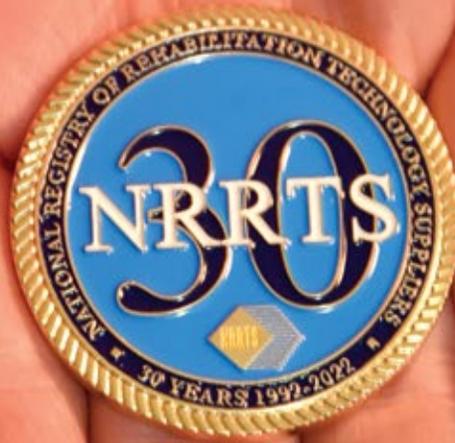
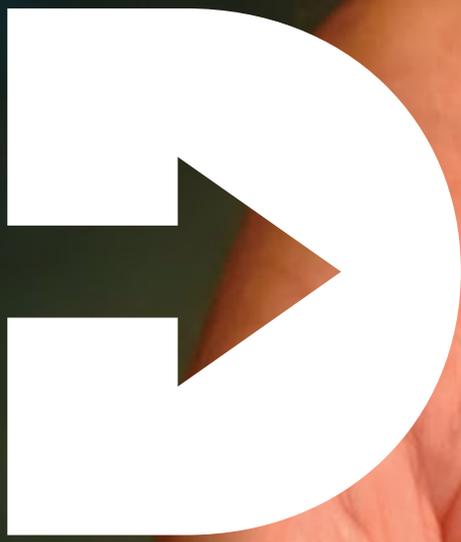


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FROM THE EDITOR-IN-CHIEF

As NRRTS celebrates 30 years, I reflect on the last 20 years of working for NRRTS. So many things have changed, and yet so many things remain the same. I've been publishing our newsletter and have watched it grow from a simple purple ink publication written by volunteers to a full-blown, industry trade magazine with paid writers. We never dreamed 20 years ago our publication would be available online or in full color. Simon Margolis challenged us to raise the bar with DIRECTIONS, and we continue to try and meet his expectations. Thank you to our advertisers for your unwavering support. Enjoy this issue, and happy birthday, NRRTS!

Amy Odom, BS

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THE END

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

To quote Jim Morrison of the Doors, January 4, 1967, "This is the end ..."

Hard to believe! This is my last message as president of NRRTS. This also signals the end of my time as a voting member of the board. For the first time since my children were young, I will no longer be able to vote on issues that concern NRRTS. It is a huge part of my life that will soon disappear.

I have been thinking about it for some time, and I'm not sure how it will finally impact me until I turn over the presidency in August to Carey Britton.

The "usual" term for a NRRTS President is two years. The madness that was COVID-19 caused Weesie Walker, executive director, to approach the NRRTS Board and ask us to serve an additional year. All the board members stepped up to the plate and served another year.

So much has changed over all of these years. People have come and gone, and some, like Simon Margolis, left us forever. Children have grown, and grandchildren have come into some of our lives, changing everything.

Much has remained the same. We still don't have a Separate Benefit Category within the Medicare program. We seem to still have the same arguments about coding, pricing and policy. The "in the home rule" still impacts consumers' lives every day. To most payer sources, it's "just a wheelchair." "Why does it cost so much?" "Do they really need tilt, recline, power legrests and seat elevation?" And on and on.

As I contemplated this final message, I tried to figure out how to express my feelings toward the board and staff that make NRRTS what it is. I thought about what I would say over and over, but nothing seemed adequate. Then, one day in a conversation with a colleague at NSM, the name Darren Jernigan came up. The discussion was about Jernigan's work in the Tennessee Legislature, but I was reminded of his ability to tell very funny jokes. I always thought he missed his calling on the comedy circuit.

SO, TO MY FRIENDS AND COLLEAGUES PAST AND PRESENT ON THE BOARD, AND TO THE NRRTS STAFF PAST AND PRESENT . . . FROM MY ENTIRE BEING, THANK YOU FOR THE ASSOCIATION!

I'm paraphrasing one of his best jokes, but it does fit perfectly:

On a piece of land outside of Worcester, Massachusetts, there is a heavily mustachioed farmer named John. He lives there with his beautiful wife, Judy, and a few animals. Two of his favorites are dogs, Rhodesian Ridgebacks. They are a brother and sister who he named Weesie and Simon. He also has an old mule, with an odd tuft of perfectly trimmed hair that sticks up an inch high and covers the entire top of his head that John named Junior.

As was his usual, John was up early one morning reading the newspaper to see which of his Boston sports teams had lost the night before. He also needed to be up early to groom Junior before an old friend, Michele, would be stopping by for a visit on her drive from the West Coast to the East Coast. Michele was coming east to get closure on some old business dealings.

The day went by quickly. Weesie and Simon were playing tug-of-war with a New York Rangers Jersey, and John was almost finished grooming Junior when an impeccably clean, almost compulsively clean, Honda Element pulled in the driveway. Michele jumped out of the driver side and gave John a great big hug. After catching up a bit, Michele asked John:

"Are you getting Junior ready to march in the Asparagus Day Parade?"

"No", said John, taking a sip of his fourth glass of wine of the afternoon." I'm getting him ready to run in the Kentucky Derby."

"WHAT???" exclaimed Michele, her tightly braided, long single ponytail flailing back and forth as she shook her head in disbelief.

"Junior doesn't have a chance of finishing the race, let alone winning it!"

"I know," replied John, handing Michele his box of Cheez-Its, "but the association will do him good!"

So, to my friends and colleagues past and present on the board, and to the NRRTS staff past and present ... from my entire being, thank you for the association!

Thank you for making NRRTS what it is. Thank you for your endless compassion and tireless work ethic. Thanks for the board meetings that made me think and helped me see things differently. Thanks for the time together, especially the Capitol Hill visits, where your love for our profession manifested itself as you passionately described what Complex Rehab Technology is and what it means to the people we serve.

I could go on and on, but space is limited. So, lastly, thanks for the personal time we spent together, the laughs at Portofino's, and the complete madness at the after parties in my hotel room! Some of the fondest memories of my lifetime.

Thanks to my wife, Pat, who happily edited my president's messages when I asked, so I didn't completely embarrass myself with my lack of grammar skills.

As I turn the presidency over to the very capable hands of Carey Britton, I know the future remains bright for NRRTS.

Again, thanks for the association,



CONTACT THE AUTHOR

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

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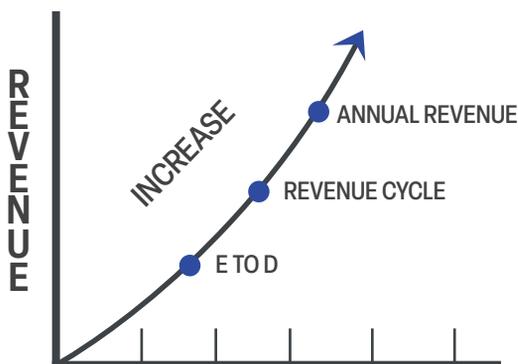
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NSM AND NRRTS: SETTING STANDARDS FOR 30 YEARS

Written by: ROSA WALSTON LATIMER

Mike Ballard founded National Seating & Mobility Inc. (NSM) in 1992, the same year NRRTS was incorporated. Recently Ballard, who retired in 2016, shared the events that inspired him to establish NSM and how NRRTS helped him realize his vision.

FIRST, TELL US WHAT INSPIRED YOU TO GO INTO THE SEATING AND MOBILITY BUSINESS.

I worked in the investment banking business and was called in as interim chief financial officer to help a large home health company with cash flow issues. I found seriously aged receivables, and as I worked through the process, I noticed a category with very old receivables titled 'wheelchairs.' I called in the person running the company's Durable Medical Equipment (DME) component. She explained she hired a 'wheelchair lady' who was a 'fitter' and a guy who worked with her was the 'fixer.' That was pretty much all she knew about wheelchairs. I wanted, and needed, to know more, so I met the 'wheelchair lady.' Because of my background in due diligence, I had learned to catch the glint in someone's eyes when they were passionate and dedicated to something. As she explained about her work, I could see that spark in her eyes, especially when she talked about working with kids. I also picked up on the vibe she didn't trust someone in a suit. I later learned, at that time in the industry, RTSs were often misunderstood.



Mike with his wife, Debbie Ballard, and granddaughter, Emory.

At this point, I didn't know a wheelchair from a martini! But, I became very intrigued and began to make telephone calls and visit individuals involved with the industry, and with wheelchairs in particular. In Mobile, Alabama, I visited a company that sold orthotics and wheelchairs. While there, a young child with cerebral palsy came in for his first wheelchair. To this day, there is nothing close to the emotional response I had when I witnessed the child self-propel for the first time in his life. I was a guy with a jaundiced view of the health care business in America but seeing the joy on the child's face was a tipping point for me. Later, I was driving on I-10 to New Orleans, Louisiana, and said aloud, 'Hey, God, I want to be in this business!'

WHAT IS THE SPECIFIC SET OF PRINCIPLES YOU ENVISIONED AND ESTABLISHED FOR NSM?

As I investigated the possibilities of this business, I realized there were many dedicated and gifted people involved in the industry. Still, often they weren't in good situations and weren't supported in their work. My vision was to bring 10 or 15 of these people under one roof to work together and make some positive changes. I followed my philosophy to hire the very best people, train them to their maximum ability, treat them with compassion and respect, and then profits would follow. And, have a lot of fun while doing it.

I realized an RTS has a very tough job, but the emotional dividends of seeing a problem, finding a solution and knowing you had an impact are enormous. The impact of giving someone mobility is right behind lifesaving. You give someone mobility, and you give life.

From the beginning, I built the company on four cornerstone principles. First was the RTSs are the head of each branch office and have authority over support staff. Second was to maintain clinical autonomy. I was not going to tell the RTSs what to sell. They would decide what was best, if they were trying to be the best. The third cornerstone was education. We required everyone to attend Medtrade every year and the International Seating Symposium every other year. Eventually, after we had grown to 20 locations, we started our annual symposium to help facilitate quality, ongoing education specifically for our RTSs. The fourth cornerstone was financial responsibility. I don't believe the purpose of a company is to make money for its stockholders. I think the purpose of a company should be the purpose of the company. In our case, we intended to be the very best in the industry. Of course, you must make money because that is the oxygen of the company. I've always said your purpose in



Mike Ballard at his Tennessee country place.

life should not be to breathe, but you must breathe to have a life. The same applies to business. You must have an acceptable level of profit to accomplish your mission.

NSM AND NRRTS PROGRESSED ON A SIMILAR TIMELINE AND WITH A SIMILAR MISSION. WHAT VALUE DID YOU SEE IN SUPPORTING NRRTS?

I had discovered many very passionate RTSs who, for the most part, were not supported by the companies they worked for and, frankly, were not appreciated. These were fabulous people – from all different walks of life before they got into this business – but then they became addicted to providing mobility solutions to the severely disabled. I saw this as an emerging ‘paraprofession.’ When I learned about NRRTS, I was all in favor of supporting it because I knew it would be instrumental in helping fulfill one of our core foundations: education. The organization’s standards were aligned with our company values. I fully supported NRRTS from day one. I required anyone who came to work with us to be a Registrant of NRRTS and participate in continuing education. We always paid the registration fees for our employees.

I didn’t get involved in the management of NRRTS because it was important to me it be a clinical organization for clinicians run by clinicians. Businesspeople needed to keep their noses out of it. Some of our employees served as NRRTS president through the years, but I never talked to them about their agenda or what they were trying to accomplish. I fully supported the goals of the organization. If you

consider the industry 30 years ago, things were very much ‘hit and miss.’ There were very few credentials or ethical guidelines. NRRTS was the starting point for delivering credentials and standards to an emerging industry and professionalism. That was a time when every market was different with different standards, and there was very little sharing of information or exchange of ideas. The community and practitioners at the time had a great need for this organization.

WOULD YOU TELL US ABOUT YOUR CONNECTION WITH SIMON MARGOLIS?

When I first met Simon, he was working for The MED Group. At that time, there was lots of talk and speculation about what I was doing with NSM. We were a startup company that was growing very fast, and rumors were flying. Simon and I had coffee together at a conference, and I had the opportunity to explain my vision for NSM. He realized he agreed with what I wanted to do in the industry and asked to come work with us as clinical director. While at NSM, Simon was a tireless worker and continued his leadership in the industry and with NRRTS. After he experienced some health problems, he had to reduce his workload and couldn’t move from Minneapolis to Nashville. The technology didn’t exist for a remote office at that time.

CONTINUED ON PAGE 10



Mike Ballard, founder and former CEO of National Seating & Mobility.



THE IMPACT OF GIVING SOMEONE MOBILITY IS RIGHT BEHIND LIFESAVING. YOU GIVE SOMEONE MOBILITY, AND YOU GIVE LIFE.



Mike Ballard (center) with sons, John Ballard and Will Ballard.

NSM AND NRRTS: SETTING STANDARDS ... (CONTINUED FROM PAGE 9)

I knew NRRTS and our industry would benefit from more quality leadership, so I underwrote Simon's position as executive director of the organization.

Many people wouldn't be living the lifestyle they are living now if it hadn't been for Simon and what he did for the profession. The leadership and work ethic of Simon Margolis hasn't been replaced yet in this industry.

CONTACT

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Mike Ballard is the founder of National Seating & Mobility (NSM). He is recognized as an industry architect and respected for his passion for providing quality products and services. Since retirement as CEO of NSM in 2016, Ballard spends most of his time either at a historic wooded property in Tennessee or near the beach in Florida.

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MATT KINNIE: ELITE CANADIAN PARA-ATHLETE

Written by: ROSA WALSTON LATIMER



Matt Kinnie and the paracycling team training in Lima at the Para Pan American games, 2019.

Canadian paracycling champion Matt Kinnie is motivated by much more than winning races. For Kinnie, it is all about challenging his personal limits. In 2005, Kinnie was a 22-year-old engineering student at the University of Brunswick when a rock-climbing accident left him paralyzed from the chest down and with limited hand and arm function.

"I liked doing anything outdoors and really enjoyed rock climbing," Kinnie said. "The accident put an end to my life as an outdoor adventurer." Although it took almost eight years, Kinnie would eventually recover enthusiasm for pushing his physical limits and enter the world of paracycling competition.

The elite athlete is now one of Canada's top handcycling racers, winning gold in the time trial and road race competition at the Canadian championships in 2017, 2018 and 2019. In 2021 he placed fourth in the road paracycling time trial and fifth in the road race at the Portugal World Championships. In May of 2022, Kinnie placed fourth in the time trial and road race at the World Cup races in Belgium and Germany World Cup races.

