One must encourage the client to trial equipment without judgment. How suggestions are made are just as important as the suggestions themselves. Some clients do not want to "disappoint" the clinical team by disagreeing with a suggestion that is made. The clinical team is there to provide the information and opportunity. Ensure the client that there are tools that can be used to help make final decisions, and that the final decision is theirs alone.

When we as seating professionals are seeing clients who are aging with a disability, we need to be prepared with knowledge of their condition and the anticipated progression and be prepared to trial equipment and ideas over a long period of time.

SUMMARY

In summary, there is now a great deal of available information on aging with a disability. This information should be incorporated into the clinical practice of the seating and mobility clinician. The clinician and the client need to consider the fact that there may be equipment and support surface changes required over time. With this type of

evaluation, everyone is in it for the long haul. It is not that unusual for an evaluation and trial(s) or recommendations to happen over months and even years before the client decides it is time to make a change. The client, however, cannot make that kind of decision without information. A fully educated consumer is one who can make the best decisions for themselves. As health care professionals, we must understand and integrate past into present (Taylor, 2017).

Barry Corbet, a survivor of spinal cord injury (I1968-2004) and editor of New Mobility magazine from 1991 to 2000, made a statement many years ago that can be applied beyond this diagnosis. An edited version is below:

"The SCI survivor must balance quality of life costs over the ability to stay independent. Bodies are abused far more by overuse than disuse. The use it or lose it maxim no longer washes … instead of doing what's possible, do what is feasible."

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Susan Johnson Taylor is an occupational therapist who has been practicing in the field of seating and wheeled mobility for 39 years primarily in the Chicago area at the Rehabilitation Institute of Chicago Wheelchair and Seating Center (now the Shirley Ryan Ability Lab). Johnson Taylor has published and presented nationally and internationally and has consulted on product development for a variety of manufacturers. She is both a member and fellow with RESNA. She is currently a member of the RESNA/ANSI Wheelchair Standards Committee and the Clinician's Task Force. She is a certified member of the International Society of Wheelchair Professionals. Johnson Taylor joined Numotion in 2015 and is the director of training and education.

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THE SKY IS THE LIMIT WHEN YOU WORK TOGETHER AS A TEAM

Written by: **JILLIAN CACOPARDO MPT, ATP/SMS**

Webster describes teamwork as, "work done by several associates with each doing a part but all subordinating personal prominence to the efficiency of the whole". While the desired outcome of optimizing a seating system and mobility device for a client is the same, each individual in the team has their own area of expertise, which makes the concept of teamwork even more important to reach the desired end result. Whether it is the clinician, provider, manufacturer's representative or the caregiver, each person brings something unique to the table that needs to be taken into account when designing the most appropriate system for a client. This had never been truer prior to me meeting Kevin.

Kevin has a smile that lights up the world and a laugh that is contagious. He also has severe functional and cognitive limitations. Kevin was born with spastic quadriplegic cerebral palsy. He arrived at my clinic in a wheelchair that was delivered to him when he was 15 years old. He is now 22. His muscle tone and range of motion limitations are so severe that he is sitting on top his custom molded seating system instead of in it. He needed a new seating system and wheelchair due to frequent and numerous repairs, growth and lack of postural support in the current seat However, it took the team to educate his mom that his posture needed to be addressed in addition to simply getting a new frame.

We knew immediately that Kevin's severe postural asymmetries would require custom seating. Initially, we thought a custom molded seating system would be recommended to capture the severity of the nonreducible asymmetries with the hope of minimizing further collapse. That was before we got Kevin on the mat (see Figure 1). The mat evaluation led to a whole new slew of limitations that were not visible with him seated in the wheelchair and that is when our wheels started turning and questions arose (see figure 2) How will we ever seat Kevin? What kind of system is best? Can he even tolerate upright? Can another Quickie Iris accommodate his hip flexion limitations while minimizing risk of aspiration during eating due to a very open seat to back angle?

The mat assessment revealed left hip flexion limitations beyond 30 degrees, left abduction to neutral, right hip flexion limited to 45 degrees,

FIGURE 1 Kevin in his current wheelchair.

