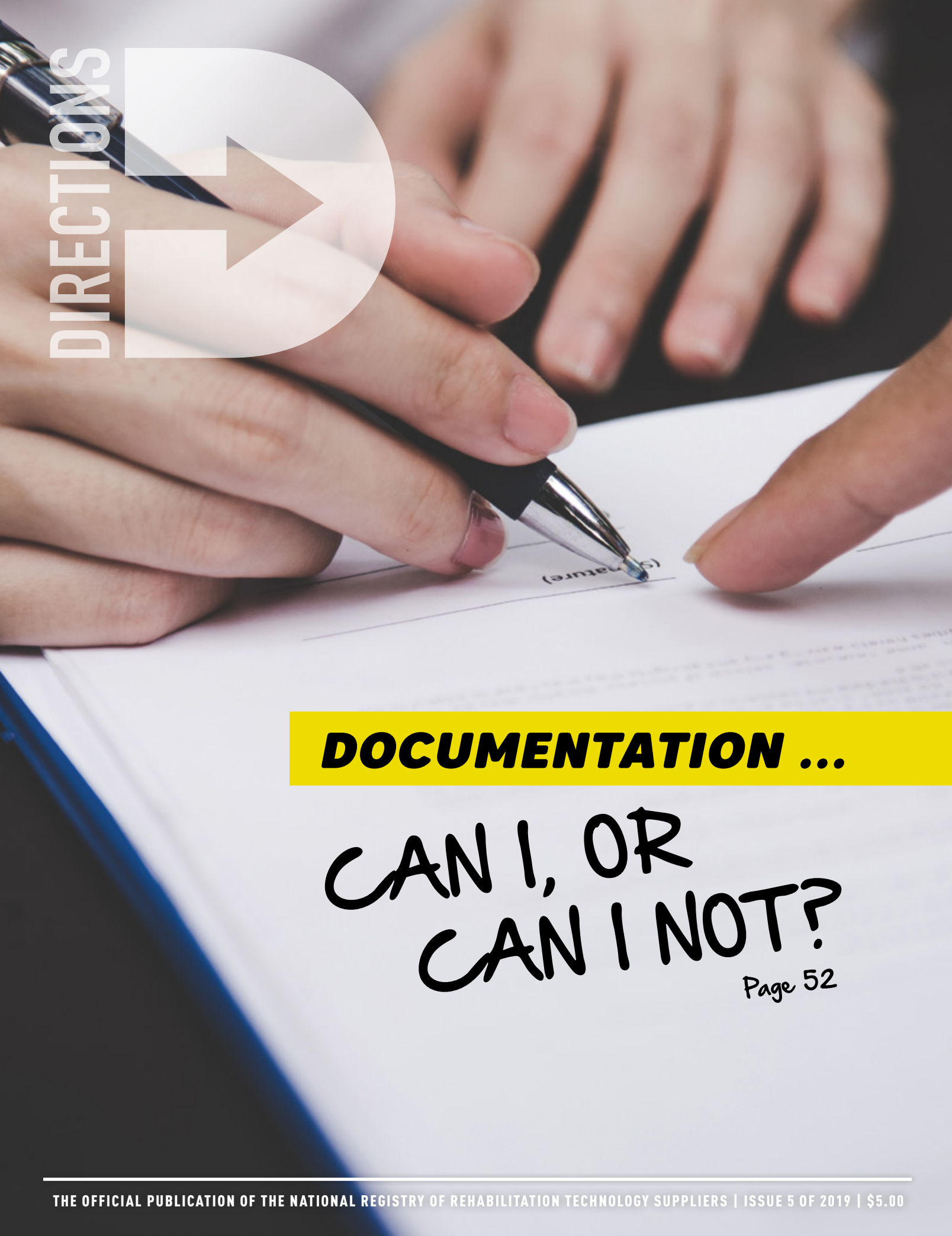

DIRECTIONS

DOCUMENTATION ...

CAN I, OR CAN I NOT?

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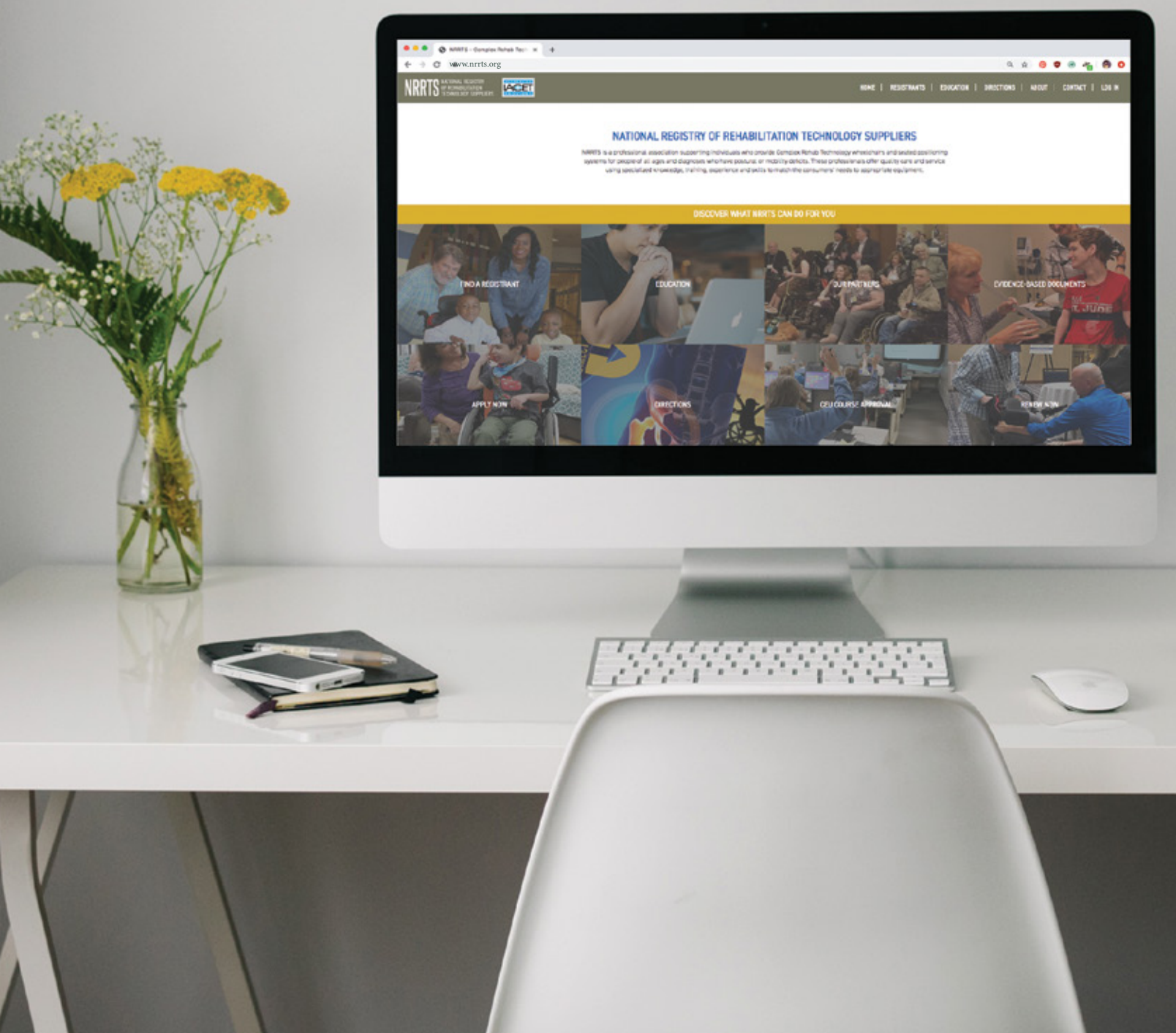

NRRTS FROM MY EYES

Written by: **GERRY DICKERSON,** ATP, CRTS, PRESIDENT OF NRRTS

This is my first message as president of NRRTS, so first things first.

A big thank you to Elaine Stewart for her service as president! I'm very proud to call Elaine my friend and even prouder of her and her commitment to NRRTS and to our profession.

As stated in her DIRECTIONS, Vol. 4 2019, article, Elaine Stewart is a wife, a mother, CRTS®, NRRTS board member, branch manager and the list goes on. Doing all these things takes an extraordinary level of energy and commitment.

I HOPE EACH OF YOU TAKES A MINUTE TO ASK YOURSELF, "AM I DOING EVEN HALF OF WHAT ELAINE STEWART DOES?"

Stewart is also an advocate. In spite of her many obligations of home and work, she makes the trip every year to Washington, D.C., to advocate for Complex Rehab Technology (CRT).

I hope each of you takes a minute to ask yourself, "Am I doing even half of what Elaine Stewart does?"

If the answer is no, I encourage you get involved. We need you!

Being elected president of NRRTS is an honor and a very humbling experience.

A BIG THANK YOU TO ELAINE STEWART FOR HER SERVICE AS PRESIDENT! I'M VERY PROUD TO CALL ELAINE MY FRIEND AND EVEN PROUDER OF HER AND HER COMMITMENT TO NRRTS AND TO OUR PROFESSION.

Visionary industry leaders have held this position in the past, including individuals who had the foresight, energy, drive and commitment to see the need for an organization like NRRTS and passion to make it a reality. There has been equally visionary leadership over the last 27 years to make NRRTS not only grow but also thrive!

Lucky for me I get to stand on the shoulders of these industry giants. Being a self-appointed historian of our industry and profession, I have saved essentially every issue of NRRTS DIRECTIONS, originally called NRRTS News, so I get to re-read their thoughts and ideas.

I also get to read historical articles on the state of the industry. It's pretty funny on how much things change and yet stay the same. In future editorials I'll cite quotes from past years and maybe we can have a contest to see who can guess the year and the individual who made the comments.

I was going to include one or two for this message, but as I was working on this message, I was also getting caught up on my reading of our industry publications and I was struck by:

"The MED Group closes its Lubbock location," "Uro-Med exits the market," "Joerns files for bankruptcy," "A scary new trend, a six-year lookback," "Significant rate cuts force Miller's to drop certain DME."

Our industry and our profession is in turmoil. While some of these headlines are not directly related to the NRRTS Registrant's typical CRT day, they do reflect trouble.

There are also bright lights. The CRT bill in New York, championed by Doug Westerdahl of Monroe Wheelchair, is a signature away from reality. The bill to stop CMS from applying bid pricing to complex manual wheelchairs (for one

OUR INDUSTRY AND OUR PROFESSION IS IN TURMOIL. WHILE SOME OF THESE HEADLINES ARE NOT DIRECTLY RELATED TO THE NRRTS REGISTRANT'S TYPICAL CRT DAY, THEY DO REFLECT TROUBLE.

year), championed by all of us, especially NRRTS and NCART, is headed for a vote. National providers continue to expand, and many regional provides are experiencing significant growth.

Change is inevitable. You can make things happen, you can watch things happen, or you can wonder what happened. Which "you" is you?

Becoming president is also bittersweet. It signals the last position on the NRRTS Board of Directors for me. One year as president-elect, two years as president and then one year as past-president. I've held every other position over the last many years. I'm not sure how I will deal with not being involved with my CRT family. The folks on the board are some of my closest friends, that seem like family, I see only a couple of times a year. It also will bring me very close to the end of my career. When my past-president term ends, I will be approaching 48 years in the field. Where did the time go? We all know it's very hard work and better suited to the younger generation.

Grandparenting is becoming much more appealing.

Lastly and personally, I hope you will all take a moment to recognize the loss of a true industry giant, Karyn Estrella. Karyn was the president and CEO of Home Medical Equipment and Services of New England. A passionate, very smart leader, advocate and friend. She passed away on July 4, 2019, from pancreatic cancer.

Until the next time,
Gerry

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

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

LIFE WITH PURPOSE

Written by: **ROSA WALSTON LATIMER**

Twenty-five years ago, an automobile accident changed Bobbi Kay Lewis' life forever. However, with the support and positive attitude of her family, coupled with genuine faith, Lewis' natural "can do" spirit and passion for life remained strong.

"I earned my undergraduate degree in advertising from Oklahoma State University (OSU) in Stillwater in 1993," Lewis said. A year later, she had almost finished her second semester in a master's program at OSU when she was involved in a serious car accident. "I was with two friends in Oklahoma City, and we were almost through the intersection when a lady hit the rear passenger quarter panel of my car. The impact sent us spinning and then we hit a large utility pole head-on. The second impact broke my neck." Lewis was in the hospital for 11 days and then transferred to the Kaiser Rehabilitation Center at Hillcrest Medical Center in Tulsa, Oklahoma. "I was in that facility for three months and learned how to do everything all over again!"

Following an additional two months of outpatient rehab, Lewis started a new job at the Cleveland American, her hometown newspaper in Cleveland, Oklahoma. "Aside from family, friends and faith, I credit getting that job as being the catalyst for me to have a happy and successful future," she said. "Living in a small town has its benefits. A friend of a friend told the publisher of the newspaper that I might be a good fit for the advertising job he was trying to fill."

"OF COURSE, I HAD MOMENTS OF SADNESS, BUT I DIDN'T ALLOW MYSELF TO GIVE IN TO DARK THOUGHTS. I BELIEVED I WAS GOING TO GET BETTER, AND FOR THE LONGEST TIME, I THOUGHT I WOULD WALK AGAIN. ALTHOUGH THAT DIDN'T COME TO PASS, THE HOPE AND BELIEF WERE TRANSFORMING."

Returning to live with her parents after the accident and adjusting to her life in a wheelchair was difficult for the young, twenty-something college graduate. "I had always been very active and was ambitious to be productive. The fact the publisher had the confidence to hire me was wonderful. I was thrilled to have a job where I could utilize my degree. The opportunity to work with and help promote the businesses in my hometown gave me a new purpose. The job was a great fit and a safe haven for me."

The challenge of her job with the newspaper helped Lewis keep a positive focus and, she believes, contributed significantly to her ability to maintain an optimistic attitude. "With too much time on my hands and nothing meaningful to do, I could have easily fallen into a depression," she said. "Of course, I had moments of sadness, but I didn't allow myself to give in to dark thoughts. I believed I was going to get better, and for the longest time, I thought I would walk again. Although that didn't come to pass, the hope and belief were transforming."

