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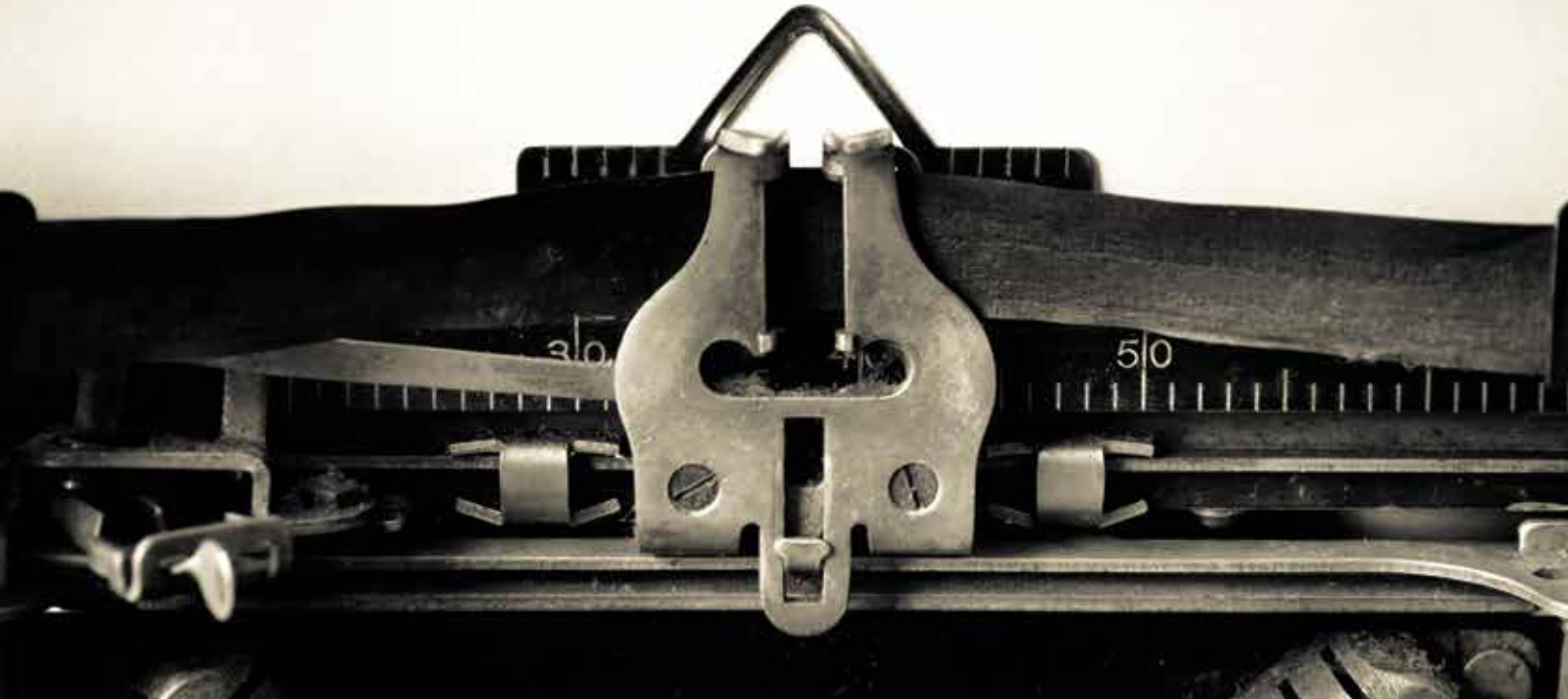

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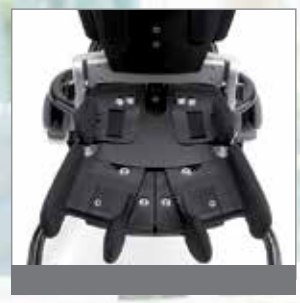
x:panda by R82

SNUG SEAT



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ADVERTISERS' INDEX

2015 NRRTS WEBINARS

This unique educational opportunity is designed with three criteria in mind: to provide quality continuing education in seating and wheeled mobility; to meet the annual CEU requirement* for ATP renewal and NRRTS Registration; and to provide this programming in a cost-effective manner.

The faculty members are among the most well-known and talented people in our industry and profession. They will present information and answer questions from participants. Prior to each session, the presenter's PowerPoint presentation and other course material will be sent via email to registered participants.

The University of Pittsburgh, School of Health and Rehabilitation Sciences, Department of Rehabilitation Science and Technology Continuing Education (RSTCE), is certifying the educational contact hours of this program and by doing so is in no way endorsing any specific content, company or product. The information presented in this program may represent only a sample of appropriate interventions. Each person should claim only those hours of credit that he or she actually spent in the educational activity.

Audience: CRTS®s, RRTS®s, other ATPs, and physical and occupational therapists (intermediate to advanced)

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*NRRTS as well as the RESNA Professional Standards Board recognizes the International Association for Continuing Education and Training (IACET) as an international standard of quality. Though the words Continuing Education Unit (CEU) are not exclusive to IACET, only CEUs from an IACET authorized provider or accredited college or university, such as the University of Pittsburgh, are accepted as CEUs for NRRTS or RESNA recertification renewal.

FOR MORE INFORMATION, PLEASE VISIT
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All participants must score a 70% on the post-test assessment to receive CEU credits.

TUESDAY, OCTOBER 20, 2015 | 7PM - 8PM (ET)

Pressure Ulcer Etiology – What is The New Evidence Telling Us?

SPONSORED BY ROHO

W. DARREN HAMMOND, MPT, CWS

Historically, pressure ulcer etiology has revolved around ischemic changes in the skin and soft tissue. However, recent evidence has demonstrated that deformation of soft tissue has earlier implications in pressure ulcer development versus just ischemia alone. Currently, there are various levels of clinical knowledge and experience when it comes to understanding pressure ulcer etiology and appropriate management strategies. Unfortunately, most health care practitioners do not understand the pathophysiology of pressure ulcers and the extrinsic and intrinsic risks, which need to be managed for successful outcomes. This webinar will review the current best evidence of pressure ulcer pathophysiology, with a focus on the new understanding of the significant role tissue deformation plays in the development of pressure ulcers.

W. Darren Hammond, MPT, CWS, has held clinical positions and faculty appointments in the U.S. for the past 21 years. In addition to being a board-certified wound care specialist by the American Board of Wound Management, Hammond's focus of treatment has been in the rehabilitation of individuals with spinal cord injuries. Throughout his career, Hammond has had extensive experience with seating and positioning, chronic wound management, pressure mapping and cushion and wheelchair prescription. He is currently the senior director of The ROHO Institute for Education at ROHO, where he lectures nationally and internationally on the subjects of chronic wound healing, pressure imaging, and seating and positioning options.

WEDNESDAY, OCTOBER 21, 2015 | 11AM - 12PM (ET)

Arthrogryposis - Challenges and Solutions When a "Non-Progressive" Diagnosis Progresses

KAY ELLEN KOCH, OTR/L, ATP

Arthrogryposis is a neuromuscular skeletal disorder that affects various joints in the body. It is congenital and classified as "non-progressive." Mobility is limited by the joints affected as well as muscular emaciation or weakness. Intelligence is not affected, but lack of mobility and exploration can affect development. As the child grows and develops, seating, positioning and mobility challenges occur. This webinar will review this disorder, orthopedic and therapeutic considerations, as well as positioning and seating challenges. Mobility and seating options and ideas for access for independent mobility will also be presented.