FIGURE 2 Mat examination.

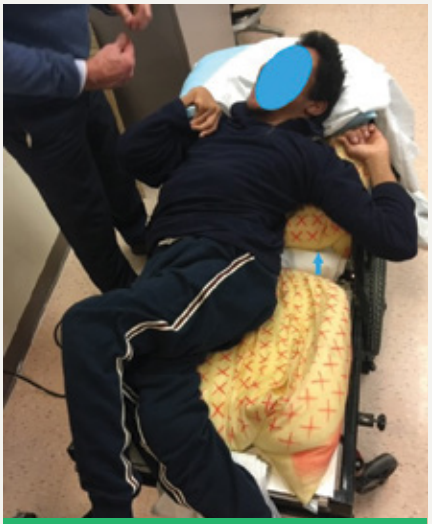

FIGURE 3
Kevin seated in molding system with 6" gap between the seat/back bags.

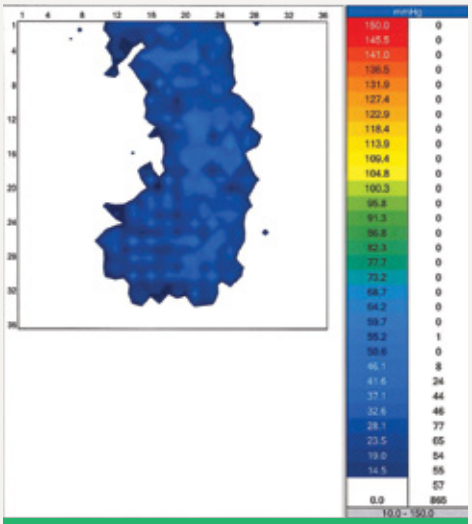

FIGURE 4
Pressure mapping image seated on Roho cushion.

and bilateral severe knee flexion contractures. He sits scissored with a nonreducible rotational kyphoscoliosis, right pelvic obliquity (right high), left anterior pelvic rotation (left forward), and leg length discrepancy (left side longer). He is unable to isolate any muscle movement due to the severity of his tone. Kevin did have a Baclofen pump at one point, however this failed twice, and he developed an infection, so it had to be removed. We decided after this first appointment that a molded seating system would indeed best meet his positioning needs.

Appointment number two was scheduled for a shape capture. What once seemed so obvious, however, was now seeming impossible. The PRM shape capture was unsuccessful. There was a 6-inch gap between the back and seat molding bags at a location that was crucial in providing support and stability for Kevin at the posterior pelvic and lower back (see Figure 3). The DME provider and I looked at each other and wondered what to do.

We went back to the drawing board which fortunately coincided with the 2019 International Seating Symposium. My provider and I strategized and planned our attack in the exhibit hall. We were optimistic that our answer would be there or that at least we would find guidance in our next steps. All our eggs were in the manufacturer's proverbial baskets, hoping that they could shed some light on something we may had missed. Was there another way to seat him outside of a mold? How will we accommodate for his hip range of motion limitations? How will he safely eat without risking aspiration at the required seating angles? And maybe most importantly, how will the world still see his smile and interact with him?

Our first stop was Broda, as Kevin needed a reclined position to accommodate his hip limitations. However, they would not be able to tilt him in a way that would allow him function and socialization. They referred us to PDG Mobility. The Stellar Leap would allow for 30 degrees of anterior tilt. This seemed like the most logical option that would allow for safety with eating and a reclining back. Unfortunately, he would still need posterior tilt-in-space and this would be limited to only 20 degrees.

Our time at the exhibit hall was running out, so we decided to divide and conquer. We hit up Ki Mobility and Invacare and discussed different molded seating options including PRM, PinDot, and Ride Designs. We ultimately met at the Sunrise Medical booth. While all of the product options have their advantages and disadvantages, we looked at Kevin's range of motion and postural specifications and, after discussing our concerns and needs with the Sunrise team, determined we could accomplish what we needed from a functional and safety standpoint using the Quickie Iris.