After working at the newspaper for seven years, Lewis felt she was ready for a new challenge with new possibilities. "I decided to go back to school and pursue my master's degree again even though I had to start over as it had been too long to apply the credits I had earned before the accident." In addition to her bachelor's in advertising and master's in mass communication, in 2009 Lewis earned a Ph.D. in Curriculum and Social Foundations of Education, all from OSU.

"During the time that I was working on my graduate degree, I went back to physical and occupational therapy with the goal of being able to self-catheterize," Lewis said. "I did not have the dexterity to self-cath, which greatly inhibited my independence." A therapist taught her how to use the Asta Cath female catheter guide. "I want people to know about that device. It was life-changing for me!"

Daniel and Bobbi Kay Lewis with her parents, Helen and Bobby Hooper

Additional therapy and the catheter device provided Lewis with the independence she needed to move to Stillwater to work as a teaching assistant at OSU while she completed her master's thesis. "Yet another door opened for me, and this experience ignited an excitement for teaching in me."

"I'M EXCITED TO BE WORKING ON THIS GRASS ROOTS EFFORT! IT WILL BE A VALUABLE TOOL TO HELP REACH OUR GOAL OF BRIDGING THE GAP BETWEEN THE PERCEPTION AND THE REALITY OF LIVING WITH A DISABILITY."

Lewis' professional career at Oklahoma State University has flourished. She is now an associate professor in the School of Media & Strategic Communications and assistant dean of the College of Arts and Sciences Outreach and Communications. She oversees online courses, study abroad and many noncredit programs, as well as leading the communications efforts for the college. "I've had this position for four years, but it still feels new," Lewis said. "That's an indication of how much I love this job. I've built a wonderful team, and I believe we are making a difference for OSU." Before becoming assistant dean, she served as associate director of the School of Media & Strategic Communications.

With a firm foundation in communications, Lewis' contribution to advocacy efforts for individuals with disabilities is thoughtful and compelling. She recently participated, along with Kyle Romano and Jenny Siegle, in the first live Unite4CRT Facebook Town Hall meeting (@unite4CRT). Created by NRRTS, the group's purpose is to provide an outlet for CRT users to share their unique stories and educate through personal experience. "I think our first Town Hall meeting provided some good information, and I'm looking forward to participating in more," Lewis said. "I'm excited to be working on this grassroots effort! It will be a valuable tool to help reach our goal of bridging the gap between the perception and the reality of living with a disability and the importance of CRT."

Lewis has attended the national CRT conference in Washington, D.C., the past two years. "The experience was exhilarating, and I was thrilled to be a part of it. However, I was somewhat discouraged by the lack of genuine interest from the health care liaisons we met," Lewis said. "In one instance, after I briefly told my story, the

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liaison's response was, 'I don't doubt there is a need, but who is going to pay for it?' I'm excited to go back to Washington, and I hope to work more on trying to get the media involved to increase the volume of our message. We need to get the able-bodied community more involved."

Lewis is also interested in effecting change to make new construction generally more accessible. "I would like to see at least one entrance to every new home that doesn't have steps and one ground floor bathroom with a wide door," she said. "This wouldn't be that difficult to incorporate into new house construction and could also make houses more marketable."

"DANIEL AND I DESIGNED OUR HOUSE TOGETHER. HE BUILT OUR HOME ON NIGHTS AND WEEKENDS IN 2014 WHILE WORKING FULL TIME AT A COMMERCIAL CONSTRUCTION COMPANY."

Certainly, Lewis has some insider help when it comes to construction ideas. Her husband, Daniel Lewis, currently owns his own construction company. "Daniel and I designed our house together. He built our home on nights and weekends in 2014 while working full time at a commercial construction company." The two-story house, located on 20 acres 15 miles outside of Stillwater, has a wheelchair lift to the second floor and concrete floors, among other features, to accommodate her wheelchair.

Bobbi Kay Lewis' husband, Daniel, in the beginning stages of building the house designed by the couple.

Daniel and Bobbi Kay Lewis at the Oklahoma State University breakfast before the Fiesta Bowl in Phoenix, Arizona.

Bobbi Kay Lewis at an Oklahoma City Thunder game with her husband's late grandmother, Rita Garrett.

"It was an exciting project for us to do together, and our marriage survived!" Unfortunately, a lightning strike that recently hit their home resulted in extensive fire damage. The couple will live in a temporary location while they rebuild and can return to the peaceful country setting they appreciate and enjoy.

Daniel and Bobbi Kay met in a karaoke bar following the first OSU home football game in 2007. "Daniel entered the karaoke contest, and he was the hit of the night," Lewis said. "When he left the stage and passed near me, I told him that he did a great job. He looked at me with a straight face and told me that if I had really liked his performance, I would have gotten up and danced." Lewis appreciated Daniel's humor. "It was refreshing for someone to make a wheelchair joke, especially a stranger," she said. "Daniel was energetic and had a great sense of humor. We had an immediate connection." The couple went on a date the night after they met and married a year later. "It is worth noting that Daniel's mother was diagnosed with MS (multiple sclerosis) when he was 5 years old," Lewis said. "She became paralyzed and has been a wheelchair user most of his life. I'm sure that experience influenced Daniel's ability to see me and not the chair."

The couple loves to travel, and they consider OSU sporting events one of their passions, especially football.

"IT IS WORTH NOTING THAT DANIEL'S MOTHER WAS DIAGNOSED WITH MS (MULTIPLE SCLEROSIS) WHEN HE WAS 5 YEARS OLD. SHE BECAME PARALYZED AND HAS BEEN A WHEELCHAIR USER MOST OF HIS LIFE. I'M SURE THAT EXPERIENCE INFLUENCED DANIEL'S ABILITY TO SEE ME AND NOT THE CHAIR."

Bobbi Kay with her event planning students who help coordinate a college night for the Big Brothers Big Sisters fundraiser, Bowl for Kids Sake.

CONTINUED ON PAGE 12

Bobbi Kay Lewis (front) with lifelong friends: Marilyn Tate, Jennifer Garrett, Tricia Raleigh and Amy Kesner-Williams.

LIFE WITH PURPOSE
(CONTINUED FROM PAGE 11)

Both support the Big Brothers Big Sisters organization, and Bobbi Kay has served on the organization's board of directors. "On a more personal level, we have a very close relationship with Braden Hurst, the 13-year-old son of a friend," Lewis said. "He is a wonderful kid and is especially close to Daniel. He got to go to Toronto with us for a week this summer. We love our time with Braden!"

Lewis' ability to seek joy in her life and to appreciate the many opportunities that she's experienced has served her well, both professionally and personally. This positive attitude is intentional. She spoke about a conversation she had with a therapist several years ago about a character in a movie who, after being shot in the head, changed from an angry, difficult man to a much nicer person. Lewis asked whether the therapist

HE BELIEVED THAT IF YOU WERE A JERK BEFORE, YOU WOULD PROBABLY BE A BIGGER JERK AFTER A SEVERE INJURY. IF YOU WERE A GOOD PERSON, YOU WOULD BE EVEN BETTER.

believed this transformation was possible. He told her that a significant injury or illness does not define who you are; it intensifies who you are. He said he believed that if you were a jerk before, you would probably be a bigger jerk after a severe injury. If you were a good person, you would be even better. "I determined that I was going to take that as a challenge, and I was not going to be a big jerk!"

CONTACT
Bobbi Kay can be reached at BOBBIKAY.LEWIS@OKSTATE.EDU

Bobbi Kay Lewis is a consumer advocate who lives in Oklahoma.


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STAY CLOSE TO THE PRODUCT AND THE SALES TEAM

Written by: **ROSA WALSTON LATIMER**

It only took one undergraduate marketing course to set Julie Jackson on her career path. The director of the Complex Rehab Business Unit for Invacare was originally planning on a degree in accounting or finance. "Once I took that first marketing class, I was hooked. I loved understanding how a consumer makes a purchasing decision and how I could influence that decision."

Jackson has been with Invacare 15 years; however, her first job after earning an undergraduate degree from Baldwin-Wallace University and an MBA from Cleveland State University was as a sales professional with Newell Rubbermaid. "I was assigned specifically to the Lowe's Home Center division, so I called on every Lowe's store in the state of Ohio," Jackson said. "That was a great opportunity for me, but I ultimately wanted to work in marketing, and after three years with Rubbermaid, I went to work for Invacare."

YOUR WORK EXPERIENCE HAS BEEN WITH TWO WIDELY DIVERSE INDUSTRIES. WHAT DID YOU LEARN FROM YOUR RESPONSIBILITIES WITH NEWELL RUBBERMAID THAT GAVE YOU A GOOD FOUNDATION FOR YOUR CAREER WITH INVACARE?

It was certainly a drastic change to go from selling a product that a consumer buys in a store for a few dollars to a few hundred dollars to working with products that are heavily reimbursed. Also, the time involved from when you show a customer a rehab product to when a sale transpires is entirely different than consumer products. One important principle I learned is that, regardless of where you work, your career is not a race; it is a journey. You benefit from every experience. I also realized it is essential to communicate within your organization about what you are doing, your goals and your successes. Once I was on board with Invacare, I was encouraged to ask questions and speak up. It definitely took time to learn this industry! For the first six months or so, it was clear that my job was to learn.

WHO WERE SOME EARLY INFLUENCERS OR MENTORS AT INVACARE THAT HAD AN IMPACT ON YOUR CAREER?

In general, our industry is small, and it feels like a family. At first, when I attended a trade show, it was surprising that everyone knew each other. It didn't take long before I felt as though I was one of the family.

Our industry is very collaborative. There are a few individuals who have been especially helpful to me. Mark Sullivan was vice president of rehab at Invacare and a manager of mine. I frequently remember his words of advice and guidance when making decisions. He always told me to stay close to the product and stay close to the sales team. When you stay close to the product, you always remember that you are developing a product that is going to help someone and make a difference in someone's life. Stay close to your sales team because helping the sales team is how the entire

CRT Conference in Washington DC. Julie Jackson of Invacare, Senator Tammy Duckworth, Johnny Miller of Miller's Rental and Sales in Cleveland and Jenny Border, advocate

Invacare team at the VA Games 2019

Trish Otter, CEO of United Cerebral Palsy of Greater Cleveland and Julie Jackson, Board Chairman

Julie and Scott Jackson

company will be successful. I always remember his words of advice as I am prioritizing projects.

Cara Bachenheimer is a great mentor for me. I have learned so much about the industry from Cara, especially regarding reimbursement and the legislative environment. And, I will always recognize Mal Mixon as an industry pioneer, appreciating all that he did for the lobbying effort as well as the growth of Invacare.

NOW THAT YOU ARE 15 YEARS INTO YOUR WORK WITH INVACARE, TELL US ABOUT YOUR RESPONSIBILITIES AND HOW YOU SUPPORT YOUR SALES TEAM. HOW DO YOU STAY ENGAGED AND ENERGIZE YOUR STAFF?

My role with Invacare is to grow the business unit. I'm responsible for the success of the business, and I work very closely with the sales team. I prioritize projects with the greatest impact and deliver to the sales team assets to be most successful in their territories. These initiatives could be for both new and existing opportunities. I also work closely with the marketing communications team on new marketing collateral, messaging and customer communications. The engineering team and I work together developing and bringing new product to market.

A few years ago we developed a product visualizer that has been very helpful to our sales team. This tool allows you to add any option and build a wheelchair as you are showing the image to a customer. We received great feedback and currently are working on enhancing the tool with additional offerings.

I believe in staying positive! Being a positive influence can make a significant difference in someone's day. Also, change what you can, what is within your control and try to cultivate influence in areas that are not within your direct control. Always celebrate wins!

I BELIEVE IN STAYING POSITIVE! BEING A POSITIVE INFLUENCE CAN MAKE A SIGNIFICANT DIFFERENCE IN SOMEONE'S DAY.

TELL US ABOUT YOUR EXPERIENCE WITH THE ANNUAL NATIONAL CRT CONFERENCE.

My participation at the Complex Rehab Technology (CRT) conference conferences in Washington, D.C., has been very rewarding. I want to emphasize this positive event and encourage others that might consider attending a CRT conference. The very first time I attended, I was apprehensive

CONTINUED ON PAGE 16

STAY CLOSE TO THE PRODUCT ...
(CONTINUED FROM PAGE 15)

that I might not say the right thing or convey the right message. I very soon realized that we only had ten to fifteen minutes in each legislator's office. You need to get your point across quickly and be very clear about what you are asking for. Conference participants tend to be the expert in the room, and you can definitely make an impact. NCART/NRRTS prepares you well and gives you all the materials you need.

WHAT ARE SOME THINGS YOU DO TO HELP YOU FIND BALANCE IN YOUR LIFE?

My husband, Scott, and I have three children: Hunter, 13, Hannah, 9, and Holden, 4. We stay busy, especially in the spring and summer. My older son plays baseball and football; my daughter plays softball and basketball; and Holden just got involved with T-Ball and soccer. Many nights we have overlapping sporting events, so we have to run parallel paths to make as many games as possible. Juggling our travel schedules also adds a fun element to life as well. As a family, we enjoy our time together. We love to travel and go to the pool or beach. My kids are good eaters and have never been afraid of trying new food, so we all enjoy trying new restaurants.

Between work and the kids, I find that time for me is very limited. I have to be intentional about making time for the important things. I received some great advice from a co-worker a few years ago that has helped me find balance in my life. She told me to remember that before I was a mother, I was a wife. It is essential to give your marriage the focus it deserves. Therefore, Scott and I decided to have a regular date night, and our goal is to have that time together at least once a month.

I also love having one on one time with each of my kids individually. It's

Hunter, Julie, Holden, Scott, and Hannah Jackson

The Jackson family at Disney World

so important for all of us to have that time. I'm also the finance manager for my daughter's Girl Scout troop, and I teach an elementary aged Sunday School class at our church.

To enhance my professional life and make a contribution to the industry, I serve on the NCART board and am an executive committee member. I have also served as board chair for United Cerebral Palsy of Greater Cleveland for two years.

JULIE, WOULD YOU WRAP UP THIS INTERVIEW BY SHARING WHAT IS MOST REWARDING ABOUT YOUR CAREER?

The most rewarding part of my job is seeing how a product or the technology of a product can make a significant difference to an individual. We develop a product, get customer feedback and show a prototype to customers. We receive confirmation whether we are going in the right direction or need to make a change. The process is exciting and rewarding. However, after all of this work, the most fulfilling experience is when I see someone using the product and realize how personally life-changing it is. This is always exciting for me.

