DIRECTIONS

THE JOURNAL OF COMPLEX REHAB TECHNOLOGY

ISSUE 1 OF 2026 | $10.00 USD

Foundations of Excellence

BUILDING BLOCKS FOR SUPERIOR CARE AND BUSINESS PRACTICE

REHAB CASE STUDY

It Takes a Team to Win in Assistive Technology

I remember my early days as an Occupational Therapist in home health...

William Danner
MOT, ATO, COST

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CLINICAL PERSPECTIVE - CEU ARTICLE

Rethinking Ethics: Applying Profession Principles

AOTA Ethics	APTA Ethics	RESNA Ethics	iNRRTS Ethics
Beneficence — Taking action to benefit others, prevent harm, protecting	Accountable for making sound professional judgments.	Hold paramount the welfare of persons served professionally.	Do everything necessary to provide high-quality equipment, ongoing support and long-term service. Strive to recognize when the physiological, functional or technical needs of the consumer are beyond the capabilities of the iNRRTS Registrant (RRTS®) and inform the consumer of the need for additional assessment and/or intervention. The iNRRTS Registrant, (RRTS®)®, will assist the consumer in identifying medical professional(s) or other rehabilitation technology supplier(s) who can meet the consumer's needs.

Amber Ward, MS, OTR/L, BCPR, ATP/SMS, FAOTA

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iNRRTS

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FROM THE EDITOR-IN-CHIEF

Welcome to 2026! If you're seeking valuable, relevant and high quality education, explore our course library. iNRRTS is committed to providing leading Complex Rehab Technology education for Registrants, Friends of iNRRTS and all CRT professionals. Our goal is to remain the primary source of relevant, cost effective educational programming in the industry. Visit https://nrrts.org/education/ for more information.

Amy Odom, BS

IN EVERY ISSUE

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THE OFFICIAL PUBLICATION OF
The International Registry of Rehabilitation Technology Suppliers
VOLUME 2026.1 | $10.00 USD

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FROM THE NRRTS OFFICE

Echoes Across Katepwa Lake:
Preparing the Next Generation of CRT Professionals

WRITTEN BY: Jason Kelln, ATP, CRTS®

Have you ever stood in a place where sound carries farther than you expect? For me, that place is Katepwa Lake (a deep glacial spillway, roughly 2 km wide and 180 meters deep, created by ice sheet meltwater) — a long, quiet valley where your voice travels out, returns and reminds you that everything we send into the world comes back in some form. Nothing we do disappears. It echoes.

This year, I heard agricultural commentators note that farmers are already preparing for the October harvest. Months of planning — before a single seed goes into the ground — so the future doesn't arrive unprepared.

That level of foresight is not unfamiliar to anyone in this room.

In Complex Rehab Technology, every strong outcome begins long before the evaluation, long before the delivery and long before the final sign off. Our "harvest" is the moment a client gains independence — and like farming, that moment is only possible because of the work we do long before it arrives.

iNRRTS know globally for the top-notch education we offer with our webinars and CRT Supplier certificate program are constantly planning. A slate of webinars for the upcoming year and more parts of the CRT Supplier certificate program, shows where we will be live on the floor.

As CRT professionals, we know what it means to plan.
We live in a world where details matter, timing matters, people matter and the consequences of our decisions last for years.

And I think often about the people who taught us that.
The mentors who shaped our judgment. The colleagues who taught us how to think, not just what to do. The ones whose voices still echo in the way we practice today.

One voice that has influenced me comes from Phil Jackson, who said: "Good teams become great ones when the members trust each other enough to surrender the 'me' for the 'we.'"

That is the essence of this profession. We stand with clinicians, clients, techs, funders and manufacturers, and we make decisions together that are far bigger than any one role. Jackson also spoke of the magic that happens when people commit themselves to something greater than their own ambition. And, everyone here knows what that feels like. We have lived it.

Which leads to a question we rarely ask out loud:
If someone hadn't invested in us, if someone hadn't guided us, challenged us and corrected us, where would we be today?

And then I think of this:
The Olympics take years of preparation to deliver two weeks of excellence.
Years of training, years of planning — all so that performers can rise to the moment when the world is watching.

If something that lasts for two weeks requires that much intention, why wouldn't we apply the same rigor to the future of our profession — a future that depends on excellence not for two weeks, but for decades?

That is why we must bring in new people now — younger Assistive Technology Professionals, Registered Complex Rehabilitation Technology Supplier, Certified Complex Rehab Technology Suppliers, new technicians, emerging clinicians.
Not later. Not someday. Now.

Invite them while our knowledge is still here to pass on. Let them see how we reason through complex situations, how we adjust when a plan changes, how we advocate when a case becomes difficult and how we serve with commitment and integrity.

Give them room to practice, to stumble, to learn and to rise — with us beside them, not behind them.

Because when their moment comes, our goal is not simply that they take over. Our goal is that they take us further.

What we invest in today — our time, our teaching, our example — will echo across tomorrow just like a voice across Katepwa Lake. We are who we are because of the people who shaped us. And who we will become depends entirely on whom we prepare now.

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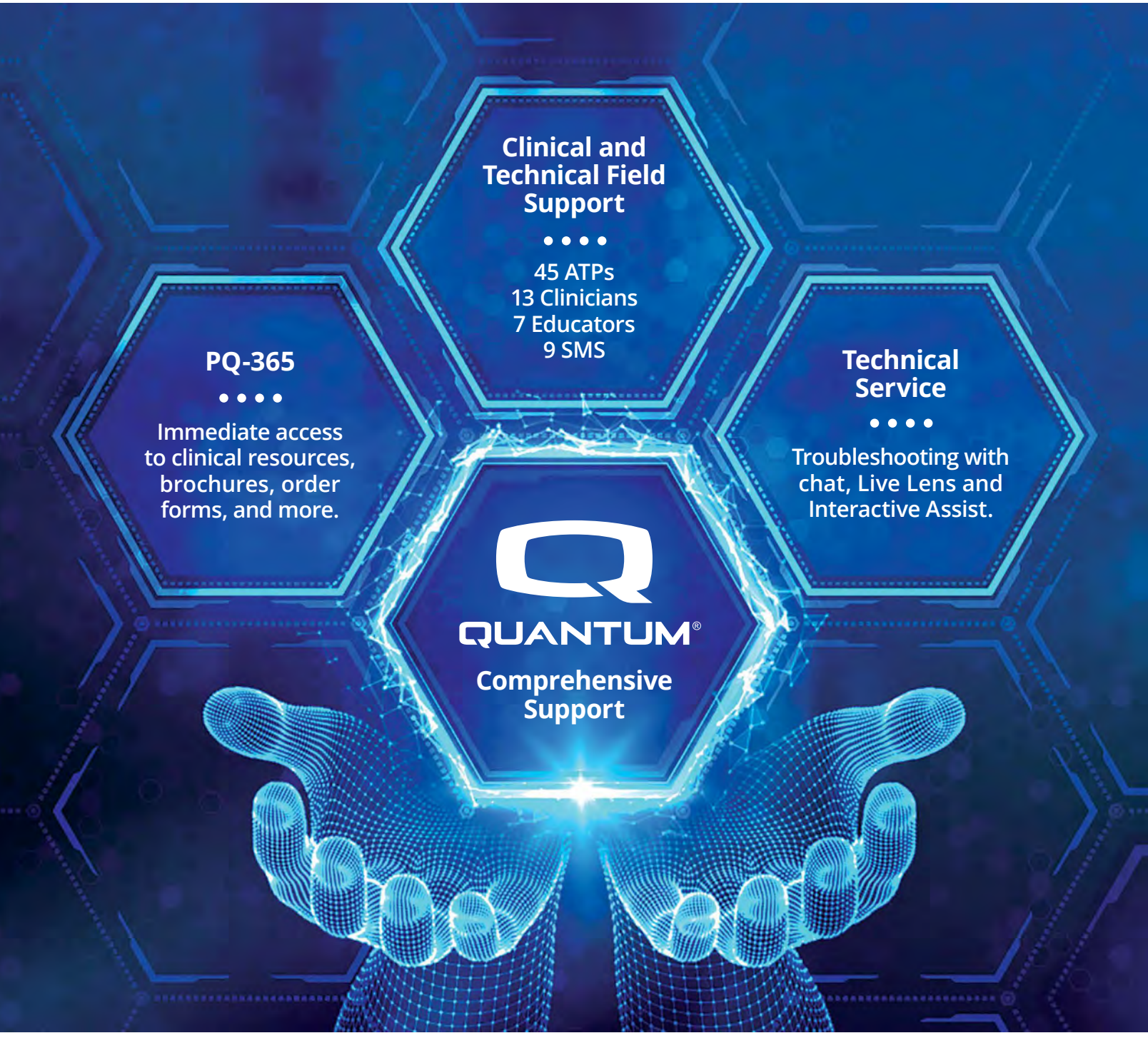
Jason Kelln, ATP, CRTS®, is president of iNRRTS and became the first Canadian iNRRTS Registrant in 2018. Kelln is the recipient of the Simon Margolis Fellow Award. Kelln serves on the Rehabilitation Engineering and Assistive Technology Society of North America's Professional Standards Board and has been an owner of PrairieHeart Mobility since 2022.



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MOMENTS WITH MADSEN

Fresh Start, Forward Look:
Learning, Leading, Growing Together in the Year Ahead

WRITTEN BY: Andrea Madsen, ATP

A new year always brings a sense of possibility, and in Complex Rehab Technology, that feeling is especially energizing. With fresh calendars, new ideas and continued momentum across our profession, this is a natural moment to pause, reflect and look ahead with optimism. At iNRRTS, we are excited about what the coming year holds and even more excited about the role our Registrants and supporters will play in shaping it.

CRT is a field defined by innovation, problem-solving and people who care deeply about doing things well. While the health care environment continues to evolve, one thing remains constant: the dedication of professionals who show up every day committed to improving lives through thoughtful, high-quality technology and service. That commitment is worth celebrating, and continuing education is one of the ways we keep that energy and excellence moving forward.

Learning That Works for the Real World

Let's be honest, continuing education can sometimes feel like something to "check off the list." At iNRRTS, our goal is to make education something you want to engage with. The most effective learning method is practical, relevant and connected to the real challenges and opportunities CRT professionals face every day.

As we investigate the new year, iNRRTS is focused on offering education that feels useful, engaging and timely. Whether it's a webinar that sparks a new way of thinking, a course that reinforces best practices or a discussion that reminds you that you're not alone in navigating complex issues, our educational offerings are designed to support both professional growth and day-to-day confidence.

Professional Excellence with Flexibility

Being a registered CRT professional is a serious commitment, but that doesn't mean the journey can't be enjoyable. Registration reflects pride in your work, accountability to high standards and a shared belief that learning never really stops. Continuing education is simply one of the ways that professionalism shows up in action.

Engaging with iNRRTS education is an opportunity to sharpen skills, stay current and reconnect with the bigger picture of why this work matters. It's also a chance to learn from peers who understand the realities of CRT and bring valuable perspective from across the field.