Kay Koch , OTR/L, ATP, has more than 30 years seating and wheeled mobility experience. She is a graduate of the occupational therapy program at The Ohio State University in Columbus, Ohio. Her focus has been on pediatric seating and positioning, wheeled mobility and assistive technology solutions. Koch has spent her years as an OT in various roles including clinician, manufacturer rep, educator and in accreditation. She has presented at various national and international conferences.

THURSDAY, OCTOBER 22, 2015 | 5PM - 6PM (ET)

The Quarter-Inch Quandary: Minor Adjustments Can Make a Major Difference

ROBIN SKOLSKY, PT, ATP

This course will provide participants visual comparisons on how even small adjustments can make big differences in a wheelchair user's posture, function and comfort. We will compare "off-the-shelf" components to custom and explore creative ways to use items that are readily available. Before and after photos will demonstrate some of the significant changes achieved.

Robin Skolsky, PT, ATP, graduated with a Master of Science in Physical Therapy from the University of Miami in Coral Gables, Florida. She received her undergraduate degree from the University of Maryland College Park, Maryland. She has worked almost 20 years as a physical therapist, and more than 10 of those has been full time in seating and mobility. Skolsky has worked in a variety of settings and with a variety of patients, from pediatrics to geriatrics. Her time is spent between Shepherd Center, Children's Healthcare of Atlanta and a students on the topic of seating and mobility and has presented at ISS. She also helped develop and implement a community advanced wheelchair skills program through Shepherd Center in Atlanta.

TUESDAY, NOVEMBER 10, 2015 | 7PM - 8PM (ET)

Postural Care Around the Clock

TAMARA KITTELSON-ALDRED, MS, OTR/L, ATP/SMS, PCT, MEMBER OF CTF

Twenty-four hour postural care is a powerful concept that can change lives. Have you ever watched a client's body shape become progressively distorted over time despite your best seating efforts? Well-planned and implemented postural care for people with movement limitations can improve functional outcomes and quality of life. By supporting symmetrical postures and avoiding destructive ones, a person's body shape can be protected and restored, sleep improved, and personal care made easier. Postural care should be considered for persons of all ages who require positioning and mobility equipment. Learn more about this gentle, non-invasive approach!

Tamara Kittelson-Aldred MS, OTR/L, ATP/SMS, PCT, has been an occupational therapist for 40 years. She studied 24-hour postural care in the United Kingdom and qualified in 2012 as the first American Postural Care Tutor through the Open College Network. Kittelson-Aldred has written and presented on this topic in the U.S. and Peru. She is principal tutor with Postural Care USA and director of Eleanore's Project, promoting postural care and responsible wheelchair provision in Peru. Kittelson-Aldred provides clinical services for positioning and mobility equipment including 24-hour postural care for children, youth and complex adults in Missoula, Montana.

WEDNESDAY, NOVEMBER 11, 2015 | 5PM - 6PM (ET)

Early Intervention

GINNY PALEG

This course will review evidence, outcome measures and clinical practice guidelines for introducing, training and purchasing mobility devices for toddlers. Clinical examples demonstrating the use of different kinds of mobility devices within different clinical practice settings will be shared. The presenter will share relevant and practical resources to assist clinicians in educating families and other therapists in the benefits of introducing mobility with young children especially for those children at GMFM, MACS and CMFCS Levels 4 and 5.

Ginny Paleg is a pediatric physical therapist from Silver Spring, Maryland. She has worked the past 14 years, for her local school system in its early intervention program. Ginny earned her master's degree in physical therapy at Emory University and her doctorate in physical therapy at the University of Maryland Baltimore. She is on the editorial board of Rehab Management magazine. Recently, she has published five articles in peer reviewed journals; two on standing (J Pediatr Rehabil Med, 2011 and PedPT, 2013), one on gait trainers (Clin Rehab, 2015) and, two on power mobility (BJO, 2013 and DMCN, 2014). Her systematic review of dosing guidelines for adult standing programs was recently accepted for publication as well. She presented a plenary on pediatric mobility at the WCPT in Singapore in May 2015. Paleg specializes in assessment and interventions for children at the GMFCS Levels 4 and 5.

THURSDAY, NOVEMBER 12, 2015 | 5PM - 6PM (ET)

Arrive Alive: The Basics of Transportation Safety for Wheelchair Riders

MARY ELLEN BUNING, PHD, OTR/L, ATP/SMS

Wheelchair transportation safety should be a consideration for therapists, rehab technology suppliers and third party payers any time a client will use their wheelchair as a seat in a motor vehicle. In the field of automotive engineering, the vehicle seat is the foundation of occupant protection. The same principle applies when the vehicle seat happens to be a wheelchair. Learn how to recommend appropriate equipment, advise those you work with, and educate them so they and their families/care givers can be self-advocates for their own safety. The topics will include: wheelchair securement, occupant safety restraints, wheelchair selection, a review of standards and best practices, and the special considerations created by school bus, public transit, paratransit and private vehicle transportation.

Mary Ellen Buning, PhD ,OTR/L, ATP/SMS is an occupational therapist with 30 years of experience in assistive technology service delivery. From 2000 to 2010 she was, as a wheelchair and seating clinician, integral to the Rehabilitation Engineering Research Center on Wheelchair Transportation Safety. She made extensive contributions in knowledge translation and development of website resources and conducted research on the impact of the WC19 wheelchairs on the safety of students who ride in wheelchairs on school buses.

TUESDAY, DECEMBER 8, 2015 | 7PM - 8PM (ET)

Optimizing Power Mobility: Programming, Tracking, Suspension and More

SPONSORED BY PERMOBIL

AMY MORGAN, PT, ATP

Many factors go into adjusting how a power wheelchair handles and drives. The drive wheel configuration and suspension of the base will change the way a wheelchair performs in various environments. Additionally, how that chair is programmed also has a major impact on overall performance. This webinar will discuss how base characteristics and programming adjustments impact the way a power wheelchair drives. We will also review various tracking technologies and their impact on power wheelchair driving. Finally, ongoing training strategies and tools will be discussed to help clients continue to optimize their driving skills.

Amy Morgan PT, ATP, has been involved in wheelchair seating from the beginning of her career as a physical therapist. She worked for Cincinnati Children's Hospital in Cincinnati, Ohio, where she was involved in outpatient and inpatient settings. This experience allowed her to work with a variety of patient populations. Additionally, Morgan was the lead therapist in the wheelchair clinic, which included evaluation for equipment as well as power mobility training for young children. She has presented lectures nationally and internationally. Morgan is currently the national clinical education manager for Permobil, Inc. and is an active member of RESNA and APTA (Pediatrics and Neurology Section Member).

THURSDAY, DECEMBER 10, 2015 | 5PM - 6PM (ET)

Maximizing the Functional Potential of Manual Wheelchair Users: Translating Research into Daily Practice

IAN RICE, PHD, MS, OT

Manual wheelchair prescription and selection can be a daunting task with the ever-changing needs of the active end user. The purpose of this webinar is to translate physical activity and biomechanical research to identify best practices to assist health care professionals in making technology selection decisions. Additionally, the real-life experiences of long-term active wheelchair users will be incorporated.