CONTACT
Julie may be reached at JJACKSON@INVACARE.COM

... AFTER ALL OF THIS WORK, THE MOST FULFILLING EXPERIENCE IS WHEN I SEE SOMEONE USING THE PRODUCT AND REALIZE HOW PERSONALLY LIFE-CHANGING IT IS.

Julie Jackson is director of the Complex Rehab Business Unit at Invacare Corporation. Jackson has 15 years' experience in the homecare industry, specifically focused on complex rehab. She has a Bachelor's degree from Baldwin-Wallace University and an MBA from Cleveland State University. Jackson has introduced several new power wheelchairs into the North American market and resides in the Cleveland, Ohio, area. She is currently a board member of NCART and is the board chair for the United Cerebral Palsy chapter of Greater Cleveland.

THE ESSENCE OF OUR WORK IS PERSONAL

Written by: **ROSA WALSTON LATIMER**

Theresa Berner, MOT, OTR/L, ATP, is the rehabilitation clinical manager at The Ohio State University Wexner Medical Center. She is certified by RESNA as an assistive technology professional, is a member of the Clinician Task Force and United Spinal's Board of Directors. Theresa and her husband, Daniel Berner, have two children. Their daughter, Katia, is 20 years old and attends the University of Cincinnati. Their 18-year-old son, Matthew, attends the University of Mount Union where he is a member of the soccer team. The family enjoys sharing their home with two white German Shepherds Mia and Gio.

THERESA, TELL US ABOUT YOUR PROFESSIONAL JOURNEY AND WHAT INITIALLY DREW YOU TO THIS CAREER.

While I was an undergrad student at The Ohio State University (OSU), I volunteered at Creative Living, an apartment complex near campus for individuals with disabilities that have school or work goals. I was a personal care attendant for an individual who was in law school that had a disability. During the three years I worked at Creative Living, I interacted extensively with other personal care attendants and students. I learned about all types of wheelchairs, home accessibility and daily needs, and transportation needs. At the time, I had no idea how much that experience would influence me and my future.

"WE REALIZED THAT MANY PEOPLE WHO DID NOT SPEND TIME IN AN INPATIENT REHAB SETTING COULD BENEFIT FROM WHEELCHAIR AND SEATING SERVICES, AND WE EXPANDED THE SCOPE OF THE CLINIC."

After graduate school, I worked at the OSU Medical Center with a spinal cord injury team at Dodd Hall, an inpatient rehab facility and met Dr. Chuck Levy, who wanted to start a wheelchair seating clinic. I jumped in, even though I didn't have any training, because I loved the equipment. I relied on the great wheelchair suppliers and manufacturing representatives to help teach me the ropes.

I was very fortunate to spend 11 years of my career as an inpatient spinal cord injury (SCI) therapist working in a wheelchair clinic one day a week. Early on, as part of the SCI team, I realized I could learn a great deal from the peer mentors for the individuals who were recently injured. Community outings to test the equipment outside of the hospital setting led us to explore adapted sports and specialized equipment. After a couple of years, I had the opportunity to help develop a wheelchair clinic in outpatient rehabilitation. We realized that many people who did not spend time in an inpatient rehab setting could benefit from wheelchair and seating services, and we expanded the scope of the clinic. Where inpatient rehab grabbed my love for the technology side of our services, outpatient rehab helped me understand the business side of service delivery.

TELL US ABOUT YOUR CURRENT RESPONSIBILITIES AT THE OHIO STATE UNIVERSITY MEDICAL CENTER AND THE SERVICES YOU AND YOUR TEAM HAVE DEVELOPED THERE.

I have been at OSU Medical Center for over 25 years and am currently responsible for the Assistive Technology Center. We have programs for full-service wheelchair seating and positioning; pressure mapping; and wheelchair skills training as well as augmentative alternative communication (AAC). We also provide computer access, Smart clinic, and driving rehabilitation. After Dr. Levy moved out of state, Dr. Dan Kim took over as our full-time physician, supporting us with all medical direction. I still do work where I first developed an interest in this career by returning to Dodd Hall to support them any way I can.

We have developed a program called the Adapted Sports Institute that supports individuals with disabilities participating in sports and wellness activities. We also recently created a team representing speech therapists across the Ohio State system and are looking at ways to strengthen AAC throughout the continuum at OSU. Our goal is to

make sure technology is accessible to everyone, no matter where you are in your health care needs.

My other responsibilities at OSU include co-teaching an assistive technology course for the Occupational Therapy Doctoral Program with Carmen DiGiovine, Ph.D., RET, ATP/SMS, who is a rehab engineer with the OSU's Assistive Technology Center center and the Department of Occupational Therapy. We review all aspects of AT and conduct labs and hands-on demonstrations. I also have the opportunity to teach wheelchair seating to doctoral physical therapy students.

OUTSIDE OF YOUR COMMITMENT TO THE OSU MEDICAL CENTER, YOU OFTEN PARTICIPATE IN NATIONAL CONFERENCES. HOW HAS THIS INFLUENCED YOUR WORK AS AN OCCUPATIONAL THERAPIST?

The networking possibilities at conferences and the opportunity to learn from colleagues that share similar interests are invaluable to me. For example, early in my career, I was fortunate to meet Tina Roesler, a physical therapist who was working for a manufacturer at the time. She introduced me to Carmen DiGiovine, and through the years, the three of us have worked and taught together throughout the United States. These experiences have provided me with additional opportunities to collaborate in all areas of seating and positioning.

WOULD YOU TELL US ABOUT VOLUNTEER WORK THAT YOU'VE DONE THAT IS PARTICULARLY MEANINGFUL?

Early in my career, I was fortunate to assist with the development of Adapted Sports Connection (formerly TAASC). This nonprofit focuses on adventure sports and working with them taught me about community access and specialized equipment. I met some lifelong friends through my work with this group.

I have also worked with another nonprofit, Bethel Ministries International, (http://www.bethelministriesinternational.com/) to help individuals in Guatemala. On two different occasions, I traveled with a team that helped distribute wheelchairs and assist with seating and positioning for people who desperately needed help. This was an incredible experience on many levels. Our work was very "hands-on" and unhindered by things such as insurance paperwork or reimbursement issues. Many times each day, after we evaluated an individual, we chose appropriate equipment from a warehouse where supplies had been gathered in advance of our trip and then shared in the incredible joy of newfound mobility and independence.

Theresa Berner (center) and The Ohio State University Medical Center Assistive Technology Team

Carmen DiGiovine and Therea Berner (standing); Tina Roesler and Bonnie Sawatzky (seated)

Chuck Levy, M.D. and Theresa Berner.

TELL US WHAT PART OF YOUR WORK YOU ENJOY THE MOST.

The best part of my job is working with amazing therapists and engineers who come to work every day knowing they can change people's lives through the use of technology. I have a team of 12 therapists with which to collaborate, problem solve, and celebrate successes every day. Frankly, words can't describe what my co-workers mean to me!

The professional relationships I've established through the years continue to be a positive influence. I value the manufacturers who travel over large geographical areas to help us understand

CONTINUED ON PAGE 20

The Bethel Ministries team of therapists in Guatemala.

Theresa Berner with one of her Guatemalan patients.

THE ESSENCE OF OUR WORK IS PERSONAL
(CONTINUED FROM PAGE 19)

the equipment available to our patients. I also appreciate the Complex Rehab Technology suppliers that stick with us and are open to our working together.

I consider Dr. Chuck Levy a great mentor who contributed significantly to my career. He believed in my potential when I didn't know anything about wheelchair seating and positioning. Dr. Levy has continued to be a positive influence even though, midway through my career, he moved to Florida. He always makes time to guide me, and I have the assurance that he is still there for me. I appreciate Dr. Levy's knowledge, cherish his friendship and am grateful for all he has done for me.

Day in and day out, I love meeting people and learning their stories! The essence of our work is very personal, and the human spirit of our patients and colleagues absolutely amazes me.

"DAY IN AND DAY OUT, I LOVE MEETING PEOPLE AND LEARNING THEIR STORIES! THE ESSENCE OF OUR WORK IS VERY PERSONAL, AND THE HUMAN SPIRIT OF OUR PATIENTS AND COLLEAGUES ABSOLUTELY AMAZES ME."

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Theresa Berner, MOT, OTR/L, ATP, is an occupational therapist and Rehabilitation Clinical Manger at The Ohio State University Wexner Medical Center. She has over 24 years' experience in seating and positioning and adult rehabilitation. Berner is certified by RESNA as an Assistive Technology Professional (ATP). She is responsible for the Assistive Technology center and is a clinical instructor at the School of Health and Rehabilitation Sciences at OSU where she is involved in teaching both in in the occupational and physical therapy programs. Berner is a member of the Clinician Task Force, AOTA, RESNA, and Academy of Spinal Cord Injury Professionals. She has participated in presentations at the International Seating Symposium in the U.S. and in Vancouver, Canada, Congress on Spinal Cord injury Medicine, The Academy of PM&R, American Spinal Injury Association (ASIA), RESNA, and Posture and Mobility Group in Glasgow, Scotland. Berner received the 2016 Academy of Spinal Cord Injury TLC Distinguished Clinical Award and the 2017 OSU Wexner Medical Center Values in Action Award.

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AMPUTATIONS AND WHEELCHAIR SEATING AND MOBILITY

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

DEFINITION

Amputation may be acquired or congenital. An acquired amputation results in the complete or partial loss of a limb from injury/trauma, disease or surgery. Congenital amputations are referred to as limb deficiencies when a baby is born missing part or all of a limb.

AMPUTATION PREVALENCE

In the United States, 2 million people live with limb loss and more than 185,000 amputations are performed annually (National Limb Loss Information Center). "In the U.S., 82% of amputations are due to vascular disease. Nearly 70% of amputations due to trauma involve the upper limbs" (John Hopkins).

AMPUTATIONS AND ASSISTIVE TECHNOLOGY

Amputations are often accommodated with prosthetics. A wide variety of prosthetics are available to address specific amputation locations and levels, as well as functional needs. Some people with a unilateral upper extremity amputation may choose to use their other arm for functional tasks and the residual limb as an assist.

AMPUTATIONS REQUIRING A WHEELCHAIR DUE TO MOBILITY LIMITATIONS

A person with bilateral upper extremity limb loss or deficiency is less able to protect themselves in a fall, though strategies to fall safely and regain an upright position can be learned. Ambulation is still possible and functional. A person with lower extremity amputations will often use prosthetics that may allow functional ambulation. However, wheeled mobility may be used for long distances or more challenging terrain such as uneven surfaces and long and/or steep slopes. Wheeled mobility in these scenarios is typically used to compensate for fatigue, to prevent skin breakdown over the stump from overuse within a prosthetic, and to reduce pain which can occur in these conditions.

A person who requires a wheelchair and also has upper extremity amputation or limb deficiency will generally require a power wheelchair (i.e. quadrilateral amputee). If the person has a unilateral upper extremity amputation, a joystick can be used. If the client has a bilateral amputation, a residual limb may have adequate range of motion to provide joystick control with appropriate mounting. If a joystick cannot be used, other driving methods, such as head array, may be indicated.

For a quadrilateral amputee, independent transfers in and out of a wheelchair base may be possible by using a seat that can lower close to floor height.

When a person has lower limb amputations or limb deficiencies, the center of gravity of a manual wheelchair is impacted. Frame adjustments will need to be made to prevent the chair from being tippy posteriorly.

AMPUTATIONS IMPACT ON WHEELCHAIR SEATING

A person with a below the knee amputation or limb deficiency will have full contact over the buttocks and posterior thighs, however, will not have weight bearing on one or both feet. It is important to ensure that overall pressure distribution is adequate to minimize pressure injury risk. Sometimes a residual limb support is used below the knee to provide posterior support to increase pressure distribution, comfort and reduce edema.

A person with an above knee amputation may not have adequate pressure distribution along the posterior thighs and so experience increased pressure under the ischial tuberosities. The seating surface materials and contours must mitigate this risk. The client will also be less stable and require more postural support at the pelvis, as a result.

Rarely, a portion of the pelvis is missing. To provide adequate postural support, stability and pressure distribution, a custom orthotic is often required which is worn while the client is seated in the wheelchair seating system.

CONTACT

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

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SOME OF THE GREATEST CHANGES ...

Written by: **ROSA WALSTON LATIMER**

With over 40 years in the industry, Gerry Dickerson could provide volumes of insightful "notes from the field." We recently asked the ATP, CRTS® with National Seating & Mobility, who is also the incoming president of NRRTS, to pass on some highlights of his knowledge and experiences.

Dickerson lives in western New Jersey and works in New York City. "I am an early morning person. My usual Monday through Thursday routine has me on the road into the city by 4:45 a.m. I leave early for my hour-long commute to try to beat the traffic. On Friday I work in my office at home," he said. However, Dickerson's return trip home is a different story. "In the afternoon my average commute time is two hours and 20 minutes," he said. "However, it isn't uncommon for it to take four to six hours for me to get home, and I have had a few 11-hour commutes." Dickerson makes good use of the extended time in his auto by returning work-related calls or catching up with friends. "There are times when I use my commute for mental health time. I shut off the radio and the phone and enjoy the view," he said. "On the really long commutes, I enjoy listening to ballgames. I've listened to entire Yankees or Mets games or entire NFL games."

"FOLLOW-UP IS ESSENTIAL! WITHOUT FURTHER CONTACTS AND INFORMATION, I BELIEVE THE EFFECTIVENESS OF YOUR EFFORTS IS DIMINISHED BY AT LEAST HALF. THE MESSAGE CAN GET LOST. FOLLOW-UP IS THE KEY TO ANY SUCCESSFUL BUSINESS, AND THIS IS NO DIFFERENT. YOU HAVE TO BE POLITELY AGGRESSIVE."

Dickerson has a long-standing reputation as a tireless advocate for the complex rehab community. "Some of the calls I make during afternoon commutes are to congressional health liaisons or a staff member at the Department of Health regarding issues important to our industry," he said. "The advocacy component is very important to me, because I believe that we are 'circling the drain.' Provision of complex rehab equipment to consumers is in jeopardy, and we need to figure out something to stem the tide. Some folks don't realize that the most significant change comes from legislation, not from yelling at the insurance company or trying to get Medicare to change."

