DIRECTIONS

FMA: CONFIRMING VALIDITY OUTCOMES MEASURES FOR CRT

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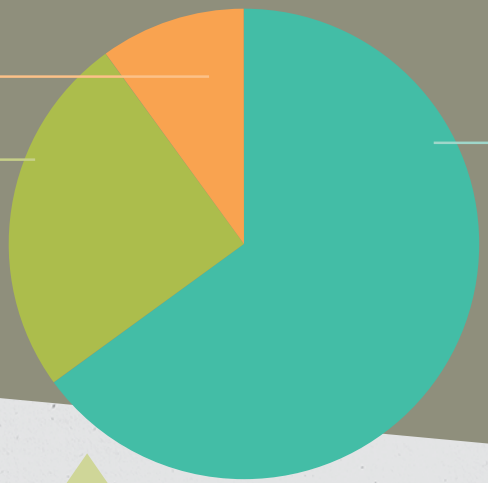

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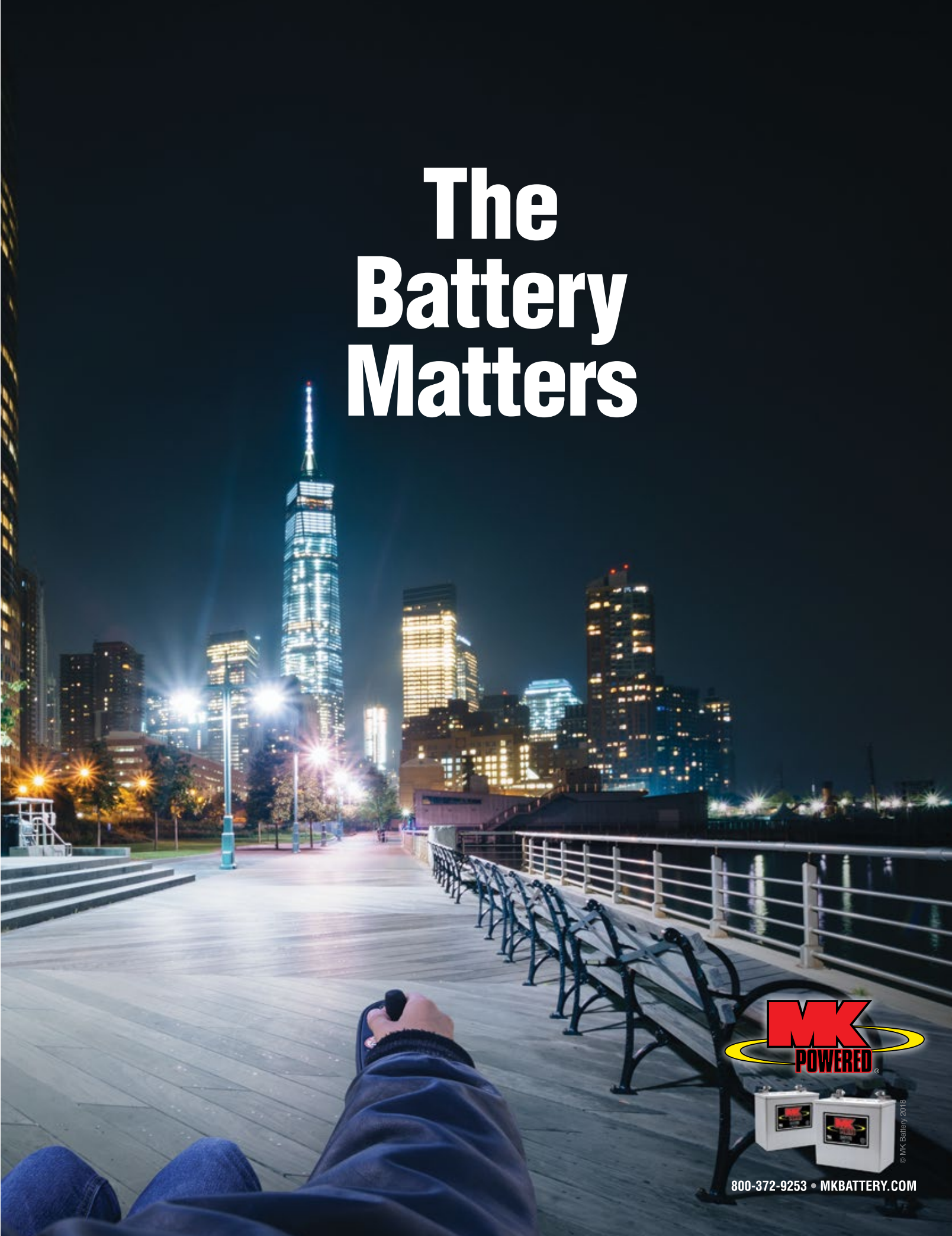
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RESPONSIBILITY

Written by: **ELAINE STEWART,** ATP, CRTS®

We, as complex rehab suppliers, have a responsibility to our consumers, referral sources and clinicians to be professional. What does this mean? We listen, absorb and assist the team to develop a plan to provide the most appropriate equipment for our clients and their specific needs.

Over the past 30-plus years of working in this industry, I have been blessed to be part of the aches and pains of growth and evolution. The development of NRRTS has given me a place to obtain education and ideas have kept me current with government affairs and new technology. I have been a Registrant since 1996.

Being a complex rehab suppliers means being invested in your profession, taking the time to learn and being informed in all the areas of necessary expertise. Below is just a small list to start …

- Understanding diagnoses.
- Body Positions- Medical Terminology.
- Funding - Understanding coverage for CRT.
- Equipment - Be current on the wide variety of equipment offerings that are available and how to interface them into a workable system.
- Electronics – Interfacing different technologies for environmental control.

The professional RTS is required to:

- Complete a minimum of 10 hours of qualified education through seminars, webinars, etc. on an annual basis.
- Be a resource to the client for alternative funding.
- Know your area of competency (be willing to step away when you can't meet the need.)
- Hold the welfare of the client paramount.

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I do get frustrated that we are still looked at as salesmen/saleswomen and not valuable participants in the medical model, although CMS states in the provider manual that an individual must be an ATP or CRTS®. We go to the home to evaluate the environment for equipment that is prescribed. We provide loaner equipment when needed. We make adjustments. We educate and re-educate on the use and maintenance of the equipment. We often make temporary repairs to keep the individual up and running. We deal with the frustration of the individuals because their plate is full. And, by the way, there is no 40-hour work week!

I believe we are a vital part of the medical model. Yes, we provide a service, and I am very proud of the profession that I have chosen. Providing equipment that can change an individual's life is priceless.

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Elaine Stewart is president of NRRTS and works for National Seating & Mobility in Fort Wayne, Indiana.

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"I WILL GRAB LIFE BY THE HORNS AND MAKE IT MINE"

Written by: **ROSA WALSTON LATIMER**

The title of this article was taken from a poem, "Romantics" written by Kyle Romano, a quad-amputee. "Although most view my situation as pitiful, I have never, and will never, regard it as such, Romano said. "I am actually thankful for the situation that I have been put in because it has allowed me to view life from an altered perspective, making me a stronger person." Romano's interest in writing took hold in high school where he was on the staff of the school newspaper. In addition to poetry, Romano is also working on a novel. Regardless of the type of writing he is engaged in, Romano's purpose is "to help others gain a different perspective on life and realize that a strong person controls their own life as opposed to allowing it to be controlled by others."

"Above all else I consider myself to be a writer," the 31-year-old said. "That's what I went to school for, and it is something I've always been passionate about." Romano's venture into poetry writing began as a method to create song lyrics. He began playing in a band with his brother, Kent, who is two years younger, when they were high school. "Kent plays the guitar and sings a bit. Our close friend, Alex, plays bass, and I sing. The three of us write music together. Although we still share the common bond of music, Kent is going to school to be a physical therapist so we don't have as much time as we once did."

Romano believes their experiences growing up influenced his brother's decision to pursue physical therapy as a career. "I was constantly in PT (physical therapy) and OT (occupational therapy), and Kent was usually there with me," Romano said. "He had the opportunity of seeing the impact therapists had on my life, and he had the experience of interacting with other children with disabilities and their siblings. If Kent could give one person a fraction of the independence that my therapists had given me by the time I was an adult, for him that would be the ultimate goal."

"MY MOM PICKED ME UP, AND WHEN SHE LIFTED THE BACK OF MY SHIRT SHE SAW THAT MY BACK HAD TURNED BLACK AND BLUE. THEY RUSHED ME TO THE DOCTOR, AND IT WAS EVENTUALLY DETERMINED THAT I HAD MENINGITIS. AMPUTATION OF MY ARMS AND LEGS WAS THE ONLY OPTION TO SAVE MY LIFE."

In addition to the close relationship with his brother, Romano has been touched with the support of a close-knit, empathetic extended family. "My dad's family is Cuban American, and we've stayed close – aunts, uncles and cousins. They have all played an instrumental part in my life. Throughout my life, everyone has always been there for me."

When Romano was a year old, his parents realized he had a fever and was restless in his crib. "My mom picked me up, and when she lifted the back of my shirt she saw that my back had turned black and blue. They rushed me to the doctor, and it was eventually determined that I had meningitis. Amputation of my arms and legs was the only option to save my life."

Romano acknowledges how difficult this experience was for his young parents. "The support of our extended family was very important to all of us," he said. "They not only helped in the sense that I needed physical help, but it was so nice to have that emotional support of a family unit. My extended family helped me to become comfortable with myself and with who I am. I knew that I was different, but they never treated that as a negative." Romano acknowledges that he is thankful that he contracted the disease when he was very young. "Instead of having

Kyle Romano advocating on Capital Hill for access to complex rehab technology with (from left) Custom Mobility CEO Bruce Bayes, University of South Florida student intern Sydney Seabaugh, and colleague and friend Jonathan Innes.

Kyle Romano at Gamers on the Edge competing in weekly Super Smash Bros.

Kent Romano and Kyle Romano after Kent was accepted into the physical therapy program at Nova Southeastern University.

"I HAD AN ORIGINAL NINTENDO ENTERTAINMENT SYSTEM, AND MY DAD BOUGHT AN ARCADE-STYLE JOY STICK FOR ME. THAT JOY STICK WAS VERY SIMILAR TO THE JOY STICK ON MY WHEELCHAIR SO IT WAS AN EASY TRANSITION. AS I GREW UP, THIS WAS A WAY FOR ME TO PLAY WITH MY FRIENDS ON THE SAME LEVEL. THAT WAS VERY POWERFUL BECAUSE IT PUT ME AS AN EQUAL TO MY ABLE-BODIED FRIENDS."

to relearn everything, I grew up this way. I never really compared or thought to compare the way I navigated the world with the way my brother did. We've always been very close, and he has always been an integral part of my life, but we just each had our own way of doing things."