New Ways to Get Involved

The year ahead offers plenty of opportunities to engage with iNRRTS in ways that go beyond logging in with continuing education units. We encourage Registrants and supporters to:

- Join the conversation by participating in webinars, panels and educational series that explore emerging topics and practical solutions.
- Share what you know by collaborating as a content contributor, your experience is exactly what makes our education meaningful.
- Try something new, whether it's a different learning format or a topic slightly outside your usual focus.
- Show your commitment by highlighting your engagement with iNRRTS education as part of your professional identity.
- Seize opportunities to connect with us in person at upcoming events such as Medtrade, Abilities International Accessibility Conference, Canadian Seating and Mobility Conference and the new CSMC East.

Education doesn't have to be one-directional. Some of the best learning happens when professionals come together to exchange ideas, ask questions and learn from one another.

Learning as a Quiet Form of Leadership

Every time a CRT professional invests in learning, it strengthens the profession as a whole. Education builds confidence, supports ethical practice and helps us speak clearly about the value of CRT to the broader health care community. In many ways, continuing education is leadership in action: steady, thoughtful and impactful.

As an organization, iNRRTS is proud to support learning that reflects the real-world expertise of our Registrants and the evolving needs of the profession.

Invitation to Start the Year Strong

As this new year gets underway, I invite you to approach continuing education with curiosity and openness. Explore what iNRRTS has to offer, participate when you can and consider how your own knowledge might help support others in the field. Small steps — one course, one webinar, one shared idea — all add up to meaningful progress.

The future of CRT is bright because of the people who choose to invest in it. Thank you for your continued support of iNRRTS, for your professionalism and for the care you bring to this work every day. I look forward to another year of learning, connecting and moving forward together.

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Andrea Madsen is the executive director of iNRRTS, the International Registry of Rehabilitation Technology Suppliers. She has over 20 years' experience providing Complex Rehabilitation Technology to adult and pediatric patients in Southern Minnesota, Western Wisconsin, Northern Iowa and internationally through her work with the Mayo Clinic. She holds a Bachelor of Science in business management and finance, is a credentialed Assistive Technology Professional and has been a certified Complex Rehabilitation Technology Supplier. She served for 10 years on the iNRRTS Board of Directors and as committee chair for the Midwest Association of Medical Equipment Services. She has lectured for the University of Minnesota Rochester, University of Wisconsin La Crosse, Mayo Clinic College of Medicine and Science, and at the International Seating Symposium.

NOTES FROM THE FIELD

Enriching Lives Comes First

WRITTEN BY: Rosa Latimer

Kristen Decker grew up listening to business conversations at the dinner table — not balance sheets or profit margins, but stories about people. People who need equipment to live more independently. Those navigating an injury, illness or aging. Individuals whose lives could be quietly changed by whether a service was done well, thoughtfully and with care. For Decker, Handi Medical Supply was never just a company. It was a living expression of a mission she absorbed from her parents long before she had a job title.

Today, Decker is the rehab field manager at Handi Medical Supply, a durable medical equipment provider founded and based in St. Paul, Minnesota. She is an Assistive Technology Professional and Complex Rehabilitation Technology Supplier and also serves as iNRRTS U.S. Review Chair for Region D — roles that reflect both her technical expertise and her commitment to her profession. With almost a decade of experience in the DME industry, Kristen leads a team of ATPs and CRTS®s delivering mobility and rehab solutions.

Handi Medical Supply was founded in 1988 by Decker's mother, Mary Benhardus, a personal care assistant in the Twin Cities at the time, who saw firsthand how fragmented and frustrating access to medical equipment could be for her patients. While studying to become a nurse, Benhardus recognized a gap: It often took several providers to assemble the basics her patients needed to live at home. Her response was practical and quietly radical: build a single, customer-focused organization that could meet patients' needs with dignity, consistency and care.

From the beginning, the founding idea — enriching lives — became the lens through which decisions were made, even as the company grew well beyond its early years. Today, Handi Medical Supply employs more than 100 people and remains a privately held company. The organization occupies a space that resists easy categorization: large enough to innovate and invest, small enough to stay deeply connected to the people it serves.

Growing up immersed in that environment gave Decker a unique view of what it means to run a health care business. Her mother and father, Shann Benhardus, were candid about the challenges and responsibilities that came with leadership. Financial sustainability mattered, of course, but it was always framed as a means to a larger end. Longevity was not about growth for its own sake; it was about remaining present for the community year after year.

Handi Medical Supply team attending Rehacare International Conference in Düsseldorf, Germany. (left to right) Shann Benhardus, Mary Benhardus, Scott Russell, Kristen Decker and Robbi Haase.

"I always knew that helping people and enriching lives was what I wanted to do," Decker said. The question was never whether she would join the family business, but in what capacity. Beginning at age 18, she worked at the front desk of Handi Medical Supply, face-to-face with customers, learning the rhythms of the organization from the ground up. She later earned a bachelor's degree in organizational communications with a focus on health care administration and management from Bethel University. This educational foundation blended people-centered communication with operational thinking.

Decker's perspective has been shaped by individual moments, especially early in her career. She recalls a customer who came in for compression stockings,

Kristen Decker and Ashley Herman at a Courage Kenny Adaptive Sports and Recreation Abilities Expo.

Handi Conference 2025, Kristen Decker and her son, Miles Decker, who joined the fun (and began his training).

a straightforward transaction she completed quickly. The man lingered, talking longer than she expected, and Decker found herself internally urging the conversation along. Then the customer apologized. He hadn't left his house in a week, he explained. She was the first person he had spoken to. "That stopped me in my tracks," Decker said. "This was bigger than just selling someone socks."

NOTES FROM THE FIELD

Dominic, Kristen and Miles Decker hiking in Glacier, Montana.

When Decker graduated from college, COVID-19 was in its early days. Amid the uncertainty reshaping the health care landscape, she used the time to explore where she could have the most significant impact. She shadowed colleagues, stepped into the rehab side of the business and quickly discovered how deeply the work resonated. She entered the Rehabilitation Engineering and Assistive Technology Society of North America ATP program, earned her certification and spent time in customer-facing sales before moving into leadership.

Working in customers' homes as an ATP, Decker encountered the full emotional weight of rehab work. Sometimes new equipment represents freedom and excitement. Other times, it marks a difficult transition — a loss, a diagnosis, a change no one wanted. In those moments, the work becomes less about orders and more about presence. "It's

Mary Benhardus and Kristen Decker at the U.S. Capitol attending the 2025 NCART National Fly-In.

an honor that people trust us to be part of their journey," she said.

Now, Decker manages Handi Medical Supply's ATP team, rehab sales and complex rehab technicians — four ATPs based in St. Paul, one in southern Minnesota and a team of technicians who support them. While she no longer carries her own caseload, Decker steps in when cases require additional consideration, providing guidance rooted in both clinical understanding and an organizational perspective.

"I take our mission of enriching lives and ask how I can enrich my employees' lives," Decker said. That means advancing the customer experience by streamlining processes, strengthening communication and removing friction so her team can focus on what matters most: the individual in front of them.

Handi Medical team supporting the "Get Up Stand Up" social. (left to right) Jake Gau, Caroline Portoghese, Lloyd McIvor, Kristen Decker and Dominic Decker.

Decker is candid about the challenges her team faces, especially the emotional and logistical stamina required in complex rehab. The work is meaningful, but relentless. There is always another referral, another documentation hurdle and another customer navigating a life-altering transition. Kristen sees her role as fostering sustainable momentum and supporting resilience without allowing burnout to become the cost of care.

That emphasis on sustainability extends beyond internal culture. One of the most explicit expressions of Handi Medical Supply's forward-thinking approach is its long-standing commitment to community education and coverage advocacy. In 1998, the company held its first equipment conference, modestly held in the company's parking lot. The goal was simple: bring health care professionals together to understand changing coverage requirements and emerging

New product training at Handi Medical Supply. (Back row, left to right) Robbi Haase, Jake Gau, John Weiss, Ashley Herman and Caroline Portoghese. (front row, left to right) Troy Tesmer (Soul Mobility), Isabel Castelnuovo-Hoffman and Mike Ruyman.

products, particularly as Medicare documentation grew more complex.

Over time, that gathering evolved into a significant regional event. Handi Medical will host the annual conference, now rebranded as the Handi Abilities Showcase, May 1-2, 2026, at the Saint Paul River Centre. The event has expanded far beyond its original scope, partnering with organizations such as Courage Kenny Adaptive Sports and Recreation and opening its doors to the broader community.

What excites Decker most is the connective role the event plays. Clinicians, vendors, customers and families share the same space, discovering not only equipment but also possibilities. She recalls customers who attended the event and later shared that they had signed up for adaptive sports they never

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knew existed. For Decker, those moments affirm her belief that education is not abstract. It is life changing.

Coverage advocacy has become another focal point of her work. Earlier this year, Decker participated in a national fly-in event in Washington, D.C., an experience that reshaped her understanding of how policy change happens. What once felt like an untouchable system became, instead, a network of people making decisions. "If we can connect with people and share stories," she said, "that's where change happens."

Her curiosity extends beyond national borders. Handi Medical Supply representatives have attended Rehacare in Düsseldorf, Germany, the world's largest rehab expo, to explore technologies not yet available in the United States. Some of those products, Decker notes, could meaningfully enrich lives in the United States but face daunting regulatory barriers. Rather than dismissing them as impractical, Handi Medical Supply has pursued partnerships, helping navigate Food and Drug Administration processes and pricing, data analysis and coding to help bring new innovative solutions to U.S. consumers. Handi Medical Supply can explore ideas simply because of the possibility of improving the quality of life for its customers.

Asked what she looks for in ATPs and technicians beyond certification, Decker points first to character and integrity. Skills can be taught; mindset cannot. She values professionals who resist easy answers — who stay curious, collaborative and persistent in finding solutions that truly serve an individual, even when those solutions require extra effort or innovation.

That philosophy mirrors her broader vision for the industry: whole-person care grounded in collaboration, curiosity and respect. As an iNRRTS Registrant since 2021 and a CRTS® since 2023, Decker continues to invest in the profession she grew up around, helping shape its future while honoring its responsibility to enrich the lives of others.

Away from work, Decker's focus shifts to home and the delight and challenge of raising a toddler. She and her husband, Dominic Decker, a union pipe fitter with St. Paul Local 455, have a 2-year-old son, Miles Decker. Time together often centers on travel, outdoor adventures, hockey and most recently, Decker has taken up sourdough baking. Regular trips to visit family in Florida and Montana provide time to slow down and reconnect.

"For me, the work is not about preserving a legacy unchanged. It is about honoring its purpose by allowing it to evolve." When Decker considers what Handi Medical Supply needs to remain thriving for the next generation, the answer is both familiar and forward-looking: listen closely, stay curious, strengthen partnerships and choose, again and again, to enrich lives.

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Kristen Decker, ATP, CRTS®, is the rehab field manager for Handi Medical Supply, based in St. Paul, Minnesota. The family-owned business is privately owned and employs over 100 people. Decker also serves as iNRRTS U.S. Review Chair for Region D.

TECH CORNER

Technicians Understand Importance of Battery Health for Power Mobility Equipment

WRITTEN BY: Larry Carter

Objective: Battery chargers and charging requirements

In today's world of active consumers, many of whom depend on their mobility equipment for daily activities and long-distance use, a technician's job can be quite challenging.