Dickerson personally pursued Joseph Crowley, the representative of New York's 14th Congressional District, for four years before the lawmaker introduced legislation for the Separate Benefit Category. "When you are trying to get an issue before a legislator, remember that politicians want votes and money." In this situation, Dickerson couldn't vote for Crowley, but he could donate money to his campaign. "I went to his campaign website, sent a $50 donation and provided my email address. Then I began to receive Mr. Crowley's fundraising schedule." Once Dickerson had this information, he "started chasing him [Crowley] through Irish bars in Queens (New York) at night after work."

A major turning point happened when Dickerson arrived early for a Crowley fundraiser. "We had had a big snowstorm, and when Mr. Crowley showed up, we were the only two people there for about 40 minutes. We just sat and talked about Medicare and people with disabilities and the issues they face. In the spring, he introduced the legislation for Separate Benefit Category."

Dickerson emphasizes the effectiveness of talking directly with a legislator as this eliminates problems in translation of the issue or the legislator not receiving your message. "It can be a long process, and then, just when you feel things are moving in the right direction, something can change."

"We continued to keep the pressure on, often attending fundraisers along with folks in wheelchairs. As with the National CRT conference in

Dave Murray, Ray Grim and Gerry Dickerson. Known as the Irish triplets, the men have been friends and worked in the Complex Rehab Technology industry together for over 40 years.

Allison Baird, OT, ATP; Congresswoman Gabby Giffords, and Gerry Dickerson.

Washington, D. C., individuals who own their own business or participate in adaptive sports, but also happen to be in a wheelchair, change the whole dynamic of the discussion." Dickerson emphasized that an additional component is necessary for successful advocacy. "Follow-up is essential! Without further contacts and information, I believe the effectiveness of your efforts is diminished by at least half. The message can get lost. Follow-up is the key to any successful business, and this is no different. You have to be politely aggressive."

Although Dickerson is approaching retirement, he isn't quite ready to make that change in his life. Since his wife, Pat Dickerson, is retired, free time to spend with grandchildren is enticing, but there's still work to do. "I'm at the stage of my career now where if I get a minute, I want it. I meter what I'm involved in, especially now with my grandchildren near. I try to be more

Gerry Dickerson (center) with former Secretary of State Hillary Clinton and former Pres. Bill Clinton.

"I BELIEVE THAT, AS HARD AS WE TRY, WE'RE STILL CHALLENGED TO COMMUNICATE THE VALUE OF NRRTS, NOT ONLY WITH CONSUMER PROTECTION-TYPE ISSUES BUT FROM AN ADVOCACY POINT OF VIEW. I WISH WE COULD DO MORE, BUT I COULDN'T ASK FOR A BETTER GROUP OF PEOPLE TO BE WITH IN THIS FIGHT."

intentional to make time for family and for me. However, I still want to leave a footprint in our industry that allows for change, and we're not there yet," he said. "When I am frustrated, I do think about being a full-time grandpa, but I just don't think it is in my DNA to do that – at least not yet."

This is good news for many people, including Dickerson's work colleagues and his clients. It is especially beneficial to NRRTS that, not only is Dickerson not retiring, he has accepted the responsibility of president of the organization. The role of president is actually a four-year commitment: one year as president-elect, two years as president and then past-president for one year. This commitment is important

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THE GREATEST CHANGE COMES ...
(CONTINUED FROM PAGE 25)

to Dickerson, not only because of the work still to be done but also because of his respect for and strong connection with NRRTS staff and board members. "I believe that, as hard as we try, we're still challenged to communicate the value of NRRTS, not only with consumer protection-type issues but also from an advocacy point of view. I wish we could do more, but I couldn't ask for a better group of people to be with in this fight." Dickerson is also a long-time member of the Clinician Task Force, NCART and RESNA.

He admits that in the beginning, he wasn't quite sure about the

John Bertone, National Seating & Mobility EVP Field Operations, Gerry Dickerson, and Bill Mixon, National Seating & Mobility CEO

The Gerry Dickerson family (l to r): daughter, Amy, and son-in-law, Chris, holding grandson, Cameron; granddaughter, Kyleigh; daughter-in-law, Katie, and son, Kyle; Gerry and wife, Pat.

Back row: Doug Westerdahl, Rep. Joseph Crowley, Bill Tobia. Front row: Carol Napierski, Jean Minkel, Gerry Dickerson.

"HOWEVER, IN OUR INDUSTRY, IN PARTICULAR, THE LOSS OF WHAT I CALL 'TRIBAL KNOWLEDGE' IS A HUGE PROBLEM. TOO OFTEN, BUSINESSES ARE CUTTING BACK AND JETTISONING THE INDIVIDUALS WHO HAVE THIS KNOWLEDGE AND EXPERIENCE, WHO UNDERSTAND THE DISTINCTIONS OF THE INDUSTRY. THERE IS NOTHING ELSE LIKE THE WORK WE DO. IT IS UNIQUE IN THE WORLD, AND IT IS A DETRIMENT TO THOSE WE SERVE TO LOSE THESE PEOPLE."

mission and vision of NRRTS. "Once it began to take shape and I realized the quality of the people involved, the organization pointed to a home for folks like me that I could identify with," Dickerson said. "You couldn't work with anyone better than Simon Margolis. We were combatants of the first order when we were trying to get things done. Then we would have dinner and drinks and enjoy our time together. I've worked with board members such as Weesie Walker, Michele Gunn and Toby Bergantino for years, and when we all get together, it feels like family. There are few people who understand the nuances of the day-to-day work that we do. It is priceless to have these relationships that I can depend on for support."

"As with any business, of course, we need to recruit and educate new generations," Dickerson said. "However, in our industry, in particular, the loss of what I call 'tribal knowledge' is a huge problem. Too often, businesses are cutting back and jettisoning the individuals who have this knowledge and experience, who understand the distinctions of the industry. There is nothing else like the work we do. It is unique in the world, and it is a detriment to those we serve to lose these people."

NRRTS is fortunate that Dickerson is willing to continue to share his "tribal knowledge" and help further strengthen the organization. Indeed, we are confident that he will bring the same dedication and energy to his term as president as has been evident throughout his career.

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

MEDICAID MANAGED CARE ORGANIZATIONS

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

With the growing number of individuals enrolling in Medicaid Managed Care plans, an understanding of related rules and regulations is important when it comes to the coverage of Complex Rehab Technology (CRT).

The following helpful information is excepted from a document entitled "Medicaid Managed Care Organizations and Their Relationship With Medicaid Recipients" prepared by Neighborhood Legal Services Inc. in Buffalo, New York.

★★★★★

All Medicaid recipients enjoy the same rights and benefits, no matter how those benefits are administered. Increasingly, states are relying on various kinds of managed care to administer Medicaid services. More and more beneficiaries are required to enroll in Medicaid Managed Care Organizations (MMCOs) or Managed Long Term Care (MLTC) Organizations. In either case, MMCOs and MLTCs must comply with all the federal and state laws that govern the Medicaid program.

While the MMCO or MLTC plans may place certain restrictions on accessing benefits, like using "in network" doctors or suppliers, these companies must still provide the same level of service and cover the same benefits as the state's Medicaid Fee for Service (FFS) program. This is true for Durable Medical Equipment as well as all other federally mandated Medicaid services.

1. DURABLE MEDICAL EQUIPMENT (DME) NOW HAS A FEDERAL DEFINITION AND A STATE (OR STATE ACTORS LIKE MMCOS OR MLTCS) CANNOT HAVE AN EXCLUSIONARY LIST OF EQUIPMENT.

Until recently, there was no federal Medicaid definition for DME. Each state was allowed to define DME for their own Medicaid programs and to determine what would and would not be covered. The only program that had a federal definition of DME was Medicare, the federal medical insurance program for the elderly and disabled. In February 2016, the federal government revised parts of the federal Medicaid Home Health Care regulations to include a definition of DME: "Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable." 42 CFR § 440.70(b)(3)(ii).

Medicaid programs in every state must now cover DME that meets this federal definition. Moreover, under the new regulations, "states are prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances." 42 CFR § 440.70(b)(3)(v). States must cover all DME that meets the federal definition, even if it does not appear in a list of covered equipment.

2. A STATE (OR STATE ACTORS LIKE MMCOS OR MLTCS) CANNOT LIMIT DME EXCLUSIVELY TO THE RECIPIENT'S PLACE OF RESIDENCE.

Medicaid programs cannot limit the use of medical equipment to the recipient's place of residence. The federal regulation is very clear on this point. "Nothing in this section should read to prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place." 42 CFR § 440.70(c)(1). DME is considered a home health service and pursuant to this regulation, medical need expands beyond four walls and should be used for full integration into the recipient's community, whether that is going to school, work, the doctor or the grocery store.

3. STATES ARE ALLOWED TO PROVIDE SERVICES THROUGH MMCOS OR MLTCS IN ORDER TO CONTAIN COST BUT, MMCOS AND MLTCS CANNOT ARBITRARILY DENY A RECIPIENT'S RIGHT TO MEDICALLY NECESSARY SERVICES AS A MEANS OF REDUCING COSTS.

The federal government may allow a state to waive or limit specific recipient rights or criteria, if it can be found to be cost-effective and not "substantially impair access to such services of adequate quality where medically necessary." 42 USC§ 1396n (b)(1). However, the state is expected "to share (through provision of additional services) with recipients of medical services under the state plan

cost savings resulting from use by the recipient of more cost-effective medical care." 42 USC§ 1396n (b)(3). Using MMCOs and MLTCs allows the state to save money in the administration of its Medicaid program, but MMCOs and MLTCs are not allowed to reduce services for their own gain.

4. MMCOS ARE BOUND BY ALL STATE AND FEDERAL LAWS THAT GOVERN THE MEDICAID PROGRAM.

To protect the Medicaid recipient's rights and access to all Medicaid services, federal Medicaid Managed Care Regulations require:

- Services provided to MMCO recipients must be provided in the same amount, duration and scope as services in FFS Medicaid. 42 CFR§ 438.210(a)(2);
- An MMCO does not have to provide all Medicaid services. 42 CFR§ 438.210(a)(l). The MMCO must inform the beneficiary how to obtain those services not provided by the MMCO from the state Medicaid agency. 42 CFR § 438.10(e)(ii)(2)(v);
- The MMCO "may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the beneficiary." 42 CFR § 438.210(a)(3)(ii); and
- An MMCO cannot define medical need in a manner that is more restrictive than the state FFS program. 42 CFR § 438.210(a)(5)(i).
- This list is not exhaustive.

5. EACH MMCO ENTERS INTO A CONTRACT WITH THE STATE THAT CLEARLY SETS OUT WHAT THE MMCO MUST PROVIDE IN EACH STATE.

Each MMCO has entered into a contract with the state to provide services. The contracts include state law definitions and mandates, as well as policies, to ensure that the MMCO recipient is not provided fewer services than the FFS recipient.

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MEDICAID MANAGED CARE ORGANIZATIONS
(CONTINUED FROM PAGE 29)

6. EACH MMCO MUST CONFORM TO STATE REGULATIONS AND POLICIES FOR PROVIDING DME.

Each state's definition of DME must now conform to the federal definition of DME. State policies defining DME cannot be narrower than the state law and regulations. In conforming to the state law and policy, MMCOs may place appropriate limits on services using medical necessity criteria or a utilization control methodology, but the limits cannot be narrower than the state regulations or policies.

In conclusion, a Medicaid recipient who elects to join an MMCO or is automatically enrolled in an MMCO or MLTC plan should not see any difference in their Medicaid services. DME is considered part of Medicaid's federal Home Health Services. The MMCO plan may offer more services than the state Medicaid FFS, but never less. In any situation where the managed care contract does not include all Medicaid services, the MMCO needs to inform its enrollees how to get the necessary services from the state Medicaid FFS agency. The MMCO cannot limit services in a manner that is more restrictive than the state's Medicaid FFS agency and, in the case of DME, it cannot exclude devices in an arbitrary manner when they meet the federal definition of DME.

*****

We thank Neighborhood Legal Services for sharing the above information. Should you require additional information or assistance in this area, please contact me using the information below.

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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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OLMSTEAD DECISION

REVIEW AND REFLECTION

Written by: **PENNY J POWERS** PT, MS, ATP AND **ANDY FOSTER,** OTR, ATP

WHAT IS THE OLMSTEAD DECISION?

In rejecting the state of Georgia's appeal in 1999 to enforce institutionalization of individuals with disabilities, the Supreme Court affirmed the right of these persons to live in their community.[1] It began with two women in a state-run Georgia residential facility, Lois Curtis and Elaine Wilson, who both had mental illness and developmental disabilities and were voluntarily admitted to the psychiatric unit. Intervention resulted in improvement, however, both women were confined to the facility even after mental health professionals recommended discharge to community care. Curtis and Wilson filed suit under Title II of the Americans with Disabilities Act (ADA) for release from the hospital.[1, 2] Title II ensures that people with disabilities have equal opportunities for access to public programs, services and activities and is often known as the "integration mandate."[3]

On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the ADA.[2] The Court held that public entities must "provide community-based services to persons with disabilities when: such services are appropriate; the affected persons do not oppose community-based treatment; and community-based services can be reasonably accommodated, considering the resources available to the public entity and the needs of others who are receiving disability services from the entity."[2] Basically, the Olmstead Decision means that when a client is willing and able to live in the community, even if community-based services are required, he or she should have the right to do so.

The Supreme Court explained, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life," and "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement and cultural enrichment."[2] This explanation boils down to the fact that people with disabilities who can handle and benefit from being in the community, should be.

Specific cases of individuals whose lives have benefited from the Olmstead Decision and the Olmstead enforcement interventions can be found at www.ada.gov. Ultimately, the "Community Integration for Everyone" Integration Mandate noted "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[2]

WHY IS THIS IMPORTANT TO THOSE OF US WHO EMBRACE AND SERVE THOSE INDIVIDUALS WHO NEED COMPLEX REHAB TECHNOLOGY?

This legislation challenges and refutes "the in-home rule" – the community by definition is much larger and more than "in the home." Our advocacy – our fight - has been about standing, suspension systems, free wheel attachments, power assist, power adjustable seat heights, light systems, etc. The inability to obtain any one of these systems and/or components "diminishes the everyday life activities of individuals;"[2] this is an independence and quality of life issue when restricted. As advocates, promoting awareness of the Olmstead Decision and employing that success is within our arsenal to affect change. Full access to not just the home, but also the community is (or should be) a protected right of clients with disabilities. As we know, access to CRT should include full use in the home, community and anywhere in between.