It took time and self-discovery for Kinnie to reach this level of success. Two years after his accident, he earned his engineering degree from the University of New Brunswick. "I was successful finishing my degree and went to work full time, yet I experienced insecurities about my disability," Kinnie said. "I was manager of a department for an engineering consultant firm and doing challenging work. Although I took pride in my work, it didn't make me completely happy. I didn't feel like the 'real' me and struggled with poor mental health." Through this time of introspection, Kinnie recalled the pride and enjoyment he experienced before his accident. "Before my accident I went skiing or hiking every day, or went to the climbing gym," Kinnie said. "I realized there was a reason for this activity. It had been an integral part of my life, and without it, I felt like crap." Rather than chase adventure as he had done before his accident, Kinnie needed to insert purposeful activity into his daily routine, balancing it with his life as a husband, father and engineer.

"I began playing wheelchair rugby, but those practices were only every couple of weeks with an occasional tournament," Kinnie said. "I needed something more routine, so I began riding a handcycle

everyday. I learned about organized handcycling racing and realized there was an opportunity to compete against others with similar abilities. As I got more fit, I constantly challenged myself to try more difficult routes or enter longer rides. Now I feel very similar to the way I felt before the accident. I feel like the real me."

Kinnie enjoys competing against himself or the clock as much, or more, than racing against others. "It matters less what I am doing, but whether I'm pushing my limits. That is what gives me meaning and purpose," Kinnie said. "I need that intense physical element and the endorphins that come with it. I also get similar meaning and joy when I challenge myself in other ways such as public speaking. I may be resistant to the preparation and feel the nerves beforehand, because it is hard to put myself 'out there.' But I know I need new, challenging experiences, and it is always rewarding when I engage with others. So much of the quality of my life comes from the people I meet, the community I am a part of and the commonalities we have. You don't have to be involved in para-sports to make space in your life to have relationships with others who share your life situation. It matters less what you are doing, but that you are doing something."



Matt Kinnie receiving best wishes from his family at the start of his time trial, 2019 World Cup in Baie-Comeau, Quebec, Canada.



Matt Kinnie, chief of operations, Tango Medical.



The Kinnie family on a Father's Day bike ride: Leah, Matt, Lily and Melanie.



Matt Kinnie, multiple Canadian championship gold medalist, training in Elzach, Baden-Württemberg, Germany prior to his World Cup races in 2022.

Kinnie recently returned from Germany and Belgium, where he competed in paracycling races. "Leading up to the race I sometimes questioned why I was putting myself through the stringent training and life stress it adds," Kinnie said. "Then I remembered the camaraderie with like-minded individuals I would experience was as beneficial as the competition. I enjoy the time spent with people who I wouldn't interact with unless I was involved in the races. In the parasport world I can have conversations with others I wouldn't have in any other setting. On my recent trip, my roommate and I talked about all sorts of things. For example, we discussed the difficulty of having kids using reproductive therapies. We talked about the complications of parenting from a wheelchair. How would I meet these people otherwise? If it hadn't been for parasports, until I began working at Tango Medical, I wouldn't have known anyone in a wheelchair."

Four years ago, Kinnie intentionally altered his career path to become a part of the management team at Tango Medical as chief of operations. "There are elements of my old job I miss, but my responsibilities at Tango are very rewarding and less intrusive on my personal life," Kinnie said. "Shawn Leger, president and CEO of Tango, wanted someone in the company who genuinely understood the perspective and challenges of our clients. I am happy to fill the role of 'not working in the company but working on the company.'"

Kinnie and his wife, Melanie, have 9-year-old twin daughters: Leah and Lily, and live in New Brunswick, Canada. Spending time with his family is important to Kinnie. "Our family enjoys playing games together, and the girls are into basketball, so we often shoot around in the driveway," Kinnie said. "We have a cottage where we spend time in the summer, or we go camping. I often bike while Melanie and the girls go to the beach or hike, then we meet for a picnic together. I am in the process of getting a mountain bike so I, hopefully, can enjoy more outdoor activities with them.

"For several years after my accident, I felt very alone," Kinnie said. "I viewed myself as different, as an imposter, even though I was secure in my work. It was as if I was trying to protect those around me from having to see the trueness or the rawness of the issues I was dealing with. I didn't want others to know how needy I was. At some point, there was a shift. I let my guard down and let everyone in on the reality of my situation. Now I'm at a place in my life where I'm OK with my disability. In many ways, I have experienced a trajectory in my personal development that others, with or without a disability, experience ... the honest self-discovery of who you are and what is essentially important to you."

CONTACT

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Matt Kinnie is chief of operations for Tango Medical in New Brunswick, Canada. He is president of the Parasport New Brunswick Board of Directors and a Rick Hansen Foundation Ambassador.

EVERY SINGLE KID I MEET IS A PERSON

Written by: WEESIE WALKER, ATP/SMS



Karen Kangas puts her client at ease to begin a power wheelchair trial.

Karen Kangas is an occupational therapist (OT) who pioneered positioning and mobility for children with disabilities. Her OT professor knew she marched to the beat of a different drummer and so recommended Kangas for a position at a residential facility working with children in a program called Infant Stimulation. It was 1976. Children with disabilities were often placed in these types of facilities because families were unable to provide the necessary care. Positioning equipment did not exist. Feeding tubes were not widely used. There were no community services at that time. Physicians encouraged the placement of these babies in residential facilities so they would get the 24-7 care they needed. This was accepted medical practice. The children had diagnoses such as cerebral palsy or hydrocephalus. Most nonverbal children were also labeled mentally retarded.

Enter Kangas. She began working with 15 children under the age of 3 and all of the adults who cared for them in a 24-hour infant stigmatic program. This program included feeding the children, bathing them and all of their ADLs (aids to daily living). Since all of the children had complex bodies, Kangas also created a learning and therapeutic environment. She realized working from the medical model was not fun, and more importantly, it was not working. She just saw

them as kids. Instead of just being a therapist/teacher she took a more wholistic, different approach, that included how children their age played and explored the world. They went to the park to swing. They sat in the shallow creeks and splashed in the water. They sang songs. The children started changing. She knew every single kid she met could learn. She learned every single kid is a person who has ideas and preferences.

It was clear to Kangas without the right equipment, families couldn't easily provide the necessary care. Parents needed strollers with postural supports. Children needed a feeding seat to position them. Children needed a bath chair to support them safely for bathing. The equipment had to meet the immediate needs of the family. If she could provide this technology, parents could confidently take their child home for a visit.

The first things she purchased were wedges and standers. From information found in a handbook, Kangas and her staff began building equipment and seating. There were just a few commercial products available. Kangas recalls, "I don't call it the good old days because there wasn't a lot of equipment available. It took a lot of hard work to provide seating and many times it didn't work."

As she began to understand the basic needs for safely handling the children, she gained a real appreciation of the issues parents of a child with a disability face. This has guided her approach in evaluating equipment needs. She starts off with the question "What do you not like about the current system?" or "What do you wish you had?" Parents may not know exactly what they want, but they know what is not working.



Karen Kangas makes it fun to try out mechanical switches on an Invacare Jaguar Power Chair.



In the '90s, there were no pediatric power bases. This Fortress Scientific was compatible with the switches, but challenging to set appropriate seat dimensions.

What is Kangas' wish list?

Children need different seating options for comfort and function. Where and how will the equipment be used? A piece of equipment should be considered in its use for an activity and not just how it looks at a singular point in time.

Hardware should be sized appropriately. Joysticks and mounts are adult size and difficult to position optimally for small children.

Kangas finds today there is less interest in doing customization but rather to rely on off the shelf solutions. Pediatric seating and positioning require the ability to customize components.

Families must be able to manage the care of their children, and the children must have independence.

Any person using a power wheelchair should have a manual wheelchair as backup. This is a safety issue, and our industry needs to challenge funding agencies to provide coverage.

Currently, Kangas is a consultant working with adults and children. She teaches clinicians how to evaluate and work with suppliers in the provision of seating and powered mobility. Across the country, Kangas does workshops with didactic and hands-on teaching. Using actual clients, she demonstrates her techniques to determine functional positioning and location for driving access. More importantly, she shows how to engage the child, which is the best lesson of all.

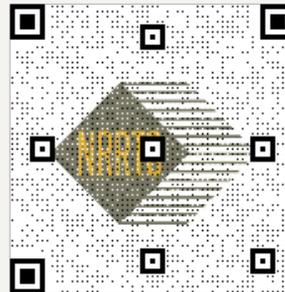
Kangas is an outspoken advocate for access to technology. Her passion is deep rooted in her early experiences working with those little souls who had so much potential no one else saw. She will never know how much positive advancement she has given to the field of assistive technology and how she has changed our perception of the people who rely on it. Because, in her words "Every single kid I meet is a person who has ideas and preferences."

Kangas presents workshops to teach clinicians and suppliers how to evaluate children for powered mobility. She shares her vast knowledge and experience on positioning for function. She strongly believes in giving children independent movement. To see a video of Kangas' workshop scan the QR code at the end of the article.

To learn more about her upcoming workshops, contact Kangas at kmkangas@ptd.net



Karen Kangas and Yuki working at an Abilities Expo.



Scan the QR code to watch the video:

This video provides a glimpse of the teaching methods Karen Kangas uses to engage her audience, and more importantly, connect directly with the child. Her workshops are a great learning opportunity.

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WHEELCHAIR MISSIONS IN JAMAICA

LONG HOURS AND BIG SMILES

Written by: ROSA WALSTON LATIMER

When Liz Merrick first visited Jamaica over 20 years ago for a mission trip to Mustard Seed Communities (MSC) homes, she found a capable, dedicated staff providing quality care to children and adults with disabilities. “At that time, the staff was providing mostly palliative care to the residents,” Merrick said. “Resources and personnel were not available to help facilitate some level of mobility. Most were bedridden, and those who weren’t might be propped up in a plastic chair or a car seat. Many of the residents were experiencing pressure sores.” Merrick took the situation to heart and set about to find a way to provide wheelchairs to the Mustard Seed Communities.

One MSC resident who Merrick met on her first trip continues to be an inspiration. “Claude is now 51 years old. During the time I have known him, he has progressed from lying flat on his back in a lawn chair for more than 15 years to now having a power wheelchair. His lungs were compressed and once we got him upright, he got his voice back and could communicate and sing. Claude experienced his first independent mobility at age 49! He is an amazing man, well respected by the staff and other residents. I could tell you so many stories like this. That is what keeps me coming back. These encounters have given my life a focus and a purpose.”

MSC is an international nonprofit dedicated to caring for the most vulnerable populations worldwide. The organization began in 1978 as a home for children with disabilities who had been abandoned to the streets of Jamaica. Today, MSC provides loving and lifelong care to over 600 children and adults with disabilities, most of whom have cerebral palsy; children affected by HIV and AIDS; and young mothers in crisis in Jamaica. The organization also serves people in Nicaragua, Dominican Republic, Zimbabwe, and Malawi.

“Many think of Jamaica as a great vacation destination and don’t realize it is a developing world country,” Merrick said. “Still, it is a beautiful country with beautiful people.” Because of the poverty level in Jamaica and a culture where single-mother families are pervasive, a child born with a disability is often left on the street. This practice has changed somewhat with facilities such as the MSC offering an alternative for care.

“I realized a great need on my first mission trip and began going back every year and eventually, multiple times each year,” Merrick said. “Early on, I would try to bring a wheelchair for one or two residents with me on each trip. Before long, I realized I needed to find a way to get more wheelchairs to the residents.”

After 10 years of educating the MSC organization about the possibilities of providing appropriate wheelchairs and equipment to the residents, Merrick began looking for an organization to help. “At that point, I didn’t know how to get this done alone.”

MUSTARD SEED COMMUNITIES (MSC) IS AN INTERNATIONAL NONPROFIT DEDICATED TO CARING FOR THE MOST VULNERABLE POPULATIONS WORLDWIDE.



Volunteer Jeff Swift, Rehab Technology Supplier, and Mustard Seed Communities resident technician, Chion Robertson.



Residents and volunteers at Mustard Seed Communities homes in Jamaica: (back) Hansen, Scott Bland, George Todd, Bryan Clever, Jeff Swift, Tavares, Donovan, Jennith Bernstein, Chris Maurer, Jane Schmitz, Liz Merrick. (front) Marat Schterenber, Bashy, Connie Divine, Chion Robertson.

Merrick certainly had the heart and the vision for this project but no hands-on experience with evaluating and configuring wheelchairs. Now a realtor, her past work was in consumer products and working with nonprofits. "For a short time, I worked for an airline so I could qualify for free airfare to Jamaica!"

For a few years, United Cerebral Palsy Wheels for Humanity worked with Merrick to help provide chairs for residents of the MSC homes in Jamaica but could not continue long term. Merrick made connections with a Rehab Technology Supplier who accompanied her on a trip to Jamaica and helped assess the possibility of continuing with her vision. "He assured me we could do this. That was the beginning of putting these trips together on my own." Through the years, many Rehab Technology Suppliers and clinicians have been critical in the continued success of the MSC wheelchair missions.

Since 2014, Merrick has collected wheelchairs with the help of amazing volunteers, fundraised to purchase parts, recruited teams, and coordinated the teams and delivery of the equipment on site. "I love it! This is my passion," Merrick said. "Everyone in our family

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Volunteer Connie Divine, ATP/SMS and Mustard Seed Communities resident, Joevan.



Mustard Seed Communities resident, Devon.



(l to r) Jennith Bernstein, Chris Maurer, Liz Merrick and Claude, in his first power chair.

After a hiatus of two years because of the pandemic, there was much work to accomplish. Merrick organized a team of 10 therapists and RTs for a trip to Jamaica in March 2022. “Typically, we take three RTs and one therapist,” Merrick said. “The need was so great, the more on the team, the better because we work 14-to-16-hour days. It is exhausting work in extreme heat. However, the rewards are great.”

The 2022 MSC wheelchair mission trip was a first-time experience for Connie Divine, ATP, CRTS®, with National Seating & Mobility; Chris Maurer, a physical therapist at Shepherd Center in Atlanta, Georgia; and Jennith Bernstein, clinical affairs manager for Permobil, although Bernstein had made similar trips with other organizations. We were interested to learn what, if anything, about this trip surprised these skilled professionals.

Although she had been forewarned, Maurer was surprised by the long hours. “The days were longer, and the work harder than I expected,” Maurer said. “However, there were many positive surprises, too. I

WHEELCHAIR MISSIONS IN JAMAICA ...
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is involved with Mustard Seed Communities in some way and, in addition to the wheelchair trips, we have traveled to Jamaica many times because we have developed relationships with the staff and residents. My daughter, Lindsay, is an occupational therapist (OT) because of the influence of our involvement with Mustard Seed. While she was in school, she was instrumental in helping establish a program for OTs to do an international field rotation at Mustard Seed homes in Jamaica.”

Usually, there are two MSC wheelchair mission trips each year. “The first trip we do evaluations to see who needs new chairs and what repairs are needed,” Merrick said. “Then we begin to source the wheelchairs and parts. We purchase new parts for seating systems and orthopedic support needs, put those together with donated frames and ship them to Jamaica in a container. Each chair has the resident’s name attached along with a copy of the evaluation. Next, the second team of the year distributes the new chairs and takes care of needed repairs.