A technician's responsibility doesn't always stop at conducting regular maintenance and repairs. Proper charger sizing and correct diagnosis of battery problems confirming the need for new batteries and/or the reason for battery failure can make all the difference in how mobility equipment will operate and provide dependability long term.

Charging Your Mobility Batteries

There are industry standards that battery chargers used in mobility equipment must meet to ensure proper battery charging. These standards are established by the American National Standards Institute and the Rehabilitation Engineering and Assistive Technology Society of North America.

This standard requires that the battery chargers must have a suitable output voltage and current to recharge fully discharged batteries to at least 80% of the energy that was removed within an eight-hour period. Utilizing the correct size charger for battery size and technology is required to meet this standard, without the risk of under- or over-charging mobility equipment batteries.

How Often Should I Charge My Batteries?

If the mobility equipment is used daily, batteries should be charged for a minimum of eight hours every night. For daily long-distance users, a 12-hour charge at least once a week is recommended to prevent potential sulfation buildup on the plates due to potential chronic undercharging that may occur daily. (See Figure 1) If the power mobility equipment is only used occasionally or in storage, the batteries should be fully charged for a minimum of eight hours once per week.

Why Type of Charger Do I Have?

Depending on the mobility equipment model, there are two types of chargers used. One is the chargers that will completely shut off after each charge cycle and will not restart a new charge cycle until they are "reset." Resetting is completed by unplugging the charger from the power source and then plugging it back in to begin a new charge cycle. Another type of charger will continuously monitor the battery's state of charge and automatically turn on and off, as needed, to maintain a full charge while the charger is in use. Therefore, it can be misleading to assume that if mobility batteries are plugged in while being stored the batteries are always being charged.

You should confirm the type of charger the mobility equipment uses prior to placing mobility equipment in long-term storage or advising the consumer of proper charging habits.

Figure 1: Stages of Sulfation

Always utilize an authorized mobility equipment repair center for your replacement or secondary charger to make sure you are not only acquiring the correct charger size for your mobility equipment but also:

- The charger should be compliant with the following standards:
  - RESNA Volume 2 Section 21 and Section 25
  - UL Listed
  - CE Listed
  - RoHS Compliant

Other factors to be considered:

- The charger should be a voltage regulated charger designed to charge valve regulated lead acid (VRLA) absorbed glass mat (AGM) and GEL batteries in mobility applications.
- The charger should have a maximum current-amp output of no more than 30% of the C20 rating of the batteries used in the mobility device.

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- The charger should have a minimum current-amp output equivalent to the original charger supplied with the mobility equipment at time of purchase.
- Example: An AGM U-1 battery rated at 33ah at the C20 rate should not be charged with a charger larger than 9.9-amps output (33ah x .3 = 9.9 amps)

Battery Charger Information

Most mobility chargers have built-in protections that will limit their ability to begin a charge cycle if the batteries are at a very low voltage threshold, generally under 18 combined volts for a pair. This will cause the charger to appear to be charging when nothing is happening. Batteries that are severely discharged can often be recovered but may require individual charging with a 12-volt low-amp charger (not) designed with a low voltage cutoff such as a trickle charger commonly used for automotive batteries. Using a charger not specifically designed for mobility batteries to recover deeply discharged batteries is something only a trained technician should undertake.

When using a non-VRLA specific charger on GEL or AGM batteries, the voltage should be carefully monitored, and the batteries should be returned to the chair's charger to finish the charge cycle once the voltage of each battery reaches around 11 volts. Continuing use of a non-VRLA charger to finish charging GEL or AGM batteries could result in over-charging the batteries including permanent dry-out and dangerous excessive gassing.

Constant undercharging can be foremost a result of lower runtime, meaning the batteries will not hold their full charge for as long they did when installed brand new. This can result in permanent sulfation on the plates and will quickly diminish the battery's ability to fully charge as well as maintain their original capacity and runtime, resulting not only in a shorter runtime but also a shortened overall battery life. Chronic undercharging can sometimes be physically noticeable by the battery case appearing concaved or rippled. (See Figure 2)

Figure 2: Rippled battery example

In most cases this also results in batteries reading very low voltage, many times due to extended storage of the batteries for long periods of time without proper charging.

Most VRLA AGM and GEL batteries should have a charge cut-off voltage no higher than 29.20 volts for a pair, or 14.60 volts individually. This cut off voltage is considered a surface charge and although required to bring a lead battery to full charge, the battery's voltage will reduce once the battery sits for approximately 24 hours or has a load placed on the battery. A fully charged battery without a surface charge should level out at approximately 12.80 volts.

A battery with a lower voltage reading reflects a various degree of discharge with sulfation remaining on the plates. (See Figure 3)

%	GEL	AGM
100%	12.85	12.80
75%	12.65	12.60
50%	12.35	12.30
25%	12.00	12.00
0%	11.80	11.80

Figure 3: Open Circuit Voltage Char

- If a pair of batteries on a charger that has just completed a charge cycle reads less than 29.20 volts, the charger may still need to complete the charge cycle, and therefore both the charger and batteries should be tested for possible concerns.

As stated earlier, ANSI and RESNA standards require the battery charger to recharge the batteries to at least 80% of the energy that was removed within eight hours. Depending on the size of the batteries and the charger, it can sometimes take 12 hours to fully charge a lead battery, even when using the correct charger size. If 12 hours of charge cannot be achieved daily, then at minimum the batteries should be allowed to be charged for 12 hours once a week. If this recommendation is not followed, the batteries could experience chronic undercharge and result in permanent damage.

There is technology available in some complex rehab equipment to determine if a battery failure might be due to chronic under-charging. Many newer power chairs have built-in systems that allow the user and the supplier to review the battery charging history remotely.

In addition, consumers of some mobility equipment can now monitor charging habits via a wireless connection through a phone app. This helps technicians quickly diagnose battery problems associated with chronic undercharging versus possible issues with the chair's charger and/or electrical components.

Although under-charging is the most common concern with mobility batteries, over-charging by using a charger that is too large by output amps or a charger that develops an issue with age or physical damage can also be problematic. Although there will be a reduced recharge time when using a larger amperage output charger than originally provided with the equipment when purchased new, this can cause permanent internal damage to the batteries that can drive out all the electrolyte, permanently destroying the battery. This damage is irreversible and can be often noticeable by the smell of sulfur while charging and the battery case's expansion or appearance of being "bloated." (See Figure 4)

Upon observing either of these conditions, the mobility equipment should not be used until the charger and batteries are investigated. If changes/corrections are not made, the replacement batteries will most likely experience the same conditions soon after charging resumes. Also remember that some consumers will purchase a secondary charger via an online store or other alternative resource that is not through an authorized repair center. This could result in the consumer acquiring and using a charger that is too small or too large for their batteries, resulting in battery problems. Always inquire with the consumer if they are using another charger besides the original charger that they received with their power chair.

Other factors that can cause overheating and permanent damage to VRLA batteries include abuse of equipment (utilizing a light-duty scooter for long-distance outdoor use) and exposing VRLA batteries to high heat. It is important to know that after 30 cumulative days of exposure to temperatures of 92 degrees Fahrenheit or higher, for about one hour per day, will reduce a lead battery's cycle life by half. Using the wrong batteries for the application can also cause battery life to be reduced, i.e., using a smaller capacity battery than the power chair requires, using a nondeep cycle battery or using an AGM battery when a more robust GEL product may be more suitable for regular outdoor use in high-heat climates.

Figure 4: Bloated battery examples

Conclusion

It is important that qualified mobility technicians:

- Confirm the charger is working properly and completing a full recharge.
- Ensure the charger's amperage output does not exceed 30% of the battery's C20 rating.
- Verify that the charger's amperage output is at minimum what was original with the power chair.
- Inquire if the consumer is using a secondary charger that may not be known at time of evaluation.
- Inquire about the consumer's daily use and charging habits.

Whether it be a Complex Rehab Technology power chair or light-duty scooter, proper charging habits and using the right charger can make a difference in battery reliability, longevity and performance.

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Larry Carter is from Dallas, Texas, and has held several positions with MK Battery since joining the company in 1995. He currently serves as MK's western regional sales manager and national sales training manager. Carter has worked closely with various home medical equipment providers and provider groups nationwide as a workshop presenter conducting battery training sessions for technicians and Assistive Technology Professionals. Carter has worked within the battery industry for over 42 years with experience in all aspects of lead battery applications and technologies, including but not limited to sealed VRLA (valve regulated lead acid) batteries used in mobility and other critical power applications. Carter is proud that MK Battery has been a reliable and trusted source for quality batteries since 1983, and they remain the preferred battery supplier for many HME providers and manufacturers of power wheelchairs and scooters.

CLINICAL PERSPECTIVE

Rethinking Ethics:
Applying Professional Principles to Daily Practices

CEU ARTICLE REVIEW

WRITTEN BY: Amber L. Ward, MS, OTR/L, BCPR, ATP/SMS, FAOTA

Ethics. Everyone knows ethical principles need to exist and they are important, but the continuing education unit topic is often one of the most dreaded requirements of many professional licenses and certifications. Ethics often seem relevant for big and terrible actions and not activities that most of us would deal with daily. This CEU article, however, is going to deal with this topic in a different way. We are going to talk about "everyday ethics" and the ways that the ethical principles and core values of a variety of our professional licenses and certifications could impact what we are trying to do every day with clients, business colleagues and others. We will go over specific ethical principles as well as case examples and some of the ways that we can think about potential ethical issues that we might come across and ways to manage them both professionally and personally.

The preparation of this article involved looking through a variety of ethical principles and practice standards, including occupational therapy, physical therapy, Rehabilitation Engineering and Assistive Technology Society of North America (RESNA), iNRRTS and others. Many of them, as you might imagine, have a lot of similarities even though they might say things slightly differently. The table below (Table 1) notes ethical principles from the American Occupational Therapy Association (AOTA), American Physical Therapy Association (APTA), RESNA and iNRRTS and matches similar concepts across the organizations. It is interesting how the similarities line up, but when you consider societal pressures to be moral and ethical individuals, it makes sense that there would be similarities among the organizations who are trying to protect the public.

Table 1: Ethical principal similarities

AOTA Ethics	APTA Ethics	RESNA Ethics	iNRRTS Ethics
Beneficence — Taking action to benefit others, prevent harm, protecting	Accountable for making sound professional judgments.	Hold paramount the welfare of persons served professionally.	Do everything necessary to provide high-quality equipment, ongoing support and long-term service. Strive to recognize when the physiological, functional or technical needs of the consumer are beyond the capabilities of the iNRRTS Registrant (RRTS®) and inform the consumer of the need for additional assessment and/or intervention. The iNRRTS Registrant (RRTS®), will assist the consumer in identifying medical professional(s) or other rehabilitation technology supplier(s) who can meet the consumer's needs.
Nonmaleficence — Avoid actions that do harm, injury or wrongdoing	Shall enhance their expertise through lifelong acquisition and refinement of knowledge, skills, abilities and professional behaviors.	Practice only in their area(s) of competence.	Accept the responsibility to expand and improve professional knowledge and skills so the consumer receives the most appropriate technology and service available.
Autonomy — Self-determination, privacy, consent	Trustworthy and compassionate in addressing the rights and needs of patients and clients.	Maintain the confidentiality of privileged or confidential information.	Respect the confidentiality of information pertaining to individual consumers and disclose such information only with proper authorization or as required by law. Explain fully the consumer's rights and responsibilities, including the right to work with a supplier of his/her choice.