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OLMSTEAD DECISION
(CONTINUED FROM PAGE 32)

We both recently met with some of the physician medical reviewers of KePro, which is a national company that is contracted with TENNCARE in Tennessee. This company employs physicians for quality improvement and care management. This company and these doctors are enlisted for review and recommendations for appeals. The purpose of the meeting was informational – show and tell products, as well as an explanation of the purpose and medical necessity of components. Time was extremely limited, so Andy Foster provided a brief explanation of the Olmstead Decision to encourage consideration of this ruling in their decision-making processes. The meeting participants were engaged and asked questions that reflected sincere interest. It was surprising to us that these reviewers were not familiar with the Olmstead Decision.

We decided that many others may not realize the impact that this decision could have on CRT implementation, thus this brief introduction. Let us begin a dialogue of how the laws, acts and decisions which already exist within the "system," could benefit our clients and help get needed equipment for all environments. We sincerely hope that this knowledge expands your horizons as it did ours.

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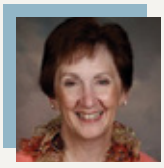

Andy Foster, OTR, ATP, works for Numotion. He holds a Master of Occupational Therapy from Texas Woman's University and a Bachelor of Science in Rehab Services Administration from Auburn University. Foster has been a co-presenter for seating and mobility courses at the University's schools of occupational therapy and physical therapy and Tennessee University's occupational therapy school. RESNA and four times at the International Seating Symposium.

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UNDERSTANDING DIFFICULT CLIENTS AND CAREGIVERS … AND HOW TO DEAL WITH THEM!

Written by: **JILL SPARACIO,** OTR/L, ATP/SMS, ABDA

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In any culture, workplace, family or social situation, we encounter people who we consider "difficult." Away from work, we are able to remove ourselves or limit interaction with those we find difficult. In our professional life, this becomes more difficult since we are unable to pick and choose which clients to work with. What we often overlook is that others may perceive us as the difficult ones. When at work, one of the most exhausting tasks can include working with a client or caregiver who is perceived to be difficult. By difficult, many definitions come to mind. It can be a serious disagreement or argument, an incompatibility or clash with another, heightened tension, or a misunderstanding. It can be a result of personality differences (choices, interaction style) or a result of a difference of expectations with what is perceived to be an inflexibility to understand or change.

USE OF LABELS

In this article, the term "difficult" is used as a more concise and positive term cannot be identified. However, one needs to keep in mind how labels influence our interactions with others. To understand this, some basic terminology definitions need to be understood. A label is a name, word or phrase to classify or categorize a person or thing. These are often inaccurate representations especially when labeled by someone else. Benjamin Whorf, a linguist in the 1930's, hypothesized that the words we use to describe what we see aren't just idle placeholders – they actually determine what we see. Therefore, a label of "difficult" is most often misleading and judgmental. An assumption is something that is accepted as true before one gathers any proof that it is so, often coming from others' labels. If an ATP assumes a client or caregiver is "difficult," there is a chance that the assumption might be incorrect. After assumptions are made, stereotypes develop. Stereotypes are incorrect assumptions made about all of the members of a particular group. A stigma is a powerfully negative label that changes a person's self-concept and social identity. If a person is labeled in a negative manner time after time, all who interact with that person can be influenced by it. Although labels may be a reasonable reflection of who that person is at a moment in time, it should not be assumed that the labeled behavior reflects the person's essence. Terms used to describe others can make all lives more stressful for those who label as well as those who are labeled. Perceiving other people's personalities in a more positive way can decrease the stress that accompanies future interactions. Human nature guides us to label, but it is inherently detrimental to label a client or caregiver as "difficult." This sets up the expectation for a negative interaction and should be avoided at all costs.

HUMAN NATURE GUIDES US TO LABEL BUT IT IS INHERENTLY DETRIMENTAL TO LABEL A CLIENT OR CAREGIVER AS "DIFFICULT". THIS SETS UP THE EXPECTATION FOR A NEGATIVE INTERACTION AND SHOULD BE AVOIDED AT ALL COSTS.

DIFFICULT SITUATIONS

There are many difficult situations that come up throughout a day in the seating and wheeled mobility clinic. Some situations are the result of simple misinterpretations while others are the result of unrealistic expectations. Situations need to be addressed as they come up instead of letting the issues accumulate.

- In one appointment, an overprotective parent of a young woman with cerebral palsy was casually told upon delivery that her daughter's custom-carved

FIGURE 1

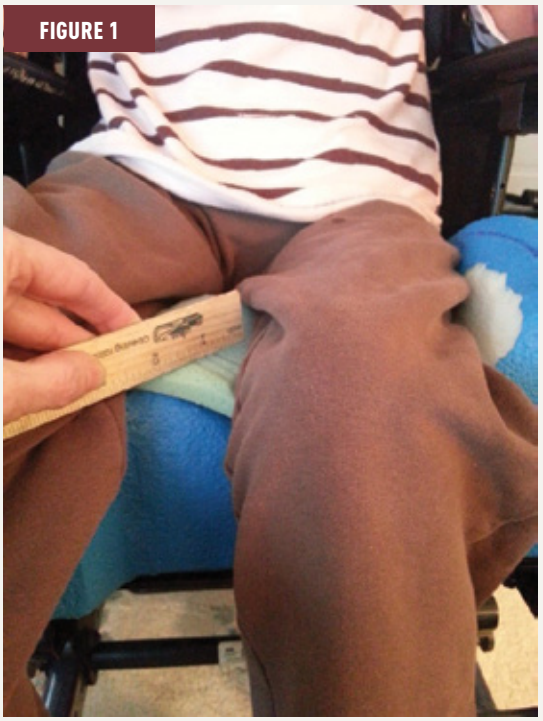

FIGURE 1: "The seat cushion is "good enough."

seat cushion was "good enough" (see Figure 1). This was said after modifications were completed during the appointment. The parent interpreted the comment as that her daughter would have to settle for the clumsily modified seat cushion and was unaware that a remake would be provided. The parent left the appointment unhappy, called supervisors to complain and started searching for a different clinic so her daughter wouldn't have to use "good enough" seating. The communication at this appointment was poor and led to a situation that was out of control. The parent was now perceived as "difficult."

- The parent of a young man who had recently received a new power wheelchair with a head array driving method was admitted to a long-term care facility. Due to many other residents on his residential unit, driving space was limited. In fact, when he attempted to drive, he frequently ran into staff and

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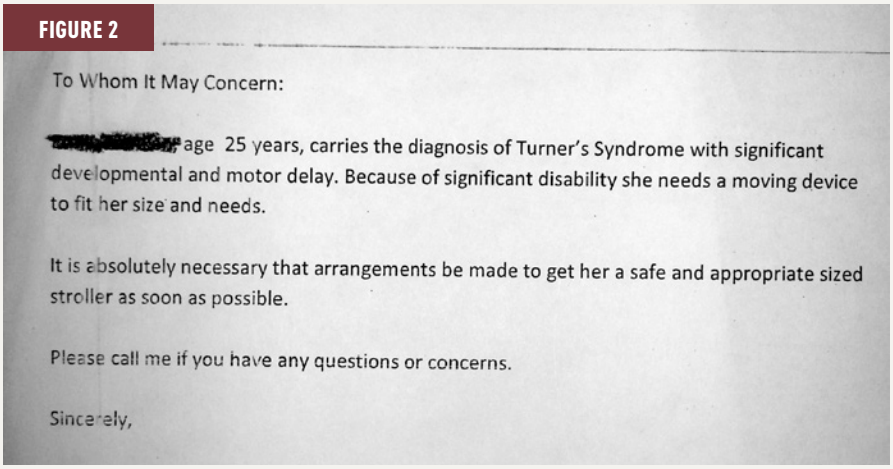
other residents. Observation of the young man showed limited attentiveness when driving, and he often refused practice time. When asked if he wanted to drive his system, he consistently answered no. In a meeting with his mother, she stated, "I won't give up my dream of my son driving a power chair." His mother's desire and contradictory requests led to her being viewed as "difficult." Other staff dreaded encounters with her as every discussion led back to him using a power wheelchair.

- "But my doctor wrote an order" is a common theme that leads to the perception of difficult clients or caregivers. A frequent misconception is that just because a physician writes an order, it has to happen. In this day and age of funding limitations, conflict occurs when expectations are not met. As the client's expectations are shot down, disappointment, frustration, blaming and arguments arise. When one's expectations are much higher than what is possible, the person can be viewed as unwilling to compromise and "difficult" (see Figure 2).

- "Mike said he wanted to eat the turtle" (see Figure 3). Some clients show difficulty in terms of how they treat/handle their equipment. A young man with an intellectual disability peeled off his joystick overlay because, in his words, he wanted to "know what turtles tasted like." He proceeded to eat the turtle from the speed control printed on the overlay. He became a "difficult" client for the RTS as repairs had to be done creatively and as needed, instead of when funding allowed. His intention was not to be difficult but his lack of judgment, cognitive limitations and impulsivity resulted in difficulty.

FIGURE 2



To Whom It May Concern:

[redacted] age 25 years, carries the diagnosis of Turner's Syndrome with significant developmental and motor delay. Because of significant disability she needs a moving device to fit her size and needs.

It is absolutely necessary that arrangements be made to get her a safe and appropriate sized stroller as soon as possible.

Please call me if you have any questions or concerns.

Sincerely,

FIGURE 2: A physician's order does not guarantee that the recommendations are appropriate or obtainable.

- "But they are adding $280 in labor for a job that will only take an hour." This comment was made by a client (who happened to be an attorney) who did not understand that the RTS was entitled to get paid for his time while completing repairs to the wheelchair. He requested an itemized quote with pricing for every order and then complained about all of the costs. The RTS shuddered every time he saw the client as he knew it would lead to an argument and a verbal lashing.

- "I have no choice who I have to work with and my job with them never ends." As an RTS or clinician, the dread of seeing some of the frequent "difficult" clients takes a toll on his life as well as all relationships, both at work and away. This can manifest itself as increased anxiety, tension or depression. The dread is frequently worse than the actual interaction, however the impact remains the same.

- Simple problems that impact all of us can lead to anyone being perceived as difficult. A bad night's sleep, not feeling well, worry about a loved one or being in the middle of an argument with their significant other, worry about personal finances: all of these can set the tone for a difficult interaction. As professionals, feelings and issues need to be compartmentalized and left out of professional interactions.

- From the client's perspective, many issues may lead to difficulty. These can include level of acceptance as to why they need a wheelchair, unrealistic expectations in terms of funding or equipment options, psychosocial factors including mental health concerns, cognitive function, interpersonal relationships and current life situations (do they have a home, going through a divorce, wondering how they will care for a child).

CLIENTS ARE BOMBARDED BY SITUATIONS WHERE THEY ARE ASKED TO COMPLY WITH TREATMENT PLANS, USE NEW EQUIPMENT AND FOLLOW SUGGESTIONS MADE TO IMPROVE THEIR SITUATION. WHEN THEY REFUSE, PEOPLE ARE OFTEN REFERRED TO AS NONCOMPLIANT.

FIGURE 3

FIGURE 3: Some "difficult" clients have limited cognition that interferes with their ability to fully understand consequences.

One of the keys to effectively dealing with "difficult" clients is to identify the true reason for the difficulty. Often the client is unaware. Non-judgmental discussions and questioning can lead to heightened awareness of behavior.

TERMINOLOGY

The concept of difficult varies from one person to another. One's "difficulty" might be the result of a lifelong process or belief that is further exaggerated by the situation at hand. "Difficult" perceptions do not happen overnight, nor do they improve with additional stress. The definition is a person-specific perspective based on how that person is able to cope with a variety of triggers. What is perceived as difficult to one person may not be difficult to another. When thinking of difficult clients, the term "noncompliant" often comes up. Compliance is simply the act of changing one's behavior under the direction or request of someone. An individual is expected to do something simply because someone asks them. Compliance differs from obedience as obedience implies that the request is being made by an authority figure. Clients are bombarded by situations where they are asked to comply with treatment plans, use new equipment and follow suggestions made to improve their situation. When not done people are often referred to as noncompliant. In the world of seating and wheeled mobility, these individuals can be perceived as "difficult" when their lack of compliance interferes with the ability of a therapist or supplier to complete a job successfully. Moreover, their difficult nature becomes a frustration to all parties involved. The term "point of crisis" occurs during an interaction where the proverbial lightbulb goes on, usually triggering a reality check. This is the moment in time when a person is faced with reality. It might be the realization for a parent that their child will never walk or that recovery will not occur. The person has likely heard these facts over and over from various professionals but suddenly it becomes real to them, leading to this reality check.

The interaction with another can be referred to as an interpersonal event. When you consider that the seating and mobility evaluation is accomplished through a multidisciplinary approach, the number of interpersonal events increases drastically. The opportunity for "difficulty" is multiplied. Although we can control our own emotions and interactions, we cannot control how the other team members and the client are going to interpret our interaction. Clarity in communication is vital to be successful.

Many factors are involved when dealing with difficult clients. These range from cultural and educational issues to mental health issues that interfere with interpersonal skills and events. Once a difficult situation is encountered, the professional needs to step back and attempt to identify the factors that are causing the difficulty; current behaviors of all involved need to be evaluated and modified. Clinical interaction can be described as a "dance" with two partners who work cooperatively; however one needs to lead while the other follows.

CATEGORIES OF DIFFICULT PEOPLE

If categories of difficult need to be defined, consider these six general types:

1. The Perfectionist: This is the individual who overanalyzes every single detail. This bogs down the entire decision-making process.

2. The Control Freak: These individuals need total control over every aspect of the interaction. All tasks need to be completed in that person's preferred method, even when that method is not the best option.

3. The Creative Soul: This individual is great at generating ideas but cannot get to a final resolution. The ideas keep coming without the ability to end by making decisions.

4. The Shaper: These individuals take charge of the process without having the knowledge and skills to do so. They are hyper-focused on a solution but have not addressed all the issues or the process to get there. For example, the involved father who sends emails demanding that a repair gets done as soon as possible starts each

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email with "hey team" to give the appearance of trying to engage the group. The next phrase jumps right to "I need a solution now" without understanding the situation or steps involved in the process.