“Most therapists who come on these trips say they have never seen the level of disabilities they see at these homes,” Merrick said. “These children don’t get therapies and early interventions provided in the U.S. This presents a challenging situation for our team in fitting wheelchairs because the needs are so complex. Once our work is done, seeing the smiles and appreciation of the residents, the majority of whom are nonverbal, is our reward.”



Chion Robertson, Mustard Seed Communities resident technician in Jamaica, with Vinroy, a 43-year-old resident, who received his first power chair.



Mustard Seed Communities resident, Claude, in the lawn chair where he spent most of his days for 15 years before experiencing his first independent mobility at age 49.



O'Neil, before and after receiving his wheelchair from the Mustard Seed Communities mission in Jamaica.

WE DID A LOT OF WORK, AND THE DAYS WERE LONG. OUR TEAM OF TEN SAW APPROXIMATELY 180 INDIVIDUALS DURING THE WEEK ... THE ENTIRE EXPERIENCE WAS VERY REWARDING.

was impressed by how well loved the residents were by the staff in each home. The staff works with limited resources, yet, overall, the residents were well dressed and clean. The caregivers put effort into making sure we knew the individual needs."

Divine found the reception by the staff and residents heartwarming. "I didn't expect such a warm, sincere welcome. When we arrived at a Mustard Seed Communities home, we were greeted with singing and 'Welcome' signs," Divine said. "The dedication of the staff was exceptional. Many have worked in a Mustard Seed home for a dozen years or more, at times walking a mile on a dirt path to work each day. The attention to individual care was a higher level than I've seen in some facilities in the United States."

"I was not surprised, but very content, to see Mustard Seed is committed to sustaining the provision of equipment throughout the island of Jamaica," Bernstein said. "Previous teams and Merrick have worked hard to build capacity by training staff on how to service the equipment between the wheelchair mission trips. In addition, because of providing appropriate seating and mobility issues to the residents, there has been a significant reduction in wheelchair and bed-related pressure injuries. As we know, this is life-changing for someone living with a physical disability.

"We did a lot of work, and the days were long. Our team of 10 saw approximately 180 individuals during the week. Plus, we had travel time between sites," Divine said. "However, the entire experience was rewarding. These homes don't get many visitors,

so the one-on-one interaction was as important as the wheelchairs. The volunteers have been coming back year after year. I liked the challenge of being able to figure something out on the spot. We couldn't order parts!"

Team members faced an ever-changing variety of tasks. "We assessed posture and positioning; the ability to sit, and what support was needed," Maurer said. "Merrick had shipped a container filled with wheelchairs and other equipment. We helped select proper wheelchairs, seating systems and positioning devices. We also helped train the recipients on how to use the chair. In some instances, repairs were needed on chairs already in use. We had to be creative with our supplies. Toward the end of the week, there wasn't much left to work with. The team also did evaluations to prepare for the next group, so there will be specific help for everyone."

One example of creative thinking by the team concerned a resident who had previously been evaluated for a power wheelchair. "The chair was supposed to use a midline joystick mount, but when we arrived the mount ordered didn't work for him. This meant we didn't have a way for him to have upper extremity support," Bernstein said.

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Liz Merrick (left), wheelchair team leader, and residents of a Mustard Seed Communities home welcome volunteers from the United States to Jamaica.

WHEELCHAIR MISSIONS IN JAMAICA ...
(CONTINUED FROM PAGE 19)

“So, Connie and I modified an old lap tray, used the attendant drive from the back of the chair and cut out a place for the joystick to attach. Then we worked on stable positioning and programming, which allowed the man, who was 43 years old, to drive his chair with his elbow and have independent mobility for the first time in his life.”

After returning home, the circumstances encountered during the MSC trip have had a lasting influence on team members. “The trip gave me insight into what products can work in a less-resourced setting,” Bernstein said. “Mostly, after this trip, I am more thankful for the access, training, equipment and specialty professionals we have here in the states. Some of the residents in Jamaica have extremely severe spasticity but do not have access to medications and treatments that are available in the U.S.

“I’ve been doing this work a long time, and this trip helped to jump start my creative thinking about how to do things with people who have few resources,” Divine said. “I am beginning to work with pediatrics more than in the past so the intense work, mostly with kids, was a ‘down and dirty’ in-service with pediatric seating and positioning.”

“I reflect on the events of this trip often,” Maurer said. “My week at Mustard Seed gave me many creative ideas relating to the work we do here. Specifically, it made a mark on me to pursue my learning and integration into our clinic of 24-hour positioning.”

Maurer recalled one especially touching encounter. “Most of the residents live in the Mustard Seed homes because their families cannot care for a child with a disability. I learned there are exceptions. One day a mother brought her teenage son to the home. He had unbelievable tone, and we worked very hard to provide him with an appropriate chair so the boy could be a little bit more independent and supported,” Maurer said. “I was moved by how dedicated this mother was. When I went with her to the car to help load the wheelchair, I realized her husband and three other children had been waiting while we worked with the teenager. They were equally attentive and concerned and eager to be trained so they could get the chair in and out of the car. I was very impressed with this mother and the entire family’s dedication.”

“The one specific experience I cannot seem to forget is a young resident who had a manual rigid wheelchair. He had grown so much the chair was two or three years past the time that it was functional for him,” Bernstein said. “I worked with Connie and the resident Mustard Seed technician, Shane, on a new manual chair fitting. The young man was so happy to get a new, comfortable chair! And, he saw Shane, using a manual wheelchair, helping everyone. The boy was so inspired he asked for my clipboard so he could help us with our work and started to act as if he were taking notes on our evaluation forms. This was a great ‘full circle’ moment for him to see representation of what he could achieve and for him to feel comfortable and confident with his new equipment.”

“Mustard Seed Communities existing is a blessing beyond belief for these residents,” Maurer said.



Volunteers Connie Divine, ATP, CRTS®, with National Seating & Mobility, and Jennith Bernstein, PT, ATP/SMS, physical therapist and clinical affairs manager for Permobil, prepare a chair for a resident of a Mustard Seed Communities home in Jamaica.



Joy, a resident of a Mustard Seed Communities home in Jamaica, in her first wheelchair.

Divine added, “We were rewarded with spectacular smiles from the residents. They were so happy to have some different personal interactions. Any help we could provide with their equipment was appreciated. A resident who received new arm pads or a new cushion was just as excited as if they had received a new wheelchair. The Mustard Seed Communities’ wheelchair mission, established by Liz Merrick and sustained by committed volunteers and contributors, has changed many lives.”

Merrick is always looking for volunteers to travel to Jamaica to distribute and repair wheelchairs. If you can’t make a trip, you can support these endeavors by donating using this link: <http://www.mustardseed.com/wheelchair> or help connect with a manufacturer so parts can be purchased direct. The organization has a great need for reclining bath chairs that can be purchased in bulk and sent in the next container. The next MSC wheelchair mission trips are planned for January and October 2023.

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Connie Divine, ATP, CRTS®, has been with National Seating & Mobility (NSM) for 17 years. Most of that time was working with Shepherd Center in Atlanta, Georgia. She recently moved to Pensacola, Florida, where she continues her responsibilities with NSM.



Chris Maurer, PT, ATP, is a physical therapist and assistive technology program manager at Shepherd Center in Atlanta, Georgia. She has worked in the seating and mobility clinic for 20 years and has contributed to multiple clinical research studies related to the field.



Liz Merrick is a realtor with RE/MAX in the Atlanta, Georgia, area. She organizes and coordinates the efforts of Mustard Seed Communities (MSC) wheelchair mission trips to provide wheelchairs to residents with disabilities in Jamaica.

SUMMER CRT UPDATE

Written by: DON CLAYBACK, EXECUTIVE DIRECTOR OF NCART

JOIN THE CRT VIRTUAL CONGRESSIONAL FLY-IN

It's time to sign up for the Sept. 14 CRT Virtual Congressional Fly-In. This annual event is jointly hosted by NCART and NRRTS to allow Complex Rehab Technology (CRT) suppliers, manufacturers, clinicians, consumers and others to meet directly with their Members of Congress. The theme for this year is "Make the Connection."

We will be holding the fly-in VIRTUALLY this year and are excited everyone will be able to deliver important CRT access messages to their members without leaving their home or office. We are also happy to report that, thanks to our generous event sponsors there is NO COST to participate.

This is the ideal opportunity to tell Congress the actions needed to protect access to CRT for people with disabilities. Topics to be covered include: (a) the unique nature of CRT and why policies that support access are important, (b) the importance of Medicare coverage of power seat elevation and standing systems, (c) the increased costs of providing CRT and the need for increased funding, and (d) the need to ensure the CRT Remote Telehealth Option for Physical and Occupational Therapists is made permanent.

Visit www.CRTAccess.com to get additional details and to register. Please join us on Sept. 14 for an important day of advocating to protect access to CRT.

COVERAGE OF POWER SEAT ELEVATION AND STANDING SYSTEMS

Center for Medicare and Medicaid Services Administrator Chiquita Brooks-LaSure has committed to opening the public comment period by August regarding the request for Medicare coverage of power seat elevation and standing systems.

This 30-day public comment period is the next step in CMS' review and processing of the formal request for "reconsideration" of the related National Coverage Determination (NCD). It will allow CMS

to gather input from stakeholders and others to use in making a decision on the coverage request for these important systems used in conjunction with CRT power wheelchairs.

NCART continues to work together with the ITEM Coalition on related discussions and advocacy actions. Once the public comment period opens, a website devoted to this issue will be shared as a hub of resource materials, talking points and comment submissions. Stay tuned for more information.

CRT AWARENESS WEEK AUG. 15-19

We celebrate CRT Awareness Week each year with five days specifically dedicated to educating others about what CRT is all about and why access is important.

The consistent efforts of many advocates from across the country create meaningful and lasting policy changes that protect access. These five days are another way for advocates to underscore the importance of access and provide information about CRT to policymakers, friends, family and communities.

No matter what role CRT plays in your life, anyone can be an advocate, and there are many different ways to get involved. Visit www.ncart.us for more information, and thanks in advance for finding ONE DAY and ONE WAY to participate Aug. 15-19!

NATIONAL CRT REPAIR INITIATIVE

There can be significant barriers for users of CRT wheelchairs and other CRT items when accessing timely repairs and service. Many of these stem from poor policies, excessive documentation requirements, unnecessary prior authorization requirements and insufficient payment rates of federal, state and commercial insurance plans that are estimated to fund over 90% of these services.

The challenges to timely access to repairs is a complicated problem that requires the pursuit of multiple changes to resolve. While there have been some targeted efforts in this area over the years, more is needed. To enhance and coordinate the collective

NO MATTER WHAT ROLE CRT PLAYS IN YOUR LIFE, ANYONE CAN BE AN ADVOCATE AND THERE ARE MANY DIFFERENT WAYS TO GET INVOLVED.

advocacy activities at the federal and state level, NCART is establishing a National CRT Repair Coalition.

The mission of the National CRT Repair Coalition is to secure needed policy and funding changes at the federal, state and commercial payer levels to enable CRT users to have access to timely and professional repair services.

Membership will include representatives from suppliers, manufacturers, clinicians, consumers and others who have involvement in the CRT repair process. Updates will be provided as we move ahead.

LEGISLATION TO MAKE HOMES MORE ACCESSIBLE

Reps. Charlie Crist, D-Fla., and Tom Suozzi, D-N.Y., have introduced HR 7676, the Home Modification for Accessibility Act of 2022, to provide tax incentives to homeowners to proactively update their houses for improved accessibility, security and safety.

This bill amends the Internal Revenue Code to promote modifications to a person's primary residence. It provides a \$30,000 lifetime benefit for singles or \$60,000 for couples who file jointly. Before age 59½, individuals would be able to use 401K or IRA funds without penalty for early withdrawal to fund eligible home modifications. After age 59½, individuals would receive a tax deduction up to the amounts specified for expenses on eligible home modifications (whether using retirement or other funds).

Passage of this bill would bring much-needed assistance and benefits to senior citizens and to people with disabilities. It will not only improve a person's quality of life and independence but also help reduce health care costs through decreasing home injuries, hospitalizations and caregiver needs.

Please let Congress know this bill should be passed. Visit www.protectmymobility.org to send an email to your representatives asking for support of HR 7676.

BECOME AN NCART MEMBER

NCART is the national advocacy association of leading CRT suppliers and manufacturers dedicated to protecting CRT access. To continue our work, we

depend on membership support to take on important federal and state initiatives. If you are a CRT supplier or manufacturer and not yet an NCART member, please consider joining. Add your support to that of other industry leaders. For information visit the membership area at www.ncart.us or email dclayback@ncart.us to set up a conversation.

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

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MEETING THE CRT NEEDS OF THOSE AGING WITH CEREBRAL PALSY

Written by: BRITTA SCHWARTZHOFF, PT, DPT, ATP

Everyone will experience age-related changes. As individuals age, the more diverse their physical presentations become. Aging impacts those living with chronic neurological conditions, such as cerebral palsy, at higher intensities and at earlier ages. Although cerebral palsy is known as a static diagnosis, the secondary effects that develop due to aging feel progressive for many adults.^{1,2} Therefore, creative strategies are essential to meet the changes in presentation and need throughout the lifespan.

The New York State Developmental Disabilities Planning Council found early-onset reports of musculoskeletal concerns in adults living with cerebral palsy such as changes in muscle flexibility, strength and endurance; spasticity; arthritis; falls and fractures; pain; and fatigue.¹ Mary and Peter, both adults with spastic quadriplegic cerebral palsy, provided their insights and personal experiences with aging. They have both experienced an increase in muscle stiffness and weakness impacting their daily activity completion. For individuals with cerebral palsy who use Complex Rehab Technology (CRT) products to participate in their mobility-related activities of daily living (MRADLs), reassessments throughout the client's lifespan and subsequent equipment and intervention changes are necessary to continue supporting independence and function.

MARY AND PETER

Various age-related changes can impact CRT needs. Mary reported increased stiffness and skin fragility have had the most impact and, as a result, she required a different type of joystick mounting in a new position, as well as a custom-molded seating system. These changes allowed her to continue to independently use her power wheelchair.

With increased stiffness, Peter has difficulty rotating his neck to see his environment to complete tight power wheelchair maneuvers in small spaces. Rearview cameras, sensor alerts or SMART wheelchair technology, for example, could greatly improve his

visibility, ability to maneuver his wheelchair and even safety. However, these items are not covered by his insurance. He now needs optional headlights to see various environments during dimly lit hours. Peter pushes off of the footplates to move back on his cushion and to shift his weight. The specific design of the footrest hanger has become more critical as his abilities change.