A self-described nerd, Romano started playing video games at the age of 3—at the same time he got his first power wheelchair. "I had an original Nintendo entertainment system, and my dad bought an arcade-style joy stick for me. That joy stick was very similar to the joy stick on my wheelchair so it was an easy transition. As I grew up, this was a way for me to play with my friends on the same level. That was very powerful because it put me as an equal to my able-bodied friends."

Romano and his friends also played football and baseball modifying the rules so he could compete. "Video games were the first space I could navigate independently!"

Romano wrote his master's thesis on accessibility in video games, or "Gamers with Disabilities," and he is a competitive gamer on Nintendo's "Super Smash Brothers." Romano supports a Tampa organization, Gamers on the Edge, owned by his friend, Angel Miranda. "I go as often as I can and have made some very good friends at these events. Angel hosts weekly tournaments and a couple of larger regional tournaments. Proceeds from the tournament entry fees go to Children's Miracle Network hospitals, specifically All Children's Hospital in the Tampa Bay area." Romano personally identifies with the work of this nonprofit group because he believes "they are helping kids who are going through the same challenges that I did. Video games were a resource I relied on for many reasons, and I know how

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"I WILL GRAB LIFE BY THE HORNS ... "
(CONTINUED FROM PAGE 7)

important they can be. I still compete when I have time, but we all grow up and have to work!"

Indeed, Romano's life isn't all music, poetry and video games! He received his undergraduate degree and his master's degree from the University of South Florida in Tampa. Through a series of events during his graduate degree studies, Romano found himself working alongside a friend and doctoral student, Lindy Davidson (Now Dr. Lindy Davidson). The duo shared an interest in exploring how our culture handles disability and how society comes to know people with disabilities through television, music, books and other media. "We focused on media representation of people with disabilities and how we could give our students the tools to know acceptable ways to represent people with disabilities and the appropriate way to talk with people with disabilities versus what is inappropriate," Romano explained. "We created and taught a class called "Communication and Disability." It was a higher level elective that met the requirement for students pursuing a bachelor's degree in communication. "Most of our students were able-bodied and with them we challenged the dominate narrative of

"I WANTED TO LEARN ABOUT DISABILITY AND LANGUAGE, BUT AS I SOUGHT HELP IN PURSUING THIS SUBJECT I REALIZED MOST PEOPLE DIDN'T UNDERSTAND WHAT I WANTED TO STUDY. I WENT THROUGH A PERIOD OF TIME WHEN I WASN'T EVEN SURE I WANTED TO STUDY DISABILITY,"

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Kyle Romano and Kent Romano on an annual family trip to the Florida Keys.

Kyle Romano with his extended family.

This setup shows the equipment that Romano uses to drive independently.

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DIRECTIONS is the premiere publication for the CRT industry. Each issue focuses on important clinical issues, individuals who use CRT, and individuals who provide CRT. Consumers share their personal stories of courage in a special section of DIRECTIONS' "Life on Wheels."

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"I WILL GRAB LIFE BY THE HORNS ... "
(CONTINUED FROM PAGE 8)

people with disabilities as being weak and unable to contribute to society both monetarily and intellectually."

While Romano's experience with the creation and implementation of this particular class offering was fulfilling, he describes his personal education experience as difficult. "I wanted to learn about disability and language, but as I sought help in pursuing this subject I realized most people didn't understand what I wanted to study. I went through a period of time when I wasn't even sure I wanted to study disability," he said. "I was fortunate to find a great professor who specialized in health communications. Dr. Ambar Basu told me he didn't have any experience in studying disability, but he was 'more than willing to learn with me.' Dr. Sara Green in the Department of Sociology was also very supportive in helping me figure out a plan of study. These two were instrumental in helping me realize the confidence to actually pursue what, until working with them, had been only an idea."

Now Romano has combined his education, life experiences and an innate talent for effective communication to fill a pivotal role with Custom Mobility, a provider of complex rehab equipment. What began as an informal discussion with Bruce Bayes, CEO of Custom Mobility, has developed into niche marketing responsibilities for the company. "My first relationship with Custom Mobility was when I was 3 years old and received my first power chair. My job now is to manage social media content for the company and write a blog for the company's web site (https://www.custom-mobility.com/blog/)," Romano said. "I have also developed and oversee a student intern program at Custom Mobility.

"I WAS FORTUNATE TO FIND A GREAT PROFESSOR WHO SPECIALIZED IN HEALTH COMMUNICATIONS. DR. AMBAR BASU TOLD ME HE DIDN'T HAVE ANY EXPERIENCE IN STUDYING DISABILITY, BUT HE WAS 'MORE THAN WILLING TO LEARN WITH ME.' DR. SARA GREEN IN THE DEPARTMENT OF SOCIOLOGY WAS ALSO VERY SUPPORTIVE IN HELPING ME FIGURE OUT A PLAN OF STUDY. THESE TWO WERE INSTRUMENTAL IN HELPING ME REALIZE THE CONFIDENCE TO ACTUALLY PURSUE WHAT, UNTIL WORKING WITH THEM, HAD BEEN ONLY AN IDEA."

Working with my old friend and colleague, Dr. Lindy Davidson who is now visiting faculty at the University of South Florida in the Honors College, we are identifying students who have experience with people with disabilities or have an interest in this population. Those chosen for an internship work with various departments at Custom Mobility and through this experience gain an understanding of all that is involved with getting clients the equipment they need." Interns are asked to create a presentation that compares their perception of CRT at the beginning of this experience with their understanding once their internship is finished.

Recently Romano joined other CRT leaders and advocates in Washington, D.C., to help educate members of the House of Representatives and the Senate regarding CRT issues. "It was very impressive and humbling to actually be in the buildings where our government makes important decisions," Romano said. "This was my second year to make this trip. The experience is very grounding, and it was made even better because we were there to try to make a difference in the lives of individuals with disabilities."

We can all learn from Romano's example of thoughtful determination to impact the lives of others. He has shown us all how to "grab life by the horns" and make it our own.

CONTACT
Kyle can be reached at KDR@CUSTOM-MOBILITY.COM.

Kyle Romano is a consumer advocate who works for Custom Mobility in Florida.

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IF YOU SEE THE NEED, THEN DO IT

Written by: **ROSA WALSTON LATIMER**

Cathy Carver had earned a Bachelor of Science in Physical Therapy at the University of Mississippi in Jackson and a Master of Science in Physical Therapy from the University of Tennessee at Memphis and was working in the spinal cord unit of the Methodist Rehab Center in Jackson, Mississippi, when she was drawn into the activities of the wheelchair and seating clinic. "I would pass by the wheelchair and seating clinic and observe therapist Allison Fracchia at work," Carver said. "I was impressed by the variety of patients in the clinic and how every situation Allison tackled was different. I found myself getting excited about the work she was doing and asked if I could sit in on some of her evaluations." Before long Carver was spending her lunch hours in the clinic with Allison. "What impressed me the most was learning how to look at the many things that people do in everyday life, and if provided the right equipment/technology, they can do more," Carver said. "All of this lit a fire in me!"

While there wasn't an opportunity for Carver at that time in the wheelchair and seating clinic at Methodist Rehab Center, she knew this was the career for her. "I had such a deep desire to do this work," Carver said. "I had to find somewhere to do it! I was single at the time with nothing holding me back so I let several facilities know I was interested in working in a wheelchair and seating clinic." One of those facilities was Spain Rehab Center at the University of Alabama at Birmingham (UAB) where Carver had worked immediately after finishing school. "Fortunately UAB said 'come back.' So I returned to Birmingham in 2005 just before Hurricane Katrina hit. I was thrilled to begin working in the outpatient department with Gayle Benson, PT, clinic manager."

Now, 13 years later, Carver is still enthusiastic about her work. "I remember what I learned from Allison. She helped me realize that giving people the right tools allows them to do more of what they want to do in life. I still draw from that understanding that I can make a significant difference in the lives of others," Carver said. "It is possible to help patients figure out what they can do sometimes before they even think about it. I ask my patients today some of the very questions that Allison asked during the time I was working with her." Carver's approach to evaluating a patient is very personal. "I always ask patients to tell me something they would really like to do that they can't do now," she said. "I also want to know if the patient had the perfect wheelchair with no thought of cost or accessibility what would that chair be. I'm not looking for a particular brand, but maybe something that can be changed that will make that individual more independent. Sometimes the answer is simple, and sometimes it is complicated."

"WE RESPOND AS NEEDS ARISE AND LOOK FOR AGE APPROPRIATE WAYS FOR THE KIDS TO BE INVOLVED. ONE OF OUR MANTRAS IS: IF YOU SEE THE NEED, THEN DO IT; CLAIRE AND JOEL ARE NOW OLD ENOUGH TO GO WITH ME TO SEE SOME OF MY PATIENTS. I DON'T WANT THEM TO BE AFRAID OF SOMEONE WITH A DISABILITY BUT INSTEAD TO FEEL COMFORTABLE HELPING OR JUST BEING A FRIEND TO SOMEONE IN NEED."

Along with this emphasis on the individual needs and desires of a patient, Carver stresses the importance of working with a strong team. "Your team members are crucial. If you are with the right team, the work gets done very well. You can help someone in a reasonable amount of time and in a cost effective way," she said. "This happens when your supplier, family members, patient and the doctor and manufacturer's rep have the same goal. That goal is to take care of a patient with integrity, quickness and a financially sound approach."

Carver is a Friend of NRRTS, a member of the Alabama Physical

"I WOULD PASS BY THE WHEELCHAIR AND SEATING CLINIC AND OBSERVE THERAPIST ALLISON FRACCHIA AT WORK," CATHY SAID. "I WAS IMPRESSED BY THE VARIETY OF PATIENTS IN THE CLINIC AND HOW EVERY SITUATION ALLISON TACKLED WAS DIFFERENT. I FOUND MYSELF GETTING EXCITED ABOUT THE WORK SHE WAS DOING AND ASKED IF I COULD SIT IN ON SOME OF HER EVALUATIONS."