We were still stumped on the best way to position Kevin. We decided to take a break and enjoy the festivities, allowing food and some sleep to recharge us. That proved a good decision. One of the ISS lectures I attended the following day gave me an idea of how to capture Kevin's back. We knew he needed a mold for his back since there are no prefabricated backs that would come close to matching his contours for pressure distribution and support. I was still unclear what to do with the seat, but thankfully I was not figuring this out on my own - my provider had come up with a solution. We had accomplished what we had wanted from ISS.

Kevin was scheduled for a third time. We borrowed a standard recliner wheelchair and placed a High Profile Roho cushion on the seat and a Ride Designs molding bag on the back. We set the seat-to-back angle to accommodate his hip flexion limitation, adjusted the Roho cushion pressure, and proceeded to mold him. Once we felt we captured his back adequately, we also pressure mapped his seated surface. His bony prominences are problematic as he weighs only 95 pounds, and we wanted to ensure we were not putting him at a higher pressure risk with our new solution (see Figure 4). His pressure map

CONTINUED ON PAGE 44

THE SKY IS THE LIMIT ...
(CONTINUED FROM PAGE 43)

FIGURE 5 Delivery day!

was unconventional in that his support base is narrow, however it was good in terms of pressure distribution and pressure relief.

Fast forward to Nov. 14, 2019, — delivery day. It had now been a while since we had seen Kevin, and I was hoping that our hard work paid off. I was nervous that Kevin's molded seating system would turn out how we hoped it would. Kevin arrived with his mother in typical Kevin spirit and in the nick of time. His mother told us that his current foot box was no longer attached to the foot plates and his posture was really deteriorating within his present seating system. We transferred him into his new wheelchair and seating system and, before he was even adjusted, a significant improvement was observed. The Roho cushion was set using a Smart Check device, ensuring no subjectivity in measuring the air pressure which was imperative due to his narrow support base and bony prominences. Adjustments were then made to the back and a long discussion was held with the DME provider to ensure we captured his lower extremities using the recommended components. Even without his foot box and custom soft knee abductor, his positioning has been significantly improved (see Figure 5). Final delivery will take place in his home by the DME provider based on foot box modifications discussed during delivery and first fitting.

I have been fortunate enough to be part of a seating and mobility team for the past eight years. It gives me the opportunity to problem solve and think outside the box for clients like Kevin to meet their unique needs. This would not have been a successful outcome without the team including, but not limited to, the DME provider, the rehab technician, multiple manufacturer's representatives, his mother, and myself, the physical therapist. Too many point guards will not get you the points down low, which is why so many team members are crucial for a big win. Experience may guide you in one direction, but that may not always be the right road to take. Being open to reaching out to the other team members and the seating and mobility community can make a very challenging situation most pleasant. Having been a team sport player my whole life, never did I think that the need for teamwork would carry over into my professional career. We are all after the same "win" and now take others under our wings. Now onto the next client, because delivery day results have opened the door to a solution for another challenging scenario.

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Rita Stanley

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Faith Saftler Savage, PT, ATP

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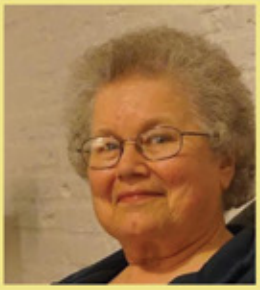

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Weesie Walker, ATP/SMS
NRRTS Executive Director

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Julie Piriano, PT, ATP/SMS

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MEDICARE IS FINALLY MAKING DOCUMENTATION EASIER! (WE THINK)

Written by: **CLAUDIA AMORTEGUI, PRESIDENT, THE ORION CONSULTING GROUP, INC.**

Well 2020 has started with a bang in the world of Medicare documentation. Surprisingly, Medicare is trying to make things easier (we think). Before getting into the details, I must acknowledge that since it takes time from when I write this article to the point you are actually reading it, things may change. Therefore, all the following information is what is known on Jan. 21, 2020. Not wanting to leave anyone hanging or wondering if what you are reading is actually true, NRRTS has agreed to a follow-up via their website/email once further details are provided. For now, let's start with what we know, and then we can review the questions that still remain.