Both Peter and Mary reported changes in the timing and coordination of swallowing in the past few years. According to the literature, gradual changes in swallowing difficulty and coordination, as well as a higher rate of other chronic health conditions, can occur in adults with cerebral palsy as they age.³ For Mary and Peter, eating and drinking have become more difficult and have led to decreased independence during meals. Therefore, positioning is more critical in order to permit safe eating.

INTERVENTIONS

Clinicians must use creative problem-solving to address the changing needs and functions of clients throughout their lifespan. Balancing the varying needs of those aging with cerebral palsy is more challenging and requires additional creative problem-solving.

TRANSFERS AND CUSHION HEIGHT

Consider an individual who performs a stand-pivot transfer and requires a low seat-to-floor height to transfer safely. Secondary to increased pain and greater skin fragility that occurs with aging, this individual may have a greater need to offload their sacrum while sitting in the wheelchair. It would not be possible to simply increase the well or cutout inside a low-profile cushion, as the client would bottom out. A high-profile cushion would be required which would, in turn, raise the overall seat-to-floor height. If the system is already at its lowest seat-to-floor height, creative solutions are needed. A front taper on the cushion may help. Anterior tilt allows the hips to safely move toward the anterior edge of the cushion during the transfer while allowing the necessary cushion height for skin protection once fully positioned into the wheelchair.

HIP STIFFNESS

Increased hip stiffness can limit hip flexion and require a more open seat-to-back angle. This increased stiffness may also make donning and doffing transfer slings more time-consuming and difficult for the individual and their caregivers. At the same time, leaving the sling

IF LIVING A LIFE WITH A DISABILITY IS DESCRIBED AS A CREATIVE ACT, THEN AGING WITH THAT DISABILITY WOULD BE ITS MASTERPIECE.

under this person throughout the day is never recommended. It can have even more damaging implications secondary to age-related changes in the skin.

ANCILLARY EQUIPMENT

In addition to wheelchair and seating system changes, ancillary equipment needs must be examined and reassessed. Adults with cerebral palsy may have decreased weight-bearing opportunities. If the client can no longer stand or ambulate independently or with assistance, options such as integrated wheelchair standing features or gait trainers with power stand transitions have the potential to provide improvements in physical and mental health.^{4,5} Peter reported using his gait trainer (with a power stand transition feature) reduces stiffness and allows for supported stepping and active stretching. These benefits have improved his ability to transfer to other surfaces, such as the bed and toilet. Without the opportunity for weight-bearing with the powered stand transition feature of the equipment, Peter would be unable to continue with this regular exercise program.

ORTHOTICS

Orthotics, such as ankle-foot orthoses, may need to be modified as individuals age. If an individual's transfers change from a stand-pivot to a mechanical lift system, the goal of the orthoses may also change. Changing from a rigid to an articulated style orthotic may require a change in footrest hanger and footplate angles. Someone who lives independently with minimal assistance may choose to stop using orthotics as independent donning and doffing is difficult. As a result, footrest hanger and footplate angles may need to be changed to accommodate increased plantar flexion. Dynamic footrests may also be helpful if tone is now higher in the lower extremities.

During evaluation for replacement systems, members of the CRT team must thoroughly investigate any changes in client's needs. Many individuals aging with cerebral palsy are experienced power wheelchair users and may be inclined to replicate the current system as this is familiar. The age-old saying, "If it's not broke, don't fix it," doesn't leave consideration for "Yes, but it could be BETTER." CRT team members must educate clients on new and emerging options to better meet changing needs. The wheelchair evaluation is also an opportune time to identify need for additional referrals, as there is a lack of specialized services for this population. Some individuals are extremely knowledgeable about their CRT system — having access to detailed equipment specifications can greatly aid decision-making and final outcomes. Small changes can have catastrophic effects on function. Upon delivery, adjusting the system and fine-tuning positioning or programming features alongside the client will also improve functional use and decrease equipment abandonment.

CONCLUSION

Aging affects everyone differently, and solutions will vary among individuals. For adults living with cerebral palsy, the effects of aging should be considered during CRT evaluations even with young adults. In her early 30s, Sarah had already experienced lower extremity arthritis, increased global pain and greater stiffness in her extremities, impacting her ability to transfer and weight-bear. She has increased discomfort during prolonged sitting and is already anticipating the changes she may need to make to her wheelchair configuration within the next few years.

Utilizing creative problem-solving and a client-centered approach during evaluation and interventions leads to long-term outcome success. Continued advocacy for increased coverage of CRT items and for increased access to specialized services is needed to maximize health, function, independence and quality of life for those aging with a disability.

ACKNOWLEDGMENTS

I would like to acknowledge Peter, Mary and Sarah for their beams of light and wisdom and for the many lessons they have provided over the years.

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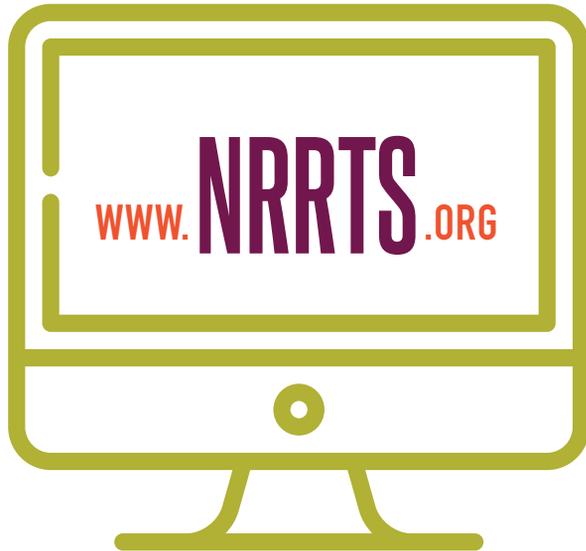
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Britta Schwartzhoff, PT, DPT, ATP, received her Doctor of Physical Therapy from St. Catherine University in St. Paul, Minnesota.. She has served in both inpatient and outpatient settings throughout her career, including working in a seating and positioning specialty clinic. She specializes in serving complex rehab needs, including adults with childhood onset disabilities. Schwartzhoff is passionate about providing opportunities, tools and Complex Rehab Technology equipment that promote independence, function and health optimization throughout the lifespan. Schwartzhoff has had the opportunity to specialize and present at universities and multiple national and international level conferences regarding the benefits and processes on standing throughout the lifespan, integrated standing features, transitioning mobility and positioning devices throughout adulthood, seating clinic collaboration, and more. Schwartzhoff currently works as a clinical educator at Numotion. She is a member of the Clinician Taskforce and the Clinical Advisory Board for Altimate Medical. She lives in Hudson, Wisconsin, and enjoys running, cooking and spending outdoor time with her children throughout the seasons.

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AUGUST 23, 2022, AT 7 PM ET

Power Wheelchairs: Thinking Beyond the Standard Joystick

Speaker: Kathy Fisher, B.Sc.(OT)

Sponsored by Invacare

Intermediate Level, Seating and Positioning, ATP/SMS Prep Content

Power wheelchair technology has developed to allow a personalized driving experience to maximize a client's ongoing functional potential. For many clients a basic joystick is not sufficient to meet their needs in all environments due to limitations in strength, coordination and fatigue. Many alternative driver controls exist but

how do you as a clinician make the best recommendation? This session will highlight these innovations and will present the options based on assessment considerations.

LEARNING OUTCOMES:

- Participants will be able to describe five assessment considerations in determining potential driver control access.
- Participants will be able to list five programming parameters that effect the functioning and performance of proportional and non- proportional driver controls.
- Participants will be able to list three statements illustrating the clinical rationale for selection of driver controls.

For more information, visit the website www.nrrts.org



AUGUST 25, 2022, AT 11 AM ET

Evaluation and Seating Interventions for Clients with Supra-pelvic Scoliosis.

Speaker: Bart Van der Heyden, PT and Sam Hannah, seating specialist

Sponsored by Symmetric Designs

Intermediate Level, Seating and Positioning, ATP/SMS Prep Content

The newly proposed technique focusing on the evaluation of supra-pelvic scoliosis will be introduced. The aim is to provide data from the supine position on the plinth that can be used 1:1 in the build of a seating system. The outcomes produced are distance measurements, ROM including multiple segments interactions with improved efficiency and outcomes. As part of the face and content validation process, an overview of this novel assessment will be presented and an outline on how you can be involved in the validation process will be given. To illustrate this technique, an intervention using the Free Form Seating kit from Symmetric Designs will be shown.

LEARNING OUTCOMES:

- The participant will be able to identify how you can be part of the content and face validation process of newly proposed Mechanical Assessment Tool (MAT) focusing on the supine part of the MAT evaluation.
- The participant will be able to list at least three measurable outcomes of this novel MAT assessment.
- The participant will be able to list at least three benefits of this novel MAT evaluation compared to the classic MAT evaluation.



SEPTEMBER 13, 2022, AT 7 PM ET

Technology and Reimbursement: How Can We Make Them Work Together?

Speaker: Claudia Amortegui, MBA

Intermediate Level, Funding and Public Policy

Less than 15 years have passed since the first iPhone was introduced. It started a revolution in the world of cell phones. For most, they are a necessity to everyday life. The features have continued to improve throughout the years. How is it that the technology for something so basic has grown exponentially, but in the world of Complex Rehab Technology (CRT) our technology seems to be stunted in many ways? Funding seems to always

be the culprit. Not knowing if something will be reimbursed and for how much places a big wall in front of innovation. In this course, we'll discuss how clinicians, ATPs, manufacturers and providers can help overcome this issue. There are many factors that involve everyone; it's time to learn.

LEARNING OUTCOMES:

- Participants will be able to describe at least three key elements in the funding of new CRT technology.
- Participants will be able to identify the language needed when justifying new technology in order to obtain proper reimbursement.
- Participants will be able to compare documentation to understand what would be considered for coverage vs. likely denials.



OCTOBER 19, 2022, AT 11 AM ET

The Pelvic-Spine Connection: The Key to Positioning and Function

Speaker: Tina Roesler, PT, MS, ABDA

Beginner/Intermediate Level, Seating and Positioning/Medical Terminology, ATP/SMS Prep Content

The wheelchair and seating evaluation has become a very specialized process that focuses on matching the most appropriate equipment with the client's postural and functional requirements. But often it has a strong focus on the equipment itself. A properly fitting wheelchair can increase a user's function within the environment physically and socially and can improve overall quality of life. On the contrary, a poor fitting wheelchair and sitting posture can negatively affect the user's health. An important aspect to proper fitting is to understand the biomechanics of the pelvis and spine and how they integrate to promote stability and function in the seated client. Back to basics.

LEARNING OUTCOMES:

- Participants will be able to identify spinal and pelvic landmarks crucial to seated posture.
- Participants will be able to describe changes to spinal and pelvic anatomy as it pertains to development.
- Participants will be able to describe how external seating and positioning devices can influence posture and mobility.



DECEMBER 6, 2022, AT 7 PM ET

The Mat Exam

Speaker: Kelly Waugh, PT, MAPT, ATP

Intermediate Level, Seating and Positioning, ATP/SMS Prep Content

The mat exam is one of the most important components of a Wheelchair Seating and Mobility Assessment. This webinar will provide the basics on this critical hands-on part of the physical assessment: What is it, who does it, when is it done, and why? After an introduction covering these key questions, we will review basic mat exam methodologies highlighting the significance of joint range of motion findings for wheelchair prescription. A summary will review how to translate supine range of motion values into the three primary body and seating system angles useful for seating prescription.

LEARNING OUTCOMES:

- Participants will be able to describe what the mat exam is and its purpose.
- Participants will be able to identify what movement of the pelvis typically results when there is a limitation in hip and knee joint flexibility that is not accommodated (i.e., the limb has been moved beyond its end range).
- Participants will be able to state the correct corresponding values when translating hip flexion, knee extension and ankle dorsiflexion range of motion into the relevant body segment and seating system angles.



DECEMBER 7, 2022, AT 11 AM ET

Ready to Play: Positioning to Facilitate Active Participation for Young Children with Physical Disabilities

Speaker: Angie Kiger, M.Ed., CTRS, ATP/SMS

Intermediate Level, Seating and Positioning, ATP/SMS Prep Content

A day in the life of a young child typically includes preschool, playdates with friends, mealtime with family, bath time, etc. Having the opportunity experience the quintessential aspects of childhood is vital for every child's overall growth and development. However, making those everyday experiences happen for a child with physical disabilities can be difficult.

During this one-hour session, common obstacles young children with physical disabilities may experience when it comes to being able to participate, the potential negative impacts of not participating, and strategies to facilitate activity participation will be discussed. Are you ready to help children play?

LEARNING OUTCOMES:

- Participants will be able to list three reasons why providing young children with physical disabilities with equipment to facilitate active participation is important for overall growth and development.
- Participants will be able to explain three strategies for implementing at least two pieces of positioning and/or mobility equipment into a young child's daily routine.
- Participants will be able to list both clinical and functional benefits of three different pieces of positioning and/or mobility equipment for young children.



DECEMBER 8, 2022, AT 3 PM ET

Support Surfaces

Speaker: Linda Norton, B.Sc.OT, MSc.CH, PhD, OT Reg(Ont)

Intermediate Level, Seating and Positioning, ATP/SMS Prep Content

Therapeutic support surfaces are a critical component of pressure injury prevention and management. Knowledgeable Complex Rehab Technology suppliers who can apply the latest research and standard terminology to the client's circumstances are in a unique position to have a positive impact on the client's health. Following a brief review of the applicable terminology, principles and best practices, participants will learn how to compare support surfaces from different manufacturers to choose the features that would benefit a specific client. Using a case-based approach, participants will explore applying research and best practices to the client's situation to determine the best options.

LEARNING OUTCOMES:

- Participants will be able to describe the key support surface definitions and best practice recommendations.
- Participants will be able to compare different products from different manufacturers in a clinically relevant way.
- Participants will be able to apply best practices and product comparisons to several case studies to determine the best option for the client.



In a time of drastic change, it is the learners who inherit the future. We appreciate our learners' willingness to adapt to the ever-changing sphere of Complex Rehab Technology, even before COVID hit our world.

We have over 100 on-demand webinars and CEU articles in our library that cover a variety of topics on seating and positioning, medical terminology, ethics, funding and best business practices.

The education program awarded over 1,356 CEUs from August 2019 to August 2020 — that equals 13,560 hours of education!

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SEEKING A BALANCE TO PROVIDE BOTH CLIENT-CENTERED CARE AND EFFICIENT SERVICE DELIVERY

Written by: JEAN L. MINKEL, PT, ATP, AND MICHELLE L. LANGE, OTR/L, ABDA, ATP/SMS



NRRTS is pleased to offer another CEU article. This article is approved by NRRTS, as an accredited provider, for .1 CEU. After reading the article, please visit <http://bit.ly/CEUARTICLE> to order the article. Upon passing the exam, you will be sent a CEU certificate.

“You do not rise to the level of your goals. You fall to the level of your systems.”