Therapy Association and the American Physical Therapy Association and an active member of RESNA. She also serves on the executive board for the Clinician Task Force, a financially unbiased group of primarily seating and wheeled mobility clinicians whose work involves providing wheelchair seating and mobility services to individuals with disabilities. According to the group's web site (www.cliniciantaskforce.us), their mission is to bring the voice of the clinical community to those issues threatening appropriate access to seating, positioning, and mobility products and services. Carver recently chaired a project that resulted in a 50-minute video available on YouTube for CE credit that educates physicians on the face-to-face exam. (https://youtu.be/H_K3nud5Hd4).

"I encourage anyone who is just getting started in this field to use the educational resources of organizations such as RESNA and NRRTS," Carver said. "Ask lots of questions of your suppliers. They can help partner a new PT/OT with someone in their region who can be helpful. I've yet to meet a clinician who isn't willing to take a phone call from a new therapist or someone in home health that needs help. A reliable supplier or an experienced therapist is invaluable as a resource when a therapist is faced with a new situation."

Carver has reduced her responsibilities at Spain Rehab to part time to allow more time with her family. "I am also a reviewer of requests for custom wheelchairs for Alabama Medicaid," she said. "These responsibilities have taught me a great deal about funding and coding and have made me a better-equipped therapist that can better help my patients."

Carver's husband, Jeff, has a doctorate in computer science and is a professor at the University of Alabama of Tuscaloosa where he teaches and conducts research in software engineering. The couple has an 8-year-old daughter, Claire, and a 5-year-old son, Joel. "We pretty much do 'kid life,'" Carver said. "We enjoy our family and our time together." The Carvers are very active in their church and its work in the community. "We respond as needs arise and look for age appropriate ways for the kids to be involved. One of our mantras is: If you see the need, then do it," she said. "Claire and Joel are now old enough to go with me to see some of my patients. I don't want them to be afraid of someone with a disability but instead to feel comfortable helping or just being a friend to someone in need."

Carver has extended this goal to homeschooled children in her community. "Our kids go to public school, but I recognized an opportunity to develop a program for homeschoolers to learn more about individuals with disabilities," she said. "The program is called 'Come Roll with Me.' Once a month we take a group of able-bodied homeschooled kids out and let them experience life in a wheelchair,

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"Come Roll With Me" program founded by Cathy Carver in 2016.

Christmas fun in the clinic.

Great to be a kid in Disney. The Carver family, January 2018.

"I ENCOURAGE ANYONE WHO IS JUST GETTING STARTED IN THIS FIELD TO USE THE EDUCATIONAL RESOURCES OF ORGANIZATIONS SUCH AS RESNA AND NRRTS."

IF YOU SEE THE NEED, THEN DO IT!
(CONTINUED FROM PAGE 13)

meet someone who uses a wheelchair and give them the opportunity to ask questions. The goal is not necessarily to inspire but to increase awareness. Following this experience, the students will draw, make a video or in some other way report to me about their experience. The graduate students with the UAB Occupational Therapy School are helping with the program, and I'm hopeful that it will soon become a research project." Carver explained that it

"THESE EXPERIENCES WILL INFORM THEIR OPINIONS AND HOW THEY REACT TO THOSE WITH DISABILITIES. I'M NOT TRYING TO GET BIG WITH THIS PROGRAM. I WANT TO KEEP IT SIMPLE AND HOPEFULLY THERAPISTS IN OTHER AREAS WILL TAKE THIS MODEL AND STRUCTURE THEIR OWN, SIMILAR PROGRAM."

is important to expose kids to situations with people with disabilities while they are younger. "These experiences will inform their opinions and how they react to those with disabilities. I'm not trying to get big with this program. I want to keep it simple and hopefully therapists in other areas will take this model and structure their own, similar program." (https://www.facebook.com/comeroll16/)

Carver's connection with people and the desire to respond to their needs is a driving force in all aspects of her life. "I'm inspired by the people I meet every day who are taking what they've been given, that they were not expecting, and figuring out how to make the most of

their situation," she said. "My patients have taught me so much about what is possible, and they make me feel that if someday I have a disability, I can handle it!"

CONTACT

Cathy may be reached at CCARVER@UABMC.EDU.

Cathy Carver PT, MS, ATP/SMS with Allison Fracchia PT, ATP/SMS

University of Alabama at Birmingham occupational therapy students help propel the "Come Roll With Me" program forward.

Cathy Carver PT, ATP/SMS has practiced in adult neurology rehabilitation for over 20 years and for the past 8 years specializes in wheelchair and seating system service provision at Spain Rehabilitation Center/UAB in Birmingham, AL. She has been teaching wheelchair and seating courses around the state and nationally since 2007. Mrs. Carver is on the Executive Board for the Clinician Task Force, a member of RESNA, APTA (Neuro Section) and a friend of NRRTS. She is a consultant for Qualis Health and reviews medical necessity requests for custom wheelchairs.

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CRT LEGISLATIVE AND REGULATORY NEWS

Written by: **DON CLAYBACK**

In the two months since the 2018 National CRT Conference in Washington, D.C., the collective work of Complex Rehab Technology (CRT) advocates has added 35 new co-sponsors to our federal CRT legislation. Twenty-two of the new co-sponsors relate to the CRT bills that will stop Medicare from inappropriately paying for CRT manual wheelchair accessories at Durable Medical Equipment (DME) Competitive Bidding Program rates.

As of this writing HR 3730 stands with 108 co-sponsors (52 republicans and 56 democrats), and S 486 stands with 23 co-sponsors (11 republicans and 12 democrats). That's a great accomplishment! Thanks to those advocates for taking the time to build supporting relationships with their legislators.

Congress will be taking their August recess in a few short weeks. They are working on various legislation, some of which may come to a floor vote before then. Now is a great time to reach out to those legislators who still haven't signed on to CRT manual wheelchair accessories bills HR 3730 and S 486.

You can visit www.protectmymobility.org to see a complete list of co-sponsors. If your legislators are not signed on to the bills yet, use the links at the site to send an email and/or make a phone call. Your polite persistence is needed to secure their co-sponsorship and their support for passage.

YOU CAN VISIT www.protectmymobility.org TO SEE A COMPLETE LIST OF CO-SPONSORS. IF YOUR MEMBERS ARE NOT SIGNED ON TO THE BILLS YET, USE THE LINKS AT THE SITE TO SEND AN EMAIL AND/OR MAKE A PHONE CALL.

The CRT community needs to continue to reach out to Congress to ensure they hear the urgent need for our CRT legislation.

MEDICARE POWER WHEELCHAIR PRIOR AUTHORIZATION

CMS has announced it is expanding the Medicare "DME Prior Authorization (PA) Requirement" to include 31 power wheelchair codes effective Sept. 1, 2018. This is a new requirement and will be applied nationwide. You can get additional information and see the codes included by visiting blog.ncart.us, or searching the CMS website.

This will replace the current "Prior Authorization of Power Mobility Device (PMD) Demonstration" that has been operating in 19 states that will expire on Aug. 31, 2018. The majority of the codes included in the PMD Demonstration will be carried over to the new PA Requirements.

The new codes will be an addition to the separate Medicare DME Prior Authorization requirement for power wheelchair codes K0856 and K0861 that has been in effect for all states. As a result, as of Sept. 1 there will be a nationwide Medicare PA requirement for 33 power wheelchair codes.

Based on Medicare PMD provider experiences to date, the Medicare PA process has been operating well and the expectation is that will continue. It will be important that Medicare Administrative Contractors provide the increased staffing and training to allow for timely processing of the greater volume of PA requests.

CMS will be issuing additional guidance, and we will be sharing more information in the weeks ahead.

MEDICAID CURES ACT IMPLEMENTATION

As reported in the last CRT Update, Reps. Bill Johnson, R-Ohio, and Bob Latta, R-Ohio, were leading a House of Representatives letter to CMS Administrator Seema Verma. The letter formally informs CMS that Congress did not intend for DME Competitive Bid payment rates to be applied to CRT items as part of the 21st Century Cures Act and to request that CMS exclude CRT items from any inappropriate payment reductions.

THE GOOD NEWS IS THE HOUSE OF REPRESENTATIVES LETTER SECURED THE SIGNATURES OF 31 REPRESENTATIVES AND WAS SENT TO VERMA ON MAY 29. OUR THANKS GO TO REPRESENTATIVES JOHNSON AND LATTA FOR THEIR LEADERSHIP AND TO THE OTHER SIGNERS ON THE LETTER FOR THEIR SUPPORT.

The 21st Century Cures Act, passed in 2016, included limits on the federal Medicaid DME subsidy to states in specific situations. This limitation, when applicable, involves applying Competitive Bid payment rates to certain DME items. The Cures Act was not meant to negatively impact CRT items, but unfortunately that is happening in some states.

The concluding paragraph of the House letter summarizes the key message to CMS: "We respectfully submit that this policy, which was designed to create federal budget savings in Medicaid, was never meant to include CRT products. Congress made this intent clear when it included policy in the same 21st Century Cures Act to protect CRT from competitive bidding, and we ask that you follow congressional intent and protect CRT from payment cuts due to DME competitive bidding pricing, whether in Medicaid or Medicare."

The good news is the House of Representatives letter secured the signatures of 31 representatives and was sent to Verma on May 29. Our thanks go to Representatives Johnson and Latta for their leadership and to the other signers on the letter for their support.

CONTINUED ON PAGE 18

CRT LEGISLATIVE AND REGULATORY NEWS
(CONTINUED FROM PAGE 17)

NCART continues to collaborate with the American Association for Homecare, state associations and others on individual state discussions, education, and advocacy.

NATIONAL CRT PROVIDER FINANCIAL SURVEY

As NCART continues to work to protect access to CRT, we need updated industry financial and operational information for our advocacy activities. And we can't get it without the help of CRT providers.

To that end we have commissioned the Saunders College of Business at the Rochester Institute of Technology (R.I.T.) in Rochester, New York, to conduct a confidential National CRT Provider Survey. The study will be supervised by Raj S. Murthy Ph.D., an associate professor of marketing at the college. This survey is open to all CRT providers.

The last time we did a national CRT industry survey was in 2008. While this information has been very helpful over the years in our discussions with legislators and policymakers, we need more current data.

The Saunders College survey seeks limited financial and operational data from CRT providers for calendar/fiscal year 2017 and will be conducted during July and August. All information will be submitted directly to the college and held in strict confidence. The survey report will only disclose group data, so no individual company information will become public.

In addition to providing information critical to CRT advocacy, participating companies will receive a free copy of the final report, which is expected in October. This is a $495 value and will provide financial and operating information that will help providers better manage their CRT business in these challenging times.