Ian M. Rice, PhD, MS, OT, is an assistant professor in the Department of Kinesiology and Community Health Sciences, at the University of Illinois, Urbana Champaign. Rice earned his PhD from the University of Pittsburgh in 2010 in rehabilitation science and technology with a focus on biomechanics. His research interests include the study of interventional and adaptive technologies to promote injury prevention, physical activity, and full-life participation in persons with mobility limitations. Rice has a particular interest in combining motor learning theory, motor control and ergonomic principles to optimize the match between person and mobility device.

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IN THIS ISSUE

CLAUDIA AMORTEGUI

Amortegui has her Master of Business Administration and more than 20 years' 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 experience 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. SEE PAGE 50

MIKE BARNER, ATP, CRTS®

Barner is president of NRRTS. Barner works for the University of Michigan Wheelchair Seating Services in Ann Arbor, Michigan. SEE PAGE 14

ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at the federal and state level. She works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health and disability communities. She graduated from Brandeis University and received her Master of Public Administration from American University. SEE PAGE 48

DON CLAYBACK

Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART). He has more than 25 years of experience in the Complex Rehab Technology and Home Medical Equipment industries as a provider, consultant and advocate and is actively involved in industry issues and a frequent speaker at state and national conferences. SEE PAGE 32

LAURA COHEN, PHD, PT, ATP/SMS

Cohen is the principal for Rehabilitation & Technology Consultants in Arlington, Virginia. She is the executive director of the Clinician Task Force (CTF), a national group of seating and mobility clinicians working to influence Medicare and Medicaid coding, coverage, and payment policies for complex rehab and assistive technology devices. The CTF provides clinically relevant information about seating and wheeled mobility device assessment and decision making to policymakers to ensure appropriate access for individuals with disabilities. SEE PAGE 54

AUTUMN GRANT

Grant, a former Ms. Wheelchair America, is a consumer advocate from Massachusetts. SEE PAGE 16

TAMARA KITTELSON-ALDRED, MS, OTR/L, ATP

Kittelson-Aldred is a Friend of NRRTS who lives in Missoula, Montana. SEE PAGE 26

KAY KOCH

Koch has more than 30 years seating and wheeled mobility experience. She is a graduate of the Occupational Therapy program at The Ohio State University. Her focus has been on seating positioning, wheeled mobility and assistive technology solutions. An ATP since 1996, Koch has spent her years as an occupational therapist in various roles, from clinician to manufacturer rep, DME reviewer and as a Joint Commission surveyor. Koch current works for The vanHalem Group, a division of VGM. SEE PAGES 40 & 44

MICHELLE L. LANGE, OTR/L, ABDA, ATP/SMS

Lange is in private practice, Access to Independence, in Arvada, Colorado. She is a Friend of NRRTS and is the DIRECTIONS Clinical Editor. SEE PAGE 36

DAVE MANCINI, ATP, CRTS®

Mancini is an at-large director for NRRTS. Mancini works for Browning's Health Care in Melbourne, Florida. SEE PAGE 26

ANN QUIGLEY

Quigley is sales manager for Motion Concepts. Quigley is also a Friend of NRRTS. SEE PAGES 20

ANDREA VAN HOOK

Van Hook is the communications and marketing manager at RESNA. She has more than 18 years' experience working on successful, award-winning campaigns that promote equal access to health care, education and employment of diverse populations, including people with disabilities. SEE PAGE 58

JENNIFER WOLFF, OTR/L

Wolff is the manager of United Spinal Association's Advocacy Alliance. Wolff is an occupational therapist and wheelchair user from Waverly, Iowa. SEE PAGE 48

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LETTER TO THE EDITOR

Dear Editor,

The NRRTS mission statement reads: "NRRTS enhances the stature of the NRRTS Registrant through the persistent achievement of rigorous professional and ethical standards; and through industry cooperation and advocacy." This critical line speaks to the emphasis on the "greater good," and challenges our industry to gather in this safe place where all interested parties can cooperate and advocate together to improve the credibility and viability of our industry as a whole. CFONs (Corporate Friends of NRRTS) should adhere to this ideal.

When one CFON, with NRRTS approval and publication, submits a position paper that is potentially inflammatory or offensive to another CFON, then the entire organization and membership suffers a blow. I am referring to the recent CFON Focus column in DIRECTIONS titled "The Perfect Fit is Ever-Changing; the Dangers of Contoured and Custom-Molded Seating."

Regardless of the validity of the science behind this paper, the article can be construed as a deliberate attack on competitive CFON membership, in fact any CFON that manufactures contoured or custom molded seating (I count 15). Everyone knows the potential risk of all seating options when not applied correctly and safely. The under/over-inflated or punctured air immersion/envelopment style cushion presents potentially the most dangerous of examples. We don't need expensive theoretical computer modeling to recognize that.

The challenge to our industry is the outliers; manufacturers of substandard quality products and providers who don't share the vision of a CRT separate benefit category that ride on the coattails of NRRTS Registrants and CFONs. Save the offensive energy and content to confront those shady elements at the fringes of our industry that continue to manufacture substandard products and deliver questionable service.

DIRECTIONS, like all periodicals, states "The opinions expressed in DIRECTIONS are those of the individual author and do not necessarily represent the opinion …" I appreciate the tight rope that is walked regarding this policy. I only ask that CFONs and NRRTS stay true to the NRRTS mission in word and action.

Humbly yours,
Tom

Thomas R. Hetzel, PT, ATP
CEO
Aspen Seating LLC
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Letter TO THE EDITOR

the COMPLETE SOLUTION

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Tell You

WRITTEN BY: MICHAEL BARNER, ATP, CRTS®

As I sit here to write my first article as the president of NRRTS, I must say I'm honored, extremely humbled and honestly a bit nervous.

Honored that I represent a Registry that truly represents the best of the best in our industry.