In 2019 the government actually recognized that certain items could be simplified in the world of documentation. It was recognized that there was an inordinate amount of varying orders/prescriptions. There was the Detailed Written Order, the 5-Element Order, the 7-Element Order, the Dispensing Order, the Written Order Prior to Delivery and the Detailed Product Description. The type of order(s) required was dependent on the type of product being prescribed — and these were just in the DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) world. What made less sense was the fact that many of the requirements on these prescriptions were very similar, if not the same.

Effective Jan. 1, 2020, Medicare updated the Standard Documentation Requirements Policy Article. This in turn affects all other policies. The new policy would remove all the different types of orders and the only one that would exist is the Standard Written Order, aka SWO. This is a very, very basic order that must be obtained by the provider prior to filing a Medicare claim and only requires the following items:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order date
- General description of the item – this can either be a general description (i.e., wheelchair or hospital bed), a HCPC code, a HCPC code narrative, or a brand name/model number.
    - o Medicare goes on to state that for equipment — in addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (list each separately).
- Quantity to be dispensed, if applicable (for wheelchair bases – not applicable)
- Treating practitioner name or NPI
- Treating practitioner's signature

For powered mobility devices, there are several extra steps.

First, this SWO must be obtained prior to delivery of the device, therefore it is called a WOPD — written order prior to delivery. The same items are required on the WOPD as listed above, however unlike any other DMEPOS, all the information on this WOPD must be completed by the practitioner writing the order. This is very similar to what we all knew as the 7-element order, but it just does not require as much information. The great news about this is that Medicare no longer requires the face-to-face date to be written on the order. This one element was a headache for many since the date Medicare was looking for never truly made sense.

Second, a face-to-face office visit must be completed by the practitioner. Like before, this visit must be specific for mobility; chart notes must be obtained and kept on file by the provider. Medicare once again allows the practitioner to refer their patient to a clinician (i.e., physical or occupational therapist) with experience and training in seating and mobility evaluations to perform part of this "mobility encounter." When this evaluation is completed, the practitioner does need to review, concur, sign and date the documentation – again, just like before. This time around Medicare is specific that the WOPD must be completed within six months after this "mobility encounter" is completed.

To summarize the WOPD:

- Currently this is only required for powered mobility devices
- Same data required as the SWO
- All data must be completed/written by a treating practitioner (MD, DO, NP, PA or CNS)
- Providers give the practitioner a template with the requirements – but the "answers" are not to be a part of this. Again, very similar to the previous 7-Element Orders.

Powered mobility devices also require:

- A face-to-face mobility exam/encounter with the practitioner. A portion of this encounter may be completed by a clinician experienced and trained in seating and mobility evaluations.
- The WOPD must be completed within six months after the above f ace-to-face encounter.

There is some more good news with these new requirements. The previous "45-day" timeline is now gone. Providers used to be required to obtain a properly completed 7-Element Order within 45-days of the face-to-face date. This was another big headache, which had caused end-users to go back to the physician for s duplicate visit. The updated six-month rule should bode well for everyone.

At this point, many of you are wondering what is all the uncertainty about? The information provided seems rather cut-and-dry. I honestly thought the same, but sadly a wrench keeps getting thrown into what we believe is correct. There are several smaller questions that need to be better clarified, but the biggest issue that I have has to do with the "general description" required on the SWO/WOPD and what that means specifically to Complex Rehab Technology (CRT) orders.

For manual wheelchairs, our question is not a problem since for all orders with the exception of powered mobility devices, providers can complete the entire SWO and the practitioner only has to review and sign. This means the provider can list the base and all options/accessories that will be separately billed.