THE SAUNDERS COLLEGE SURVEY SEEKS LIMITED FINANCIAL AND OPERATIONAL DATA FROM CRT PROVIDERS FOR CALENDAR/FISCAL YEAR 2017 AND WILL BE CONDUCTED DURING JULY AND AUGUST.

The first step in the survey process is to register your company with the Saunders College indicating you are willing to participate. You can go to https://goo.gl/jY2m5R to view a 2-minute video invitation, get additional details and follow the instructions to sign up.

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Don Clayback is executive director of NCART. NCART is national organization of Complex Rehab Technology (CRT) providers and manufacturers focused on ensuring individuals with disabilities have appropriate access to these products and services. In this role, he has responsibility for monitoring, analyzing, reporting and influencing legislative and regulatory activities. Clayback has 28 years of experience in the CRT and Home Medical Equipment industries as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences.

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THE AMERICAN PHYSICAL THERAPY ASSOCIATION AMENDS POLICY ON ACCESS TO DURABLE MEDICAL EQUIPMENT

Written by: **LAURA COHEN** PT, PHD, ATP/SMS

The role of the American Physical Therapy Association (APTA) to support and advocate for appropriate durable medical equipment (DME) and related services on behalf of consumers is consistent with the APTA's advocacy priorities. The APTA is committed to advancing the quality of health care and promoting access to appropriate health care services and supplies in the current environment of fiscal constraints. With continuous changes in policies surrounding DME, the APTA is concerned that the numerous changes impacting provision of DME has resulted in barriers and delayed consumer access to timely medically necessary care, quality DME technologies, and related technology and clinical services.

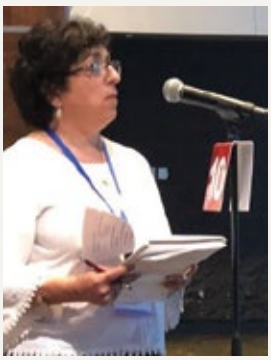
Oftentimes policy improvements advance incrementally. This year a DME motion (including CRT), initially introduced in 2013 with Clinician Task Force (CTF) member leadership, was revisited. To modernize and strengthen the organization's current position statement, the 2018 House of Delegates of the APTA, this week, amended their policy on access to DME. The adopted policy is a meaningful accomplishment and one that resulted from leadership and engagement of CTF members.

American Physical Therapy Association (APTA) House of Delegates in session.

A Special Committee of the House of Delegates was tasked to review and update existing APTA policies. On the list was the motion the CTF facilitated in 2013 about DME. With the leadership and participation of numerous CTF members an amendment to incorporate language in the policy to modernize the policy and address the increasing delays and barriers consumers regularly encounter was put forth. Amendment language was proposed to support and advocate for consumer choice and the client's timely access to cost effective, appropriate high-quality DME and related services.

After months of education, outreach and politicking by CTF members and colleagues the motion language was refined and replaced with broader more inclusive advocacy language.

Members of the CTF reached out to their local state and regional delegates to communicate case examples and urge co-sponsor support for the recommended language changes. Official testimony was read by delegates from numerous states into the verbatim minutes of the HOD including examples provided by CTF members demonstrating a nationwide concern.



Laura Cohen PT, PhD, chief delegate District of Columbia speaking in support of DME Motion Amendment at 2018 American Physical Therapy Association House of Delegates.

THIS IS A CHALLENGING TIME FOR ALL OF US WHO WORK IN THE CRT INDUSTRY. WE NEED TO PERIODICALLY STEP BACK AND PAUSE TO ADMIRE OUR PROGRESS. WE BELIEVE THAT OUR EFFORTS TO EDUCATE AND SUPPORT OUR PROFESSIONAL ORGANIZATIONS IS VALUABLE TO THE CRT INDUSTRY TO GARNER SUPPORT OF THE CLINICAL COMMUNITIES ON CRT ISSUES AND EXPONENTIALLY INCREASE THE OPPORTUNITY FOR DME AND CRT ADVOCACY ACTIVITIES. THE CTF IS THANKFUL TO OUR DONORS THAT CONTINUE TO SUPPORT OUR WORK AND ENABLE US TO MAKE STEADY PROGRESS!

The amended motion was passed without objection. In summary, the impact is the addition of expanded APTA policy language to support ongoing DME advocacy activities such as the APTA Action Network that lists legislation the APTA supports, includes talking points and tools for APTA members to communicate with their members of Congress. Historically, CRT Separate Benefit Category language has been posted on the Action Network. It is our intent that the amended language will now support independent APTA action related to the WC accessory legislation and other important DME policies. From a practical perspective, this means expanding the grass roots reach to include 100,000 APTA members with DME related communications, education and advocacy tools to support our legislative and regulatory activities.

Increasing the number of clinical stakeholders participating in consumer advocacy activities is paramount to moving the needle on DME and CRT legislative, regulatory and policy issues. Clinical voices (PT, PTA, OT, OTA) along with consumer stakeholder voices (consumers, families, caregivers) are critical when speaking with policymakers and conspicuously missing when not voiced.

The CTF works with our professional clinical organizations (e.g. APTA, AOTA, AAPMR, AAP, etc) and coalitions (ITEM, HAB, CPR) to mobilize clinical stakeholders to join DME and CRT advocacy efforts. This allows us to exponentially broaden our reach and potential to impact DME and CRT issues impacting consumer access.

Dating back to 2005, the CTF has led the effort to bring DME and CRT motions to the APTA House of Delegates and AOTA Representative Assembly, the highest policy making bodies of these organizations. It is a lengthy process requiring steady engagement and leadership. CTF members have successfully and incrementally worked to get organizational positions, policies and actions adopted by our professional organizations that incorporate DME and CRT. Passed motions have resulted in allocation of resources and personal to address DME and CRT policy issues within our professional organizations.

This is a challenging time for all of us who work in the CRT industry. We need to periodically step back and pause to admire our progress. We believe that our efforts to educate and support our professional organizations is valuable to the CRT industry to garner support of the clinical communities on CRT issues and exponentially increase the opportunity for DME and CRT advocacy activities. The CTF is thankful to our donors that continue to support our work and enable us to make steady progress!

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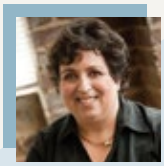
Laura Cohen is the executive director of the Clinician Task Force (CTF), a national group of seating and mobility clinicians working to influence Medicare and Medicaid coding, coverage, and payment policies for complex rehab and assistive technology devices. The CTF provides clinically relevant information about seating and wheeled mobility device assessment and decision making to policymakers to ensure appropriate access for individuals with disabilities.



WHO IS UNITED SPINAL ASSOCIATION?

Written by: **ALEX BENNEWITH,** MPA

As we finished our organization's fiscal year in June and we begin a new year with new challenges and opportunities, I thought it fitting to go back to the drawing board and introduce the newer readers of DIRECTIONS to our organization.

United Spinal Association is the largest nonprofit organization, founded by paralyzed veterans, dedicated to enhancing the quality of life of all people living with spinal cord injuries and disorders (SCI/D), including veterans, and providing support and information to loved ones, care providers and professionals. United Spinal has over 70 years of experience educating and empowering almost 2 million individuals with SCI/D to achieve and maintain the highest levels of independence, health and personal fulfillment. United Spinal has over 50,000 members, 52 chapters, close to 200 support groups and more than 100 rehabilitation facilities and hospital partners nationwide including 10 distinguished Spinal Cord Injury Model System Centers that support innovative projects and research in the field of SCI. United Spinal Association is also a VA-recognized veterans service organization serving veterans with disabilities of all kinds.

We believe no person should be excluded from opportunity based on their disability. Our goal is to provide people living with SCI/D programs and services that maximize their independence and enable them to remain active in their communities. With our advocacy and policy network, we have an advocacy representative at every chapter and an advocacy coordinator in one of six regions across the country, United Spinal is actively engaged in advocating for policies that benefit paralyzed Americans and all people with disabilities. Our signature advocacy and policy event, Roll on Capital Hill, brings wheelchair users from across the country to Washington, D.C., every June. For more information, please visit www.unitedspinal.org/action-center and www.unitedspinal.org/events/roll-on-capitol-hill/. We have a national chapter network that supports the SCI/D community by promoting health and well-being, inclusion and independence, organizing local events and projects, advocating for rights and accessibility, and offering information and support. Our Spinal Cord Resource Center Information Specialists connect people with personal guidance and state and local resources through our 'Ask Us' help desk at https://unitedspinal.org/ask-us/. Our Pathways to Employment program supports the pursuit of new career opportunities for people with SCI/D. With our membership program, we connect people with SCI/D to their peers and support services such as our Peer Mentoring Support Groups, our New Mobility magazine and our New Beginning Backpack program, which provides information and resources as a person transitions into a 'new beginning' after SCI/D. Our Product and Service Providers form a directory of products and services covering the full spectrum of clinical care, products and services. Our Accessibility Services program ensures that the built environment is accessible to all people with disabilities. A team of certified accessibility specialists and staff architects provides training to design professionals and reviews design plans on national projects.

For more information about United Spinal's programs and services, you can call (800) 404-2898 or askkus@unitedspinal.org. You can also visit https://www.unitedspinal.org/our-programs/; https://unitedspinal.org/spinal-cord-injury-resources/; or https://www.unitedspinal.org/united-spinal-network/.

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Alex Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at both the federal and state level. She works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health and disability communities. She graduated from Brandeis University and received a Master of Public Administration from American University.

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ORTHOSTATIC HYPOTENSION

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

Orthostatic hypotension is low blood pressure that typically occurs upon standing from a sitting or lying position. Therefore, the condition is also referred to as postural hypotension. Hypotension can cause a person to feel dizzy, lightheaded, have blurry vision, hear roaring in the ears, feel nauseous, be confused or even faint. The condition is more likely if a person is dehydrated, has low blood sugar, is overheated, or has been on prolonged bed rest. People with certain chronic health conditions are more likely to experience orthostatic hypotension.

When we stand up, gravity can cause more blood to remain in the lower body rather than circulating back to the heart, leading to low blood pressure. Baroreceptors sense low blood pressure and signal the brain which cues the heart to pump more blood. When this process is interrupted, orthostatic hypotension may occur.

Certain nervous system disorders can affect the normal blood pressure regulation system. This includes Parkinson's disease, multiple sclerosis, and spinal cord injuries. In spinal cord injuries, nervous system control, which typically keeps blood pressure stable, is damaged and loss of muscle tone reduces the ability of the body to return blood to the heart. Orthostatic hypotension is more common during acute recovery and in people with higher level injuries.