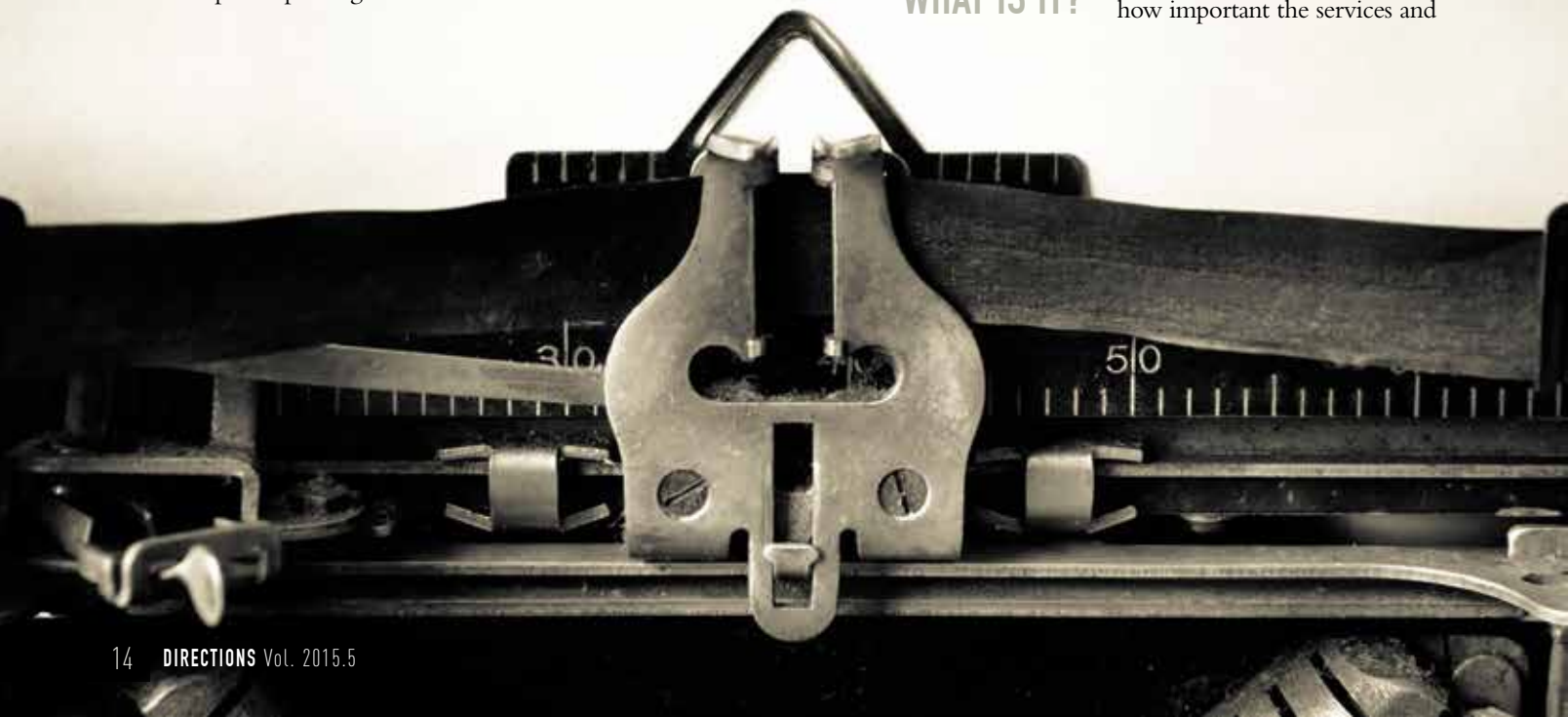
Humbled as I think of all the amazing people who have held this position in years past, including our current past President Mike Osborn. Mike is NRRTS; he lives it every day and has represented all of us with a high level of integrity and commitment. I think his last article speaks volumes to this. Thank you, Mike!

A bit nervous, as I think of all of the daunting challenges that face our industry, companies, personal careers and, more importantly, the people we serve. To say the least, we have a lot of plates spinning.

This summer, I was speaking with a close family friend of mine and her husband, and the conversation turned to how our careers were going. They are both successful independent business owners. She is in real estate, and he has a construction company. Of course, I'm in Complex Rehab Technology (CRT). After the usual explanation of what that is and how our industry works, the inevitable was said: You have to be crazy to work in a business model like that. You don't get paid for 90 – 180 days, or more? You only get paid what the insurance thinks you require and not what your labor plus overhead is? And they can come back and take your money just about anytime they want, for just about anything they can think of, like a clerical error? **You have to be CRAZY!**

MAYBE I'M TOO CLOSE TO THE SITUATION TO SEE THE OBSTACLE IN UNDERSTANDING IT, YET MY FRIENDS GOT IT RATHER QUICKLY, SO IT CAN'T BE THAT. SO WHAT IS IT?

Then I started explaining to them who the people were we serve and how important the services and



ur Story

WE MUST TELL THE STORY WITH OUR CONSUMERS AND TELL IT FOR THEM WHEN THEY ARE NOT ABLE TO DO SO THEMSELVES.

equipment are to their independence. They started to understand and even related to a family member who had muscular dystrophy years ago and had passed away. I then proceeded to explain all of the battles we face in getting our customers the equipment and the pending cuts we are facing in reimbursement via policy change. They actually started to get a bit upset, and the light bulb once again went off. How do we get the policymakers and insurance companies to understand this? I mean a couple of hours, and I have two people who had no clue of what CRT is ready to go to battle with us. Maybe that is it, get them on a beach somewhere with a few beverages. Is that all it takes…?

Honestly, to me it seems quite simple: people have a diagnosis or injury that requires equipment to restore what was lost due to that diagnosis or injury. Maybe I'm too close to the situation to see the obstacle in understanding it, yet my friends got it rather quickly, so it can't be that. So what is it?

I truly believe it comes down to what happened that day on the beach. We must tell our story. We must tell it consistently across the country and frequently. And NRRTS is here to help.

NRRTS has many resources available for you to help tell that story. We have an industry leading staff with an executive team just a phone call away; the website has tons of information available; the onelist to use to collaborate with others; educational programs to help sharpen the sword; and we have a host of great partners and colleagues such as NCART (Access2CRT.org), RESNA, VGM/US Rehab, MED Group, AAHomecare, etc., that are all in the battle with us and willing to help you with just a click or phone call. So what are you waiting for? Go tell your story! Or are you just crazy enough to think you can't make a difference?

We must tell the story with our consumers and tell it for them when they are not able to do so themselves. After all, isn't that what we truly do, advocate for our customers? Even if you don't think you're advocating, you are. When you send in that prior authorization request to obtain the equipment and services for your customer, you're advocating for them. Now I'm suggesting that we just need to expand that a little and rather than asking for a prior authorization from the insurance, tell the same story to your state official, congressman, or senator. Why not? They work for you. Oh, and maybe make them foot the bill for the conversation on the beach.

Now go tell that story and don't forget to let NRRTS know how we can help you.

With great respect for what you do every day,

Michael B.

CONTACT THE AUTHOR

Mike may be reached at mkbarner@med.umich.edu.

EXPAND YOUR CIRCLE … REACH OUT

WRITTEN BY: ROSA WALSTON LATIMER

Autumn Grant, a former Ms. Wheelchair America, admits that her work is very important to her as is her family and her "fur babies" – two dogs and three cats. However, she quickly adds, "Advocacy is also a big part of my life."

Her active role in advocating for individuals who use Complex Rehab Technology (CRT) began when Grant was chosen Ms. Wheelchair Massachusetts in 2006. Her individual platform for the event was "Independence through Education." She immediately began educating Massachusetts lawmakers about issues that those with disabilities face, appearing at a rally at the Massachusetts State House. The purpose of the demonstration was to gain support for a bill that would grant rights and higher wages and benefits to personal care attendants for the disabled.

The following year Grant was selected Ms. Wheelchair America and expanded her advocacy activities to the national level. "Between being Ms. Wheelchair America and being introduced to NRRTS and its mission and values, my involvement greatly increased."

Autumn Grant, Ms. Wheelchair America 2007

Autumn with fiancé Kenny Bergeron and their dogs, Henson and Zoe

"NOW THROUGH MY ASSOCIATION WITH NRRTS, I'M CONNECTED ALL ACROSS THE COUNTRY. THIS EXPERIENCE GIVES A FULLER MEANING TO MY ADVOCACY EFFORTS. I'VE LEARNED THAT OTHERS HAVE NEEDS SIMILAR TO MINE; HOWEVER, SOME ARE VERY DIFFERENT.