For power wheelchairs, this is a whole different problem since providers are not allowed to complete the information on the SWO/WOPD. What practitioner do you know will list every billable item for a CRT powered wheelchair order on their own? Remember, we are not to tell them any answers. Some of you may be reviewing the wording above and think, Medicare specifically wrote: "may" include all concurrently billed options — it does not say "must." I thought the same and felt we would all be ok. However, we are being told that if all the options are not listed, a provider would then need to create a second SWO with all the options. The practitioner could then review and sign this second form if appropriate. My immediate reaction was "you might as well have told us to keep the DPD."

As of today, Jan. 21, contradictory information still exists. Some within the contractors are stating we would need the two orders if all options are not on the WOPD written by the practitioner; yet others are stating we do not need this second SWO. Obviously, this is important as it will determine if an additional document is required, meaning more time taken to complete the order and get to the client. This issue also creates another question: if two orders are required, could they be completed/signed by the practitioner at the same time? I wish I could give you the easy answer and say yes, however I am not sure if that would be correct. As soon as everything is clarified, I will update this information through NRRTs.

Even had we known the above answer, I would still raise a flag to all providers. Prior to making any big changes, I would strongly recommend you talk with commercial payers and even your state Medicaid programs. What are they requiring? Will they make the same changes? If so, when will this be effective? Are they even aware of the Medicare changes? If you are unsure, I would then recommend that you obtain the two orders – WOPD for the base and SWO for all items. You will then want to have the conversation with all appropriate funding sources to confirm what they will accept and/or if they are making any changes based on Medicare.

By all means, I do feel Medicare is headed in the right direction, but sadly it does not appear that all was thought out prior to the effective date. I will say that although the contractors are the one's providing the "education," they were also under the gun and dependent on the Centers for Medicare and Medicaid Services. With that said, providers can only go by what they are being told. When you hear/see three different answers to the same question in the span of two days, the level of concern continues to rise.

Stay tunes for more details …

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Claudia Amortegui has a Master of Business Administration and more than 20 years of experience in the DMEPOS industry. Her experience comes from having worked on all sides of the industry, including the DMEPOS Medicare contractor, supplier, manufacturer and consultant. For many of these years Amortegui has focused on the rehab side of the industry. Her work has allowed her to understand the different nuances of complex rehab versus standard DME. This rare combination of industry experiences enables Amortegui and her team at The Orion Group to assist ATPs, referrals, reimbursement staff and funding sources in understanding the reimbursement process as it relates to complex rehab.

IT TAKES A VILLAGE

Written by: **WEESIE WALKER, ATP/SMS, EXECUTIVE DIRECTOR OF NRRTS**

For anyone involved in Complex Rehab Technology (CRT), it is a known fact that providing CRT is not a solo event. For the best outcomes, many people are involved in the process. The CRT consumer is at the center of a team that involves clinicians, physicians, suppliers, providers, case managers, manufacturers, billers and technicians. It takes a village.

And, for NRRTS, as an organization, it also takes a village. About 20 years ago, NRRTS started a program called "Friends of NRRTS." The goal was to offer participation in our organization to groups and individuals who otherwise did not meet the criteria for Registry. The program evolved over the years into four different categories.

First, the Charter Corporate Friends of NRRTS (CCFON) are the original supporters who saw the importance of a professional organization for CRT Suppliers. They supported the mission then and continue to this day.

CHARTER CFONS

Over the years, NRRTS has been supported by additional organizations that provide CRT products and education to further the profession.

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For individuals working in the CRT field, another category was created for Individual Friends of NRRTS (IFON). This category includes clinicians, reps and others that would not qualify as a Registrant. IFONs receive a 50% discount on all NRRTS education.

The fourth category of "Friends" include Association Friend of NRRTS (AFON). Any nonprofit organization who shares our mission can join NRRTS.

Truly, the NRRTS mission is shared by many people in many different roles. NRRTS is supported by the "CRT Village."

NRRTS thanks all our supporters!

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https://nrrts.org/our-partners/

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Weesie Walker, ATP/SMS, is the executive director of NRRTS. She has more than 25 years of experience as a Complex Rehab Technology supplier. She has served on the NRRTS and GAMES board of directors and the Professional Standards Board of RESNA. Throughout her career, Walker has worked to advocate for professional suppliers and the consumers they serve. She has presented at the Canadian Seating Symposium, RESNA Conference, AOTA Conference, Medtrade, ISS and the NSM Symposium. Walker is a NRRTS Fellow.