—James Clear, Author of *Atomic Habits*

INTRODUCTION

Systems of care are needed to meet the needs of our clients, organizations and industry. Our systems are just that, ours. The pandemic presented us with the “unreal” reality that all “systems” are subject to change, in this case, in a moment’s notice. As we look forward, we thought it was a good time for some self-reflection regarding our Complex Rehab Technology (CRT) systems of care. Each of our systems has been developed by human beings, implemented by human beings and deserves to be questioned by human beings.

The provision of CRT is complex. One of the most basic aspects of our field is we work in a “third party payment” system, which functions differently than other consumer markets. Despite the challenges of the payment system, we are individuals, working with clients/patients/consumers/end users who are looking for solutions to their seating and mobility challenges. We are inviting you to do some self-reflection on your own practices, within the system of care where you work, knowing we all work within the context of a third-party payment system. Systems only change when we are truly honest about what is working and what is not, and when we are willing to fight to change the status quo when the system is no longer working. This is especially true when we reflect on whether

the system is working for our ultimate “beneficiary,” the end user of our products and services.

In this article, we will explore how we can provide both client-centered care and efficient service delivery within our systems of care – all while addressing potential barriers to this model.

LANGUAGE IS IMPORTANT

Choosing a word to describe the “end user” provides some insights to the many challenges we face when reflecting on our own practices or systems of care. For this article we will not be using the term “patient,” though reflecting on providing true “patient-centered care” was an important exercise, leading us to write this article. We are all likely to be “patients” in a health care system at some time in our lives: for wonderful reasons like pregnancy and the birth of a child, for routine reasons like an annual physical or a screening test, or for critical care needs like an acute illness. When we are in this patient role, we want to work with competent health care providers and many of us are comfortable participating in an “Expert Model of Care.”¹ No one wishes to have cancer, but if needed, we want access to experts in that type of cancer. We hope the “expert” embraces “patient-centered care” and is willing to listen to our questions and concerns, even if we do not have any prior experience living with cancer.

So, what term do we use? “User” can have a negative connotation in our society, implying that a person is using illicit substances. “Wheelchair User” implies this is a person who uses a wheelchair and is a more acceptable term. “Consumer” focuses on a person in the role of a purchaser. “Client” is a more generally accepted term in our industry at this time.

EVOLVING FROM AN EXPERT TO A PARTNER

While an Expert Model of Care may work well when we need to find a cure for an acute illness, it is not the most effective model to use when supporting a person with a mobility limitation to find the most effective seating and mobility solution. Many people living with a disability, express frustration when finding themselves working with a CRT team (therapist and supplier) who do not value their experiences as a wheelchair user. A critical shift in our system of care may be needed to achieve the best client-centered outcomes. While we all strive professionally to be experts in our field, our model of care needs to evolve even further. Effective CRT service delivery needs to embrace the Partnership Model of Care.¹ In a partnership, we are not working with patients, we are supporting clients to find an affordable seating and mobility solution that works for them. In this model of care, our systems and practices need to be grounded in an understanding the client is THE EXPERT in their life. Only that person knows what has been successful in the past. Only that person knows what they hope to achieve as a result of “getting the right chair.” Only that person really knows about their own functional abilities and environments of use.

Admittedly, the first-time wheelchair user does not have this same “lived experience” and needs to rely on the “expertise” of others, including the CRT team, to help make the “best, first time choice.” However, first-time wheelchair users want to be heard, even if they are expressing reluctance² and fear. For many people, the wheelchair IS a symbol of disability. Just the thought of needing to rely on a wheelchair for mobility is depressing for many people who equate walking with independence. Instead of seeing a tool for freedom of movement, they see a symbol of disability, dependence and loss of function. These feelings are understandable and need to be acknowledged, not ignored. Too often, “experts” don’t want to get involved with this partner’s “emotions!”

As “experts,” we bring valuable knowledge to the table. We must also include clients (and caregivers, as appropriate) as partners in our service delivery model. Clients also bring valuable knowledge and deserve our



respect. This system of care improves ultimate client outcomes, as goals, priorities and information are more complete.

DIGNITY OF RISK

A full expression of the Partnership Model of Care is when we, as professionals, choose to support the “dignity of risk.” Dignity of risk means being able to make a choice even if it could have negative consequences. You have this right. People with disabilities also have this right. So how does supporting this right influence your practice? Here is an example.

From The New York Times Magazine article:

The author, Harriett McBryde Johnson, was asked by the reporter:

Q: “Was he (Peter Singer) totally grossed out by your physical appearance?”

This question, about my physical appearance, needs some explaining.

It’s not that I’m ugly. It’s more that most people don’t know how to look at me. The sight of me is routinely discombobulating. The power wheelchair is enough to inspire gawking, but that’s the least of it. Much more impressive is the impact on my body of more than four decades of a muscle-wasting disease. At this stage of my life, I’m Karen Carpenter thin, flesh mostly vanished, a jumble of bones in a floppy bag of skin. When, in childhood, my muscles got too weak to hold up my spine, I tried a brace for a while, but fortunately a skittish anesthesiologist said no to fusion, plates and pins — all the apparatuses that might have kept me straight. At 15, I threw away the back brace and let my spine reshape itself into a deep twisty S-curve. Now my right side is two deep canyons. To keep myself

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upright, I lean forward, rest my rib cage on my lap, plant my elbows beside my knees. Since my backbone found its own natural shape, I've been entirely comfortable in my skin."

From – "Unspeakable Conversations," by Harriett McBryde Johnson, The New York Times Magazine, Feb. 16, 2003. <https://www.nytimes.com/2003/02/16/magazine/unspeakable-conversations.html>

Johnson was an author, attorney and disability activist who lived much of her life in Charleston, South Carolina (see Figure 1). As a seating therapist working in 2003, I (Jean Minkel) found it exciting to see a person using a power chair on the cover of The New York Times Magazine. It was also horrifying, as a professional, to see her sitting posture. And then to read, "I'm ... a jumble of bones in a floppy bag of skin" and "since my backbone found its own natural shape, I've been entirely comfortable in my skin."

So, we need to ask ourselves, are we comfortable in allowing a person to be "a jumble of bones in a floppy bag of skin" if that is what works for them? Embracing the dignity of risk, allowing people to exercise self-determination, is not easy. First, it requires the ability to listen to the person. Really listen. Listen with the genuine intent to try and understand the other's perspective, not just try to convince them that you are right. It is important to demonstrate you respect the client's expertise in their own life experiences. Second, patiently share information about potential alternatives, pros and cons, and provide the time needed for the person to process the information provided. Here comes the hard part — the person has the right to make their own decision, even if that decision has the potential to lead to negative consequences. We all have the right to make our own decisions, even bad ones. By the way, Johnson lived 36 more years after letting her backbone find its own shape.

Professionally, as in any client situation and in this situation specifically, documentation must record the decision-making process and that the person is making an informed decision. The outcomes will sometimes be negative. Lessons learned from partnering with and listening to persons with the lived experience have been some of our longest lasting, practice changing lessons — resulting in very good, long-term, functional outcomes.

Is it ethical for the clinician or supplier to recommend something that has a high likelihood of leading to a pressure injury, even if the client wants it? Is it ethical and acceptable for the clinician or supplier to recommend something they believe will not work, only to turn around in six months and need to recommend something else? As the professional who is being asked to write and sign a Letter of Medical Necessity, you have an equal right to tell the client

you are unable to support their choice and ask them how they want to proceed. Their choice can include finding another provider or continue to try and find a solution that you can both agree to.

PRACTICING CLIENT-CENTERED CARE WITHIN A MEDICALLY NECESSARY SYSTEM OF CARE

Service delivery is greatly impacted by trying to meet the individual client's needs within a medically necessary payment framework, our industry largely relies on the "third-party payment system." Most CRT solutions are funded by either public or private health care insurance plans. In the U.S., and largely in Canada, payment for equipment needed by people with a disability must meet the "medically necessary" criteria. Medical necessity is not a universal criterion, however, to provide government or societal support for this equipment. Several other countries in northern Europe and the southern hemisphere, use a "functional necessity" criterion to determine coverage policy. What is the functional impact of not being able to stand and fully extend an upper extremity over your head to reach for items in your environment? What are possible technologies to restore the person's functional reach? Using a functional necessity coverage policy, seat elevators and standing devices would be covered items. The Australian government pushes the public policy even further to meet the needs of persons living with a disability. The National Disability Insurance Scheme (NDIS) is a national government program designed to get people the support they need to improve their skills and independence over time. Use the QR code at the end of the article to visit their website.

A key tenet of the NDIS system is the person with the disability deserves "choice and control" in making decisions about the supports needed to improve their skills and independence. While service providers in the U.S. and Canada may not soon be working in a similar model of care, practicing in a manner to provide the client choice and control should be a goal of our own individual standard of practice. So, what does a client-centered, choice and control professional practice look like? This requires a mind-shift from "what is covered" to "what is available?" Many of us struggle with the tension that arises when

what the client needs for functional improvement is not considered “medically necessary” and likely will not be covered by a third-party payer. Here is your decision-point. Do you even show or offer information about the “not covered” item, or do you limit the choice to just “the covered item”? Do you only show solutions you are most familiar with, or are you willing to arrange for a demo of a different device that might be better suited for the person’s needs, even if your profit margin will be impacted? Do you actually ask the person if they have a preference for a specific brand or style of seating or mobility product, before you start offering your own suggestions? Client choice goes way beyond what color the shroud should be. Offering choice and control takes work. It also invites the client to be an active participant in decisions with a profound influence on their lives — very often for the next five or more years! Partnership requires shared decision-making. Shared decision-making also allows for us, the professionals, to say “I don’t know” or “This is not likely to be covered; are you up for a fight or do you have access to other resources to fund this choice?” Learning to be comfortable saying, “I don’t know, AND I will get back to you with more information” is one of the most empowering statements you can make to invite your client into a joint decision-making process.

QUESTIONING THE SERVICE DELIVERY PRACTICE OF THE ‘ONE AND DONE’ SEATING AND WHEELED MOBILITY (SWM) EVALUATION

When many of us first worked in a seating and wheeled mobility (SWM) clinic, our average evaluation lasted three hours. It was attended by a physical therapist, occupational therapist, complex rehab supplier, and even a rehab physician! Sometimes a manufacturer’s rep was also present. During this evaluation, we interviewed the client and caregivers (and other team members who were often present), did a mat evaluation, placed the client in our seating simulator, and, if appropriate, tried various power wheelchair driving methods. Finally, we recommended seating, a manual wheelchair, a power wheelchair, a bath seat, and/or even an adaptive car seat! Whew, it’s tiring just thinking about it!

In comparison, when a client is referred for a rehab therapy service, that therapist performs an initial evaluation. The goal of a traditional therapy evaluation is to identify the client’s strengths, skills and goals and to then identify a problem list and therapy needs and then determine a treatment plan. The therapist recommends a specific number of visits to complete the treatment plan and meet the client’s goals.

AN EVALUATE AND TREAT PROCESS

What if we shift away from a “one and done” SWM evaluation and move toward an “evaluate and treat process?” A number of SWM clinics are already using this service delivery model. This process encompasses several visits. The initial visit, as in a typical occupational therapy or physical therapy initial evaluation, includes gathering information through an intake interview, conducting a supine and seated mat evaluation, and identifying the client’s functional abilities. Using this initial evaluation, the therapist and the client define mobility, posture and skin goals and develop a treatment plan. This treatment plan defines the next steps.

Here is an example of what the next several appointments may include:

- Visit #2: Use of a seating simulator or accessing demo back and seat supports, possibly pressure mapping in current seating, problem-solving specific functional parameters, and determining possible and general postural and skin protection solutions.
- Visit #3: Equipment trials of mobility bases and postural/skin supports, based on visit #2. This may include equipment trials in different environments, such as the van, the neighborhood outside of the clinic, or even in the home. This step may need to be repeated, depending on the outcome of the trial.
- Visit #4: Order specifications, determined with the client, care partners and the CRT supplier.
- Visit #5: Fitting and delivery, including all who were involved in the final specifications.
- Visits #6 and more: Training, as needed; follow-up at required intervals.

Each visit is enhanced when all team members are present. Given our collective experience with responding to this pandemic and our current access to telehealth services, “being present” can be very effective by means of a video link, for any team member, depending on the site of the trial.

Clearly a drawback to this “evaluate and treat” model of care is the increased number of visits for the client. The client now must attend

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a number of visits, coordinating caregivers, transportation and possibly time off from work. Another drawback is team members must also coordinate a number of visits into their schedules. Documentation, again, is so critical in this model so that all team members are reminded about what was discussed and planned at previous appointments.

However, this process also has a number of advantages.

- The client and caregivers have more time to participate in the process, think of questions and concerns between appointments, process information to help in decision-making, and trial equipment before a final decision is made.
- The clinician has more time to consider gathered information, determine what equipment to arrange for trials and discuss issues with other team members. The clinician can also communicate the plan with all team members after the initial evaluation visit.
- The complex rehab supplier may not need to attend the initial or even second visits. This increases the efficiency of their time spent with the client. If they are asked to supply equipment for trials, the supplier has more time to arrange this and more confidence that the trials will be useful as part of the evaluation process is already complete.

HOW DOES THIS PROCESS LOOK FROM A BILLING STANDPOINT?

As clinicians, we have several evaluation codes available to us to bill for a SWM evaluation. Some of these codes, including occupational therapy evaluation (97165, 97166, 97167) and physical therapy valuation (97161, 97162, 97163) are reimbursed at a fixed fee for one evaluation. However, if provided on the same day, a limited number of treatment codes, based on units of time, can be added to the evaluation code for that one appointment. For clients with multiple technology needs, the assistive technology assessment code (97755) can be used. This assessment code is billed on a time-basis, each 15-minute unit. This code is designed for more complex evaluations and specific funding sources may limit how many units can be charged in a single day. By separating one long visit into a focused evaluation visit, followed by ongoing evaluation and treatment plan visits, these evaluation codes are more likely to be reimbursed at a rate to cover the clinician's actual evaluation time.

The treatment plan then outlines the additional visits required to address the postural support, skin and mobility needs on separate or combined visits. This treatment plan needs to be included in a plan of care and/or a request for authorization for therapy services. These treatment visits, depending on the service being provided, are then billed using the wheelchair management (97542), neuromuscular re-education (97112) and/or assistive technology

assessment code (97755) codes, based on the activity during the appointment. Training can encompass many goals including general equipment use and maintenance (often completed by the complex rehab supplier), use of the equipment within the environment, such as transferring in and out of the wheelchair (typically completed by the clinician), and mobility skills in the wheelchair (again, completed by the clinician). These last two training categories can be billed under wheelchair management or self-care/home management training (97535). For more information on proper use of CRT codes and billing for clinical services, check out the article from Barbara Crume, PT, ATP, by scanning the QR code at the end of the article.