5. The Aggressor: Also known as a defensive person, they often stop the process. These individuals can be threatening, mean and nasty. They rarely take any responsibility for the situation, issue or possible solutions. These individuals should not be confused with assertive. Assertive individuals have a forceful personality, but it is positive and with confidence, never mean or aggressive.

6. The Submissive Person: This individual lacks the confidence needed to make decisions. Even when options are concisely outlined, they are unable to make decisions and rely on others to make the decision for them. This person is reluctant to take a stand or take ownership in a situation. They have a fear of failure that results in negative energy within interactions. These individuals are often emotionally draining for the others.

There are many ways to categorize difficult individuals. The common thread with all is that a full understanding of the typical characteristics of difficult individuals, whether the client, caregiver or team member needs to be identified. According to Debra Beaulieu, there are four typical groups:

- Dependent clingers: These individuals tend to be very appreciative for everything the professional does for them, often verbally praising and thanking them for every little detail. As a result, the professional often offers to go beyond what is necessary which further exaggerates their dependency. Soon, the client starts calling and asking for additional favors and requests. These individuals deal with feelings of powerlessness and abandonment, often unconsciously. The professional needs to reassure while creating definite boundaries.

- The entitled demander is the individual who tells the professional how to do his/her job. From their perspective, they want to take aggressive control even though they usually feel rather helpless and powerless. Gentle encouragement to "work together" is helpful, often bringing the client back to cooperate instead of demand.

- The manipulative, help-rejecting complainer is the client who finds fault with every solution offered. The recommendations of the professional are never good enough even though the client continues to come back with future issues. At times, this group can be aggressive and blaming, taking little responsibility for themselves.

- The last group of difficult clients is the self-destructive denier. These individuals knowingly participate in behaviors that are self-destructive and detrimental to the process. They hide their feelings of hopelessness through their overt destructive behaviors with an "I don't care" attitude. No matter what is recommended, they continue to sabotage the situation. Oftentimes there can be an undiagnosed depression or anxiety. If the behaviors are significant enough, referral to a mental health professional may be needed.

THERE ARE MANY WAYS TO CATEGORIZE DIFFICULT INDIVIDUALS. THE COMMON THREAD WITH ALL IS THAT A FULL UNDERSTANDING OF THE TYPICAL CHARACTERISTICS OF DIFFICULT INDIVIDUALS, WHETHER THE CLIENT, CAREGIVER OR TEAM MEMBER NEEDS TO BE IDENTIFIED.

EDUCATION

So, what happens when there is perceived difficulty? The provision of education in a manner that the difficult person can understand needs to be provided. As with the wheelchair evaluation process, needs have to be determined along with possible solutions. The ability to educate depends on many factors including the client's cognitive ability and education level, current and prior life experiences, generational learning styles and cultural issues. The ability to provide education will allow for informed decision-making by all parties involved in the wheelchair evaluation process. Consensus among the team members can only be obtained when all findings and recommendations are understood by all.

GENERATIONAL LEARNING STYLES

Generational learning styles are key in providing education. Generations are categorized by years of birth. Generational groups include traditionalists, baby boomers, Generation X, millennials and post-millennials.

- Traditionalists (born before1945): These people display strong work ethics, are loyal and dedicated, and are willing to sacrifice (as they lived through World War II). They respect authority, avoid conflict and are at times slow to change habits. Traditionalists prefer structured learning situations to gain new information. Use of technology is limited as they are usually self-proclaimed technologically challenged. This group never questions authority such as a physician or a therapist who tells them what to do versus working with them to create a plan. It is imperative that they become a part of the team process instead of being told what to do.

- Baby boomers (born between 1945 and 1964): This group is also hardworking, achievement-oriented, independent and self-reliant. They question authority (think hippies from the '60s). They value face-to-face time instead of working remotely as some of the younger groups prefer. When providing education, a personally focused learning structure is preferred with a friendly approach versus an authoritative manner. This group is interested in maintaining optimal health and wellness.

- Generation X(born between 1965 and 1980): Gen X'ers prefer instant gratification and are independent and resourceful. They expect immediate and ongoing feedback, often utilizing email and text

THE ABILITY TO PROVIDE EDUCATION WILL ALLOW FOR INFORMED DECISION-MAKING BY ALL PARTIES INVOLVED IN THE WHEELCHAIR EVALUATION PROCESS.

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messaging. They prefer to learn through self-directed learning opportunities on their own schedule. This group is open to education through technology as it facilitates self-directed learning. Collaboration with the team is essential while they are provided with choices and ideas to help devise a plan to meet their goals.

- Millennials (born after 1980): This group is tech savvy as they have been exposed to technology since adolescence. They tend to be hard working on their own terms. Millennials seek out experiences rather than things. They look for highly personalized training that is self-directed, preferring education through on-demand technology. They also seek out problem-based learning, using their skills to problem solve.

- Post-millennials (born after 1987): This group is sometimes separated from millennials because of access to different life experiences. They have had access to technology throughout their lives and are reliant on technology, specifically smartphones. They have never experienced dependence on a telephone with a cord or life without instant communication or access to information. This group is highly ambitious with high expectations. They want to understand the process and the rules in order to get what they want. Education needs to be on-demand with technology, but post-millennials also seek affirmation to make sure they are on the right track.

LEARNING STYLES

With each generation, the provision of new information needs to be delivered in a manner that they can understand. In addition to the above, consideration needs to be given to learning styles. Some individuals learn best through auditory or visual opportunities. Some need the kinesthetic (active) approach that pairs new information with motor tasks. Some people are sequential learners, needing specific step-by-step instructions while others need to step back to see the big picture (global learning). Lastly, some individuals are reflective learners who need to gather information, ponder different applications, perhaps try a few options and then make a decision. Oftentimes, questioning the client can lead to how they best learn. At that point, the team needs to provide information in the determined style.

SOME PEOPLE ARE SEQUENTIAL LEARNERS, NEEDING SPECIFIC STEP-BY-STEP INSTRUCTIONS WHILE OTHERS NEED TO STEP BACK TO SEE THE BIG PICTURE (GLOBAL LEARNING).

INEFFECTIVE COMMUNICATION

In situations where interaction escalates negatively, there are some basic "don'ts." If individuals engage in any of these techniques, situations go from bad to worse. Although these seem obvious, they get lost in the emotional responses that can go hand in hand with difficult interactions. These include:

1. Don't tell the client they are wrong. The last thing a difficult client needs to hear is that they are wrong. They will react by either striking back or retreating as the encounter becomes very uncomfortable. Instead, engage in providing some parameters for more positive solutions, giving the person a framework of possible options to choose from.

2. Don't argue with the client. If emotions are high, argumentative interaction will escalate the tension even more. Both sides will dig their heels in to prove they are right in order to win the argument. Think of the process from the bigger picture instead of individual battles. Be proactive in your discussion instead of reactive.

3. Don't speak with an authoritative tone as if you have to prove the client wrong. This puts all of the control with the professional instead of creating a team-based discussion. The client's value is taken away with the professional taking control. The message that the client receives is that they are not worthy of having a role in the process.

4. Don't say things like, "We could never do that." The client hears that their idea or choice is ridiculous and would never be the correct option. Speaking with absolute descriptors (never, always, etc.) should be avoided.

5. Don't be afraid to apologize. It is not an admission of fault, merely a means to explain, terminate an argument or start over. The apology should be directed at the dispute, not toward another individual.

WHEN COMMUNICATING WITH CLIENTS, THE CHOICE OF WORDS CAN MAKE OR BREAK A THERAPEUTIC INTERACTION. FOR EXAMPLE, TELLING A MOTHER THAT HER DAUGHTER'S NEW SEAT CUSHION IS "GOOD ENOUGH" MAY TRIGGER AN EMOTIONAL RESPONSE FROM THE MOTHER, WHO MAY HEAR THAT THE THERAPIST IS SETTLING FOR MEDIOCRITY.

EFFECTIVE COMMUNICATION

Communication skills are vital in all interpersonal events, whether difficult or not. Effective communication on the part of the professional is imperative to set boundaries and provide education while also alleviating stress and anxiety. The provision of education is imperative for so many reasons. Requests for actions with an understandable purpose are more apt to be accepted and honored. In the seating and mobility clinic setting, education needs to include information regarding the client's condition, potential problems and potential solutions.

When communicating with clients, the choice of words can make or break a therapeutic interaction. For example, telling a mother that her daughter's new seat cushion is "good enough" may trigger an emotional response from the mother, who may hear that the therapist is settling for mediocrity. Listening to the client's words while also observing their body language can give cues as to how the interaction might be interpreted. Body language can communicate anger, frustration and withdrawal as well as understanding and agreement.

Differences of opinions regarding a situation can lead to a difficult interaction. These differences might be as simple as a color choice or as complex as the client or caregiver having unrealistic expectations either of themselves or the equipment. The role of the professional is to provide clarification through education, helping to set reasonable expectations and goals and making sure all goals are consistent.

BOUNDARIES

The creation of boundaries is also needed in dealing with difficult clients. Although personal examples can be effective, they might reveal too much personal information about the professional. Instead, the professional needs to be empathetic to the individual's needs, keeping the focus on the client.

GENERAL SUGGESTIONS

For a cookbook approach when dealing with difficult clients, here are some additional suggestions:

1. Listen carefully. Really listen – don't just hear the words, understand what the words and the body language are saying. Summarizing and paraphrasing what the client says are effective ways to check for understanding. Validation and empathy are also effective tools.

2. Don't interrupt. Interrupting sends the message that what they have to say is not important.

3. Keep a record of what is said and done, itemizing steps that address the concerns. If necessary, review the list at the end of the session and ask the difficult person to initial/sign off on the recommendations to show that they are in agreement. This can be a helpful document during future encounters.

4. Try to see things from the client's point of view, no matter how unreasonable or irrational. The old adage of "walk a day in their shoes" has a place. Each client brings different life experiences to the situation. Although one client might present similarly to another, do not assume that they are the same.

5. Avoid arguments. This cannot be stressed enough. Once an argument emerges, both parties end the ability to discuss issues rationally. It is the professional's responsibility to do this (see Figure 4).

FIGURE 4

FIGURE 4: Arguments interfere with rational discussions

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6. Be encouraging. Do not be condescending and demeaning. Genuine encouragement will lead to greater participation of the client who might be willing to share or interact on a more involved level. Attempts to separate the person from the issue can be helpful.

7. Stay calm. Count to 10. The professional cannot be effective if they have lost their composure. When this does happen, remove yourself from the situation.

8. Everything starts by stopping! If a situation develops, assume that your behavior is not effective. The professional must stop, re-evaluate the situation and make changes in their approach. This does not mean the professional's behavior is wrong, it is simply ineffective in the current setting (see Figure 5).

Most importantly, when a situation is developing, the professional needs to modify his/her behavior in order to remedy the situation. Modification of actions needs to occur from all parties; however you can only control your own behavior. In life, most of the stress we feel comes from the way we respond to situations around us. Adjustments in our own attitudes are difficult, but they are key to improving interaction and decreasing stress.

FIGURE 5

FIGURE 5: If a situation develops, stop, change your behavior, and move forward.

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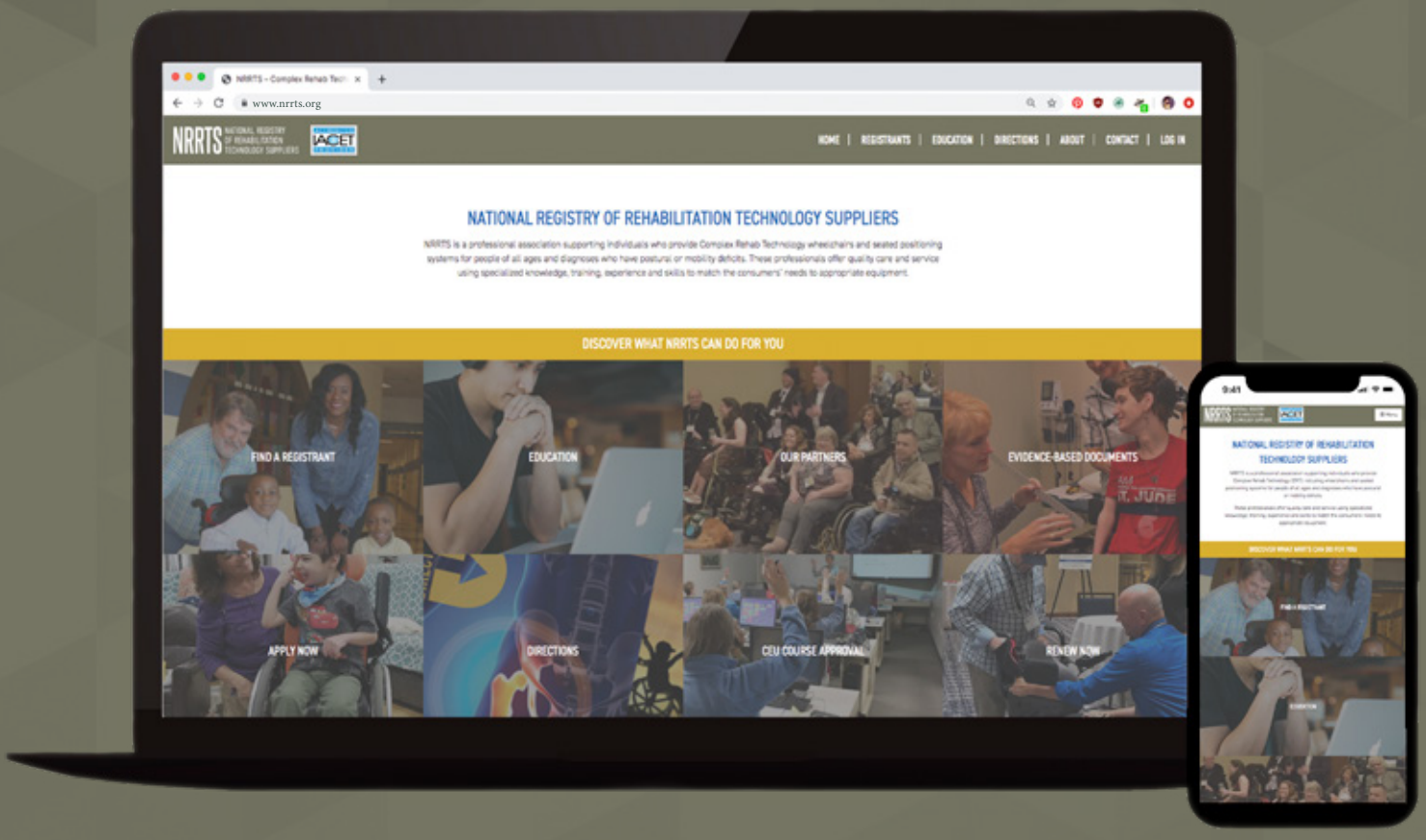

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DEALING WITH "DIFFICULT" CLIENTS

Written by: **AMY MORGAN,** PT, ATP

NRRTS thanks Permobil for sponsoring this article.