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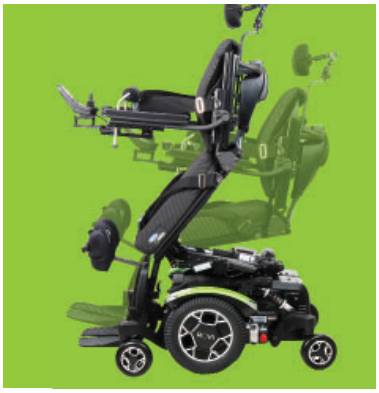

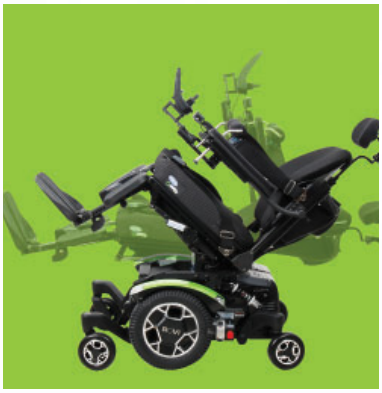

Prior to evaluation and use, all consumers must consult with a qualified Physician and receive medical clearance and approval to use an assisted standing device. An experienced Occupational Therapist or Physical Therapist should be present during the evaluation and prescription process

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NEW NRRTS REGISTRANTS

Congratulations to the newest NRRTS Registrants. NAMES INCLUDED ARE FROM NOV 11, 2019 THROUGH JAN 15, 2020.

Shaun Davis, ATP, RRTS®
Reliable Medical Supply
9401 Winnetka Ave N
Brooklyn Park, MN 55445-1618
Telephone: 612-214-5354
Registration Date: 11/26/2019

Nick Dyer, ATP, RRTS®
MRS Homecare
3744 Woodruff Rd
Columbus, GA 31904-5601
Telephone: 706-596-8855
Registration Date: 12/11/2019

Eric Gray, ATP, RRTS®
Numotion
4301 Founders Way Ste A
Chattanooga, TN 37416-3680
Telephone: 423-468-4872
Registration Date: 12/20/2019

Bradley S. Hannan, ATP/SMS, CRTS®
Numotion
6350 Regency Pkwy, Ste 540
Norcross, GA 30071
Telephone: 678-392-4202
Registration Date: 1/11/2020

Christopher Jay Pickelman, RRTS®
National Seating & Mobility, Inc.
G1101 N Ballenger Hwy Ste B
Flint, MI 48504-4433
Telephone: 810-250-4110
Fax: 810-275-1840
Registration Date: 11/14/2019

Noel Riley, ATP, CRTS®
National Seating & Mobility, Inc.
101 Fairchild Ave
Plainview, NY 11803-1725
Telephone: 516-833-1797
Fax: 516-576-0011
Registration Date: 12/19/2019

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not.
NAMES INCLUDED ARE FROM NOV 11 THROUGH JAN 15, 2020.

FOR AN UP-TO-DATE VERIFICATION ON REGISTRANTS, VISIT WWW.NRRTS.ORG, UPDATED DAILY.

David Becker, ATP/SMS Torrance, CA
Dominique Bowdoin Fayetteville, GA
Thomas Enfinger, ATP Augusta, GA
Wil Garay Alexandria, VA
Matthew S. Howard, ATP Dothan, AL
Michael Nwosu Fayetteville, GA
Greg Otwell, ATP Pelham, AL

CRTS®

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. NAMES INCLUDED ARE FROM NOV 11 THROUGH JAN 15, 2020.

Bradley S. Hannan, ATP/SMS, CRTS®
Numotion
Norcross, GA

Kevin Jackson, ATP, CRTS®
Numotion
Tifton, GA

David Lobato, ATP, CRTS®
Rocky Mountain Medical Equipment
Lakewood, CO

Noel Riley, ATP, CRTS®
National Seating & Mobility, Inc.
Plainview, NY

RENEWED NRRTS REGISTRANTS

The following individuals renewed their registry with NRRTS between Nov 11, 2019, through Jan 15, 2020.