Veracity — Accurate and objective info about role; truthfulness	Shall participate in efforts to meet the health needs of people locally, nationally or globally.	Disclose all conflicts of interest.	Present the consumer with complete information on the choices of available equipment, pricing, funding options and the consumer's financial responsibility.
Justice — Equity, inclusion, objectivity	Shall fulfill their legal and professional obligations. Shall promote organizational behaviors and business practices that benefit patients, clients and society.	Know and comply with the laws, regulations and policies that guide professional practice.	Serve all consumers equally regardless of race, creed, gender, sexual orientation or reason of disability. Abide by all applicable federal and local laws. Notify the consumer of the iNRRTS complaint resolution procedure.
Fidelity — Respect, fairness, integrity, discretion	Respect the inherent dignity and rights of all individuals. Demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers and the public.	Act in a manner that positively reflects upon the assistive technology profession.	Provide competent, timely, high-quality equipment and services to meet the physiological and functional needs, as well as the goals of the consumer.

(AOTA, 2020; APTA, 2025; RESNA, 2023; iNRRTS, 2026)

AOTA and APTA go a step further by having a number of core values and standards of practice/conduct. RESNA also has standards of practice, required duties and certain responsibilities (see Table 2 and Table 3).

Table 2: Core Values

OT Core Values	PT Core Values	RESNA Standards of Practice
Altruism: Caring for others in an unselfish way; committed, caring, responsive, dedicated and understanding	Accountability Duty, altruism Excellence	Keep paramount the welfare of those served professionally. Provide assistive technology recommendations that maximize outcomes and minimize a consumer's exposure to unreasonable risk.
Equality: Treating all clients the same, regardless of differences in an unbiased way Dignity: Respecting each person's inherent worth and uniqueness	Compassion and caring Social responsibility	Respect consumers' rights and not discriminate in the provision of services or supplies on the basis of impairment, diagnosis, disability, race, national origin, religion, creed, gender, age, sexual orientation, primary language spoken, financial situation or any other protected status.

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Freedom: The individual's right to make their own decisions about their care; autonomy, independence, self-direction and initiative	Collaboration, inclusion	Inform consumers of their rights and responsibilities and promote their full participation in each phase of service. Inform the consumer about device options and funding mechanisms, regardless of financial status or funding available, and provide consumer choice in the development of recommendations.
Justice: Respecting the moral and legal rights of patients, providing them with the services that they need, and full inclusion	Accountability	Disclose to all stakeholders the role they serve in the provision of assistive technology services and devices, any financial interests or professional affiliations that may be perceived to bias recommendations and recuse themself if the conflict is likely to impair judgement.
Truth: Honest, faithful to facts and to reality and truthful	Integrity	Not engage in fraud, dishonesty, misrepresentation, criminal activity or any forms of conduct that adversely reflects on the field of assistive technology or the ability to serve consumers professionally. Not misrepresenting their credentials, titles, role or responsibilities in the field of assistive technology.
Prudence: Using reason and logic to approach decisions and self-discipline	Integrity Collaboration	Maintain professional boundaries in relationships with consumers, their families, and caregivers discouraging any behavior that exploits the consumer's trust.

(AOTA, 2020; APTA, 2025; RESNA, 2023)

Table 3

OT Standards of Conduct	RESNA Standards	PT Standards of Practice
Professional integrity, responsibility and accountability	Abide by all laws, regulations and policies that govern the provision of assistive technology products and services and provide consumers with the applicable information to make informed decisions. Consider the consumer's current, future and potential emerging assistive technology needs when making recommendations.	Ethical/legal considerations, Advocacy
Therapeutic relationships	Refer consumers to other professionals, including assistive technology professionals, or provide resources when necessary to meet the consumers' identified needs.	Community responsibility
Documentation, reimbursement and financial matters	Perform or participate in the steps of the assistive technology process, which may include assessment, evaluation, trial, simulation, recommendations, procurement, delivery, fitting, training, adjustments, repairs and/or modifications.	Administration of PT services
Service Delivery	Verify a consumer's needs by using direct assessment procedures. Perform or participate in the steps of the assistive technology process, which may include assessment, evaluation, trial, simulation, recommendations, procurement, delivery, fitting, training, adjustments, repairs and/or modifications.	Patient and client management

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Professional competence, education, supervision and training	Engage in only those services within the scope of their competence, level of education, experience and training; recognize the limitations imposed by the extent of their personal skills in any professional area, as listed in the Directory of Certified Professionals.	Education, Research
Communication Professional civility	Work in a collaborative manner with all stakeholders.	Community responsibility

(AOTA, 2020; APTA, 2025; RESNA, 2023)

Let us drill down into a few of these concepts with situations many of us face daily, starting with professional integrity, responsibility and accountability, all of which focus on maintaining public trust. Our industry has taken hits over the years with some high-profile fraudulent behavior, which is touted on the news networks as the way the industry acts. This of course, could not be farther from the truth, but each time a client or caregiver feels like they are being taken advantage of, that they are not getting what they need or deserve, or that they got the wrong product for their needs, the suspicion grows.

This concept is about having respect for all, paying attention to our roles and competence and the responsibilities we have to the public, our clients and the industry. Some of us fear looking less than competent, or we want the business of a complex client so we may try to perform a task beyond our abilities. Not only is this not the best outcome and could harm the client but also it means the next time it is even easier to go beyond our abilities. Anyone ever been doing things a certain way for a long time because you "figured it out" yourself but find out years later that you were wrong? This accountability concept also goes along with not speaking up when we know something is not OK, such as when a therapist is convinced that they are correct and the supplier decides not to rock the boat. The last part of this principle is to maintain those professional boundaries in relationships; we all have those clients we are closest to and would go out on a Saturday if they were stuck and in need. Just be careful; taking the gift of a water bottle is one thing, but concert tickets, a bottle of alcohol or a free meal is another thing entirely. Also, guard against any preferential treatment, social media posts and getting too involved in their lives. The client's welfare is paramount, and our relationships should be friendly and fun but professional.

The therapeutic relationships standard is all about respect, shared decision-making and collaboration. This is when we understand our clients may not choose wisely in our estimation, but they are allowed to make that choice. For me, it is especially those folks who insist on a scooter when they cannot stand up for pressure relief. It is also our respect for clients who know their needs and issues better than we ever could; they are the most important members of the team. It avoids "sour grapes" when a client prefers another supplier or Assistive Technology Professional over us and means we facilitate the transition to the other supplier/therapist with grace. It addresses conflicts immediately and directly instead of talking about the situation with other parties. This ability to communicate effectively leads to a stronger and more cohesive team and only increases satisfaction when an excellent outcome occurs. One example is a client who insists on a Group 2 basic power wheelchair with a captain's seat for their new chair despite progression of multiple sclerosis. The OT talks her into a Group 3 complex power wheelchairs with power features as it will medically assist and is the "right" chair for her. A week after the delivery/fitting, the client goes back to her old chair as the new one is an inch higher and she can no longer transfer herself on/off the toilet and bed. As she lives alone and cannot afford caregivers, a very small change had a very large impact. A discussion to consider transfers or a closer look at the client's issues may have caught this concern. A solid relationship with the client's team means collaboration with all stakeholders, including those who might be more difficult to work with. Refer to other professionals or offer resources (when a need is identified by the client), such as a state assistive technology office when applicable, for help with tasks such as home automation and integration with the power wheelchair.

The documentation, reimbursement and financial matters standard is a nod to the justice principle as well as the paperwork process. It is about having the correct documentation at the right time without delays, which would impact or harm clients. A letter of medical necessity that is not written with the information required and the equipment is thereby denied is an unnecessary delay and potentially medically impactful. Occasionally, therapists will just never finish the letter after completing the evaluation, forcing the client to start over months later. Finding resources to assist and educate ourselves is key. This also includes the illegal issue of Complex Rehab Technology

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Suppliers "helping" therapists by completely writing the evaluations or letters for them. It is charging fairly for services delivered and working with clients to understand the payment and reimbursement process. It informs the client about all options for devices, features and funding, regardless of financial status or funding and offering choices when available. This means letting the client decide about fighting their insurance for a typically non-covered item or to decide about seeking an alternative funding source. Another part of this standard is "no arbitrary directives that compromise rights or well-being of others," which would involve not assisting certain kinds of clients or situations where one client is charged differently than another. Any roles, affiliations or financial interest in AT services and devices should be disclosed to the team, and we should pull out of the decision-making process if those conflicts would impair our judgement.

The service delivery standard notes that working with clients should be client-centered and consistent with all the ethical and other values we hold via our licenses and certifications. The evaluation must be appropriate to the specific needs of the client, such as a second (or third) visit to trial demos, or a request for consultation with a manufacturer's representative as an expert with a complicated system. Just because it is hard to do or a hassle is not enough to not put client needs at the forefront. The practitioner should provide services that are current, based on evidence when possible and fall within the person's scope and skills. It includes making sure we are aware of the best products on the market to meet specific needs and that we stop using products that are not appropriate but familiar. Some examples might be using the backrest that comes as a standard item on the chair instead of an aftermarket back that is more appropriate or recommending the same type of familiar stroller when the client could benefit from the features of a different brand. It also might be using the same brand/make/model of power wheelchair for all clients instead of considering the specific benefits and features of each brand for each client. It is up to us to educate ourselves and our clients as to the best options to meet their needs. We must perform evaluations and trials when appropriate, such as a home trial when a client has poor vision or a second visit to trial various demo backrests. We can respect their right to refuse a device entirely, refuse the one we think is best and ultimately refuse to work with us any longer. This goes both ways as the ATP/therapist can also refuse to write an evaluation/letter of medical necessity that notes justification for a mobility option with which they ethically do not agree. An important part of this is also making sure the final product chosen is as appropriate as possible for the current, future and emerging AT needs, and the client/caregiver has the information required to make good decisions. Putting a client in a Group 2 basic power wheelchair with a captain's seat when they have fast-progressing cancer with pain/weakness and will very soon be entirely unable to stand/walk could lead to long-term health implications such as pressure injuries and blood clots. We must decrease the risk of harm and maximize short- and long-term outcomes. One of our biggest jobs is to not just passively act in an ethical manner but also take steps to make positive change. One way is to fight any discriminatory policies or those that limit access to consumers. Most of us in the CRT world have fought for client rights with Medicaid, funding agencies or insurance policies, which limit access to medically necessary items. One such fight currently occurring in the U.S. is the denial of recline and expanded electronics for many CRT systems, deemed not medically necessary when they are extremely important if not vital. If you have a client willing to take the time to fight the system versus downgrade to a lesser chair, please continue to write the addendums. Pursue further action such as requesting a peer-to-peer review from the funding agency when available and help the client self-advocate for these items.