Moving away from thinking about the wheelchair evaluation as a "one and done" process will require more time. Depending on when the "E" of the Evaluation to Delivery metric is defined, this change in process may increase the E to D cycle time. That one metric should not be defining our service delivery processes. Multiple visits do not reduce productivity or revenue. In fact, for the clinical community, the opposite is true. Clinicians and clients get to focus on one problem at a time and bill for that time. This model does require good communication between the clinician and the supplier who may not have been present during the initial evaluation. The therapist can synthesize their evaluation findings, communicate this to the supplier, and provide the client an opportunity to demonstrate their understanding of the plan and add input, all before any product decisions are made.

It is important to discuss the pros and cons of each service delivery model with the client and caregivers. Reduced number of visits may be just fine for a very experienced client, who "knows exactly what they are looking for." For others, while seemingly more convenient, a reduced number of visits mean that the client has less input into the final recommendations. An evaluation with a treatment plan, including multiple visits, will allow the client to try different options before making a final decision — a real chance to participate in exercising choice and control.

To learn even more strategies and methodologies to increase the success of wheelchair clinic service, register for NRRTS' On-Demand webinar, featuring Theresa Berner by scanning the QR code at the end of the article.

SUMMARY

The provision of CRT is, as the term implies, complex. What the last two and half years have shown us is how practice can be turned upside down, literally with a moment's notice. The pandemic provided all of us an opportunity to look at our practices with a new lens. We have been forced to reconsider each phase of our service delivery practices. Many of us found access to telehealth options opened up whole new insights, especially when we could remotely "see" inside a person's home, to actually watch the person function in the environment of use. These insights are incredibly helpful in finding effective seating and mobility solutions. We also recognized that much of our work is "hands-on," and we had to create safe spaces for our hands-on work to continue. Many of us modified our practices, got used to working in personal protective equipment, and maybe even grew fond of the smell of cleaning solutions!

Just as the pandemic forced us to work differently, we are inviting you to review your own service delivery practices through the lens of client-centered care. If you value client-centered care, this is an invitation to respond to the question, "Are you practicing that way?" There are no right or wrong answers. Each practice, each account, each client presents a set of realities that must be considered during this exercise of self-reflection. The most important part of the exercise is to question if your current practice(s) can be modified to improve the client's direct involvement in decision-making about products and solutions that will impact their lives, every day, often, for the next five or more years.

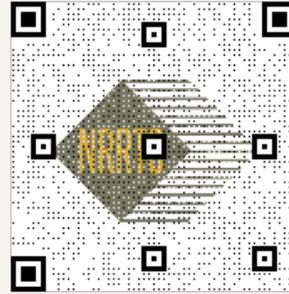
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Scan the QR code to access supplemental learning information mentioned in the article.



Jean Minkel is a physical therapist and master clinician well recognized for her work in Assistive Technology. She is currently the senior vice president of Rehab and Mobility Services at Independence Care System (ICS), where she leads *On A Roll*, an OT/

PT private practice specializing in seating and wheeled mobility services. She is a published author, including many peer-reviewed journal articles, and most recently, she co-edited, with Michelle Lange, the newly published textbook, *Seating and Wheeled Mobility: a clinical resource guide*. The A.T. community has recognized Minkel for her contributions by naming her a RESNA Fellow award in 1995 and conferring the Sam McFarland Mentor Award in 2012.



Michelle Lange is an occupational therapist with 35 years of experience and has been in private practice, *Access to Independence*, for over 15 years. She is a well-respected lecturer, both nationally and internationally and has authored

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JUMPING TO PRODUCT BEFORE DEFINING PARAMETERS

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

We've all been there. The client has shown up late because the accessible ride service is running behind. You are secretly happy about that because your last appointment went long and now you actually have time for a 5 minute "lunch," — which consisted of devouring a sandwich so fast it resembled some competitive eater's contest. You walk into the evaluation room, take a glance at the current wheelchair and seating system and try not to think of the chaos formerly known as your desk.

THE PROBLEM

When we are rushed and pressured to see a large volume of clients, it is easy to just start rummaging through the closet and pulling out equipment. After all, we've seen this situation before, right? We can guess what should work and save a lot of time.

However, after doing this for many years I know one thing for certain. The clients I work with never stop surprising me. Just when I think I know what product may work, the intake information forces a direction change. Just when I'm convinced that a client's spine is symmetrical from looking at them sitting in the wheelchair, I find an entirely different scenario once we are on the mat table.

THE CLIENTS I WORK WITH NEVER STOP SURPRISING ME. JUST WHEN I THINK I KNOW WHAT PRODUCT MAY WORK, THE INTAKE INFORMATION FORCES A DIRECTION CHANGE.

We can save time on the front and back end by completing the evaluation to determine specific client needs so that we can narrow the field of options by identifying required and specific product features. Can we agree on that? Probably. But how do we really get there?

THE SOLUTION

A wheelchair seating and mobility evaluation is a process including intake, mat evaluation, a whole lot of problem-solving, specifying recommendations, product trials, all sorts of paperwork, funding, fitting and delivery, and follow-up. Many service delivery models rely on one primary evaluation. Perhaps the clinician may also attend the fitting and delivery. But that's about it.

So maybe it is time to consider a different model. Here are some thoughts:

1. Intake: Get as much information as possible from the client, caregivers and other team members before the evaluation.
2. Evaluation: If you are working in a setting where you have inadequate time for the evaluation itself, here are a few ideas. First, find out what the hurry is. Your employer may want you to see more clients in a day because there are many clients to see and, more often, because the clinic relies on this revenue.
 - We have codes that cover a longer evaluation. If you simply need more time, talk to your supervisor about scheduling more time for evaluations and using the right codes.
 - Split the evaluation into multiple appointments. The advantages include seeing more clients in a day, identifying client parameters so that you can try potential solutions at the next appointment, and

WE CAN SAVE TIME ON THE FRONT AND BACK END BY COMPLETING THE EVALUATION TO DETERMINE SPECIFIC CLIENT NEEDS SO THAT WE CAN NARROW THE FIELD OF OPTIONS BY IDENTIFYING REQUIRED AND SPECIFIC PRODUCT FEATURES.

easing billing. The disadvantages include making the client return several times and remembering what you did at the last visit.

- And, of course, if there are just too many clients to see in the available time, your setting needs more staff.
3. Documentation: We can't bill for this one, though the evaluation doesn't do much good if our recommendations are not funded. We need to set aside adequate time for paperwork. Too many of us are typing reports after dinner on the couch.
 4. Fitting, Delivery and Follow-up: I will never get my oil changed unless I look at that sticker on my windshield and notice I'm over on miles. We need some sort of system so that we know when a delivery is coming up and when a client needs follow-up. We can bill for participating in the delivery – it is a continuation of the evaluation process.

I encourage you to read the Clinical Perspective article in this issue that addresses these concerns in more detail, as well as other challenges in our industry.

I'd love to hear your thoughts, as well! Please email me and keep the conversation going!

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Michelle Lange is an occupational therapist with 35 years of experience and has been in private practice, Access to Independence, for over 15 years. She is a well-respected lecturer, both nationally and internationally and has authored numerous texts, chapters, and articles. She is the co-editor of Seating and Wheeled Mobility: a clinical resource guide, editor of Fundamentals in Assistive Technology, Fourth Edition, NRRTS Continuing Education Curriculum Coordinator and Clinical Editor of NRRTS DIRECTIONS magazine. Lange is a RESNA Fellow and member of the Clinician Task Force. Lange is a certified ATP, certified SMS and is a Senior Disability Analyst of the ABDA.

USING DYNAMIC SEATING TO REDUCE CLIENT INJURY AND EQUIPMENT DAMAGE

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

NRRTS thanks Seating Dynamics for sponsoring this article.

Daniel is a 22-year-old young man with the diagnoses of cerebral palsy and seizures. Daniel has high tone in his extremities and low tone in his trunk and neck. His tone is so extreme he has broken components of his wheelchair frame in the past and dislocated both of his elbows and ruptured both patellae. I have had the privilege of working with Daniel, his mother, Mary, and his complex rehab supplier, TD Schenck of Numotion, for many years.

EXTENSION AND INJURY RISK

Over the years, Daniel has used many different types of seating systems and manual wheelchair bases. When he was 6 years old, he used a linear seating system with an antithrust seat, a semi-rigid pelvic positioner, lateral trunk supports, an H-style anterior trunk support, shoe holders with ankle straps, and a head support. In this system, he tended to 1) extend his hips, 2) push against the head support and hook under it, and 3) assume a posture of upper extremity adduction, extension and internal rotation in combination with scapular protraction to hold his head upright. He required additional support and stability within the seating system to reduce the need for this posturing. Prolonged posturing in this pattern had already led to a very narrow shoulder girdle, anterior shoulder subluxation and elbow hyperextension. We felt he was at risk for long term orthopedic consequences including distortion of the rib cage, shoulder dislocation, elbow dislocation, and permanent range of motion loss.

We recommended several modifications to his current seating system: a sub-ASIS bar to maintain the position of the pelvis and reduce overall extension (I know, we recommended this. It was 12 years ago, after all ...), a Y-strap across the shoulders to reduce scapular protraction (one strap crossed the clavicle and the other crossed the head of the humerus), and arm troughs with straps to maintain the upper extremities in a more neutral position (see Figure 1). As Daniel did not have functional use of his arms, we were comfortable blocking the head of the humerus.

Daniel tolerated the sub-ASIS bar well and this did reduce his overall extension by preventing extension at the hips. The Y-straps were not effective, and so we worked with Aspen Seating to fabricate custom shoulder pads that covered the head of the humerus, pulling his scapulae back into a more retracted position. His shoulder girth increased from 9–13", as a result. Daniel did not tolerate the arm



FIGURE 1 Arm trough to maintain upper extremity flexion.

“They don’t get any tougher to position than Daniel! I’ve had the pleasure of working with Daniel and his family for most of his young 22 years of life. Daniel’s postural control is the challenge we all look for as a Rehabilitation Technology Supplier: years of comprehensive evaluations revolving around how we keep him in a functional position, prevent him from shearing off bolts, and provide proximal stability for distal function. Luckily, we have new technologies in the seating/positioning world to address the challenges associated with our clients’ tone and orthopedic asymmetries. Dynamic seating components on Daniel’s current chair, along with aggressive molded seating, has been a game changer. Daniel’s functional positioning continues to be a work in progress, but on the right track — stay tuned!”

— TD Schenck, ATP/SMS
Numotion, Aurora, Colorado

troughs but continued to extend against the arm straps. His doctor was worried he would break one of his arms (and we agreed), so use of the straps was discontinued.

CLIENT INJURY

At age 10, Daniel was using a Stealth i2i head support to better manage his head position and prevent hooking. This was working well. Daniel had grown, and a new linear seating system was recommended. He was extending quite a bit within his current linear seating; however, he was scheduled to receive a Baclofen pump and we hoped this would reduce his overall muscle tone. As a result, we did not change much in the recommended seating.

Unfortunately, Daniel had serious complications with the pump, placement and his Baclofen dosage was greatly reduced, leading to an increase in tone (compared to his tone levels when previously taking oral Baclofen). After receiving his new linear seating system, Daniel experienced a hairline fracture of the lower right femur and had some tendon tearing bilaterally below and lateral to the knees. We believed these injuries were due to the extreme forces generated in his lower extremities from extension. His orthopedist diagnosed Daniel with Osgood-Schlatter disease and recommended Daniel be positioned in increased knee extension to reduce force through the knees. His parents began to place a large pillow under his lower legs, which increased the angle of the knee but also lifted his feet off the footplate – taking away his leverage during extension. We also had to replace the sub-ASIS bar, as this caused pressure over the Baclofen pump. Unfortunately, the pelvic positioning belt was not maintaining the position of his pelvis. We tried various style pelvic belts, angles of attachment, and a four-point attachment style without improvement. Daniel continued to extend, leading to loss of position of the pelvis (into a posterior pelvic tilt), though force was reduced through his knees and ankles as he was no longer contacting the footplates. He was not tolerating the seating system for long periods of time and was often in his alternative positioning system (positioning wedge system) on the floor.

In addition to these injuries, Daniel's extreme extension was also leading to loss of component alignment and damage of his seating system and wheelchair frame. This led to frequent adjustments and repairs. Depending on the extent of required repairs, Daniel could not use the wheelchair at all, instead remaining in bed or in his adaptive seating system and missing school.

DYNAMIC SEATING

After continuing to try various seating modifications, we trialed the Kids Rock 2 manual wheelchair with Reaction Dynamic Seating when Daniel was 12 years old. We hoped to diffuse his muscle tone by allowing movement of the seating system in response to Daniel's movement at the hips and knees (see Figure 2). The seating on the loaner wheelchair did not provide the support he required; however, we determined the base would work well for him. He enjoyed the movement and when he returned to a starting position, his pelvis returned to neutral.

Daniel was still extending quite a bit, and when he relaxed, he tended to collapse due to low tone in his trunk and neck. Daniel continued to grow and was starting puberty, and we were concerned that spinal curvatures were likely to develop, as a result. We recommended an orthotic molded seating system (the Aspen Seating Orthosis/ASO) to provide better postural support of his low tone trunk and to minimize development of spinal asymmetries. This is typically a one-piece system; however, was modified to work with the Kids Rock, as the seat-to-back angle opened in response to Daniel's extension. A Stealth Products tone deflector was added to the i2i head support to absorb force behind the head, as well. As movement was now

CONTINUED ON PAGE 42



FIGURE 2

Daniel in the Kids Rock 2 and Aspen Seating Orthosis.



FIGURE 3 Dynamic Rocker Back



FIGURE 4 Dynamic Elevating Footrests

“If it weren’t for dynamic seating, my son’s knees would still be swollen & bruised, and he would still be breaking wheelchairs by shearing screws in half when he pushes with his high-muscle tone. The moving parts allow him to be comfortable for longer periods of time and alleviates his pressure points, along with more options for positioning adjustments.”

— Mary, Daniel’s mother

USING DYNAMIC SEATING ...
(CONTINUED FROM PAGE 41)

provided at the knees in response to extension, Daniel no longer required the pillow, and his feet could once more contact the footplates, better distributing his weight along his buttocks, posterior thighs and feet. Shoe holders were mounted on the Kids Rock’s single footboard.

Daniel eventually outgrew the Kids Rock 2 at age 14. He was so tall his hips and knees were no longer aligned with the pivot points of the dynamic components. A Kids Rock 3 was ordered; however, this system was so wide the family returned it. They were unable to get the chair in and out of their accessible van or the school bus (the Kids Rock wheelchairs were eventually discontinued). We were reluctant to put Daniel back into a static wheelchair frame. We chose instead to try the Seating Dynamics Dynamic Rocker Back Interface (DRBi) and Dynamic Footrests on a Quickie IRIS tilt manual wheelchair base. The dynamic back moved in response to Daniel’s extension, absorbing and diffusing his force (see Figure 3). The back also worked well with the articulated Aspen Seating Orthosis. The DRBi comes with four different elastomers, allowing us to determine the right amount of resistance. If the resistance was too “soft,” the back tended to activate or open in response to the frame being tilted. If the resistance was too “hard,” Daniel’s



FIGURE 5 Using dynamic components has helped Daniel to better tolerate his seating system, to posture less and be more functional. He has not broken anything on his wheelchair frame for a long time either!