When a client using a wheelchair experiences orthostatic hypotension, it is critical to have them lay down immediately to restore normal blood pressure. It may not be possible to transfer this person to a lying position quickly (i.e., out in the community) and so recline can be used to remediate this condition. The client should return to upright sitting slowly to maintain stable blood pressure. In the morning,

the client should also slowly raise the head of the bed to accommodate before transferring into the wheelchair. It is also helpful to be well hydrated. Abdominal binders and compression socks may be used to minimize hypotension upon positional changes.

Orthostatic hypotension is a serious medical condition that can lead to fainting. If a client is already sitting upright in their wheelchair when this occurs, the brain may not receive enough blood supply and brain damage could occur. It is critical that the client can independently recline and do so quickly before fainting occurs. If a client experiences a sudden worsening of hypotension symptoms, they should return to their doctor to determine the cause. An infection can sometimes trigger orthostatic hypotension.

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Michelle Lange is an occupational therapist with 30 years of experience and has been in private practice, Access to Independence, for more than 10 years. She is a well-respected lecturer, both nationally and internationally, and has written 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, 4th ed.; NRRTS Continuing Education Curriculum Coordinator and Clinical Editor of DIRECTIONS magazine. Lange is on the teaching faculty of RESNA and is a member of the Clinician Task Force. She is a certified ATP, certified SMS and is a Senior Disability Analyst of the ABDA.

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CLINICAL PERSPECTIVE

PEDIATRIC STANDING

ARE THERE BENEFITS OR ANY EVIDENCE TO SUPPORT THIS INTERVENTION?

Written by: **JACKIE CASEY,** BSC HONS OT, MSC; OTR/L

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INTRODUCTION

This paper will explore reasons for and uses of standing devices and what evidence exists to support these as a therapeutic modality. Standing has long been considered an important element in all physical rehabilitation and management regimes (Pope, 2007). Standing is a critical part of our postural development as children, enabling us to move in an upright plane against gravity so we can explore and interact fully with our worlds. Standing, along with lateral weight-shifting skills, can be viewed as a prerequisite for stepping and walking and as a means to enable the child to engage and participate in everyday life for children with complex physical disabilities. It also should be considered within 24-hour postural management programs, along with sitting and lying (Pope, 2007; Pountney, et al., 2002).

For the children we work with, standing becomes integral to many of our therapeutic interventions for several reasons. Firstly, much of our clinical work tends to mirror the pathway typical child development follows, and we use this as a guide for determining appropriate intervention. Secondly, standing is generally accepted as being a requirement for children to achieve walking, and our society continues to place huge emphasis on the importance of independent walking. Thirdly, clinicians recognize the many benefits standing affords the child in their overall developmental achievement, health and well-being. Standing contributes across all the child's domains of physical, sensory, emotional, cognitive and social development.

TYPICAL CHILD DEVELOPMENT

As we know, children develop at different rates depending upon their makeup, intrinsic motivation, the environment, and opportunities afforded them. However, despite all of these variables, we see that children typically pull themselves up to stand at approximately 7-10 months of age (Sharma & Cockerill, 2014; Mulligan, 2003). The child usually progresses onto furniture cruising, supported walking holding their caregiver's hand and ultimately to independent walking at approximately 10-12 months (Mulligan, 2003).

However, when a child has a physical disability or global developmental delay we often see that developmental milestones are not achieved within this typical time range. These children might not be able to sit upright against gravity between 6-8 months. They may have poor core postural control, struggle to hold their head up against gravity or lack the ability to weight bear independently, making standing and walking unachievable without either physical assistance from a caregiver or through using assistive technology devices such as standing frames. Subsequently, we as clinicians use our knowledge of typical child development to determine when we should intervene and offer both hands-on and assistive technology devices to support these children to experience and/or achieve their postural and motor development. So, at 8 months when that child is not yet standing or pulling up to stand, therapists typically introduce standing frames and standing programs with the

child and their caregivers. Indeed, the Mackeith Consensus statement on 24-hour postural management recommended provision of such early intervention. This statement also recommended considering standing, lying and sitting interventions by 12 months of age for those children who have cerebral palsy and GFMCS levels IV and V (Gericke, 2006).

STANDING FRAMES

A wide range of standing frames are now commercially available to provide assisted support in standing for children. These usually have a rigid frame and a wide base of support, with various knee, pelvis, trunk and upper extremity supports to correctly and safely align the child within the standing frame. Most tend to be static in nature, with passive loading or weight-bearing through the lower limbs. However, a small number of available standing frames offer mobility or a dynamic weight-bearing component. Equally, the available range of standing frames enables clinicians to select the most appropriate device to meet the diverse needs of the child and their caregivers. Features may include:

- adjustable height.
- postural supports (including various sizes and placements).
- plane of use (supine, upright, prone, 3-in-one).
- degree of available hip abduction.
- pelvis positioning options to support or better align the pelvis.
- various methods of adjustment and hardware.
- aesthetics (particularly important for parents of very young children).

REPORTED REASONS FOR USING A STANDING FRAME

Therapists select a device tailored to the individual child for many reasons, ultimately to improve the functional skills and position of the child (Wintergold, et al., 2008), yet there remains little robust evidence investigating functional improvement of the child and the rather dated evidence that does exist provides limited or inconclusive support for functional improvements (Miedaner & Finuf, 1993; Kramer, et al., 1992). Reasons identified for using standing frames included muscle stretching and prevention of contractures, enhancing circulation, digestion and bowel function, facilitating hip joint formation, as well as improving skin integrity, alertness and bone mineral density.

Seminal work by Stuberg (1992) explored the relationship between static standing and bone mineral density. This research has had much influence on the recommended dosage of 60 minutes standing five times per week routinely prescribed to children with cerebral palsy to prevent bone mineral density loss. Caulton et al. (2004) found small increases in bone density (with a mean of 6 percent in vertebral bone mineral density); however, insufficient detail was provided as to what angle therapists in the study positioned the children in standing or what the knee joint position was. More recently, there has been increased focus on using a dynamic component (such as a vibrating platform) during standing to develop postural control and bone mineral density (Ward, et al., 2004). However, commercial availability of dynamic options is limited.

Static standing frames have also been described as an effective passive method of stretching muscles and vulnerable tissues (Pin, 2007; Pope, 2007), with Stuberg (1992) suggesting use of the standing frame for a minimum of 45 minutes two to three times per week to address this goal. Gibson et al. (2009) investigated the effect of static weight-bearing in standing frames on hamstring length in five children with cerebral palsy. They found improvements in hamstring length after six weeks of standing for one hour per day for five days per week, and easier management by caregivers for transfers and activities of daily living. However, it is not apparent as to how much hip and knee extension was achieved in standing for each child, or how much hip abduction was applied.

Another primary reason for using standing frames with children is to support the integrity of the hip joint. Hip surveillance has shown that children with cerebral palsy are born with normal hips but, because of abnormal muscle tone activity around their hips, can develop hip subluxation and dislocations that can cause pain, asymmetries and further complications. Hip dislocation is a real problem affecting 15 to 20 percent of children with cerebral palsy (Hagglund, et al., 2014) and increasing to 70 to 90 percent of those with GMFCS levels IV and V (Soo, et al., 2006). For these children, we realize the the need to provide weight-bearing opportunities through standing frames to help deepen the acetabulum and subsequently promote congruency between the acetabulum and the femoral head and so help reduce the risk of hip subluxation.

Following publications by Martinsson & Himmelmann (2011) and Macias-Merlo et al. (2015a; 2015b), academic discussion has developed in regard to the optimum direction and magnitude

CONTINUED ON PAGE 30

(CONTINUED FROM PAGE 29)

of forces that should be applied through the hip joint in abduction (Wright, et al., 2016). Findings from these studies suggest that the child should be positioned in as close to 600 of hip abduction and 00 knee extension as the child is able to tolerate in order to develop and maintain hip integrity. These studies examined heterogeneous groups of children with cerebral palsy, had small or uneven group sizes, and no control group in the Macias-Merlo et al. (2015a; b) studies and therefore no comparison is possible between the suggested 60° degrees of hip abduction and the 25-30° neutral alignment. Whilst the Martinsson & Himmelmann (2011) study provides much more descriptive information on hip abduction and knee extension, possible co-interventions are not fully accounted for in their analysis. Subsequently, caution should be exercised when determining the optimal degree of hip abduction for the individual child.

Further, engagement with ongoing hip surveillance programs to monitor and provide intervention to prevent hip subluxation occurring in these children is vital (Scrutton & Baird, 2001). Prevention of hip subluxation through good postural alignment is important as this can lead to pain; further progressive disabilities for the child (Goodwin, et al., 2017) such as contractures, scoliosis and even pressure areas; and increased risk of tissue injury and skin breakdown. Pountney & Green (2006) have advocated for positioning equipment such as standing frames to manage posture if the child with cerebral palsy shows a hip migration percentage of greater than 15 percent at 30 months of age.

A survey completed by Goodwin et al., (2017) of physical therapists and parents of children with cerebral palsy in the UK in 2016 reported that the provision and use of standing frames was principally based upon clinical experience as opposed to research or any published best practice guidelines or protocols. This again serves to illustrate the lack of evidence available to justify our standing interventions and the value of standing frames for children (Ben-Shlomo & Kuh, 2002). Intervention also relies upon the skill of the therapist in individualizing the application of standing programs to the unique needs of the child, making it difficult to complete rigorous research beyond case study designs in this field. Interestingly these survey findings illustrate the discrepancy between therapist and parent utilization of standing frames. Daily use of standing frames was advocated by 82 percent of the prescribing therapists, however, achievement of this was reported by only 18 percent of parents. Additionally, the prescribed duration of standing for 30-60 minutes by 76 percent of therapists was attained by only 52 percent of parents and with variations of longer or shorter duration periods reported by 24 percent and 12 percent of parents respectively (Goodwin, et al., 2017).

Therapists and parents also reported environmental barriers to adhering to standing programs including: having adequate space for both use and for storage of the standing frame, receiving adequate instruction in how to use the standing frame, and how to transfer the child in/out of the stander.