The concepts of professional competence, education, supervision and training do not mean we are CRT experts in every area but that we work within the scope of our competence, experience, training and personal skills. If I am not sure what seating solutions will best suit a young man with scoliosis, legs windswept to the side, neck lateral rotation and spasticity, then I need to seek help. After 23 years of seating, I still learn and ask every day; I had a case last week where at the initial evaluation, the supplier and I were unsure which product would meet the needs of the client. We agreed to a second visit with the client to request assistance from manufacturer's reps from two companies offering potential solutions. Some of the most difficult parts of the CRT evaluation process can be the ability to self-assess skills and knowledge when there is a need. Most of us feel like we can figure it out on the fly and even though this may lead to a reasonable outcome, let us always shoot for a great outcome. Take specific action to maintain and grow knowledge and competence as well as to resolve incompetent practices. As we are all aware, having the ATP after our name does not automatically mean the ability to provide CRT effectively. Newly credentialed ATP suppliers and clinicians must have the appropriate guidance and supervision required to have excellent results, and this requires determination and potentially extra time and money to make this happen. The extra effort is worth it, as happy, comfortable

and functional clients will keep coming back and giving grace when there are challenges with service and other business factors. Any resources being used or shared must be credited and follow copyright standards, including items such as an image off the internet for a brochure or an excellent tip your clients would love. Standing up for incompetent, illegal or unethical practices may put one's job at risk but save a client's life and health. Resources such as AOTA, APTA, RESNA, iNRRTS, National Coalition for Assistive & Rehab Technology and others can offer guidance and support if action is required.

The standard of communication involves offering full confidentiality, privacy, discretion and respect to client information and "story." An interesting client may be a fascinating or funny story at a party but is unique enough to be identifiable. This includes verbally as well as social media. Some of us use social media for connecting with current and potential customers and must continually make sure of client/caregiver's permissions as well as the understanding that once posted, the information can often be passed on and could be used worldwide. Our marketing must be truthful and accurate; for instance, say, "We will help work to maximize insurance coverage," instead of "Medicare covers these power wheelchairs!" The "under promise and over deliver" concept in combination with truthfulness and respect moves beyond focus on a single sale to a lifelong relationship with a satisfied client. Resist the temptation to talk only to the caregiver when the nonverbal client is present; assume they can understand and would like to be included, even if the caregiver answers the questions. Try to use the preferred communication method of the client/caregiver; it is OK to say, "I can't understand you, could you please repeat that," for clients who speak very softly or are difficult to understand. Some clients will only use their communication device if the communication partner cannot understand their speech. Collaboration and communication with the entire team is imperative. A seating team in a clinic helping a school-aged client get a new complex power wheelchair should include (even peripherally) the school practitioner who will know the specific school issues. An adult wheelchair user who, on various days is at a group home, parent's home and adult day care should have communication with a team member who can consider all locations. Allow clients and caregivers to take the time to ask questions, even simple ones, and avoid dominating the conversation. When conversations such as "My insurance says they will cover this folding wheelchair, and that is what I want," occur and the response is a scoffed, "I'm sorry, but they say that, but these things are not a covered item, plus you have Parkinson's so that is a really bad idea," it tends to make the client feel silly/embarrassed and shut down. Being impatient and dismissive with questions may seem like it may not be large enough to be an ethical concern, but respectful communication also involves autonomy, beneficence, altruism and prudence. It may not be worthy of an ethical discussion/query or anything besides a bad review, but it also may be a pattern of negative behavior that can lead to a larger ethical issue over time.

Professional civility ties in with respectful and clear communication but is also about all professional and equitable treatment. It involves careful and active listening as much or more than talking and getting your own point across. Being nice is easy when everyone is getting along, but treating others with courtesy and civility when there is strong disagreement or opposing viewpoints can be much harder. Really listen to what clients and caregivers are saying, sometimes anger about a folding power wheelchair not being appropriate for their needs is more about grief related to their disease process and developing challenges with mobility and function than about just being angry. Clients who dig in about wanting a power wheelchair they can take apart for transport despite needing a Group 3 more complex chair may have real fears and issues about continuing to live alone if they cannot get to the grocery store. They may also live in a rural community without consistent wheelchair transport. Respectful and inclusive language is part of this as well, as we avoid describing the new client with a spinal cord injury as a "para" or the client for a stander as "the CP kid." Using language/behavior that offers respect and refers to a client with their preferred pronouns (even if in transition), avoids the assumption that a female companion accompanying a male client must be a caregiver (but is really his wife) and leads us to assume competence of a client who may appear severely/profoundly impaired by not talking around but to him.

An ethical issue worthy of discussion is a case example which recently occurred in a seating clinic. A young man with spastic quadriplegic cerebral palsy is attending the outpatient seating clinic with his mother and older sister for a new wheelchair. He is 21 and no longer attending school as of a few months ago. He uses an older complex power wheelchair with tilt, recline and elevation to maneuver around the home and community with supervision from family and uses only public transportation. He is able to follow directions but requires supervision and assistance for most daily tasks. Now that it is time for a new chair, his family came into the appointment asking for a manual wheelchair or stroller instead of a new

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power wheelchair. The family noted the chair was bulky; they could not transport it; and the client banged up the walls of the home as he tried to maneuver. The therapist noted no difficulty with maneuvering from the lobby to the seating clinic. The mother is legal guardian for this young man. The therapist led a discussion with the group about what they were interested in for a new device and shared his dismay when the dependent mobility device was brought up as the desired choice. The therapist included the client in the discussion, and he agreed that he was okay with the new option. Unsure about the dynamics, the therapist strongly encouraged independence and autonomy for the client, but the mother was insistent. The therapist advocated for independent mobility and the desire of the client to have control over his movement and expressed his discomfort with taking this away from the client. As the guardian, the mother is allowed to make the choice she perceives is best for the family and client, and the client agreed.

Another ethical scenario takes place at an ALS clinic where a supplier attends the clinic to assist with all equipment needs for clients. She attends each week and is there all day to assist. A gregarious and friendly individual, she makes connections with clients and caregivers as she notes items to be repaired, changed, and ordered. She does end up processing all new items such as alternative drive controls and support items through her company, even if the company the chair came from was a different supplier. She also sees all clients with ALS requiring new evaluations for complex chairs with the clinic therapist. Together, this CRT Supplier and therapist recommend a certain brand of chair with a certain cushion and controls for all new clients for their first chairs. They feel that they do a good job and clients are pleased with the outcomes. The supplier and members of their company often take the therapist to lunch and give her Christmas and birthday gift cards to a coffee shop. This case includes ethical concerns about integrity, truthfulness, beneficence and justice via effective service delivery. Clients deserve the right to have unbiased information to make an informed choice without undue influences related to the close relationship of the clinic with the supplier.

Another example to consider are the ethics of inaction. We must take action to resolve incompetent, unethical and impaired practices and report potential or known unethical or illegal actions. Avoiding thoughts such as: "Not my business," "I don't want to get involved," "I am sure they are OK," "It's not really a big deal," "It doesn't really matter," "I'm just one person," "Someone else will do it," is paramount to hold the welfare of the clients we serve professionally in the forefront. Taking ethical action can be uncomfortable or make life more challenging, but it is the right thing to do. Some other not so obvious everyday situations might include:

- Providing an evaluation/chair/device that you are not adequately trained to support or manage.
- Deciding on a device too quickly when the client needs a second visit or demo trial to really know what would be best.
- Billing for not-completed work such as labor or items that did not work on the chair.
- Blurring the lines of personal and professional relationships.
- Refusing to move off formulary lists or refer to another supplier to meet client needs.
- Not fully considering long-term needs with progressive disorder.

One way to manage ethical issues that may present is to consider the process of how you may need to act when an issue arises. The bulleted list below are common strategies for managing ethical issues in an organized manner (Tech Leaders, 2025).

- **Understanding the ethical issue/gathering the relevant facts** — Make sure you have all the information you require about the situation, stakeholders and actions.
- **Apply ethical principles and consider issues** — Find additional information and resources. Consider what the issues are that are being violated and by whom.
- **Assess and determine alternatives for action** — What might you possibly do about the issue? What are the potential short- and long-term impacts?
- **Choosing the best course of action** — Take action after considering all options. Communicate with stakeholders.
- **Implement and evaluate the results of an action or outcome** —Did the action you took resolve or manage the issue? Monitor, document, and apply information for future situations.

A few other situations to consider how you might take action could include the following cases. Think through each scenario with the five-step process noted above.

1. A resident physician refers a client for a scooter when they asked for it in a recent appointment. The doctor's notes indicate the client has multiple sclerosis, leg weakness with difficulty standing/walking, spasticity and lower body numbness. The client wants a scooter but has not done any research on available options. You do not have a qualified CRT Supplier on your company staff but could use the sale.

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2. A therapist recently left the school where she assessed complex wheelchairs without finishing the documentation for some of the children on her caseload. Your supervisor and the families want these letters of medical necessity completed so the paperwork and equipment can be funded and dispensed and ask you to finish them, even though you have not met/treated the kids in question. You, as a therapist, are not experienced with CRT like the original therapist, but as long as the CRT Supplier helps, it should be fine.

3. A client with a complex power wheelchair has been "a total pain" and called you out many times to the home. She calls you again to apologize for being difficult and gives you two tickets to an event that you are dying to go to as "payment" for all your trouble.

4. Your company has been having terrible trouble getting certain electronics and power features covered by the funding source for complex power wheelchairs. So, to save time and trouble, your team has decided to offer new clients with a basic power wheelchairs with tilt and elevate instead of a complex power wheelchair with additional recline and elevating foot platform as well as expandable electronics. This will save disappointment and allow you to have a much faster eval to delivery timeframe.

Navigating the everyday ethics of working with clients with mobility needs can be daunting at times and there are pressures from employers, state/provincial and federal laws, client and caregiver needs and others. Hopefully, the information and examples provide options to consider and keep at the forefront. If you encounter ethical issues in your practice, information about who to turn and resources for ethical issues might include:

- State/provincial, district, territorial or national authority responsible for regulating the occupational therapy and physical therapy professions.
- RESNA, iNRRTS, NCART
- U.S. Department of Health and Human Services, Office of Inspector General (800) 447-8477, TTY: (800) 377-4950 or http://oig.hhs.gov/fraud/report-fraud/index.asp
- Centers for Medicare and Medicaid Services (800) 633-4227, TTY: (877) 486-2048
- Individual insurance carriers, other third-party payers or health plan sponsors.
    - Note: Most entities have reimbursement policies and procedures that outline coding methodology, industry-standard reimbursement logic and regulatory requirements. Inquire directly to the specific company when reimbursement information or clarification is required. Most policies and procedures can be found on the payer's website.
- State agencies regulating the insurance industry.
    - Office of the Insurance Commissioner (Commissioner of Insurance) or (state) Department of Insurance www.naic.org/state_web_map.htm

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CLINICAL EDITORIAL

‘The One That Broke Me’

WRITTEN BY: Melanie Parker

In health care, customer service is not a luxury — it is foundational. Our personal experiences with service shape whether we trust a business enough to return. We expect to feel seen, heard and valued. In Complex Rehab Technology, that expectation should be nonnegotiable. The decisions we make directly affect safety, health, comfort, independence and quality of life. When we fall short, the consequences extend far beyond dissatisfaction; they can cause lasting harm.