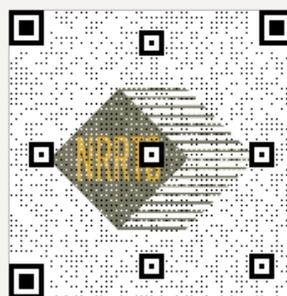
OVERALL, DYNAMIC SEATING, IN COMBINATION WITH AN APPROPRIATE SEATING SYSTEM AND WHEELCHAIR BASE, HAS REDUCED DANIEL'S ACTIVE EXTENSION THROUGHOUT HIS BODY AND PREVENTED FURTHER INJURY OR EQUIPMENT BREAKAGE.

extension did not activate the dynamic movement, despite his strong extension. The Dynamic Footrests elevated and telescoped in reaction to Daniel's extension. These were mounted at a starting position of 60 degrees to match his current available knee range. The footplates were also mounted in a position of external rotation to accommodate his tibial torsion. Shoe holders were mounted on the footplates to maintain foot contact to activate the dynamic feature (see Figure 4).

RESULTS

At age 15, Daniel had been using these new dynamic components for a year (see Figure 5). His knees were no longer red and swollen. Although he continued to extend at his hips and knees, he did so less frequently and with less force. It appeared just knowing movement was available was enough to reduce his active extension. If the dynamic back is locked out, he notices quickly and will begin to extend more frequently and with more force. The family has stated they will never go back to static seating again (scan the QR code at the end of the article).

Daniel's molded seating system has needed to be modified, and several new shape captures have been required over the years as his curvatures have continued to worsen. This seating has worked well, providing adequate postural support and distributing pressure to reduce pressure injury risk.



To watch video of Daniel, please scan the QR code.

Video 1: Daniel watching his favorite baseball team, the Colorado Rockies!

Overall, dynamic seating, in combination with an appropriate seating system and wheelchair base, has reduced Daniel's active extension throughout his body and prevented further injury or equipment breakage. This has been a successful intervention for Daniel and his family.

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Michelle Lange is an occupational therapist with 35 years of experience and has been in private practice, Access to Independence, for over 15 years. She is a well-respected lecturer, both nationally and internationally and has authored numerous texts, chapters, and articles. She is the co-editor of *Seating and Wheeled Mobility:*

a clinical resource guide, editor of Fundamentals in Assistive Technology, Fourth Edition, NRRTS Continuing Education Curriculum Coordinator and Clinical Editor of NRRTS DIRECTIONS magazine. Lange is a RESNA Fellow and member of the Clinician Task Force. Lange is a certified ATP, certified SMS and is a Senior Disability Analyst of the ABDA.

HAPPY ANNIVERSARY, NRRTS!!

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



This year has been dedicated to celebrating 30 years of NRRTS. As we reflect on the last three decades, we see the innovative ideas that made this organization thrive. But we also realize some things are just as they were in 1992.

In the beginning, NRRTS was simply a way to recognize the men and women who specialized in custom seating and mobility. How could clinicians or people who needed Complex Rehab Technology (CRT) find qualified suppliers? What should be the criteria for a CRT supplier to become a Registrant? How can NRRTS promote awareness of proper access to CRT?

NRRTS has been under the guidance of a volunteer board of directors made up of Registrants. Each board member uses their experience, expertise and vision to define the supplier role in the Standard of Practice. The board is constantly updating and improving the policies and procedures to keep the organization relevant. This collaboration keeps moving NRRTS forward.

Once the Registry was established, the board looked for ways to offer more to the Registrants. All CRT suppliers need high-quality continuing education. In the beginning, in-person education was offered at the annual Leadership Planning Conference. The two-day event included education and hands-on instruction. In 2009, NRRTS started a program to roll out accessible, low-cost Continuing education units (CEU) courses via online education. Today, the Education Committee develops over 20 live webinars a year. In addition, recorded webinars are offered on demand from a library of dozens of topics. The wide-ranging content offers something for anyone involved in CRT.

Four recent photos showing NRRTS Registrants doing what they do best! As a valuable seating team member, their mission is providing client-centered service. This was true in 1992 and still true today!



Connie Divino, ATP, CRTS®, works with the clinician to fit new system for client.

In 2009, NRRTS started CELA (Continuing Education and Legislative Activity) to advocate for better CRT access. This annual event continues to draw CRT consumers and other industry stakeholders to Washington, D.C., to raise awareness and understanding of the importance of having the right technology.

Communication with Registrants and Friends of NRRTS began with a newsletter that evolved into DIRECTIONS, a bi-monthly publication that is also centered on education and CRT awareness. With the

addition of social media and email, NRRTS has increased its reach to consumers, clinicians, funding sources and anyone wanting to know more about CRT.

In 2020, NRRTS expanded the Registry into Canada. Working with the Canadian Advisory Committee, bylaws were amended, new review chair positions created, and Canadians were added to the board of directors. This collaboration has made NRRTS a stronger voice for the professional CRT supplier.

The NRRTS website (www.nrrts.org) is another way to communicate current information. All Registrants are listed by state/province, organization or name. There are other resources including seating evaluation forms, RESNA position papers and case studies.

Although many things have changed over the past 30 years, there are many things that have stayed the same.

The NRRTS Board of Directors and staff continue to identify opportunities to raise the bar and improve access to CRT.

NRRTS Registrants understand the importance of offering ethical, client-centered services.

NRRTS owes a deep gratitude to the hundreds of volunteers who support, guide, develop and encourage the very best service delivery of CRT.

Our mission is to support professional Complex Rehab Technology (CRT) suppliers through education and advocacy to improve access and provide quality services to people who rely on CRT.

**HERE'S TO THE NEXT 30 YEARS FOR NRRTS
AND TO ALL THE DEDICATED PEOPLE
WORKING EVERYDAY TO PROVIDE THE
BEST CLIENT-CENTERED SERVICE!**



Rafael Ibarra, ATP, CRTS®, takes client measurements during seating evaluation.

This has not changed since 1992!

Here's to the next 30 years for NRRTS and to all the dedicated people working everyday to provide the best client-centered service!



Derek Register, ATP, CRTS®, checks seat upholstery during seating evaluation.



Chad Jones, ATP, CRTS®, molds the client for custom seating.

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Weesie Walker, ATP/SMS, is the executive director of NRRTS. She has more than 25 years of experience as a Complex Rehab Technology supplier. She has served on the NRRTS Board of Directors, the GAMES Board of Directors and the Professional

Standards Board of RESNA. Throughout her career, she has worked to advocate for professional suppliers and the consumers they serve. She has presented at the Canadian Seating Symposium, RESNA Conference, AOTA Conference, Medtrade, International Seating Symposium and the NSM Symposium. Walker is a NRRTS Fellow.

NEW CEU OPPORTUNITIES WITH RESNA

Written by: **ANDREA VAN HOOK, EXECUTIVE DIRECTOR, RESNA**

RESNA is pleased to announce we now have new continuing education opportunities available for all ATPs and members. With the launch of “RESNA Learn,” we are now able to offer webinars on demand through a customer-friendly interface that is easier to navigate.

On RESNA Learn, you will find a variety of on-demand webinars from our past two years of virtual conferences, along with AT Journal Quizzes. You can also self-track the continuing education units (CEU) you earn, whether from RESNA or other sources, for your certification. Most continuing education will offer IACET CEUs.

In addition to RESNA Learn, we also partner with quality continuing education providers who are approved to offer RESNA continuing education. These providers offer courses, many of which are online and on demand, on a variety of Assistive Technology (AT) topics. Visit the RESNA website under Certification/Continuing Education to access the list of providers. Remember, renewing ATPs can earn up to 10 continuing education hours that are not IACET CEUs.

Finally, as you know, NRRTS offers a robust continuing education program, with high quality live and on-demand webinars. NRRTS is an accredited IACET CEU provider, and all the offerings are accepted for RESNA ATP certification renewal.

THANK YOU FOR ATTENDING THE RESNA CERTIFICATION TOWN HALL

Thank you to everyone who attended the RESNA Certification Town Hall during the RESNA conference. It was a productive conversation, and we appreciate all the comments we’ve received regarding the updated Code of Ethics and Standards of Practice. The Professional Standards Board is in the process of reviewing all the comments and making further changes, as warranted, to the draft revisions. We anticipate the RESNA Board of Directors to approve the final version at a fall board meeting and announce the implementation date for the new Code and Standards.

RESNA RESOURCES

RESNA Position Papers summarize current research and best practice on a variety of AT devices. Check out position papers on dynamic seating, seat elevation and ultralight manual wheelchairs. These are very useful for those letters of medical necessity! Look under “Resources” on the RESNA website.

RESNA IS PLEASED TO ANNOUNCE THAT WE NOW HAVE NEW CONTINUING EDUCATION OPPORTUNITIES AVAILABLE FOR ALL ATPS AND MEMBERS. WITH THE LAUNCH OF “RESNA LEARN,” WE ARE NOW ABLE TO OFFER WEBINARS ON DEMAND THROUGH A CUSTOMER-FRIENDLY INTERFACE THAT IS EASIER TO NAVIGATE.

RECERTIFICATION: MAKE IT EASY

Do your part to ensure your recertification paperwork is complete! Send your paperwork to RESNA at least three to five weeks prior to your certification expiration date. We strongly recommend you scan and email your paperwork (including all your CEU certificates) to certification@resna.org.

We offer a free webinar, “The Ins and Outs of ATP Recertification” in the new RESNA Learn. Just use the search box to find it. It has tips and advice on how to make the process easy and efficient.

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AN INHERENT CONFLICT OF INTEREST

(ATP/LCMP ROLE IN COMPLEX REHAB WHEELCHAIR DOCUMENTATION)

Written by: **DAN FEDOR**

For complex rehab wheelchairs (K0835-K0864, K0005, and E1161), Medicare requires a specialty wheelchair evaluation performed by a LCMP (Licensed Clinical Medical Professional) (usually an OT/PT) who has no financial relationship with the wheelchair supplier and an assessment performed by a supplier-employed ATP (Assistive Technology Professional). As the policy notes, the LCMP can't have a financial relationship with the wheelchair supplier (Exception: If the supplier is owned by a hospital, the PT or OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face encounter), and the ATP must be an employee of the wheelchair supplier, so it's pretty clear who can write (contribute to) each required document and who can't. This policy language has been in place since 2005. Their roles are different in that the LCMP's role is to identify the mobility limitation, and the ATP's role is to select the correct product based on the limitations identified by the LCMP; therefore, the wheelchair evaluation and the ATP assessment should be on separate documents.

Due to different interpretations of this policy within the industry, some supplier ATPs may have been either writing the evaluation or scribing for the LCMP, which in turn may have resulted in a favorable relationship with the LCMP since it reduced their workload and in turn they would only want to work (refer) with those suppliers who helped them with their wheelchair evaluation. To resolve this discrepancy in how suppliers were interpreting the policy, this question was raised with the Medicare contractors in 2019, and the answer was as expected, this is in fact an inherent conflict of interest and the ATP should not be writing the evaluation or scribing for the LCMP during the wheelchair evaluation. The AOTA (November 2018) and APTA (April 2021) also weighed in on this issue and stated a therapist should not allow the supplier ATP to contribute (write or scribe) for the LCMP wheelchair evaluation. "The supplier and the medical professional, in this case the ATP and the physical therapist, cannot have any financial relationship, and scribing for the physical therapist is providing in-kind value, which violates the MACs' local coverage determinations. This can also lead to a possible anti-kickback violation," according to the APTA.

See Article 1 (AOTA) and Article 2 (APTA) by scanning the QR codes at the end of the article.

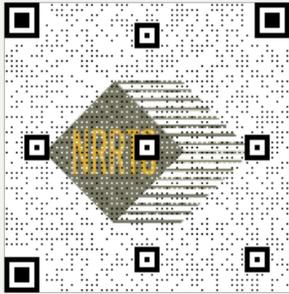
The purpose of this article is a reminder of how VGM Group and U.S. Rehab have been educating suppliers all along regarding this issue. Remember don't offer to write or scribe for the LCMP

wheelchair evaluation, and if an LCMP asks for assistance in writing/scribing the specialty wheelchair evaluation and states other suppliers do it, please remind them this is not, nor has it ever been, compliant, and if they accept this type of help, they may put their license in jeopardy or worse.

Some therapists may want to accept this help or even seek it since they are not well-versed in insurance requirements for mobility products and unfortunately their evaluations aren't as detailed or pointed as required, which results in either having to write an addendum or even denial. This is not good for the therapist who is already pressed for time due to productivity requirements of seeing patients, and it's not good for the patient as they can't receive the wheelchair until the documentation is detailed enough to clearly address the medical necessity for the items ordered.

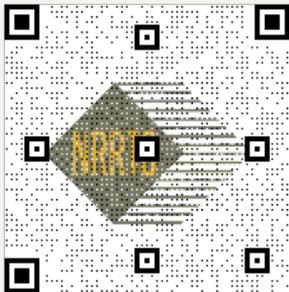
So is there a way for a supplier to compliantly help the therapist? Education is the key, and the supplier can do this by providing therapists with a document on mobility assistive equipment coverage criteria and maybe even offer an in-person or virtual education course on coverage criteria and documentation requirements. If possible, offer continuing education units (CEU) as that is always a draw for therapists. In addition, the supplier ATP may be present at the wheelchair evaluation, and it is a good practice if this is possible, and while there an ATP CAN verbally educate the LCMP on coverage criteria for wheelchair bases and accessories. At U.S. Rehab we developed a two-hour CEU course that is approved by VGM Education (an authorized IACET provider) several years ago to educate therapists how to efficiently and effectively document for the appropriate mobility product along with accessories for qualified patients. If you'd like to schedule this two-hour (0.2 CEU) course (live or virtual) titled "Documentation LIFE Preserver" for therapists in your area, please contact me.

MEET YOUR BOARD AND STAFF



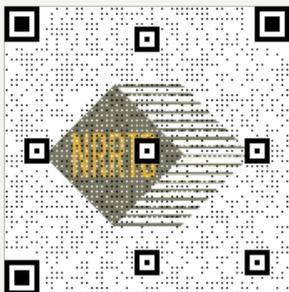
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Article 1: (AOTA) Medicare
Power Wheelchair Evaluation
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Frequently Asked Questions



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Article 2: (APTA) Medical
Suppliers and Medicare Power
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Documentation



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WORKING TOGETHER TO ELEVATE EQUIPMENT PROVISION IN CANADA

A SUPPLIER'S PERSPECTIVE

Written by: **MICHELLE HARVEY, RRTS®**

When I entered the industry 10 years ago as a supplier, I moved from the occupational therapist field. Being a supplier was very different to being a therapist; however, it had one singular vision that was a common thread.