"I have had the opportunity through the CELA event and other events to meet with representatives in Washington regarding CRT," Grant said. "At one time my focus was on my Massachusetts representatives and senators trying to get them involved." She soon realized these efforts were not enough. "There were many more people I could share my story with and get the information to a broader audience."

Grant was diagnosed at the age of 10 with limb-girdle muscular dystrophy. This life-changing event came at a time when the young girl had been very physically active and although generally the muscle weakness of the disease is slowly progressive, the effects on Grant's life are ever-present. Soon after earning her Bachelor of Arts from Providence College, graduating summa cum laude, Grant began using a wheelchair. Four years later she received her Master of Arts in Higher Education Administration from Boston College.

"I have faced situations when I had to fight for the equipment I needed," Grant explained. "I've gone through the rejection and appeal process and dealt with the out-of-pocket expense of getting the equipment I had to have." She described the difficulties she experienced when the technology wasn't quite right, "When I received my new power wheelchair over a year ago, I was in pain all day. I'd get home and just want to get out of my chair and go to bed."

Through this experience Grant learned that the challenge of correcting the situation was shared by her and the durable medical equipment dealer. This

experience made CRT advocacy very personal. "I understood we both had certain responsibilities. I learned to advocate for myself. I realized it is my right for my equipment to meet my needs." Grant realized she had become part of the group for whom she once advocated.

"My story is similar to a lot of people in the fact that if it weren't for CRT I wouldn't be working," Grant continued. "I would be at home. If I were working it would be part time, because I wouldn't have the stamina or comfort to be at work all day. Her current responsibilities as associate director of Academic and Student Affairs for the College of Professional Studies at Northeastern University in Boston, require a commute into Boston weekdays.

Grant describes her hour-long commute via commuter rail to and from Boston as one of her greatest challenges. Even though there is a station only three minutes from her job, twice a day she must negotiate the fluctuating width of the gap between the train and the platform. If the gap is too wide to negotiate safely, she has to use the next station further away."

"This is something I face every day I go to work," she explained. "That gap can make it very difficult for me to get off and on the train in my power chair. Most times the conductor is helpful."

Grant has made phone calls trying to get the situation corrected, with no success yet. "The tracks are owned by Amtrak, but they don't own the station platforms. The issue is often discussed, but unfortunately it will probably take someone getting hurt to get it fixed."

Grant continues to manage the situation although she admits it can be scary, "I'm certainly not driving to Boston!"

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Speaking at a Ms. Wheelchair America event.

Autumn in front of the Capitol in Washington, D.C.

EXPAND YOUR CIRCLE ... REACH OUT
(CONTINUED FROM PAGE 17)

"Even though I am in a very large city daily and take a commuter rail, I don't often come in contact with someone else in a wheelchair," Grant explained. "Now through my association with NRRTS, I'm connected all across the country. This experience gives a fuller meaning to my advocacy efforts. I've learned that others have needs similar to mine; however, some are very different. Regardless, there are many who do not have the resources or the means to get the help they need. I'm driven by helping people. If something doesn't have that spin on it, it isn't worth it to me."

> "IT DOESN'T TAKE GOING TO WASHINGTON TO MAKE AN IMPACT. THE MOST IMPORTANT THING TO DO IS SHARE YOUR STORY WITH FRIENDS AND FAMILY."

"My first trip to 'The Hill' [Capitol Hill in Washington, D.C.] was with NRRTS," Grant said. "That experience was very eye-opening! I don't know what I was expecting, but we had all gathered together and there was close to one hundred of us. So you think we'll make this big impact. However, we weren't the only group of a hundred people. Others were there, and their cause is just as important to them as ours is to us."

Grant realized through this experience that the House and Senate staff members were meeting with different groups all day long. "That's a staffer's job, but I realized how overwhelming that must be for them. I'm sure they want to do all of it – to help everyone, but that just isn't possible."

At this point in her first trip to Washington, Grant determined that CRT advocates needed to make a much bigger impact. "We won't get it done with a one-time, annual visit. There has to be follow-up: the bigger our network, the bigger the impact. We need to form that network. We need to help people with physical disabilities share their experiences more."

Now Grant has made more than a half-dozen trips to Washington. "I enjoy all aspects of it. It is exciting and exhilarating to be with like-minded people sharing a common goal. Certainly these efforts are rewarding, but it isn't the only thing you can do," she explained. "It doesn't take going to Washington to make an impact. The most important thing to do is share your story with friends and family."

Grant believes the sharing of individual circumstances and challenges will prompt others to become advocates. "There might be something out there that will improve your situation; that will

Meeting with a congressional staffer.

allow you to do things independently and more comfortably. People will hit a wall and not know where to go next, and many give up. If you connect with the right people, they may show you some options or help you find solutions that will apply to your situation."

"NETWORKING IS VERY IMPORTANT. EXPAND YOUR CIRCLE, REACH OUT. CONTACT YOUR LOCAL AND STATE AS WELL AS NATIONAL REPRESENTATIVES. TAKE TO FACEBOOK AND TWITTER. THIS CAN BE DONE FROM ANYWHERE BY ANYONE."

Grant has initiated "Advocacy Saturday," setting aside time on Saturdays to update information with a CRT Advocates Facebook group. She also uses this time to stay in touch with health care liaisons for House representatives and senators. "This is my way of keeping this issue in front of these decision-makers. I often get a response thanking me."

Grant strongly believes it is important to share individual, personal stories. "CRT industry leaders can go in day after day to garner support, but if we tell the impact CRT, or of not having CRT, has on our lives, hopefully those stories will be compelling enough for a staffer to take to his boss."

Rolling down the halls on Capitol Hill with Susan.

The former Ms. Wheelchair America invites everyone to participate in CRT advocacy efforts. "Networking is very important. Expand your circle, reach out. Contact your local and state as well as national representatives. Take to Facebook and Twitter. This can be done from anywhere by anyone."

CONTACT

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OH, CANADA

QUIGLEY'S CAREER SPANS TWO DECADES WITH GROUP OF NORTH AMERICAN ENTREPRENEURS

WRITTEN BY: DANETTE BAKER

Like many in the industry, Ann Quigley's introduction happened quite coincidentally. But after taking that proverbial leap of faith, Quigley now leads Motion Concepts' customer service and sales division.

DIRECTIONS recently had the opportunity to visit with Quigley and learned about "the best decision she ever made."

HOW DID YOU BECOME INTERESTED IN THE MEDICAL EQUIPMENT INDUSTRY?

Getting in the medical industry was not my plan. It really happened accidentally or by "fate" as I like to call it. I was working for a well-known land developer in the Buffalo, New York, area renting office space, handling rental contracts, etc. In 1992, we decided to start an executive office/service center, as these were becoming a very popular and cost-effective way for new businesses, or satellite offices, to operate. We rented one 10 foot by 14 foot office to a small company called Genus Medical (Tarsys). Genus quickly monopolized most of our executive team's time with its fast growth under the leadership of Pat Suda. For those of you who know Pat, you know how "pushy" she can be. I say that affectionately, because we instantly had a connection. Pat offered me a job on several occasions. I declined as I was very attached to my boss who had become a mentor and like a father to me. However, Pat asked me one more time if I would like to come and work for her, and I really started to think about it. While I loved my job, it was a family-owned Italian business, and I knew I was only going to go so far. I saw how fast Genus was growing, and I decided to take a leap of faith. It ended up being the best decision I ever made.