Communication, clinical judgment and professional accountability are, in my opinion, among the strongest predictors of optimal outcomes in CRT. When any of these fail, even well intentioned care can become dangerous. The following case, while uncomfortable, illustrates why our industry must hold itself to a higher standard.

Nearly six years ago, I was the physical therapist that evaluated a client whom I will call Sarah. Sarah was in her 60s and had spastic quadriplegic cerebral palsy. Sarah had used a power wheelchair in the past but was bedbound and presented with severe contractures in all extremities, scoliosis and significant medical fragility. Her roommate, who also has cerebral palsy, would crawl on the ground to attend to her needs.. Sarah had limited nursing care.

At the time of the initial evaluation, it was clear that Sarah required custom seating due to multiple non-correctable postural asymmetries. We collaborated on the design of a power wheelchair using the same base and drive configuration she had successfully used in the past. The Assistive Technology Professional (“John”) involved had strong technical knowledge but limited clinical experience in custom seating and was dependent on my skills to complete the seating process.

When Sarah’s seating system was delivered, I performed a gentle correction of her pelvic alignment after transferring her into her new seating. A popping sound was noted. Sarah initially reported that she felt fine but soon requested to return to bed. I was informed later that Sarah had sustained a femur fracture related to severe osteopenia. Sarah and her roommate did not attribute the injury to malpractice and expressed understanding of the risks involved. They indicated they would reach out when ready to resume services, but they never did.

Five years later, John asked me to complete an evaluation for Sarah’s new power wheelchair. John and I returned to Sarah’s home, joined by her roommate, her nurse and a manufacturer representative invited by John. The representative was from John’s preferred manufacturer, not the manufacturer Sarah had been using. During the visit, much of the ATP’s communication was directed toward Sarah’s roommate (his longtime friend) rather than Sarah herself while the therapist and manufacturer representative evaluated Sarah. Clinically, Sarah presented herself in a healthier state due to increased nursing care, but her contractures had worsened, including fixed internal rotation and knee flexion of the left leg, with persistent extension positioning of the right leg since the femur fracture.

Given her history and body changes, all parties agreed that another custom mold would not be appropriate. Instead, we (the manufacturer rep and I) designed a seating system using foam and adjustable air components, with the agreement that the setup would be trialed prior to funding submission.

The trial was successful. However, Sarah’s nurse expressed concern about Sarah’s ability to safely operate a power wheelchair, though the team remained optimistic and Sarah was motivated. Funding was approved, but the delivery process revealed another critical breakdown. Because the order had not been flagged as requiring a team delivery, the wheelchair was scheduled just prior to month end with a technician who had never met Sarah. The delivery was refused on site because Sarah “did not fit” in the chair. Fortunately, she was not injured during the attempted transfer.

I became aware of this incident after the technician approached me. When I raised concerns about the communication failures, safety risks and liability involved, John did not appear to understand why the situation was so serious and why I was so upset, which I found infuriating. John’s lack of accountability in this situation

and the lack of accountability from John's superiors to John was even further disappointing and infuriating.

Several weeks later, the manufacturer representative and I returned to Sarah's home. The wheelchair had already been accepted with the assurance that adjustments would be made. John was not present as he was "busy with evaluations." We determined that Sarah had gained additional weight due to tube feeding changes and did not fit the originally delivered back support, and her lower extremity positioning did not reflect the plan established during evaluation. We collaborated with John to replace the back support with a wider size. The rep and I returned later to complete installation, which included multiple adjustments. Sarah demonstrated ability to initiate driving but would need further assessment for joystick placement and programming. We requested the nurse to coordinate further training for nursing staff and trials for Sarah. At the nurse's request, Sarah was returned to bed. The nurse never scheduled the requested follow-up visits to address driving and staff training. John did not follow up with Sarah to advocate for further visits.

The outcome of this case is, at best, incomplete. Sarah now has a seating system that fits her appropriately, yet it is unlikely she will use it to its full potential. Her dependence on caregivers for transfers limits her ability to advocate for herself, and unresolved caregiver concerns have become a primary barrier to functional use.

This situation was resolved only through the persistence of the therapist and manufacturer representative. The ATP's limited clinical engagement, inconsistent communication and absence during key decision points contributed to repeated failures in care. Compounding this, business relationships and productivity pressures appeared to outweigh accountability and patient-centered decision making.

This case is not about assigning blame to a single individual. It is about recognizing systemic failures that place medically fragile clients at risk. When communication is poor, when roles are unclear and when financial pressures override clinical judgment, patients like Sarah pay the price.

What we do in CRT can mean the difference between dependence and independence, comfort and suffering, and health and injury. While this work exists within a business model, no delivery timeline or sales target should ever supersede safety, dignity and meaningful outcomes. Sarah's goals should have guided every decision; instead, they were repeatedly sidelined.

I titled this article as "The one that broke me" because, after this incident, I decided to pivot professionally. I am no longer doing seating and mobility evaluations full-time, only on occasion. I found my anger had surpassed a righteous level, and I noted I was chronically frustrated by what I perceived as the constant compromise of best practice for productivity. While I completely understand the nature of business (I ran my own), and the need for revenue to keep running, I can no longer stand by or participate in the perpetual lack of accountability.

I hear technicians asking for more training on seating and positioning principles to offer better service, but productivity demands outweigh their desires to offer more to their customers. I see ATPs who lack the skills to properly discern needs and service their complex customers not held accountable for poor outcomes because of their good productivity. I see high-producing ATPs given increasing administrative support to sustain their crazy schedules, but no accountability given for lack of timely and accurate documentation or availability that causes delays in care. Meanwhile, this causes lesser productive ATPs to be under supported administratively, resulting in their clients also receiving delays in care.

We know better. Hopefully, we want better. So why don't we do better? This constant compromise of our moral and ethical values is the essence of burnout. We have to stop doing or we have to stop caring. I chose to care, so I then also chose to "do" differently.

We promote "see something, say something" in other areas where we value safety. I've seen too much to not say something.

CONTINUED ON PAGE 24

CLINICAL EDITORIAL | CONTINUED FROM PAGE 23

I encourage each of us to speak up and to megaphone others who do. Say something when a client's complexity is out of your skill set. Don't just abandon the work to someone else. Say something but also commit to learning what you lack. Our professional integrity is built on our commitment to learning and growing our skills each day.

If our field is to mature and earn the trust it requires, we must be willing to reflect honestly on cases like this and ask difficult questions:

- What do I do when a client's needs exceed my experience or skill set? Am I handling this in the same way I would want other medical professionals to handle my care or that of a loved one?
- How clearly and consistently do I communicate client needs to my team?
- What safeguards exist in my organization to prevent these breakdowns in care?
- Am I willing to accept the same level of accountability that I expect from others?

These are not abstract considerations. They are ethical imperatives. The lives and well-being of people like Sarah depend on how we answer them. The moral integrity of our field depends on it.

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Melanie Parker, DPT, ATP/SMS, has been a physical therapist for 22 years in a variety of clinical settings and has performed seating and mobility evaluations the majority of her career for clients of all ages. She is passionate about a client-focused model and advocating for the best outcomes possible for her clients. She owned and operated Confident Living, a comprehensive seating and mobility clinic in Richmond, Virginia, from 2019 to 2024. She now works in a variety of areas providing therapy and consultative services. Based on the struggles heard and seen from clients and families new to disability and her own struggles to find the resources for her son who has autism, she founded The Whole Family Foundation, a nonprofit to educate, empower and connect families who have a member with a disability in order to strengthen the family unit. Outside of work, she loves spending time with her husband, three teenagers and two dogs, in addition to traveling and being active in her community.

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Foundations of Excellence:
Learning from Industry Leaders

WRITTEN BY: Michelle Harvey, B.Sc. Hons OT, RRTS®

At the heart of excellence is a commitment to learning, growing and continually raising the bar — for us, our teams and the clients we serve.

As part of this commitment, I recently sat down with two highly respected industry veterans, Michael Joyce and Dino Padula, to hear their perspectives on the new Complex Rehab Technology certification program. Both leaders completed the course in December 2025 and shared thoughtful insights rooted in decades of real-world experience.

Joyce brings over 25 years of industry experience, specializing in pediatrics and corporate programs, and currently leads a team of sales representatives.

Padula specializes in complex rehab and manages a high-performing CRT sales team.

Together, they offer a powerful lens into how continuing education supports both individual growth and organizational excellence.

Interview with Michael Joyce:

Q: How did you find the course?

A: Very good overall. I would like to see a little more on the technical side of the equipment, but the course met my expectations and there was clear value in it for reps. We spend so much time training reps, and these courses are so helpful to be able to evaluate how much each person is learning and retaining.

Q: Did it take much time to complete?

A: Yes, it does take time to complete the entire course. I would estimate about six to eight hours to get through it fully. But very enjoyable.

Q: How do you think sales representatives can apply this in their everyday client work?

A: It broadens their knowledge and helps them gain confidence when working with clients. It is a good credential to have and shows commitment to professional growth. Lots of areas that traditionally you don't learn from manufacturer workshops.

Q: Was there Canadian-specific content included?

A: Yes, that said, our industry doesn't have major differences across borders. The main difference is funding, and the course doesn't — and probably shouldn't — focus on funding models as they differ state to state and province to province.

Q: What surprised you about taking the course?

A: I was surprised at the variety of subjects the course offered, every condition and every piece of equipment we work with. This is super helpful to make individuals well-rounded as experts in their field.

Q: Why do you think we should continue offering courses like this and stay focused on continuing education?

A: In every career, the work becomes stale, and you have your go-to options; it's important that we continue to explore, advance and learn. It benefits us an employee but also our clients. It forces us to evaluate equipment and use clinical reasoning; become better problem solvers for our clients.

I think the curriculum is best targeted toward representatives who have a few years of education who want to continue to advance and maybe take on more complex clients. Everyone should strive to be better, and continuing education supports that goal.

Interview with Dino Padula:

Q: How did you find the course?

A: I found it helpful overall, though I would have liked to see more in-depth case studies included.

Q: Did it take much time to complete?

A: Around six hours if done uninterrupted. It can take longer when trying to complete it during the workday.

Q: How do you think sales representatives can apply this in their everyday client work?

A: Completing the course shows a strong commitment to their work and to continuing education, which carries over

into how they support clients. Knowing the options for equipment and why you choose them gives the best outcomes for clients.

Q: Was there Canadian-specific content included?

A: Yes. Equipment and clinical practice are universal, with funding being the only real difference.

Q: What surprised you about taking the course?

A: I was expecting it have forgotten lots of areas that I don't practice daily, but after doing each module the information came flooding back.

Q: Why do you think we should continue offering courses like this and stay focused on continuing education?

A: With continuing advances in manufacturing and new equipment monthly, continuing education helps keep representatives at the top of their game and ensures they continue delivering high-quality service. If you're not learning and pushing yourself and your company, how can you be at the top of your game?