PLEASE NOTE **IF YOU RENEWED AFTER JAN 16,** YOUR NAME WILL APPEAR IN A FUTURE ISSUE OF DIRECTIONS.
IF YOU RENEWED PRIOR TO NOV 11, YOUR NAME IS IN A PREVIOUS ISSUE OF DIRECTIONS.

FOR AN UP-TO-DATE VERIFICATION ON REGISTRANTS, PLEASE VISIT WWW.NRRTS.ORG UPDATED DAILY.

Mala Aaronson, OTR/L, ATP, CRTS®
Cyglenda Abbott, ATP, CRTS®
Lydia Aceves, ATP, CRTS®
Alisa K Adams, ATP, CRTS®
Tracey Ashley, RRTS®
Jeff Auter, ATP, CRTS®
Michael Barner, ATP, CRTS®
William Bryan Beck, ATP, CRTS®
James Chad Bennett, ATP, CRTS®
John Boswell, RRTS®
Roger J. Boylan, ATP, CRTS®
Stephen W. Brewton, ATP, CRTS®
Kenneth Bridge, ATP/SMS, CRTS®
Carey Britton, ATP/SMS, CRTS®
Benjamin Douglas Burton, ATP, CRTS®
David Butcher, ATP, CRTS®
David Charette, RRTS®
Matthew Edward Convery, ATP, CRTS®
Alicia Correa, RN, BSN, ATP, CRTS®
Colin Coyle, RRTS®
Tony Cresta, ATP, CRTS®
Mike L. Daniels, ATP, CRTS®
Anna Davis, MPA, ATP, RRTS®
Gerald Dickerson, ATP, CRTS®
Seth Downie, ATP, CRTS®
Doug Driscoll, ATP, CRTS®
Jason Duewel, PTA, ATP, CRTS®
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Marvelena Green, RRTS®
Robbi Haase, ATP, CRTS®
Rullie Hallman, ATP, CRTS®
Kevin Hams, ATP, CRTS®
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Tommy Wade Holley, ATP, CRTS®
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Rafael Ibarra, ATP, CRTS®
Vann Johnson, ATP, CRTS®
Robert Jones, ATP, CRTS®
Troy Lapp, ATP, CRTS®
Wayne L. Leavitt, RRTS®
Jason Lehman, RRTS®
Roger G. Lichty, ATP, CRTS®
David Lobato, ATP, CRTS®
Josh Lyon, RRTS®
Jerry L. Maples, Jr., ATP, CRTS®
Brian Matthews, ATP, CRTS®
Edward J. Maubach, Jr., ATP, CRTS®
Donald V. Maulucci, ATP, CRTS®
Joel C. Maxey, ATP, CRTS®
Christopher L. Mayo, ATP, CRTS®
Allen McNiece, ATP, CRTS®
Cynthia D. Miller-Orahood, ATP, CRTS®
Darven Miller, RRTS®
Lester Miller, ATP, CRTS®
Russell L. Montoya, ATP, CRTS®
Luke Moore, ATP/SMS, CRTS®
Cody Murphy, ATP/SMS, CRTS®
David Nix, ATP, CRTS®
Jay L. Nussbaum, ATP, CRTS®
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Patrick J. Pearson, ATP, CRTS®
Daniel Phillips, ATP, CRTS®
Jason Raymond, RRTS®
Rafael Rivas, RRTS®
Brenda L. Roehl, ATP, CRTS®
Jeffrey W. Shinn, ATP, CRTS®
Angela Smith, ATP, CRTS®
Wayne C. Smith, ATP, CRTS®
Elaine M. Stewart, ATP, CRTS®
Jason Tate, ATP, CRTS®
Courtney A. Thompson, ATP, CRTS®
Jimmy Thompson, Jr., ATP, CRTS®
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