What is a "difficult" client? Clients with extremely complex presentations or situations can be a great challenge for the rehab team. On the contrary, some people with very basic physical needs may have simple equipment solutions, yet have interesting social/family dynamics, that result in a difficult situation as the team attempts to manage expectations, educate, and work within those challenging dynamics. In these types of situations, clients and/or their caregivers may be labelled as "difficult" and even possibly carry that title throughout their lifetime. The seating and mobility world is a small industry, and clients who burn bridges may find it difficult to find a supplier that will work with them. This creates a very tough situation for the clinicians who are working with that client. Before we begin to discuss a relevant case study, it is important to note that an informed client who knows what they need and want is a GOOD thing. However, when a person (whether client, caregiver, supplier, clinician, manufacturer, etc.) does not respect other team members, attempt to understand other's perspectives, and has unrealistic demands, things become problematic quickly. All members of the rehab team should ultimately want what is best for the client and do everything they can to achieve the end goal of a successful outcome. Likewise, clients should be able to trust that the team is working in their best interest and doing everything they can to achieve that common goal.

THIS CREATES A VERY TOUGH SITUATION FOR THE CLINICIANS WHO ARE WORKING WITH THAT CLIENT. BEFORE WE BEGIN TO DISCUSS A RELEVANT CASE STUDY, IT IS IMPORTANT TO NOTE THAT AN INFORMED CLIENT WHO KNOWS WHAT THEY NEED AND WANT IS A GOOD THING.

This case began with a seasoned client in a prominent assistive technology clinic. This particular client, who we will call John (not his actual name to respect his privacy), was born with Spina Bifida and had been using wheeled mobility since he was a young boy. John lives with his mother and is fairly independent as an adult male; however, his mother continues to speak on his behalf. She wants John to be independent but seems to be trapped in her role as his sole caregiver, and at times may overstep this role. It was time for John to obtain a new manual wheelchair with power assist wheels, as he had been using for several years. Unfortunately, John and his mother had a reputation for being "difficult" and had burned many bridges in the local assistive technology community. Several local suppliers would no longer work with them as customers due to negative past experiences. NuMotion stepped up to give them another chance and agreed to work with them despite their reputation. From the beginning, both the clinic and the supplier were aware of the undesirable history.

John received a thorough evaluation at a well-respected assistive technology clinic by a clinician and supplier who both are certified Assistive Technology Providers (ATPs). John was satisfied with his existing manual wheelchair and power assist wheels and wanted to replicate what he was currently using. Unfortunately, John's wheelchair was no longer being manufactured, and a new product was required. The team chose a TiLite Aero Z because of the customization this product allowed. John had several orthopedic issues and required a significantly abducted frame on the left side only to accommodate limited hip adduction (see Figure 1). He also wanted a drop seat as he had successfully been using one for years. He and his mother were extremely resistant to any change because he hadn't experienced any issues with skin breakdown in the past in his more recent chairs. Since it was impossible to replicate his current chair exactly, the team did everything they could to achieve the desired outcome. This included customization from TiLite as well as from NuMotion.

At the first delivery appointment, John's mother expressed concern with the rigidizer bar on the TiLite frame below the custom fabricated drop seat. She was particularly concerned with the geometry of the angles and felt it might create increased risk for skin breakdown near John's greater trochanters. John's mother refused the highly customized chair because

SHE WAS PARTICULARLY CONCERNED WITH THE GEOMETRY OF THE ANGLES AND FELT IT MIGHT CREATE INCREASED RISK FOR SKIN BREAKDOWN NEAR JOHN'S GREATER TROCHANTERS.

of this and would not even agree to try it despite several conversations and having a signed CAD that she agreed to. She insisted that those angles were not clearly evident on the CAD drawing she signed. Additionally, the backrest width was identified as being too wide and limiting John's ability to propel the wheelchair. In this first phase of the process during which the issues were identified, one lesson was learned: The team could have possibly discussed the CAD in greater detail with the family prior to placing the chair on order. This would have possibly helped identify the family's concerns before the chair was manufactured and many hours of custom work were completed.

At this point, NuMotion reached out to me as the manufacturer's representative for TiLite, asking if there was anything that could be done. Mom was requesting to speak to an engineer at TiLite to tell them about what she considered to be a "design flaw." She immediately began contacting executive level management at both companies instead of going through the appropriate chain of communication. Because of this escalation, TiLite agreed to meet with the family and hear them out to see if there was anything different that could be done in this case. Unfortunately, any desired changes required building and designing an entirely new frame with a custom rigidizer bar and tapered backrest. After many discussions with the team, a new frame was designed and fabricated for John. A CAD was presented to the family, and they approved the new design.

When the new chair with requested changes was delivered, it seemed to resolve all of the issues and concerns related to the seating/positioning needs and John and his mother agreed to take delivery of the chair. After several weeks of use, NuMotion received another call from the client's mother expressing

FIGURE 1

FIGURE 1: This shows the customized abducted frame on the left side only. The overall width of the frame is shown with the yard stick.

FIGURE 2

FIGURE 2: This shows the front caster wheel sticking out further than the rear wheel. This was done to allow the chair to track properly when moving forward. The front caster angles are equal on both sides.

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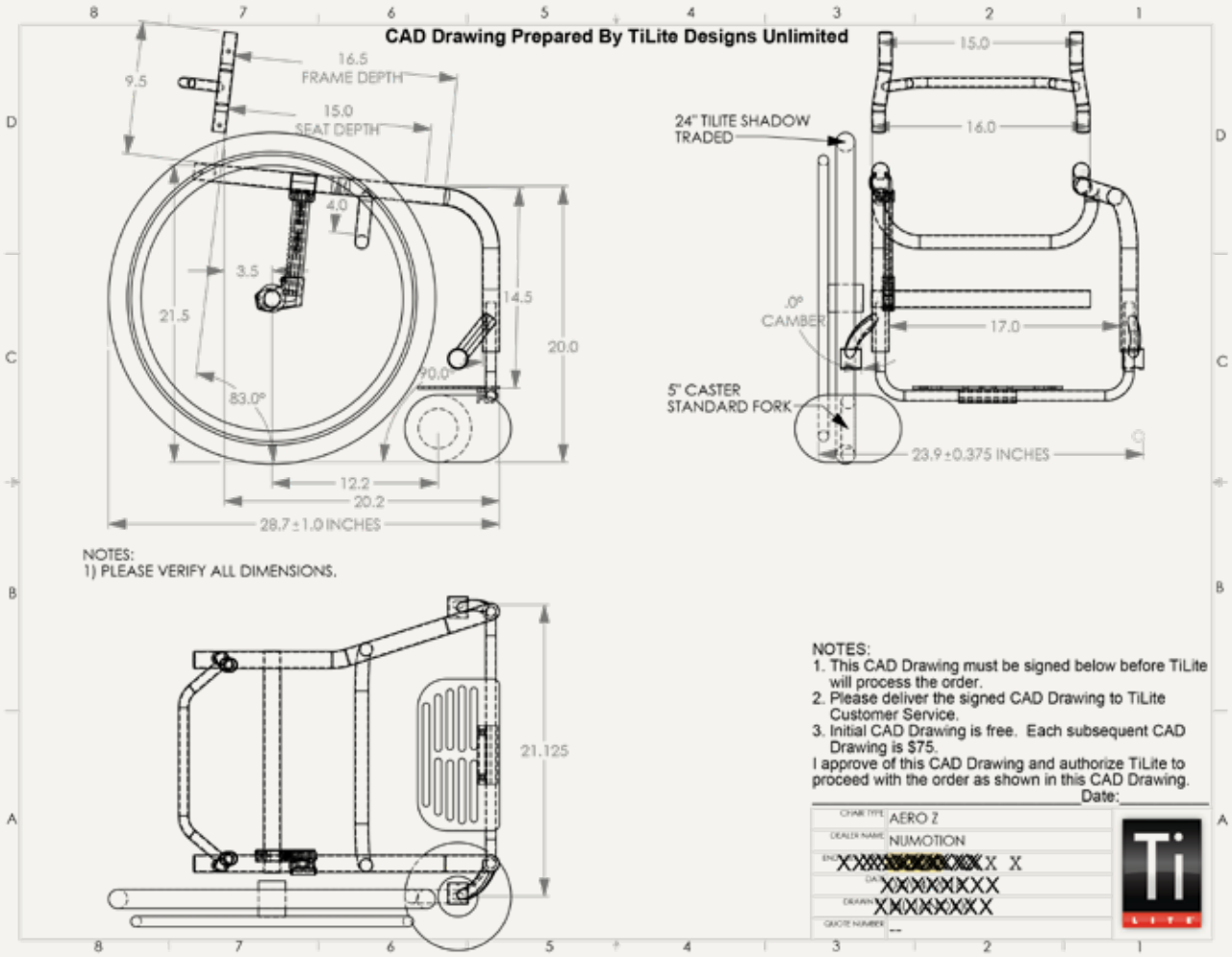
FIGURE 3 FIGURE 3: This is the final CAD for the chair to get the front caster inside of the rear wheel, the caster angles are different on each side. The abducted side (left) has a smaller angle for the caster arm.



DEALING WITH "DIFFICULT" CLIENTS
(CONTINUED FROM PAGE 47)

concern about how the front caster stuck out further than the wheel on the abducted side (See Figure 2). This was limiting John's ability to use the chair in tight spaces, especially in conjunction with the power assist wheels. John was constantly bumping into things and having difficulty getting through doorways. John's mother felt this design was unsafe and needed to be fixed.

To avoid any miscommunication between individual parties, the team got together again at the clinic to discuss these concerns and problem solve possible solutions. Several ideas were generated including modifying the components of the current frame to improve maneuverability and safety. One of the main ideas was to increase the camber angle of the wheels, which unfortunately was not possible with the power assist wheels. The only way to resolve this issue was to build and design yet another frame!

SHE AGAIN TOOK HER CONCERNS TO THE EXECUTIVE LEVEL OF THE COMPANIES AND EVENTUALLY NUMOTION AGREED TO TAKE ON THE COST OF THE SECOND REPLACEMENT CHAIR TO ACHIEVE THE OPTIMAL OUTCOME AND SATISFY THE CLIENT.

Normally, this would not be an option since the frame had already been replaced one time and resulted in a total loss for the manufacturer. To design and build another custom frame would require even more engineering time and design in addition to the materials and manufacturing process. There was no way that

THE CHAIR NEEDED TO BE FABRICATED FROM TITANIUM TO ACHIEVE THE FRAME BENDS IN THE REQUESTED CONFIGURATION. TILITE TOOK ON THIS EXPENSE TO SWITCH TO TITANIUM IN ORDER TO ACCOMPLISH THE END GOAL.

TiLite could utilize the extremely customized frames that were already built for John. The initial response was that we would not be able to make the desired changes. John's mother felt that the caster position was a safety risk to John and that he was not able to use the chair with that design. She again took her concerns to the executive level of the companies and eventually NuMotion agreed to take on the cost of the second replacement chair to achieve the optimal outcome and satisfy the client.

The team met, once again, and included a designer from TiLite on FaceTime to discuss several different options to improve the front caster position while maintaining the abducted frame design that John needed orthopedically. Everyone agreed on the final design, (See Figure 3) and the mother and John both signed off on the CAD with the clear statement that this would be the last frame replacement. They both also verbalized understanding of this.

The chair was so complex that during fabrication it was determined that the specific bends of the tubing required could not be achieved with aluminium metal. The chair needed to be fabricated from titanium to achieve the frame bends in the requested configuration. TiLite took on this expense to switch to titanium in order

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DEALING WITH "DIFFICULT" CLIENTS
(CONTINUED FROM PAGE 49)

to accomplish the end goal.

When the third chair was delivered, it finally met the expectations of the client and caregiver. Ultimately, the lessons learned by all involved were as follows:

1) When faced with an extremely complex and difficult technology solution, do everything possible to get renderings/CAD/drawings of the recommended equipment and discuss these in detail with the client/family. Get their approval prior to ordering the product.

2) Listening to the client and caregivers and responding with compassion reinforces that the team is trying to accomplish the best outcome for the client and a more reasonable response is more likely.

3) Having the support of the entire team collectively will help standardize the message and avoid the "he said/she said" argument. It is especially important that the team members discuss viable options and the barriers to each prior to presenting them to the client/family.

In summary, despite all of the stress and challenges with this case, the ultimate goal was eventually achieved, and the client and family were happy with the end result. Even though there was great financial loss on the part of TiLite and NuMotion, it was good to know that we took care of the customer's needs. It also showed the seating clinic that we are committed to taking care of the client which went a long way in our relationships with the clinical staff there!

EVEN THOUGH THERE WAS GREAT FINANCIAL LOSS ON THE PART OF TILITE AND NUMOTION, IT WAS GOOD TO KNOW THAT WE TOOK CARE OF THE CUSTOMER'S NEEDS. IT ALSO SHOWED THE SEATING CLINIC THAT WE ARE COMMITTED TO TAKING CARE OF THE CLIENT WHICH WENT A LONG WAY IN OUR RELATIONSHIPS WITH THE CLINICAL STAFF THERE!

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Amy Morgan, PT, ATP, Amy has been involved in wheelchair seating since beginning her career as a physical therapist. Morgan worked for Cincinnati Children's Hospital in the past where she was involved in both outpatient and inpatient settings. This experience allowed her to work with a variety of patient populations. Additionally, Morgan was the lead therapist in the hospital's wheelchair clinic, which included evaluation for equipment as well as power mobility training for young children. She has presented lectures both nationally and internationally as the national clinical education manager for Permobil Inc. She is now the territory sales manager for Permobil Mobility products in the central/southwest Ohio area.