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Michelle Harvey, B.Sc. Hons OT, RRTS®, is an iNRRTS board member, serves on the Canadian Advisory Committee and became a NRRTS registrant in July 2021. She is vice president of sales and product for HME Home Health.

REHAB CASE STUDY

It Takes a Team to Win in Assistive Technology

WRITTEN BY: William Danner, MOT, ATP, CPST

I remember my early days as an occupational therapist in home health. One case stands out — a client desperately needed a wheelchair, and I was the only therapist available to help. It was one of the most demoralizing experiences of my career. I had no idea what my client truly needed, nor any clue about the equipment or seating that would meet their daily needs. Thankfully, that was the only home health case where I had to order a wheelchair.

Fast-forward 20 years. For the past decade, I've specialized in assistive technology at the Aaron W. Perlman Center at Cincinnati Children's Hospital, working with wheelchair clients every day. I'm much more comfortable now, but the road to this point wasn't simple — and I couldn't have gotten here without a lot of help.

At the Perlman Center, we're fortunate to have some of the best vendors and Assistive Technology Professionals in the world. Being surrounded by knowledgeable colleagues and seasoned Complex Rehab Technology Suppliers made my journey possible. More importantly, it allowed me to stay in my lane as an occupational therapist — using my clinical expertise to complement the technical knowledge these professionals bring to the table.

We've all heard the saying, "Fake it till you make it," but that doesn't work in the complex world of assistive technology.

Phil Wesley, ATP, with Numotion said, "It's very important to pair new therapists in assistive technology (AT) with knowledgeable ATPs and vendors. That way, both professionals can focus on their specific roles while providing the best service for the family." [1]

At the Perlman Center, we see individuals with complex diagnoses — cerebral palsy, Duchenne muscular dystrophy and spinal muscular atrophy, to name a few. Each client brings unique challenges, but these cases often push even the most experienced therapists to their limits. They highlight the need for a team approach to achieve the best outcomes in positioning and equipment.

Ricky Alonzo, ATP, CRTS®, with National Seating & Mobility, said, "Strong collaboration between therapists and ATPs is essential for meaningful outcomes. When we communicate openly and problem-solve together, we turn clinical goals into practical equipment solutions that support function, safety and real participation in daily life. Open communication also builds confidence for clients and families and reduces future headaches." [2]

I recall one of my first AT cases — a child needed modifications to her wheelchair. I had completed the evaluation and determined her medical and positioning needs, but I had no idea how to order or fabricate the necessary components. I even doubted it was possible. Then the attending CRT Supplier walked me through the mold capture process and explained how custom molds can meet the most challenging needs. It was as though a whole new world opened up, and I felt grateful to be part of a team with such expertise.

John Stevens, ATP, Cincinnati Children's Hospital Medical Center, said, "The vendor/therapist relationship is a team effort to produce positive outcomes. Therapists know the client's physical strengths and limitations. Vendors know the equipment options to help overcome those limitations. Caregivers are also part of the team — their input ensures the equipment is transportable and home-accessible." [3]

CRT Suppliers bring critical experience to the table. As a therapist, my job is to address the medical aspects of each case with confidence in my OT training. While CRT Suppliers often understand medical considerations, their true expertise lies in matching equipment to the therapist's assessment and the client's needs. There's overlap, of course, but when both professionals stay focused on their roles, the client benefits and quality of care is maintained.

Kelly Ball, PT, DPT, with Permobil, said, "Other clinicians may have more experience than I do, but I love collaborating with therapists, ATPs, and vendors because we all bring different perspectives. That diversity benefits the patient by providing well-rounded care from day one." [4]

Being a team player took some getting used to — and still does at times. I like autonomy and control, especially with my clients. But in the complex world of assistive technology, one brain is rarely enough. Each week, I navigate numerous cases with vendor support — from positioning a bath chair in a home environment to installing gaze propulsion or optics for power wheelchair access. These cases underscore the importance of multiple viewpoints and creative solutions. Most CRT Suppliers would agree: a team approach beats working in isolation every time.

John Stevens, ATP, Cincinnati Children's Hospital Medical Center, said, "Vendors and therapists are in the 'helping' business. If you don't care about people with disabilities, you

shouldn't be in this field. Life is hard enough for the able-bodied —anything we can do to make life easier for clients and caregivers makes this work worthwhile and rewarding." [5]

I'm thankful every day for the incredible vendors and ATPs who help balance my perspective and achieve the best outcomes for our clients.

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William Danner, MOT, ATP, CPST, has been an occupational therapist for over 20 years. He currently works at the Aaron W. Perlman Center at Cincinnati Children's Hospital, which specializes in assistive technology.

RESNA

RESNA Update – January 2026

WRITTEN BY: Andrea Van Hook, RESNA Executive Director

2026 RESNA Releases 'On the Road' Schedule

The Rehabilitation Engineering and Assistive Technology Society of North America is back on the road for 2026! By the time of publication, we've already been at the Consumer Electronics Show in Las Vegas, Nevada, and Assistive Technology Industry Association conference in Orlando, Florida. Future stops include:

- National Seating and Mobility Seating Symposium in Dallas, Texas, February 20–22. Stop by the RESNA booth and meet Kennedy Smith, RESNA's operations manager, and pick up information about the seating and mobility specialists certification.
- Abilities International Accessibility Conference in Los Angeles, California, March 26-27. RESNA sessions include how to connect with your state's Assistive Technology Act program, the use of artificial intelligence in augmentative and alternative communication, ethics, tech transfer, scientific papers and the ever-popular Developers Showcase.
- American Occupational Therapy Association Inspire in Anaheim, California, April 23-25. RESNA President Jim Lenker is presenting on career pathway options for occupational therapists in assistive technology.
- Abilities International Accessibility Conference in New York Metro, April 30–May 1. RESNA sessions include leveraging data in assistive technology service provision, a guide to Do It yourself assistive technology, augmentative and alternative communication for the non-speech-language pathologist, adaptive video gaming, scientific papers and the Student Design Challenge.
- Heartland Conference in Waterloo, Iowa, June 8 –10. RESNA members will be presenting at this conference. More information to come soon!

Monthly 'Certification Pop-Ups' Continue

Do you have new employees interested in finding out more about the Assistive Technology Professional certification? RESNA is holding free webinars, called "Certification Pop-Ups," on the fourth Thursday of every month at 12 p.m. ET. Staff provide an overview of the ATP certification eligibility requirements and answer questions.

Annual Notice: RESNA Code of Conduct and Certification Standards of Practice

RESNA's Code of Ethics and Standards of Practice reflect the commitment of all RESNA members, certificants and applicants for certification to the high standards of practice and ethics in the assistive technology field.

The Code of Ethics and Standards benefit and protects the public, provides practice standards for the assistive technology field and advances the duty of care for professionals in our industry. Compliance with the Code and Standards is a requirement of initial certification and recertification as it is critical to the integrity of the individuals who hold RESNA credentials. Violations of the code and standards may subject a certified individual or a candidate for certification to discipline as outlined in the Ethics Policies and Procedures.

We encourage all certified ATPs to review the Code of Ethics and Standards of Practice at least once a year to refresh their understanding and appreciation of the principles and ethical standards that guide our profession and industry. The code and standards may be downloaded from the RESNA website. All ATPs are also emailed the document directly by RESNA.

If you have knowledge of a RESNA-certified ATP who you believe is not following the Code of Ethics or Standards of Practice, you may want to consider filing a complaint with RESNA. RESNA's Complaint Review Committee of the Professional Standards Board is charged with investigating and evaluating complaints through a peer review process that is credible to the public and fair to all parties. Complaints may be filed online through the RESNA website. Email certification@resna.org for more information.

For a practical review, RESNA offers an on-demand webinar, "RESNA's Code of Ethics and Standards of Practice." Taught by Julie Piriano, PT, ATP/SMS, this course uses real-world scenarios to show how the code and standards apply. Learners who complete the course and all elements can earn 0.1 IACET CEUs.

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Andrea Van Hook is executive director of RESNA. She has more than 20 years of experience in nonprofit association management and lives and works in Washington, D.C.

CRT UPDATE

CRT Update:
CMS Online Complaint Form for Medicare Advantage Plans; CRT Industry Pushes for Reforms

WRITTEN BY: Wayne Grau

Complaint Form — Medicare Advantage Plans

The Center for Medicare and Medicaid Services has created an online complaint form for Medicare Advantage Plans.

The form will need to be filled out by the provider on behalf of the consumer.

So, if you have a consumer having issues with their Advantage Plans, you can file a complaint here:

(https://www.cms.gov/medicare/health-drug-plans/provider-complaints-form)

Thanks to Gerry Dickerson for bringing this to our attention. We realize more time on paperwork is not how most of us want to spend our day, but this is a great tool for holding the Advantage Plans to the rules.

And So, It Begins...

The 2026 state legislative sessions have begun. The Complex Rehab Technology industry is working on legislation to remove burdensome requirements, such as prior authorization for repairs. This duplicative process only slows down the repair process for consumers. Many states have either removed repair prior authorization requirements or have set a cap — anything under a certain amount does not require prior authorization. In one state that completely removed prior authorization for repairs, we saw a 21-day reduction in overall repair times. This is great for consumers and providers because we take care of our patients much more quickly, and we can focus on others who need our help.

We are working on bills in Massachusetts, New York, Florida, California, Hawaii and Alabama.

Preparation for the Unknown and Your Help

We have begun to see some proposed fee schedule changes and cuts from several states, in part due to the federal Medicaid changes passed by President Donald Trump's administration. The National Coalition for Assistive & Rehab Technology utilizes a federal and state tracking program to monitor these proposals. However, technology is great when it is working properly, but we do need you to keep your eyes and ears open and report anything that you hear from your state Medicaid program. Please email Wayne Grau, executive director of NCART, at Wgrau@Ncart.us.

Thank You

I would like to take the opportunity to thank all the customer service staff who work with our patients for answering their questions and pushing through the paperwork required by insurance companies and all the payers. Consumers, caregivers, legislators and others do not understand the complexity of providing complex rehab equipment and services. We all rely on these dedicated team members to be the front person who works with the consumers to educate them about the process. This is not an easy job, and we say thank you for all the work you do.

Advocacy Quotes

"It took me quite a long time to develop a voice, and now that I have it, I am not going to be silent."
— Madeleine Albright

We have the voice of the people we serve! Let's not be silent.

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Wayne Grau is the executive director of NCART. His career in the Complex Rehab Technology industry spans more than 30 years and includes working in rehab industry affairs and later exclusively with complex rehab companies. Grau graduated from Baylor University with an MBA in health care. He's excited to be working exclusively with complex rehab manufacturers, providers and the individuals we serve who use CRT equipment.

CLINICIAN TASK FORCE

Capturing Accomplishments, Vision Through CTF Progress, Future Opportunities

WRITTEN BY: Leslie Jackson, OTD, OTR/L, ATP, CEASIII, LSVT BIG Certified

The Clinician Task Force continues to advance access and promote best practices in the Complex Rehabilitation Technology industry through educational outreach, advocacy and leadership.