TYPES OF STANDERS

Supine standers are useful for those children who struggle to activate their antigravity muscle patterns to keep their head and upper body upright against gravity (Labandz, 2011). Further, supine standers can accommodate children with significant contractures of the hips and knees and facilitate transfers. The angle of use needs to be carefully considered as the child's upper body and head may now be upright, however, their field of vision might no longer be at the desired angle. Further, children's reach and functional task participation may also be compromised, or they may not be weight-bearing in the desired areas. Prone standers, on the other hand, offer the child support on the anterior surface of their body, whilst they actively work on extension to hold their head upright against gravity, and on shoulder girdle stability. Again, the clinician needs to be aware that the child might weight bear no more than 70 to 75 percent through their lower limbs (Stuberg, 1992). Upright standers, if used to provide stretch and weight bearing, can be the most effective; however, consideration must be given to the position of the pelvis and knees, ensuring neutral-to-anterior pelvic tilt and knee extension (Pope, 2007; Pountney, et al., 2000), as this more closely resembles the posture to prepare for walking.

With dynamic standers, typically the child is in an upright or slightly prone position and the child initiates their own mobility by hand, pushing the large wheels on the side of the stander. These standers require space and level floor surfaces to enable the child to experience mobility from an upright position and participate in some activities of daily living including recess at the same eye level as their peers!

DOSAGE

The evidence base prescribing frequency and duration of use of standing frames remains sparse and varies depending upon clinical goals for standing and who is facilitating the standing program. Paleg et al. (2013) undertook a systematic review of research studies on standing dosages for children and found variations in prescribed duration for standing programs. They were able to make some recommendations for clinical practice, as outlined in the table below. Dosage varies depending upon the desired intervention goal for using the standing frame with the child.

Table showing: Standing Program Dosage (courtesy of Paleg, et al., 2013)

TREATMENT GOALS	DOSAGE - 5 TIMES PER WEEK
Bone mineral density	60-90 minutes each day
Hip stability	60 minutes per day in 30-600 total bilateral hip abduction
Range of motion of hip, knee, ankle	45-60 minutes per day
Spasticity	30-45 minutes per day
Muscle stretch	60 minutes per day

Practically, many caregivers find it difficult to achieve the longer dosage programs and to this effect Weschler (2011) advised that several shorter periods of standing each day may actually be more beneficial than one longer period of standing each day. It is also important to consider how best to support caregivers in integrating standing programs into everyday life to better ensure the recommended dosage is realized. Working collaboratively with other health and education colleagues can help with this end goal by incorporating some of their clinical or educational activities during assisted standing in the standing frame. The child may tolerate longer periods of standing, and in a more upright position, if distracted through engagement in other activities. Activities could include hand washing and teeth cleaning at a sink whilst in the standing frame or writing on an interactive classroom white board from an upright, prone or mobile stander.

In introducing a standing program, Paleg, et al. (2013), Rosen (2010) and Pope (2007) stress the importance of considering a number of potential cautions and contraindications for standing and in determining the optimum duration for standing. These include the child's age (for example, is the use of supine age appropriate), their tolerance to standing, history of fractures and surgery, the presence of contractures, induced hypotension, pain, compromised breathing or circulation, and the amount of effort required to get the child into the stander and correctly aligned. These clinicians advise that, despite these recommendations for dosage, the standing program should be tailored to address that child's specific intervention goals and individualized presentation. Further, Hagglund, et al. (2007) reported that hip abduction in standing is optimally effective in promoting hip joint integrity only when it is performed in combination with other interventions. Ideally, standing should form part of a 24-hour postural management program, offering alternate positions to sitting and lying throughout the day-night cycle for the child.

Whilst positioning the child in the standing frame, it is important to ensure correct postural alignment, where the center of gravity is, stability of the child, and upper limb function whilst using the stander. In seating, we generally consider where the pelvis is placed and its orientation; equally the pelvis should be supported in standing so that weight bearing occurs in the correct direction and is of the correct magnitude. This will ensure that the trunk and lower limb muscles work in balance with each other, and that the appropriate muscle stretch is applied. Otherwise, you may not achieve your desired results from the standing frame regardless of dosage, frequency or degree of hip abduction.

CONTINUED ON PAGE 32

PEDIATRIC STANDING
(CONTINUED FROM PAGE 31)

Whilst examining the literature, both the dearth of research available and the low level of methodology quality is evident, and there remains a gap about documented benefits of standing frames and programs with children (Ben-Sholomo & Kuh, 2002). Studies examine different goals for using standing, each with different outcome measures, small sample sizes and lower level study designs.

In summary, clinically our experience tells us that providing assisted standing support through assistive technology devices is a positive experience to the health and well-being of children. We know that being upright gives a different visual and spatial experience from that of sitting or lying; draws peers to the child to interact; uses gravity to support digestion and elimination processes; improves bone mineral density; and through good postural alignment, and as part of an overall 24-hour postural management program, can be used to reduce postural asymmetries. However, we need to be more conscientious in recording what our standing goals are and subsequently the dosage, frequency, orientation (prone, upright, supine), as well as the knee, hip and pelvis alignment we use to match that particular standing goal. This documentation is vital to build an evidence base on the effectiveness of standing, enhancing quality of life and reimbursement requests, rather than anecdotally reporting the benefits on quality of life for the children we work with.

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Jackie Casey has been working in the field of seating and positioning in various capacities since graduating in the UK as an occupational therapist in 1994. Jackie has worked in elderly rehabilitation and in children's services with children with physical, sensory, and/or intellectual impairments. She has over two decades of experience in teaching, clinical research and working with industry. She worked as a lecturer and program director at the University of Ulster, Northern Ireland before joining Permobil in 2018.

REHAB CASE STUDY

RIGHT STANDER. RIGHT TIME.

Written by: **LAUREN ROSEN,** PT, MPT, MSMS, ATP/SMS

The right equipment at the right time can make the difference between using standing equipment and it becoming a nice coat rack. Usually, these articles only include one client, but I'm including two, each with different issues yet a similar theme of providing the right equipment at the right time so that the family will use it.

The first case focuses on the importance of considering many product options with the family to assure best outcomes. The second case shows the limitations of standers in active teens and the potential results of stopping regular standing.

LINCOLN

Lincoln is a 4-year-old with the diagnosis of myotubular myopathy. He is a bright and engaging young man. He has a tracheotomy and uses a ventilator full time.

Lincoln was referred to me at 12 months old for an evaluation for a wheelchair and a stander. As he has no cognitive impairments but has very little active movement, he was evaluated for, and eventually received, a Permobil Koala power wheelchair that he operates with an Adaptive Switch Labs (ASL) switch tray (for a fun story, ask me sometime about the appeal hearing for his wheelchair - that was super fun) (See Figure 1).

Based on Lincoln's decreased strength, very poor trunk and head control, and his use of a ventilator, an R82 Caribou supine stander was prescribed for him (See Figure 2). This was also chosen based on sizing and appearance. It was one of the few supine standers that was small enough for him. I'm happy to report that there are now many more options.

THE FIRST CASE FOCUSES ON THE IMPORTANCE OF CONSIDERING MANY PRODUCT OPTIONS WITH THE FAMILY TO ASSURE BEST OUTCOMES. THE SECOND CASE SHOWS THE LIMITATIONS OF STANDERS IN ACTIVE TEENS AND THE POTENTIAL RESULTS OF STOPPING REGULAR STANDING.

At the time, Lincoln was 31" tall and only weighed 22 lbs. After a lot of work by the supplier to get the tray below shoulder height where he could use it, this stander was initially very easy for the family to use. They used it regularly and Lincoln enjoyed being upright.

Three years later, Lincoln and his family came back to me because he could no longer use the stander (See Figure 3). He was now 42" tall and

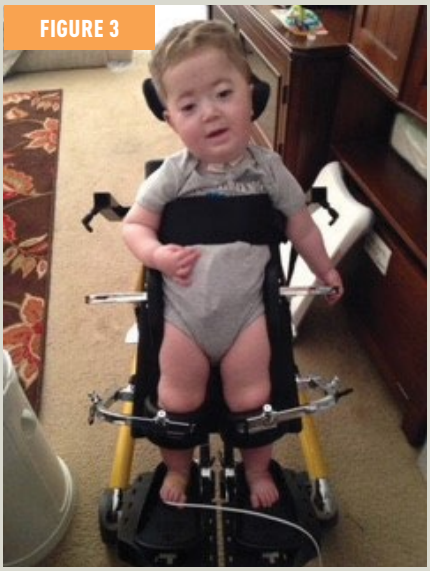
FIGURE 1

Lincoln Power Wheelchair

FIGURE 2

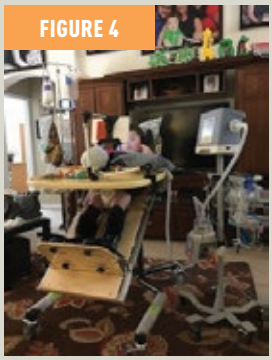
Lincoln first stander new

FIGURE 3



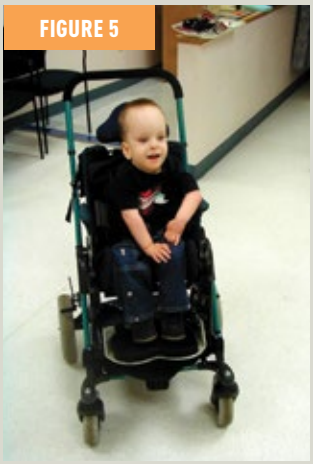
Lincoln First Stander Old

FIGURE 4



Lincoln second Stander

FIGURE 5



Daniel medical stroller

FIGURE 6

Daniel First Stander

he weighed 33 lbs. He was too tall for this stander and it had become difficult for his family to operate.

To be honest, I do not use many supine standers in my clinic. Most of the young children I work with have better or improving head control so I usually choose a multipositional or occasionally a sit-to-stand stander. I do not choose sit to stand as much for very young children, as these tend to be more expensive and most payors in Florida do not like the price point.

In discussions with the family and supplier, it became clear that a different style of supine stander was better for Lincoln. The current stander could have been grown into a larger size but the family felt it was difficult to use and did not feel as safe positioning him into it now that he was taller and still had very low function.

The supplier suggested a more basic supine stander by Rifton with less moving parts and less attachments to position and support Lincoln (See Figure 4). After a home trial with the recommended stander, his family was very pleased with the new device so this was requested and delivered to them.

MOST OF THE YOUNG CHILDREN I WORK WITH HAVE BETTER OR IMPROVING HEAD CONTROL SO I USUALLY CHOOSE A MULTI-POSITIONAL OR OCCASIONALLY A SIT-TO-STAND STANDER.