GETTING IN THE MEDICAL INDUSTRY WAS NOT MY PLAN. IT REALLY HAPPENED ACCIDENTALLY OR BY "FATE" AS I LIKE TO CALL IT.

WHAT ARE SOME OF THE MOST SIGNIFICANT MILESTONES IN YOUR CAREER?

I started as a receptionist with Genus Medical and quickly worked my way to sales administrative assistant. The company was only three years old when Invacare bought it in 1995. Shortly thereafter, several of us from Genus started a new company and called it MedBloc. MedBloc consisted of a "block" of medical manufacturers, and we were going to be the sales and distribution arm. Companies that bought into the concept included Motion Concepts, PDG, Dolomite, Waverley Glen and FSA (Pressure Mapping Systems). Motion Concepts quickly monopolized the majority of our time and eventually bought out the other companies.

Interestingly, Motion Concepts sort of happened "accidentally" too. David Harding and his team had developed a tilt product they were selling in Canada. It shipped out in a small box and consisted of an actuator and mounting bracket. They were pleasantly surprised when it really started to sell and thought, "I wonder what we could do with this in the U.S.? This could be another power positioning company." Needless to say, it worked, and the rest is history.

When we started Motion Concepts, there were only three of us — all from Genus — our accounting supervisor and our general manager. Who was going to handle areas such as education, technical service, etc.? Who was going to handle customer service and find the sales force? Well, by process of elimination, that's how my role with Motion started. Throughout the years, I went from being "the" customer service person to hiring and training a wonderful team of customer service representative, as well as hiring the best rehab sales team in the industry.

In 1996, I was promoted to sales manager, as it was really a role that I had evolved into over the years anyway. We had many of the same reps that

"I WONDER WHAT WE COULD DO WITH THIS IN THE U.S.? THIS COULD BE ANOTHER POWER POSITIONING COMPANY." NEEDLESS TO SAY, IT WORKED, AND THE REST IS HISTORY.

worked for us with Genus Medical now with us at Motion Concepts. Many of them are still with us today! That says a lot about the product and teamwork we have. I am very proud of the fact that I have worked for the same group of Canadian entrepreneurs in my 23-year career in this industry.

WHAT AREAS OF THE INDUSTRY HAS MOTION CONCEPTS TAKEN A LEAD IN?

Power positioning is our culture and in our blood. We have some of the same engineers and designers as we did with Genus Medical. We even have some of the same assemblers and production staff. Cumulatively, we have thousands of years of tribal knowledge.

For many years it has been our policy to listen to the therapists and clinicians and see what they would like to "envision" for their clients. Some of our designers actually have worked in clinic with patients so they truly understand "real world" applications – hence, our tagline "Solutions … For the Wide Range of Client Needs." If you can dream it, we can design it. We don't ever want to hear a therapist say, "If only my patients could have this it could make their lives so much better." Just let us know, and we will help make their lives better too.

Some of the groundbreaking products that we have designed are:

Independent Transfer Solutions such as our Latitude and Attitudes.

Condition Specific Solutions like bariatric seating systems that are effective and durable for this client population. We also do many clinical presentations throughout the year on bariatric applications. We affectionately call Stephanie Tanguay, OT, our clinical education specialist, the "Bariatric Whisperer." We have also led in the design of anterior tilts, lateral tilts and horizontal flatbed tilts.

On-Board Programming Solutions, including the M270. This lets the therapist make configuration changes without the need of additional electronic equipment like programmers, laptops, etc.

(CONTINUED ON PAGE 22)

OH, CANADA!
(CONTINUED FROM PAGE 21)

Universal Platforms so you can easily take the system from one chair to another if the client doesn't like how the power base performs.

On-Chair Seating – I believe we were the first to provide a wide selection of on-chair ergonomic backs and cushions. We have the most complete line of seating and positioning in the industry. Other manufacturers have had to buy other companies to round out their portfolio. We design and create what we need to round out ours.

WHAT'S ON THE HORIZON FOR MOTION CONCEPTS?

We are a solutions company, so we are always evolving our product line. We introduced our Ultra Low Maxx system last year. We also introduced the Libra seat cushion, which is rapidly growing. But I think the biggest thing we did this year was when we partnered with a longtime industry friend of ours, Cody Verrett, and launched the ROVI X3 power base. That really was the missing link for us. Until now, we have always been an aftermarket player, which, admittedly, added to the delivery time of the power chair. Now

BUT I THINK THE BIGGEST THING WE DID THIS YEAR WAS WHEN WE PARTNERED WITH A LONGTIME INDUSTRY FRIEND OF OURS, CODY VERRETT, AND LAUNCHED THE ROVI X3 POWER BASE. THAT REALLY WAS THE MISSING LINK FOR US.

that we have combined our power positioning with a power base that the company was instrumental in designing, our lead times have been drastically reduced on our orders. The ROVI X3 power base is stocked right in Buffalo so the lead-time is only days. We all know the efficiency – the ETD (evaluation to delivery) times are synonymous to price and function in the industry right now. Now we are able to offer one purchase order, one invoice and one shipment – yet another "solution" that we have come up with.

I WOULD ALSO LIKE TO SEE THE CONSUMERS BECOME BETTER ADVOCATES. I DON'T THINK THEY UNDERSTAND THEY HAVE A VOICE AND IT NEEDS TO BE HEARD!

What ROVI and Motion Concepts have today is a new power base referred to as "elegantly simple," combined with the power positioning options that clinicians and ATPs have come to expect from Motion Concepts.

Other goals that we are moving toward include having a worldwide presence as we expand our product offering; the addition of specialty bases to enhance the function of our specialty products like bariatric, pediatric and transfer solutions; and further electronic enhancements to help simplify the interface for the consumer and/or caregiver.

WHAT ARE THE FUTURE CHALLENGES FOR MOTION CONCEPTS AND THE INDUSTRY AS A WHOLE?

Motion Concepts has been very fortunate to continue to evolve as a company, even in this crazy industry. I think a big part of this is that we are small and can react quickly to changes in the marketplace. Even though we are owned by Invacare, we have remained fairly independent day-to-day and still enjoy strong relationships with some of Invacare's competitors, mainly Quantum Rehab and Sunrise Medical. This is key to the success of Motion Concepts.

As price cuts are constantly happening, we are looking for cost-cutting measures from the funding supply as well as the availability of generic competitive equipment. Funding is important if the user's needs are specific and these systems are usually more expensive to acquire. Cookie cutter solutions can be had for less, but don't provide the proper operation needed for most applications. We are not known as a cookie cutter company, we are more of a tailor creating a suit for an individual. We never want to lose the ability to do this for the consumers that depend on these chairs.

WHAT CHANGES WOULD YOU LIKE TO SEE IN THE INDUSTRY?

Mostly, I think we need changes to

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OH, CANADA!
(CONTINUED FROM PAGE 23)

the monetary prescribing and buying practices in the industry. These practices need to evolve, so they are not so influential in driving the design, development and availability of inferior products.