Under the leadership of the Executive Board and Executive Director Tamara Kittelson, MS, OTR/L, ATP/SMS, the CTF is active and committed, as evidenced by key accomplishments in 2025 and excited about future projects and opportunities.

Expanding Representation

The CTF Executive Board continues to make progress toward its goal of having CTF representation in all 50 states. This is vital when state-specific advocacy issues arise in the states where CTF members reside. CTF members have sought potential members through local efforts and national platforms. On April 23, 2025, iNRRTS published Kittelson's letter to introduce CTF and request assistance from industry stakeholders in recruiting additional members. Eleven new members were added to the CTF membership roster in 2025. In 2026, efforts will focus on expanding CTF representation in 11 remaining states.

Educational Outreach

In 2025, the education workgroup and Executive Board introduced a student membership program to encourage potential specialization in CRT. The workgroup also created mentorship lists to help connect interested students with CRT clinicians providing mentorship. The workgroup will continue to update resource lists with newly published journal articles, books, videos and sources to assist interested students, educators, clinicians and stakeholders.

State-Level Progress

Several CTF members advocated for key state-level policies in their respective states. In Minnesota, the Senate passed a bill requiring insurance funding of standing power wheelchairs with three CTF members testifying in person. Several Colorado CTF members are advocating for appropriate use of telehealth for Medicaid evaluations. Additionally, a CTF member in Washington state testified for a Right to Repair bill's safety amendment.

CTF's state advocacy workgroup is active with several key projects. The group is creating a survey on current billing practices to capture a snapshot of current best practices and challenges related to CRT billing. They are also working on a one-page resource to educate policymakers and reviewers on the roles and responsibilities of CRT members involved in service and delivery provision.

CTF Representation in Organization

Several members serve other key organizations on behalf of CTF. Organizations include the National Pressure Injury Advisory Panel, American Society of Exercise Physiologists, Academy of Spinal Cord Injury Professionals and Disability and Rehabilitation Research Coalition. Serving through national, state and local organizations allows CTF members to provide education, support decision-making and shape policies. In 2026, CTF is looking forward to additional partnerships to support key associations.

Federal Accomplishments

On the federal level, CTF supported the Centers for Medicare and Medicaid Services' recognition of the National Coverage Determination reconsideration request on power standing systems. Two members represented CTF at the meeting hosted by CMS. The CTF also provided letters urging CMS to address funding challenges, preventing wheelchair users receiving home health care from obtaining specialty CRT evaluations.

CTF's federal workgroup published an updated resource titled, "Guide to Practicing Telehealth for CRT Evaluations." This guide integrates current literature and best practice principles to support high-quality service delivery through telehealth. The publication outlines key factors for conducting successful telehealth visits, the process from referral to fitting, training and delivery and includes a documentation checklist to support clinicians using the telehealth modality. The published guide was shared with Colorado's Medicaid program as it explores policy changes for telehealth service delivery. The updated guide is readily available on CTF's website.[1]

The committee also closely monitored the federal resolutions extending Medicare telehealth services through January 30, 2026, and retroactive to October 1, 2026.

Based on members' concerns with CMS changes for the five-year replacement rule for powered mobility devices, the CTF submitted letters to CMS, Item Coalition, Rehabilitation Engineering and Assistive Technology Society of North America, iNRRTS, National Coalition for Assistive & Rehab Technology, American Association for Home Care, and HME News.

Clinical Coverage Projects

Members of the clinical coverage workgroup advocated for key reimbursement issues with respect to home health and outpatient seating wheelchair mobility. Several CTF members co-authored "RESNA and CTF Position on the Application of Supported Standing Devices: Current State of the Literature."[2] CTF members are actively participating in various research projects, including a study examining the impact of follow-up visits to support repair and maintenance of power wheelchairs.

Social Media Outreach

The Social Media team continues to expand outreach efforts to educate the public about CRT, highlight CTF's resources and share achievements of CTF members. The workgroup shares information about presentations, publications and project successes on LinkedIn, Instagram and Facebook. These platforms included posts about CTF's updated telehealth guide, the Medicare coverage extension and a CRT holiday gift guide resource. Be sure to follow these platforms to be among the first to learn about updates and resources.

Abilities Expo Partnership

The CTF Executive Board formally announced a collaboration between NCART, RESNA, iNRRTS, US Rehab and the International Seating Symposium in supporting the Abilities International Accessibility Conference. This conference aligns with the 2026 Abilities Expos. Several CTF members will serve on plenary panels for the Abilities Expo in Long Beach, New York Metro area and Chicago. The plenary panels will focus on 24-hour posture care management, supported standing options, pediatric mobility devices and the psychosocial adjustment and logistics impacting evolving needs for CRT. You are encouraged to invite others and attend these panels and connect with members at the CTF booth.

Looking Ahead

As we reflect on the meaningful progress achieved this year, we are reminded that our work is far from finished. Progress is not a destination but rather a responsibility — one that our members actively choose and work toward every day. Our members remain steadfast in their commitment to advancing clinical expertise that shapes public policy, elevates best practices and drives positive outcomes for people who rely on CRT.

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Leslie Jackson, OTD, OTR/L, ATP, CEASIII, LSVT BIG Certified, has served as an occupational therapist for over 25 years in various settings, including outpatient, acute care, home health, acute rehab and a doctoral-level academic program. She currently leads the outpatient Seating and Mobility Clinic for Marion Health and serves as an occupational therapist for the Department of Veterans Affairs. Jackson earned the Assistive Technology Professional certification from RESNA in 2008 and is certified in ergonomics and LSVT BIG, a treatment protocol for individuals living with Parkinson's disease. She volunteers as an executive board member for Services for the Visually and Hearing Impaired, a nonprofit organization providing assistive technology and education to its clients. Jackson is honored to contribute through the Clinician Task Force's advocacy and educational initiatives.

Renewed iNRRTS Registrants

The following individuals renewed their iNRRTS Registration between December 1, 2025 and February 6, 2026.

PLEASE NOTE **IF YOU RENEWED AFTER FEBRUARY 6, 2026**, YOUR NAME WILL APPEAR IN A FUTURE ISSUE OF DIRECTIONS.
IF YOU RENEWED PRIOR TO DECEMBER 1, 2025, YOUR NAME IS IN A PREVIOUS ISSUE OF DIRECTIONS.

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

Abood Qureshy, RRTS®
Adam Majors, ATP, CRTS®
Adriaan Biebaut, RRTS®
Alicia Correa, RN, BSN, ATP, CRTS®
Alisa K Adams, ATP, CRTS®
Allen McNiece, ATP, CRTS®
Ameer Alwash, RRTS
Anacleto Gutierrez, ATP, CRTS®
Andrew Gilberti, ATP, CRTS®
Angela Smith, ATP, CRTS®
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William Bryan Beck, ATP, CRTS®
William C. Mattern, ATP, CRTS®
William Geoffrey Phillips, ATP, CRTS®
Xavier Harrison, ATP, CRTS®
Zachary Andrews, RRTS®

Congratulations to the following individuals who have completed Level 1 of the CRT Supplier Certificate Program.

These individuals can state they are a iNRRTS Certified CRT Supplier, Level 1.

NAMES LISTED ARE FROM DECEMBER 1, 2025, THROUGH FEBRUARY 6, 2026.

Sam Cassaniti | Mac Hew | Dino Padula | Diptesh Patel

Former iNRRTS Registrants

The iNRRTS board determined RRTS® and CRTS® should know who has maintained his/her registration in iNRRTS, and who has not.

NAMES INCLUDED ARE FROM DECEMBER 1, 2025, THROUGH FEBRUARY 6, 2026. FOR AN UP-TO-DATE VERIFICATION ON REGISTRANTS, VISIT WWW.NRRTS.ORG, UPDATED DAILY.

Terry Buetow, ATP
Bismarck, ND

Jody Jesus, ATP
Woodstock, GA

Stephanie Schultz
Ballina, New South Wales

Josh Garska
Edmonton, Alberta

Sandro Leone, ATP
Southborough, MA

Michelle Lawson
Edwardstown, South Australia

Nadege Visseyrias
Hoppers Crossing, Victoria

New iNRRTS Registrants

CONGRATULATIONS TO THE NEWEST INRRTS REGISTRANTS. NAMES INCLUDED ARE FROM DECEMBER 1, 2025, THROUGH FEBRUARY 6, 2026.

Alejandro Bravo, RRTS®
Verio Healthcare
Riverside, CA

Allen Jeff Stout, ATP, CRTS®
National Seating & Mobility, Inc.
Jacksonville, FL

Austin Decker, ATP, RRTS®
Reliable Medical
Orlando, FL

Daniel Trevean, RRTS®
Independent Living Specialists
Norlane, Victoria

Diptesh Patel, RRTS®
Independent Living Specialists
Fyshwick, Australian Capital Territory

Eric Wott, RRTS®
KJK Service
Indianapolis, IN

Gerry Rodgers, MS, PT, ATP, RRTS®
Numotion
Birmingham, AL

Hayk Mirzoyan, RRTS®
Aabica Medical Inc
Rancho Cordova, CA

Jason Bloomfield, ATP, RRTS®
Pinnacle Mobility
Sherman Oaks, CA

Jordan McClellan, RRTS®
CareLinc Medical
Grandville, MI

Jose A Rey, RRTS®
Medcare Infusion Services
Sunrise, FL

Kelsey Ebenstein, RRTS®
CareLinc Medical
Grandville, MI

Madison Hyndman, RRTS®
Island Mediquip
Courtenay, British Columbia

Matthew Pritchett, RRTS®
HME Mobility & Accessibility
Kelowna, British Columbia

Rainer Olson, BBA, RRTS®
PrairieHeart Mobility
Moose Jaw, Saskatchewan

Ronald Lysinger, ATP, CRTS®
Dick's Homecare, Inc.
Altoona, PA

Ryan Strap, RRTS®
NSM-Canada
Red Deer, Alberta

Stacey Riddoch, RRTS®
Brandon Mobility
Brandon, Manitoba

New CRTS®

CONGRATULATIONS TO INRRTS REGISTRANTS RECENTLY AWARDED THE CRTS® DESIGNATION. A CRTS® RECEIVES A LAPEL PIN SIGNIFYING CRTS® OR CERTIFIED REHABILITATION TECHNOLOGY SUPPLIER® STATUS AND GUIDELINES ABOUT THE CORRECT USE OF THE DESIGNATION. THE NAMES LISTED ARE FROM DECEMBER 1, 2025, THROUGH FEBRUARY 6, 2026.

Allen Jeff Stout, ATP, CRTS®
National Seating & Mobility, Inc.
Jacksonville, FL

April Meadows, ATP, CRTS®
Cook Medical Supply
Morton, MS

Christian Raffield, ATP, CRTS®
Patients Choice Medical
Macon, GA

Joseph Smith, ATP, CRTS®
National Seating & Mobility, Inc.
Madison, WI

Lindsay Adams, ATP, CRTS®
Reliable Medical
Orlando, FL

Ronald Lysinger, ATP, CRTS®
Dick's Homecare, Inc.
Altoona, PA

Sandra Valadez, ATP, CRTS®
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Albuquerque, NM

Shawn Adams, ATP, CRTS®
National Seating & Mobility, Inc.
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