CHOOSE THE BEST POSSIBLE REHAB SOLUTIONS AVAILABLE TO PROVIDE CLIENTS WITH SUPERIOR OUTCOMES.

To do that I believe you need three items:

1. Education for all parties (funder, supplier and therapist).
2. Standards of Practice.
3. A belief you must constantly improve yourself, the company you work for and the industry as a whole.

Having been on the therapist side and now the supplier side, I believe elevating equipment provision in Canada should be tackled by all parties.

1. EDUCATION

Education in this industry comes in many forms: education on funding, education on products, education on clients' conditions. So, we must work together with organizations like NRRTS (National Registry of Rehabilitation Technology Suppliers), RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) and the DMERT Group (Durable Medical Equipment Repair and Training) to elevate knowledge of therapists, funders, technicians and suppliers.

Attending shows and education sessions together (funder, supplier and therapist) allows different perspectives to be heard, different challenges to be assessed and an understanding of each pivotal role.

Funding and equipment change so rapidly, having access to training and education at your fingertips is invaluable. NRRTS was introduced to Canada in 2020.

Since becoming a NRRTS Registrant in 2021, it has been a game changer in allowing me to upskill and share education with my sales representatives and therapists.

2. STANDARDS OF PRACTICE

When you read the mission statements of RESNA, the DMERT Group and NRRTS, they are all very similar:

"NRRTS' mission is to support professional Complex Rehab Technology (CRT) suppliers through education and advocacy to improve access and provide quality services to people who rely on CRT."

Source: <https://nrrts.org/>

"The purpose of RESNA is to contribute to the public welfare through scientific, literary, professional and educational activities by supporting the development, dissemination, and utilization of knowledge and practice of rehabilitation and assistive technology in order to achieve the highest quality of life for all citizens."

Source: <https://www.resna.org/about>

"Our mission is to establish and uphold industry-wide standards for DME (Durable Medical Equipment) and CRT (Complex Rehab Technology) repair technicians through industry collaboration."

Source: <https://www.dmertgroup.com/about-us>

Standards of Practice are important across Canada. From province to province, there can be so many changes: funding, availability of equipment, climate, geography, availability of therapists. Having a standard of practice for providers and therapists buy into, and those funders believe in, is important and elevates everyone.

Standards of Practice help develop and assess governance, leadership and quality of service. This protects the our patients.

3. A BELIEF YOU MUST CONSTANTLY IMPROVE YOURSELF, THE COMPANY YOU WORK FOR AND THE INDUSTRY AS A WHOLE

I believe it's critical for rehab equipment suppliers to lead the charge to adhere to higher business standards to protect both the short-term and long-term interests of clients, rehab professionals and the industry.

What does that look like?

Join our industry's organizations that support that mission, ensuring all team members are engaged in continuous upskilling and education through NRRTS, continuing education programs and manufacturer education.

During the COVID-19 pandemic, in-services and big shows like CSMC (Canadian Seating & Mobility Conference), and ISS (International Seating Symposium) were canceled. In-person education was nonexistent, which forced us as an industry to be more creative.

As an industry, we had time to complete education sessions online and suppliers began to embrace offering them to funders and therapists. A huge positive was, we accessed more therapists and clients and mitigated travel time and expenses.

We found ourselves doing education online with Zoom and Microsoft Teams and recording short clips on new products showing the features and benefits that could be emailed to therapists.

I found myself recording videos on how to put a power chair in tilt, elevate, etc. so I could share this with families and schools. This was needed, as the delivery appointment was one quick appointment wearing a mask. With the potential for lots of information lost in translation, I found parents loved these videos because they could refer to them and show friends, family, etc. They now ask for them.

I found suppliers were getting creative on doing tutorials for clients on how a floor lift works and how the functions on a hospital bed work. Suppliers were uploading these to YouTube, and clients loved them.

As the restrictions on the COVID-19 pandemic begin to ease, I believe as suppliers we should all continue to push to educate ourselves and join industry organizations that strive to improve the industry. We need to keep the creativity going!

We need to educate our funders to work with suppliers who believe in education, standards of

practice and elevating our industry. We need to push therapists and funders to write contracts and request for proposals that value education of suppliers and place emphasis on suppliers who are NRRTS Registrants, RESNA ATPs and RESNA SMSs.

This will allow us together to elevate equipment provision in Canada.

CONTACT THE AUTHOR

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MICHELLE.HARVEY@HMEBC.COM



Michelle Harvey has more than 17 years in the Mobility and Accessibility industry. With a background in occupational therapy, Harvey is currently the sales and client services manager at HME British Columbia. She has been a speaker at the International Seating Symposium, the European Seating Symposium, and the Canadian Seating and Mobility Conference. Additionally, she is also certified in Ride's Custom Seating and Manual Handling. Harvey is a NRRTS Canadian Review Chair, serves on the Canadian Advisory Committee and became a NRRTS Registrant in July 2021.

OIG Report – Medicare “Advantage” Organizations Restrict Beneficiary Access to Medically Necessary Services



Dan Fedor outlines the recent report from the Office of the Inspector General (OIG) and how it confirms that many Medicare Advantage (or replacement) plans can lead to denials, underpayments, and delays in payment.

**What does this mean for CRT providers?
U.S. Rehab's Dan Fedor has the answer.**

**Scan the QR code
to learn more.**



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NEW NRRTS REGISTRANTS

Congratulations to the newest NRRTS Registrants. NAMES INCLUDED ARE FROM MAY 18, 2022, THROUGH JULY 1, 2022.

Bruce Guitard, RRTS®

Tango Medical
355 Elmwood Dr
Moncton, New Brunswick E1A1X6
Telephone: 506-855-8842
Registration Date: 06/21/2022

Henry Buyting, RRTS®

Tango Medical
100 Woodside Ln, Unit B103
Fredericton, New Brunswick E3C2R9
Telephone: 506-459-4449
Registration Date: 06/13/2022

Michael Cheung, MScPT, RRTS®

Durham Medical
242 King St. E.
Oshawa, Ontario L1H1C7
Telephone: 905-728-1112
Registration Date: 06/02/2022

Colin Fairley, ATP, CRTS®

National Seating & Mobility, Inc.
854 Lakeside Dr., Suite B
Mobile, AL 36693-5135
Telephone: 251-259-6943
Registration Date: 06/14/2022

Jason Simpson, ATP, CRTS®

DME Services, LLC
3600 5th Ave S
Birmingham, AL 35222
Telephone: 205-591-4792
Registration Date: 06/08/2022

Mitchell Koplowitz, RRTS®

Brant Arts Mobility
672 Brant St
Burlington, Ontario L7R2H3
Telephone: 888-678-3144
Registration Date: 05/26/2022

Cynthia Bohlmann, RRTS®

Avera Home Medical Equipment
2400 S. Minnesota Ave Suite 102
Sioux Falls, SD 57105
Telephone: 605-322-1887
Registration Date: 07/01/2022

Joshua Luke Hogan, RRTS®

Numotion
1821 Old Ocilla Rd Ste A
Tifton, GA 31794-1667
Telephone: 229-472-0055
Registration Date: 06/09/2022

Tammy Wilcox, RRTS®

Lawtons Home Healthcare
107 Catherwood St
Saint John, New Brunswick E2M5J7
Telephone: 506-343-5855
Registration Date: 06/29/2022

Emilie Addy, RRTS®

The Good Access Company
1-15 Antares Dr
Ottawa, Ontario K1H6W7
Telephone: 613-298-2340
Registration Date: 06/14/2022

Krystle Pettapiece, RRTS®

Action Health Care
566 Queen St. E
St Marys, Ontario N4X1A4
Telephone: (519) 284-4348
Registration Date: 06/02/2022

German Bermudez, RRTS®

Custom Mobility
7199 Bryan Dairy Rd
Largo, FL 33777
Telephone: (800) 622-5151
Registration Date: 06/16/2022

Luc Perron, RRTS®

The Good Access Company
1-15 Antares Dr
Ottawa, Ontario K2E7Y9
Telephone: 613-319-6767
Registration Date: 06/03/2022

BE SURE TO FOLLOW NRRTS ON SOCIAL MEDIA!



CRTS®

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. NAMES LISTED ARE FROM MAY 18, 2022, THROUGH JULY 1, 2022.

Colin Fairley, ATP, CRTS®
National Seating & Mobility, Inc.
Mobile, AL

Garret Ebernickle, ATP, CRTS®
Numotion
Greenville, SC

Jeremy Kilgore, ATP, CRTS®
National Seating & Mobility, Inc.
Columbus, OH

Sam Abboushi, ATP, CRTS®
Dynamic Repair Solutions
Santa Ana, CA

Fernando Castillo, ATP, CRTS®
Patients Choice LLC
Clarkston, GA

Jason Simpson, ATP, CRTS®
DME Services, LLC
Birmingham, AL

Jody Mair, ATP, CRTS®
Motion
Burnaby, British Columbia

FORMER NRRTS REGISTRANTS

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

NAMES INCLUDED ARE FROM MAY 18, 2022, THROUGH JULY 1, 2022. FOR AN UP-TO-DATE VERIFICATION ON REGISTRANTS, VISIT WWW.NRRTS.ORG, UPDATED DAILY.

James Black
Whitehorse, Yukon Territory

Ness Aguirre
Kelowna, British Columbia

Mylene Tendler
Hamilton, Ontario

Michele Bechard
Chatham, Ontario

Kelly Nitchie
Home Medical Solutions
Calgary, Alberta

Paula Branco
Hamilton, Ontario

Alison Meloche
Ottawa, Ontario

Stephen Longo
Oshawa, Ontario

Nick Favia
Surrey, British Columbia

Jacqueline Cloutier
Calgary, Alberta

Jason Prodan
Amherstburg, Ontario

Jarrett Chalmers
Ottawa, Ontario

Gary Dormer
Calgary, Alberta

Dwayne Toews
Surrey, British Columbia

Michelle Salt
Calgary, Alberta

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RENEWED NRRTS REGISTRANTS

The following individuals renewed their registry with NRRTS between May 18, 2022, and July 1, 2022.

PLEASE NOTE IF YOU RENEWED AFTER JULY 1, 2022, YOUR NAME WILL APPEAR IN A FUTURE ISSUE OF DIRECTIONS. IF YOU RENEWED PRIOR TO MAY 18, 2022 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.

Aaron McKenzie, RRTS®	James Arsenault, RRTS®	Paul Lamothe, RRTS®
Alicia Truebenbach, ATP/SMS, CRTS®	James Taylor, RRTS®	Peter Lorentz, RRTS®
Amy Johnson, ATP, CRTS®	James A. Golick, ATP, CRTS®	Ray Cazalet, ATP, CRTS®
Angela Naranjo, ATP, CRTS®	Jasmine Libarian, ATP, CRTS®	Richard Petersen, ATP, CRTS®
Bennie G. Jones, ATP, CRTS®	Jason Melms, ATP, CRTS®	Robert Ford, ATP, CRTS®
Bernard Opp, RRTS®	Jay Lujan, ATP, CRTS®	Robert McLean, ATP, CRTS®
Bradley Coughlin, RRTS®	Jean-Francois Cormier, RRTS®	Robert Lamarche, RRTS®
Brennan Arbogast, ATP, CRTS®	Jeanne Hegg, ATP, CRTS®	Robert Harry, ATP/SMS, CRTS®
Brent Manning, ATP, CRTS®	Jeff Hager, ATP/SMS, CRTS®	Robert Cooper, ATP, CRTS®
Brian Coady, RRTS®	Jeffrey Decker, ATP/SMS, CRTS®	Robert J. Williams, ATP, CRTS®
Cacee Reuben, RRTS®	Jeffrey B. Swift, ATP, CRTS®	Ronald Mack, ATP, CRTS®
Carl A. Mulberry, ATP/SMS, CRTS®	Jeremy Kilgore, ATP, CRTS®	Ronald J. Seely, ATP, CRTS®
Cary Marsh, ATP, CRTS®	Jeremy Booker, RRTS®	Ronald Keith Hayes, ATP, CRTS®
Chad Jones, ATP, CRTS®	Jody Mair, ATP, CRTS®	Sarah Moeller, RRTS®
Charles Santiago, ATP, CRTS®	John Fullmer, Jr., ATP, CRTS®	Scott Leikala, ATP, CRTS®
Charles P. Barrett, III., ATP, CRTS®	John Zona, ATP, CRTS®	Scott C. McGowan, ATP, CRTS®
Chris Rogers, ATP, CRTS®	Jonathan Jesme, ATP, CRTS®	Sean Jones, ATP, CRTS®
Connie Divine, ATP, CRTS®	Joseph B. Bodiford, ATP, CRTS®	Stefanie Laurence, RRTS®
Crystal Lee, ATP/SMS, CRTS®	Joshua Forester, RRTS®	Steven Shipley, ATP, CRTS®
Danny Ward, ATP, CRTS®	Judy Taylor, ATP, CRTS®	Steven E. Williams, ATP, CRTS®
David Black, RRTS®	Keith A. Schwartz, ATP, CRTS®	Thomas Connelly, RRTS®
David St. Louis, ATP, CRTS®	Kim B. Borck, ATP, CRTS®	Thomas Ouimette, ATP, CRTS®
David Anderson, ATP, CRTS®	Kimberly F Cooper, ATP, CRTS®	Timothy A. Schrag, ATP, CRTS®
David T. Murray, ATP, CRTS®	Laura Frey, ATP, CRTS®	Toby Bergantino, ATP, CRTS®
Dawn Ruth-Larson, ATP, CRTS®	Lino Castro, RRTS®	Trevor Gould, RRTS®
Deborah J. Lazure, ATP, CRTS®	Marc Suddarth, RRTS®	Vincent Handrick, ATP, CRTS®
Desmond Wiles, ATP/SMS, CRTS®	Marcus Page III, PTA, ATP, CRTS®	Wesley Dykstra, RRTS®
Donald Wrye, RRTS®	Mark Brazeau, RRTS®	William Johnson, RRTS®
Dustin Swartz, ATP, CRTS®	Mark Swanson, ATP, CRTS®	William Fournier, ATP/SMS, CRTS®
Edward Bonk, PT, ATP/SMS, CRTS®	Mark A Tucker, ATP, CRTS®	Zane Jacobs, ATP, CRTS®
Eric Gilbert, RRTS®	Marshall Callaway, ATP, CRTS®	
Eric Sale, ATP, CRTS®	Mary Hitt Young, ATP, CRTS®	
Ethan "Jake" McDonald, RRTS®	Matt Topf, ATP, CRTS®	
Felice "Phil" Ioculano, RRTS®	Matthew Tarrant, ATP, CRTS®	
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