NRRTS has done an amazing job in helping create "awareness" on the importance of Complex Rehab Technology and the need for it to our politicians. As an industry, we need to focus on this even more than we do. More people need to get involved. This affects all of us. I would also like to see the consumers become better advocates. I don't think they understand they have a voice and it needs to be heard!

WHAT HAS KEPT YOU WORKING IN THE INDUSTRY?

We have an amazing leadership team, David Ciolfe and Joe Bornbaum, who impress me every day with their business minds and talents. I am blessed to be able to have worked with these entrepreneurs for the past 23 years. I have also been very fortunate to work with Brad Peterson for the last 12 years. We affectionately refer to each other as "work husband and wife" as we talk many times throughout the day discussing opportunities, issues, etc. While we may not always agree, we always come to an agreement and understanding. It is really a fantastic working relationship.

At the end of the day, this is a wonderful industry to work in even with all of the challenges. Also, I honestly love people. I love dealing with people, and I love helping people. I know it sounds corny, but it's true. Knowing that we are able to help change someone's life for the better is very rewarding. Knowing I can get up in the morning and put two feet on the floor gives me a sense of appreciation for what people can do who cannot.

ALSO, I HONESTLY LOVE PEOPLE. I LOVE DEALING WITH PEOPLE, AND I LOVE HELPING PEOPLE. I KNOW IT SOUNDS CORNY, BUT IT'S TRUE.

WHAT OTHER ROLES DO YOU HAVE IN THE MEDICAL EQUIPMENT/COMPLEX REHAB INDUSTRIES (BOARDS, ASSOCIATION MEMBERSHIPS, ETC?)

I am a FRIEND OF NRRTS, and I also help with fundraising for a local nonprofit organization that is associated with Duchesne's muscular dystrophy.

WHAT DOES A TYPICAL WORK DAY/WEEK LOOK LIKE FOR YOU?

Well, what I plot out the day to be like in the morning and what actually happens throughout the day are two very different scenarios. We have a very small, busy office, so it can quickly spin out of control.

In the morning I look at my list of tasks to do from the previous day and attempt to get those done before the phone starts. As I am in charge of customer service and sales, I am pulled in many different directions all day long. I could start the day with a customer service meeting to make sure everyone is up to date on new products being released or product enhancements. Lunchtime might be a meeting out with a local dealer or sales rep (or even a conference call that couldn't be rescheduled), and afternoons could consist of a marketing meeting, production update or conference call with our sales force. In addition, our reps are calling in throughout the day while they are in a clinic or at a dealership and they need to have answers to questions, so they need to be dealt with immediately.

WHAT'S LIFE OUTSIDE OF THE 9 TO 5 LIKE FOR ANN QUIGLEY?

I have recently started morning Pilates classes three days a week. I am finding they really help me keep my focus during the day. I love to go for walks and gardening. Basically doing anything that keeps me out in the fresh air. That is, until the Buffalo snow starts flying. One thing that I would love to be able to do in the near future is travel more. The world is a beautiful place. We need to remember to smell the flowers!

CONTACT
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NOTES FROM THE FIELD

MANCINI FINDS IT'S ALL ABOUT RELATIONSHIPS, ADVOCACY

WRITTEN BY: JULIE BARNETT

David Mancini knows exactly what makes his work worthwhile.

Mancini, ATP, CRTS®, is a newly elected member of the NRRTS Board of Directors who works for Browning's Pharmacy and Health Care in Melbourne, Florida. After 20 plus years in the medical equipment industry, he might not recall exactly how he became interested in the field, but the relationships forged with patients and families of patients mean everything.

"I enjoy every aspect of my job," Mancini said. "What could be better than going to work every day knowing that you will make a difference in someone's life today?

"I have worked in the medical equipment industry for over 20 years, and I have worked my way up from delivery technician to ATP," he continued. "I enjoy the relationships with my clients over the years from their war stories to stories about their families and grandchildren."

"THE MONTHLY WEBINARS ARE ALWAYS ABOUT CURRENT TOPICS, AND THEY ALWAYS HAVE THE BEST PRESENTERS. I ALWAYS COME AWAY LEARNING SOMETHING NEW."

Mancini says even better than feeling like a welcome member of the family is the joy he can bring with much needed equipment.

"This is the best part of the job – it's like you are part of their family now. The best feeling in the world is to see that big smile when you walk in the door," he said. "The same goes for a new, shiny wheelchair. When you walk in and see that big smile, it makes your heart melt. I don't remember what interested me in this field, but that's what makes it worth it."

Mancini's daily duties include assessing patients for complex rehab equipment, and working with therapists to provide the best equipment to give individuals with disabilities independence in their home, as well as in the community.

He most enjoys working with the more challenging seating clients.

"I guess my biggest influence was when I worked at Parkwood with Steve Fox," he recalled. "I was a delivery technician, and he really showed me what complex rehab was all about. I think that's when I realized that I wanted to be a seating specialist and work with the most difficult and challenging clients."

Mancini has been a NRRTS Registrant since 2001, and he has found that the numerous educational opportunities help keep him fresh.

"Being a NRRTS Registrant has been great for me over the years keeping me informed about our industry," he said. "The monthly webinars are always about current topics, and they always have the best presenters. I always come away learning something new."

And now as a board member, he hopes to better advocate for clients. His co-workers, Michele Gunn, ATP, CRTS®, and Thana France, ATP/SMS, CRTS®, have also served on the board, with France still serving as at-large director.

"I am very interested in trying to make a difference. That is why I want to be involved with visiting Capitol Hill. Thana and Michele have been on the board for several years and felt I could do my part by participating as a board member.

"The biggest challenge over the years has been reimbursement, yet still trying to provide the best equipment for the individual," he continued. "Insurance companies don't see the clients like we do; unfortunately they are just a claim number. If they had to go into the client's home and see what we see every day, I think they would not be so quick to deny a claim just for a set of codes."

Mancini said he has done everything in the industry from driving to working

"WHERE WOULD THIS INDUSTRY AND OUR CLIENTS BE IF WE DIDN'T KEEP FIGHTING FOR THEM?"

for a manufacturer as a sales manager, but that's still not as rewarding as dealing with patients day-to-day.

"I have helped hundreds of clients over the years with their mobility and seating needs, but I still feel like something was missing," he said. "I ran for the board, so I could make a difference on the advocacy side and keep fighting for disability rights. I love my job, but I wanted to be able to help on the other side too and be an advocate for people who don't have a voice.

"Where would this industry and our clients be if we didn't keep fighting for them?"

Mancini has been married for 30 years and has three children and three grandchildren, with another on the way. He enjoys all sports including football and hockey, which he played until just a couple of years ago.

Another favorite hobby is boating, which he does with his wife just about every weekend.

And fortunately for him, and his clients, he derives just as much joy from his work day.

"I love going to work. It's not a job for me, it's fun," he said. "If I couldn't be doctor or help people on that end, this is next best thing. It's pretty cool. Besides, I'm too old to be a doctor."

CONTACT

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WE HAVE TO INVEST OURSELVES

WRITTEN BY: ROSA WALSTON LATIMER

Tamara and a little guy who is very excited to have his first wheels.