Lincoln has had his stander for just over a year. He's continuing to grow so he's now 43" tall and he weighs 45 lbs. His mother reports they are still able to use the stander without difficulty. His passive motion in his legs remains good.

In another few years, it will be time to evaluate Lincoln again for a new stander. As we did with each evaluation, we will start from scratch and determine he and his family's needs based on his current function, size, and the equipment options available.

DANIEL

Daniel is a 15-year-old who is a very active young man. He enjoys skiing, horseback riding, and he is the manager of his high school football team. He has a lot of friends and is a very active young man.

I first met Daniel in 2003 when he was 8 months old (See Figure 5). He was born with a gap in his spinal cord from C5 to T1 making him a complete quadriplegic at the C5 level. Fortunately for Daniel, his parents accepted his disability and worked to maximize his function from the very beginning.

His first visit to my office was for a medical stroller. His parents were transporting him in a standard stroller. Daniel had poor trunk control, could not sit independently and did not have good use of his upper extremities. His passive

CONTINUED ON PAGE 36

RIGHT STANDER, RIGHT TIME
(CONTINUED FROM PAGE 35)

motion was great despite having spasticity in his lower extremities. He had already experienced a few urinary tract infections, as he was being catheterized.

During that visit, we recommended the medical stroller and his first sit-to-stand stander, an EasyStand Magician EI (this stander no longer exists but is similar to the current Bantam Extra Small) (See Figure 6). We knew that Daniel was never going to stand independently, and we really wanted to maximize his function and lessen the negative effects of sitting from a young age. Our goals back then were to help deepen his acetabulum depth, prevent lower extremity contractures, lessen his spasticity, and lessen his risk of urinary tract infections.

Daniel received his stroller and his stander a couple of months later. His family quickly got into a routine of using the stander daily for at least an hour. He has getting therapy regularly and his function in his arms improved.

Two years after getting the medical stroller, he tried his first power wheelchair. This was very successful as he was very motivated to move himself and quickly learned to operate the wheelchair. After working with his supplier and insurance company, Daniel got his first power wheelchair (See Figure 7). Once he received this, sitting still became difficult for him, as it is with any child.

Daniel used the original sit-to-stand stander for two years before growing out of the seating system. Fortunately, we were able to grow the system into a larger seat and back so he could continue to stand (EasyStand Magician conversion … again, not made

FIGURE 7

Daniel First Stander

FIGURE 8

Daniel Activities

FIGURE 9

Daniel Activities

FIGURE 10

Daniel Glider

FIGURE 11

Daniel Permobil VS with TD Schenck

THIS WAS VERY SUCCESSFUL AS HE WAS VERY MOTIVATED TO MOVE HIMSELF AND QUICKLY LEARNED TO OPERATE THE WHEELCHAIR. AFTER WORKING WITH HIS SUPPLIER AND INSURANCE COMPANY, DANIEL GOT HIS FIRST POWER WHEELCHAIR.

I'M NOT SAYING THAT STANDING FOR DANIEL SOLVED ALL THE PROBLEMS IN THE WORLD. IT COULD BE COINCIDENCE THAT HE LOST ALL THE MOTION AROUND THE SAME TIME HE STOPPED STANDING.

anymore). He did not always stand every day for as long as he did originally, but his family still prioritized standing.

Unfortunately for me, Daniel's father changed jobs and the family moved to Denver, Colorado. However, I was lucky that his mom has kept in touch and allowed me to assist them in equipment decisions over the years. Through the magic of email and social media, I've also gotten to watch him grow up and excel.

Over the next few years Daniel got a larger power wheelchair and, thanks to a much better insurance industry then here in Florida, he also got a manual wheelchair. With his function, he was able to self-propel the manual chair some of the time and even used it to play some sports. He even participated in some camps where he got to play sports (See Figures 8 and 9).

Simply standing in a static stander got boring for him considering his energy level and his ability to move himself. So, when he was 7 years old, we decided he could benefit from a glider (See Figure 10). He liked being able to exercise in the stander. We also liked the additional benefits of dynamic standing, which could better assist with maintaining bone density than static standing.

As Daniel got older and busier, taking time to stand became more difficult. Between schoolwork and extracurricular activities, he stopped standing. As a result, he started to lose passive motion in his lower extremities.

Daniel performed a trial with a standing power wheelchair when he was 14 to see if he could incorporate standing into his day and use it more frequently (See Figure 11). Unfortunately, this was not a good fit for him, and he got another Group 3 power wheelchair.

With no stander, after only a year, Daniel's hamstrings and ankle plantarflexors have become significantly tight. It is affecting his sitting position in his wheelchair. He's now headed for possible surgeries that may have been avoided or at least less invasive had he been able to continue a standing program. Considering that he made it to this age before surgery was discussed is a positive thing for sure for him, regardless of the procedures performed.

I'm not saying that standing for Daniel solved all the problems in the world. It could be coincidence that he lost all the motion around the same time he stopped standing. However, based on research evidence, I believe it had a strong affect.

I also need to point out that Daniel maintains a very active and very fulfilling life. With everything in life, people make choices on what is most important. I would never say that Daniel and his family made the wrong choice by prioritizing activities and sports. I think that he and his family have a great life, and I'm so excited for what he has and will accomplish.

Two very different kids with very different needs. For Lincoln and his family, we are currently able to meet their needs and he is able to stand regularly. That may change as he gets older, but remains to be seen. For Daniel, unfortunately, we were not able to continue to meet his standing needs as he got older. But again, we did not fail in either case. Both families have seen many benefits from standing and both speak positively about their experiences. So good outcomes all around.

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"SPECIALTY" EVALUATION, ATP INVOLVEMENT

WHAT DOES MEDICARE EXPECT?

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

As I work with providers and clinicians, I am learning that a good portion of this group still question what Medicare really wants from the "Specialty Evaluation" and what they mean by "direct-involvement" of an ATP. These specifically relate to Medicare policy requirements of both manual and power complex rehab technology (CRT) wheelchair systems.

For those of you who have been in this business for a rather long time, you may recall that both of these requirements stemmed from industry recommendations to Medicare; supporting the need for qualified individuals to be a part of a CRT wheelchair order. It is hard to believe that these requirements have been in place for over 15 years; somehow, they still create issues for some during the wheelchair ordering process.

Let's first look at the Specialty Evaluation. Medicare policy for both manual and power CRT wheelchairs, require that a Specialty Evaluation be completed by a clinician who has experience and training in mobility evaluations. The policy specifically calls the clinicians, Licensed/Certified Medical Professionals (LCMPs). Do not get hung up on the LCMP terminology. I also do not recommend you use this term with the referrals; this is a Medicare created description that clinicians are not familiar with, therefore it only creates confusion. Medicare does not define the specific clinical credentials required, but in our CRT world it will obviously be a physical or occupational therapist in the majority of cases. The focus needs to be on the fact that the clinician is someone who is experienced and trained in seating and positioning.

As for documenting the evaluation, some people tend to believe that certain formats are required versus others. Per policy, there is not a specific form or format that is to be completed for the mobility evaluation. It is my opinion that a clinician experienced in these evaluations already has his or her own form, granted at times that form may not be the easiest to interpret (or to actually read). I also find that some providers' internal staff are more comfortable reading certain types of evaluations, this cannot be the reason to request an additional form be completed. Providers need to be certain that their staff is able to fully read through any type of clinical documentation and understand if the coverage criteria are met.

IT IS KNOWN THAT MEDICARE IS NOT A FAN OF FORMS THAT ARE ONLY COMPRISED OF CHECK BOXES. THERE NEEDS TO BE AREAS THAT ALLOW OPEN FREE-FORM DESCRIPTIONS. AS WE ALL KNOW, A CLIENT'S CONDITION CANNOT FULLY BE DESCRIBED WITH ONLY CHECK-BOXES; THIS IS ESPECIALLY TRUE FOR THOSE REQUIRING CRT.

It is known that Medicare is not a fan of forms that are only comprised of check boxes. There needs to be areas that allow open free-form descriptions. As we all know, a client's condition cannot fully be described with only check-boxes; this is especially true for those requiring CRT. If the clinicians are looking for assistance with the type of evaluation form that should be completed, these can easily be found within our industry – online or by asking fellow clinicians.

Something else to keep in mind is that Medicare does not require an actual Letter of Medical Necessity (LMN). The required mobility evaluation can be on an evaluation form or can be transposed to an LMN, but both are not required. However, some state Medicaid's may require the LMN. Be sure to check with the appropriate person in your office (or with Medicaid) to understand exactly

"IN THE CRT WORLD, A LARGE PORTION OF THESE MEETINGS WILL BE DURING THE CLINICIAN'S SEATING EVALUATION. THIS ALLOWS THE "TEAM" TO WORK TOGETHER ON THE BEST SOLUTION TO MEET THE CLIENT'S NEEDS. EVEN IF THE ATP IS PRESENT DURING THE SEATING EVALUATION, AND EVEN IF THE THERAPIST DOCUMENTS THEIR PRESENCE, THE ATP MUST COMPLETE THEIR OWN DOCUMENTATION.

what they require in terms of documentation. In my opinion, if the therapist has a good evaluation form, they can complete most of this while with the client and not worry about finding time outside the office to complete the paperwork.

Next is the requirement of "ATP Involvement," what does this actually mean? The Medicare policies read that "the wheelchair is provided by a RTS that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient." This means that the ATP must actually meet with the client, and not just sign-off on another employee's or clinician's paperwork. In the CRT world, a large portion of these meetings will be during the clinician's seating evaluation. This allows the "team" to work together on the best solution to meet the client's needs. Even if the ATP is present during the seating evaluation, and even if the therapist documents their presence, the ATP must complete their own documentation.

If the ATP is not present during the seating/mobility evaluation, they must meet with the client in-person. Per policy, the ATPs involvement is part of the wheelchair selection process, therefore this would not be done at delivery. If the ATP meets with the client prior to the seating evaluation, clinical documentation/prescription should exist showing that the physician initiated the order process. Medicare wants to be sure that providers are not simply "knocking on doors" for a wheelchair sale.

There is not a specific required form that the ATP must complete. Most ATPs/providers have their own form that they use to document information regarding the client, recommended mobility system and specific details on the set-up. I strongly recommend that the ATP name, date and signature are on the form.

Keep in mind that both the Specialty Evaluation and the ATP involvement is required by Medicare for K0005, E1161, Group 2 PWCs with powered seating, and all Group 3 and above PWCs. These are requirements that truly are for the betterment of the industry and are not meant to be obstacles.