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DOCUMENTATION ...

CAN I, OR CAN I NOT?

Written by: **CLAUDIA AMORTEGUI**

You may have looked at the title of this article and thought... what do you mean? There are many answers to this question; it just depends. It could depend on who you are – a clinician, a supplier, both or even anyone else. With this in mind, let's break it down and try to simplify it as much as possible.

Before we look into the answers, how about the core part of the question?

Documentation. For this article, the question is focused on clinical documentation – chart notes, seating evaluations, etc. There is of course other documentation but the answer to those is much more straightforward.

We all know that obtaining documentation for our CRT wheelchair orders can be very challenging in many cases. Many suppliers do their best to find the easiest way to collect all the documents needed in an effort to submit their orders for review in hopes of their clients receiving their equipment timely. Sometimes the challenge is from the ordering practitioners (MD, DO, NP, PA), sometimes from the seating therapists, and unfortunately, sometimes from both. With technology these days, you would think this would not be so difficult, but it certainly can be.

In my experience, I have found that obtaining the physician chart notes is not nearly as difficult as it was in the past due to Electronic Health Records (EHR). The bigger issue is making sure the chart notes include everything Medicare requires. This typically starts a back-and-forth scenario with the suppliers asking for more specific details. It is frequently found

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All of this comes down to the fact the person responsible for signing the documentation is the person who should be completing the documentation. It is really that simple.

DOCUMENTATION... CAN I, OR CAN I NOT?
(CONTINUED FROM PAGE 53)

that suppliers ask for more than what is needed based on all other documentation for the specific client. Suppliers need to ensure their staff understands Medicare's policy on the meaning of a "full" wheelchair seating examination. Many, if not most, of the requirements will be completed during the evaluation by the therapist specialized in seating and positioning. The physician's portion may be very basic when it comes to the specific details, which may be sufficient with the addition of the therapist's evaluation report.

When it comes to completing the ordering practitioner's chart notes, it is rather straightforward. They are the ones who would complete the exam, write their notes, and then sign and date them. These days most will be electronically signed, which makes things much easier. Many times, you will find that the nurse or clinical assistant will complete the basics (i.e. height, weight, blood pressure); this is not an issue, especially with EHR, which will document that person's name. As suppliers you do need to make sure that the ordering practitioner is the one completing the exam (and the notes) and not one of their associates/partners who has no direct involvement with the patient's care.

As for the seating evaluation, I have seen it all. Some therapists complete most of their documentation during the evaluation and others complete it after everything is done, but it may take months to return the completed work. In a perfect world, we would like it done right then and there; however, we also want the documentation to be thorough for proper reimbursement.

Many therapists complete their own (or their facility's) evaluation form; while others will use an industry type evaluation form/template and finally some will write a letter. The main issue for all is time. When can it all be done and done right? For those whose evaluation documentation is completed in EHR, the turn-around is rather quick. The other options typically take much more time – again, something that is very limited.

Some have wondered if during the seating evaluation if the supplier's ATP who is also present could complete some if not all of the documentation for the therapist as they are conducting their hands-on evaluation. The thought is the therapist would be dictating his or her findings to the ATP, and they would document the information recited to them. Is this allowed? Is this acceptable? Simply put, can it be done?

My immediate reaction is not the best. In my opinion, it is a bit too close to that line that I do not want to cross. After some research, I did find that my concerns were validated.

In my opinion, this documentation should occur during the seating evaluation. This has to be its own separate document and not part of the therapist's documentation. The only person required to sign the ATP assessment is the ATP. As a reminder, there is no official ATP assessment form that needs to be completed. The providers I work with each have their own, which tend to be fairly similar.

My immediate reaction is not the best. In my opinion, it is a bit too close to that line that I do not want to cross. After some research, I did find that my concerns were validated. Many would say, the ATP is only transcribing the documentation. This is true, but it's too close for comfort.

CMS has published information regarding "scribes." The Joint Commission has also published such information. "Scribe" has actually become an occupation for some, specifically in health care. What I found is a scribe is allowed as long as the person is an employee of the clinician/facility, and they are not a supplier of a service (in our world, of a product). Even if we just look at the Medicare wheelchair policies, they are very clear there is not to be a financial tie between the supplier/ATP and the clinician. Although there may not be money exchanged, it is still a service the ATP would be providing. Some clinicians reading this may think they would never ask for this help; but the reality is, many do. I've learned some therapists actually expect the help. Needless to say, it is not recommended and based on everything I found, should not be happening. The team just needs to think of other ways to assist the therapist with the time issue.

As for the actual ATP assessment, this obviously is completed by the supplier's ATP with direct involvement from the client and the wheelchair selection. In my opinion, this documentation should occur during the seating evaluation. This has to be its own separate document and not part of the therapist's documentation. The only person required to sign the ATP assessment is the ATP. As a reminder, there is no official ATP assessment form that needs to be completed. The suppliers I work with each have their own, which tend to be fairly similar.

All of this comes down to the fact the person responsible for signing the documentation is the person who should be completing the documentation. It is really that simple.

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

FIGHTING FOR A BETTER FUTURE FOR HME PROVIDERS AND PATIENTS

Written by: **TOM RYAN,** PRESIDENT/CEO OF THE AMERICAN ASSOCIATION FOR HOMECARE

Working as a respiratory therapist and in home care my entire career, I worked with thousands of individuals and families navigating changes with their medical and lifestyle needs. For some, it's a gradual process as challenges with mobility, breathing or taking care of daily activities set in. For others, this has been a way of life for a long time, or perhaps even their whole lives. And for some, there was a finite moment in time where things shifted, and the new world began. No matter how or when their health care needs changed shape, they came to a place where home medical equipment (HME) became an integral part of their lives.

For 25 years, I owned an HME supplier business where our daily mission was to work with people in their homes and give them the support and resources they needed to navigate their evolving medical requirements. We celebrated successes and shared in setbacks with the people we served, and every day we were reminded of why we do what we do. Home care is a critical component of the care continuum, enabling individuals to remain in their homes, with their loved ones, and engaged in the community. We didn't simply provide equipment, we helped people keep their dignity and quality of life in the face of advancing age, severe disabilities and challenging chronic conditions.

NO MATTER HOW OR WHEN THEIR HEALTH CARE NEEDS CHANGED SHAPE, THEY CAME TO A PLACE WHERE HOME MEDICAL EQUIPMENT (HME) BECAME AN INTEGRAL PART OF THEIR LIVES.

From home oxygen therapy to highly-customized complex rehab technology wheelchairs to assistive devices to medical supplies, HME suppliers work closely with individuals, their doctors and family caregivers to find the right solutions to managing their needs at home. HME professionals are on the front lines of patient care, on call 24/7, 365 days a year, providing quality products and compassionate care to the people they serve.

As the national trade association representing HME suppliers, manufacturers and affiliated support companies, we are honored to work with large and small companies across America who share our mission of empowering families and individuals and providing the care they need. Founded in 1982, the American Association for Homecare represents approximately 70% of HME supplier locations nationwide and is at the epicenter of efforts to shape home care policy.

Advocacy remains a cornerstone of our work as we partner with other health care stakeholder groups — including NRRTS — to fight for better policies to ensure patient access to HME products and services in the years to come.

Current federal legislative priorities include keeping non-invasive ventilators out of Medicare's Competitive Bidding Program, rolling back Medicare reimbursement cuts in rural and non-bid areas, fixing outdated payment rates for oxygen concentrators, and advocating for policies that protect patient access to highly specialized Complex Rehab Technology wheelchairs and accessories.

In addition to our Medicare-focused federal advocacy, AAHomecare is also actively involved in initiatives to fight for HME interests with a wide range of payers, including state Medicaid authorities and Managed Care Organizations (MCOs) that administer these programs. Working with leaders at state and regional HME associations, we've had great success in maintaining sustainable reimbursement rates, helping prevent or limit proposed cuts to dozens of states since the beginning of 2018. We have also had considerable success in maintaining open supplier access to MCOS and prevented plans from applying sales tax for HME products in several states — all of which ultimately help ensure that everyone who needs HME and related services has access and choice, regardless of payer source.

I am proud to attribute our growing successes to our dedicated members, passionate staff and collaboration with homecare champions — including the dedicated mobility professionals — who play a leading role in improving the lives of millions of patients and caregivers across America. By harnessing our collective power and working with creative and innovative thinkers who understand the tremendous value in HME products and services that help people remain in their homes and take part in their communities, we are rewriting our story. There is room at the table for HME. There is hope. And there is a bright future for those who are willing to lean in and seize it.

For more information about our mission and to get involved, please visit us at www.aahomecare.org. Follow Tom on Twitter at @TomRyanHME.

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Thomas Ryan is president and CEO of the American Association for Homecare (AAHomecare), the national association that works to preserve and strengthen access to care for the millions of Americans who require medical care in their homes. Ryan holds a degree in respiratory therapy from New York University Medical Center/ Bellevue Hospital and a Bachelor of Science in Health Administration from Saint John's University in New York.

ON CRT AWARENESS … ONE APPROACH

Written by: **WEESIE WALKER,** ATP/SMS

Cathy Carver, PT, ATP/SMS, is a vast resource when it comes to creating Complex Rehab Technology (CRT) awareness. She has put together a learning experience that puts people in a wheelchair to navigate everyday environments. Her goal is to connect the able-bodied community to the disabled community and bridge gaps in communication, appreciation and respect for how we all do life.

Recently, I met up with one of Cathy's groups at a library in Birmingham, Alabama. On that day, the expert CRT user was W.D. Foster. The group consisted of middle schoolers, their parents and several occupational therapy students. Some students were in lightweight wheelchairs while some were in "clunkers." They had been all through the library and then on to the outside where the environment and terrain were quite different. Although they were on a paved sidewalk, they quickly realized who had the best chair to push up the hills.

This group had lots of questions for Foster. They learned how he accessed his van using a ramp and how he drove using hand controls.

Now it was time for us to head out to lunch. The parents had to fold up the chairs and load them into their cars. Once we arrived at the restaurant, it was another lesson on finding a handicap space in this particular retail center, we only saw one handicap space near the restaurant! If you are unfamiliar with Birmingham, it is a hilly terrain. The group had to find the most level spot to park and then push themselves into the restaurant.

Once inside, the kids had to go up to the counter, place their order and pay. These everyday activities took on a new understanding for the children and their parents.

This is truly a grassroots approach to understanding what CRT is and why it is so important. To learn more about "Come Roll With Me," visit their Facebook page https://www.facebook.com/comeroll16/.

Do you have other ideas to share? Contact me, and let's create more CRT advocates!!!

TOP: W.D. Foster and his students.

MIDDLE: W.D. Foster explaining life in a wheelchair.

LEFT: Ordering food is challenging.

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

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Telephone: 760-599-8800 x.1009
Fax: 855-928-2525
Registration Date: 8/13/2019

Marcelle Balcerzak, RRTS®
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Telephone: 239-936-7070
Fax: 239-936-7367
Registration Date: 7/17/2019

Donald W Callaway, ATP, CRTS®
AtoZ Medical Equipment
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Telephone: 214-349-2869
Fax: 214-349-2871
Registration Date: 7/10/2019

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Telephone: 973-576-0025 x.220
Toll Free: 866-262-7328 x.220
Fax: 973-576-0028
Registration Date: 6/25/2019

Eric Dion, RRTS®
National Seating & Mobility, Inc.
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Woburn, MA 01801-2802
Telephone: 781-897-6100
Registration Date: 7/22/2019

Lynn Ferguson, ATP, CRTS®
National Seating & Mobility, Inc.
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Countryside, IL 60525
Telephone: 630-495-3751
Fax: 866-294-8101
Registration Date: 7/22/2019

Jeff Lane, ATP, CRTS®
Phoenix Rehab and Mobility
7931 One Calais Ave
Baton Rouge, LA 70809
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Registration Date: 8/15/2019

Eric Sale, ATP, CRTS®
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5444 East Ave Unit A
Countryside, IL 60525-361
Telephone: 844-774-8348 x.1073
Toll Free:
Fax: 866-294-8101
Registration Date: 6/29/2019

Shean Wages, ATP, RRTS®
PHM/Care Medical of Georgia
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Telephone: 770-842-1426
Fax: 770-369-6894
Registration Date: 8/8/2019

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not.
NAMES INCLUDED ARE FROM JUNE 22 THROUGH AUG. 26, 2019.

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

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Joseph Foggio Suwanee, GA
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James Hearn, ATP Eureka, CA
Thomas Hedges, ATP Parma, OH
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Randall B. Keith, ATP Tampa, FL
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David J. Schultz, ATP East Peoria, IL
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Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. NAMES INCLUDED ARE FROM JUNE 22 THROUGH AUG. 26, 2019.

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Oak Creek, WI

Anthony Boudreau, ATP, CRTS®
Numotion
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Joseph Vance Bryant, ATP, CRTS®
Southern Home Medical
Tifton, GA

Donald W Callaway, ATP, CRTS®
AtoZ Medical Equipment
Addison, TX

Carlos M. Collazo, ATP, CRTS®
National Seating & Mobility, Inc.
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Joshua Janiszewski, ATP, CRTS®
National Seating & Mobility, Inc.
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Jeff Lane, ATP, CRTS®
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Steven Shipley, ATP, CRTS®
National Seating & Mobility, Inc.
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Dustin Swartz, ATP, CRTS®
National Seating & Mobility, Inc.
Columbus, OH

ATP

Congratulations to NRRTS Registrants who earned the ATP credential. Depending upon their registration date, they will be awarded CRTS® upon completion and approval of the renewal following fulfillment of required registration. NAMES INCLUDED ARE FROM JUNE 22 THROUGH AUG. 26, 2019.

Shean Wages, ATP, RRTS®
PHM/Care Medical of Georgia
Athens, GA

RENEWED NRRTS REGISTRANTS

The following individuals renewed their registry with NRRTS between June 22 and Aug. 26, 2019.

PLEASE NOTE **IF YOU RENEWED AFTER AUG 26,** YOUR NAME WILL APPEAR IN A FUTURE ISSUE OF DIRECTIONS.
IF YOU RENEWED PRIOR TO JUNE 22, YOUR NAME IS IN A PREVIOUS ISSUE OF DIRECTIONS.

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David Anderson, ATP, CRTS®
Brennan Arbogast, ATP, CRTS®
David Bachelder, ATP, CRTS®
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