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

Written by: **DANETTE BAKER**

FMA: CONFIRMING VALIDITY OUTCOMES MEASURES FOR CRT

"AS WE WORK TO IMPROVE ACCESS TO CRT (COMPLEX REHAB TECHNOLOGY), WE MUST BE ABLE TO SHOW HOW PROPER APPLICATION OF TECHNOLOGY CAN REDUCE OTHER HEALTH CARE RELATED COSTS. USING A SCIENTIFIC METHOD OF MEASURING OUTCOMES PROVIDES CREDIBLE EVIDENCE THAT PROVES THE IMPORTANCE OF CRT."

-- ***Weesie Walker**, executive director, NRRTS*

Four years ago, Elaine Toskos, MAOTR/L, ATP/SMS, had the task of revamping the seating and mobility clinic for NYU Langone Health's Rusk Rehabilitation at Ambulatory Care Center from taking outside orders to becoming solely an internal feeder for the hospital system, which shifted the focus to complex rehab technology. Also, an affiliate of the principal teaching hospital of New York University (NYU) School of Medicine, the center had a responsibility to parallel the health system's research, education and patient care aims, she said.

"But you can't really do traditional research in what we do, right? What are we going to do, not give someone a wheelchair and compare them to someone who has one?" said Toskos, the clinic's program manager, who holds certifications as an ATP and a seating mobility specialist (SMS). "At the end of our strategic planning, we were faced with the question of how to measure outcomes success. Having a program that is able to produce outcomes is something an organization such as NYU health system strives to incorporate. It shows a commitment from the beginning of wanting to have a solid specialty program."

Toskos knew of the work begun by Mark R. Schmeler, Ph.D., OTR/L, ATP, associate professor at the University of Pittsburgh Department of Rehabilitation Science and Technology. Schmeler developed the Functional Mobility Assessment (FMA) tool and process for measuring patient outcomes.

Through due diligence, Toskos also investigated two Canadian outcomes measures tools: Quebec User Evaluation of Satisfaction with Assistive Technology, or QUEST, and Wheelchair Outcome Measure, or WhoM. "The Canadians have been so forward thinking when it comes to understanding the need for outcomes," Toskos said. "But when I looked at both of those, they didn't really capture what we were doing on a clinical level, and they seemed cumbersome to administer.

"The (FMA) was the best match for what we wanted to capture, which was functional performance using the equipment that people received as part of our evaluation process and being able to monitor that over a lengthy period of time," Toskos said. "And it seemed like something we could easily incorporate into our assessments."

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[EDITOR'S NOTE: The Vol 2012.4 issue of DIRECTIONS featured an article about the Outcomes Measures Project, a one-year pilot study conducted in 2011 by NRRTS on the University of Pittsburgh's Functional Mobility Assessment Tool (FMA). The following article provides an update on the FMA, which the university licensed to U.S. Rehab in 2015 for commercialization. The FMA has outcomes measures that validate the role of the Assistive Technology Provider (ATP) as well as establish and defend pricing for complex rehab equipment to the Centers for Medicare and Medicaid (CMS), policymakers and payers.]

FMA: CONFIRMING ...
(CONTINUED FROM PAGE 41)

Toskos implemented the FMA Outcomes Program in December 2016 and became one of the first clinics to utilize the program in practice. "One of the best things we've discovered is that it creates a very good clinical conversation about how someone uses their wheelchair.

"It doesn't feel like you are adding another level of work; the information the FMA asks for is information that should already be gathered within the scope of a good practice. We're already seeing the value of the ATP in patient satisfaction with their equipment."

"IT DOESN'T FEEL LIKE YOU ARE ADDING ANOTHER LEVEL OF WORK; THE INFORMATION THE FMA ASKS FOR IS INFORMATION THAT SHOULD ALREADY BE GATHERED WITHIN THE SCOPE OF A GOOD PRACTICE. WE'RE ALREADY SEEING THE VALUE OF THE ATP IN PATIENT SATISFACTION WITH THEIR EQUIPMENT."

BACKING UP OBSERVATION

Like Toskos, a growing number of industry professionals recognize the need for evidence-based data spurred by changes in policies and significant cuts in allowables not favorable to suppliers or their clients, said Schmeler. "As we are trying to challenge these decisions and plead our cases, we have minimal evidence to do so other than 'take my word for it.' To be able to exist and get the payment deserved, something critical needed to happen. We have to justify our role in patient care."

The FMA is an easily administered questionnaire that measures the effectiveness of the equipment provided to a patient as well as role certified providers have in patient satisfaction as well as health outcomes.

"When we were doing the pilot study, we had no funding," said Schmeler. "We were just doing it all out of goodwill and were thankful for any support. We had some success with NRRTS participation, and we learned a lot from it. We also recognized this was a bigger project or was going to be a bigger project than we anticipated, and we realized we needed to generate a larger database to validate our findings."

So, he turned to an industry leader and longtime colleague Greg Packer, president of U.S. Rehab.

U.S. Rehab is one of the largest member service organizations in the rehab industry, with almost 400 members in 1,400 locations. Packer agreed to take the lead in introducing FMA into the industry. It took about four years to get the deal finalized through university contracting, but in September 2015, the University of Pittsburgh licensed worldwide commercialization rights for the FMA assessment tool and process to U.S. Rehab through a 10-year renewable contract. U.S. Rehab manages data collection, follow-up phone calls and the de-identification of data, which is then sent to Schmeler who performs analysis and develops reports from the results.

"Before FMA, there was no tool in the marketplace, whatsoever, that showed any correlation to what job we do and the effect it has on patients," Packer said. "I knew the history of this project and had known Mark for about 15 years. We would continuously chat about where we (industry) were going and how we would get there. Like Simon (Margolis), I have a deep desire to make sure that CRT is recognized as a true profession and the ATP as a true practitioner."

U.S. Rehab launched a beta-test version of the FMA in late 2016; in the first full collection year, 2017, they received 2,000 pieces of data. By the end of this year, Packer anticipates adding more than 5,000 pieces in the system, possibly providing enough data to identify relevancy for a single issue, such as seat elevators.

One of the challenges, Schmeler said, is collecting enough specific data—you need approximately 300 to 500 pieces—to ensure valid results. If U.S. Rehab collects 5,000 pieces of data in 2018, and only 5 percent involves Lou Gehrig's, that's only about 250 pieces of specific data, explained Packer.

"WE HAVE TO BE ABLE TO SHOW THEM (CMS, PAYERS), WITH HARD NUMBERS, THE CHEAPEST IS NOT ALWAYS THE MOST COST-EFFECTIVE AND THE FMA WILL HELP US DO THAT."

"That's why need to continue gathering data," Schmeler said. "There are so many variants among the people we serve. Also, there are new products continually coming into the market, and the payer policies continually change. You want to continue to be able to identify problems if they happen or if you continue to do good work report that, too.

TIMING IS EVERYTHING

The major provisions of President Obama's Affordable Care Act had come into play by 2014, which cast a greater light on patient outcomes, Packer said. "So, for a therapy department to send a patient home with the improper equipment and it causes the patient not to be able to follow their care plan on a daily basis, they are probably going to have a negative outcome and potentially end up back in the hospital. That's going to cost the hospital, and perhaps the payer, additional money.

"We've always known that proper equipment plays a key role in the patient's ability to manage their care; now, we're looking to show that with statistical evidence and then communicate it to CMS, policymakers and payers as hard numbers to impact pricing for CRT," Packer said.

Legislators were interested in the preliminary data shared in April during CELA, he added. "I think the interest level will continue to build as we develop and collect data. By the end of 2019 or beginning of 2020, we will be able to show CMS and the legislative process some solid evidence of the impact we have in the health care system."

PRESSING ON TOWARD THE GOAL

In the meantime, Toskos said she has already begun to see evidence to validate the clinic's educational and clinical aim of having all staff members certified as ATP's. Preliminary results from their FMA indicate a higher patient satisfaction with initial equipment when an ATP is involved, she said.

Likewise, Schmeler said he has data from about 20 other sources supporting improved outcomes provided by ATP's versus non-ATP's—further validating Toskos' goals and that of the overall FMA Outcomes Program. "The larger database not only gives you evidence about your specific patient outcomes, but you also can see how you measure up to other clinics doing what you do, which is significant."

Moreover, improved outcomes can translate into improved cost savings, which hits the ultimate two-fold goal for the industry's future, Packer concludes. "We are in a disruptive health care system, and we have to be able to look at where those disruptions are happening and what the outcomes will be in five years to 10 years. Costs are the biggest drivers because we see that a large number of folks (aging baby boomers) are going to feed into the Medicare and Medicaid system.

"We have to be able to show them (CMS, payers), with hard numbers, the cheapest is not always the most cost-effective and the FMA will help us do that."

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Elaine Toskos is a Program Manager at NYU Langone Health responsible for development & clinical oversight to the continuum of seating and mobility programs at Rusk Rehabilitation, in New York City. She is an occupational therapist with over 24 years of clinical practice experience, and has lectured both nationally and internationally in the areas of assistive technology, seating & mobility and rehabilitation services.

Mark Schmeler, PhD, OTR/L, ATP, is Director of the Continuing Education Program in the Department of Rehabilitation Science & Technology. He is the course director for the International Seating Symposium and directs several other continuing education venues including web-based post-professional education and training. He also directs a national contract to develop Assistive Technology Clinics within the Veterans Administration's Polytrauma System of Care. Schmeler is the co-developer of the Functional Mobility Assessment and manages a registry of large data related to mobility outcomes. He has over 25 years of clinical practice experience and continues to practice as an Occupational Therapist and Assistive Technology Professional in the Center for Assistive Technology at the University of Pittsburgh Medical Center which he helped establish and directed until 2005.

Greg Packer is president of U.S. Rehab. Greg's background, which includes sales management for Pride Mobility Products Corp. and Biocore Medical Technologies, Inc., provides him with an understanding of both the sales and product areas of rehabilitation technology. Greg served three terms in the Kansas House of Representatives, and is familiar with the regulatory and governmental issues facing the rehab/HME industries. A graduate of Iowa State University, Greg received his master's degree from Baker University.

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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 17 THROUGH JULY 5, 2018.

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

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RENEWED NRRTS REGISTRANTS

The following individuals renewed their registry with NRRTS between May 17 and July 5, 2018.

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IF YOU RENEWED PRIOR TO MAY 17, YOUR NAME IS IN A PREVIOUS ISSUE OF DIRECTIONS.

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