The phrase, "We have to invest ourselves" is the driving force behind annual trips to Peru by a team of therapists sponsored by Eleanore's Project. The non-profit organization was founded by Rick Aldred and Tamara Kittelson-Aldred, who live and work the majority of the time in Missoula, Montana. "Our personal investment of time and expertise will help empower the people who live in Peru to do this work," Kittelson-Aldred said referring to the group's efforts to provide wheelchairs and training in the South American country.

In addition to her work with Eleanore's Project, Kittelson-Aldred is an occupational therapist, a RESNA certified Assistive Technology Professional, a Seating and Mobility Specialist, and a Friend of NRRTS. She currently maintains a small clinical practice focusing on wheelchair seating and mobility integrated with 24-hour postural care.

Eleanore's Project was created by the Aldreds in memory of their youngest daughter. Eleanore Kittelson-Aldred was born in 1989 and died just before her 12th birthday in 2001. "Our daughter was a wheelchair user all of her life and was profoundly deaf," her mother explained. "My life as Eleanore's mother taught me so much that I didn't learn in school or as a practicing therapist for 11 years before she was born. Being her mother taught me the passion for empowering families to make changes for their kids."

"The efforts with which we are involved are based on what we as a family and I as a therapist learned were important during our time with Eleanore," Kittelson-Aldred continued. Eleanore's Project is an all-volunteer, family-based organization.

"WE HAVE WORKED WITH MOTHERS, FATHERS, AUNTS, UNCLES, GRANDMOTHERS AND GRANDFATHERS WHO HAVE TRAVELED LONG DISTANCES, OFTEN CARRYING THEIR CHILDREN,"

Eleanore's Project takes a team of approximately 20 people once a year to Peru and conducts wheelchair clinics working side-by-side with Peruvians. Members of the team include occupational therapist students from St. Catherine University in St. Paul, Minnesota, (Kittelson-Aldred's alma mater) and a faculty member as well as therapists with extensive experience in wheelchair mobility. Everyone involved must also be trained in 24-hour postural care.

"We have worked with mothers, fathers, aunts, uncles, grandmothers and grandfathers who have traveled long distances, often carrying their children," Kittelson-Aldred wrote after a recent trip. "After a visit to our clinic these children and families finally have a way to get around and engage in new experiences. In addition, information about proper nighttime positioning for each child will improve their sleep, health and body shape."

The group conducts wheelchair demonstration clinics that teach appropriate modifications and also how to assess wheelchair users for 24-hour postural care including nighttime therapeutic positioning. "This is very important and families are a vital part of our team," Kittelson-Aldred explained. "The 24-hour postural care prevents or improves problems such as scoliosis. We

Lucho from Nasca, Peru and Ed from Washington collaborate to get the job done!

Working on her own wheelchair in the clinic, she is learning to care for it at home.

As she moved in her wheelchair for the first time, Zariela proclaimed "Mama, I'm walking!"

look at the whole picture paying attention to the position of the patient when he or she is not in a wheelchair."

The clinics include a full-scale fabrication set up with necessary tools and sewing machines. "We have everything we need to make such things as seating systems and positioning pieces. We have donated sewing machines to our partners to use throughout the year.

"In preparation for the project visit each year, our partners in Peru do evaluations and measurements so we can then raise money and arrange to send a shipment of chairs for specific people," Kittelson-Aldred said. "We have invested a great deal of time and energy in training and mentoring our Peruvian partners."

These Peruvians are also trained to take care of wheelchair repairs and adjustments after the U.S. team has come home. "This is the only way I would consider doing this," Kittelson-Aldred emphasized. "We simply are not going to hand out chairs and not provide a way for ongoing, quality support."

During the first few trips to Peru, Kittelson-Aldred and her team would fit the wheelchairs, but there was little or no support until they returned the next year. In 2007, the group began working with a program called Yancana Huasy which means "house of work" in an indigent language of Peru. The program obtained funding from a foundation in Spain and built a biomechanical workshop in 2010. "Now, throughout the year when chairs need repair or modification they can take care of it," Kittelson-Aldred said. "Moreover, when we take our shipment down we are typically involved in fitting one-third to less than one-half of the wheelchairs we send. Our shipment this year was 170 wheelchairs, and our team was directly involved in about 50 of those. The Peruvians want us to work with them on the more complicated situations. They work right along with us and continue to do the work after we are gone."

During a recent interview, Kittleson-Aldred told this story:

> During our visit this year, a 20-year-old man was carried into the clinic by his father. The young man had never had a wheelchair before we were able to set him up. In situations such as this, the patient has had no access to therapy or mobility, so by the time they can get some help they have very complex body shapes. We can train the family in 24-hour postural care and even if there is a wait for a wheelchair, at least the patient can receive care and help with positioning. When they are finally able to get a chair, the patients are in much better health. They aren't prone to related issues and are much better able to sit in a chair. Parents are so excited to learn they can do postural care themselves. They are thrilled to help their family members!

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WE HAVE TO INVEST OURSELVES
(CONTINUED FROM PAGE 29)

"All of our referrals in Lima come from Yancana Huasy," Kittelson-Aldred explained. "The facility originally provided a broad spectrum of services. We have been working with this group for eight or nine years and now they are doing their own outreach trips. Their staff – a technician, occupational therapist and social worker – goes out into the jungle and teaches about 24-hour postural care, does measurements and provides appropriate wheelchairs. Peruvian people helping Peruvian people. I feel wonderful about this!

"Many of the wheelchairs we provide in Peru are Complex Rehab Technology (CRT) chairs and our team is highly skilled in dealing with this type of equipment," the experienced therapist said. "However, again the focus on the 24-hour postural care plays an important role. If we can help keep bodies straight and help kids grow straight then we can keep the wheelchairs simpler."

SHE EMPHASIZED THAT ELEANORE'S PROJECT IS ALWAYS LOOKING FOR CREATIVE INDIVIDUALS WHO "LOVE DOING CRT; ENJOY TEACHING AND MENTORING OTHERS; ARE GOOD TEAM PLAYERS; AND LIKE TO THINK OUT OF THE BOX."

www.eleanoresproject.org.

Eleanore's Project also spends time during these annual visits in Nasca, a city approximately six hours south of Lima. Working with a Canadian-based charity, Equip Kids, the project is helping develop a new program.

left: Arriving at the venue for the wheelchair clinic - this lucky teenager will get his first wheelchair.

above: Many children and youth arrive on their mother's backs.

below: Marco relaxes in a comfy supported lying posture while waiting for his wheelchair to be customized.

bottom: Peruvian therapists practice mat evaluation and taking measurements.

left: Group photos are popular - it often takes a village!

below: A home visit in Lima – wheelchair access is often challenging.

"Outside of Lima situations are very different. There are very few therapists," Kittelson-Aldred said. "We are partnering with a local Lions Club in Nasca that has taken a strong interest in sponsoring kids with disabilities.

"We just spent our first time with them during our trip this year. We trained and continue to mentor some of the men in how to service, maintain and modify wheelchairs."

Kittelson-Aldred also trained some of the Lions Club women in 24-hour postural care so they can continue to provide support and encouragement for families."

Now the Lions Club has purchased some property and is setting up a workshop, so they will have a facility in which to take care of wheelchairs. "This is all very positive," Kittelson-Aldred said.

According to the International Society of Wheelchair Professionals website, it is estimated that more than 300,000 individuals in Peru need wheelchairs.

"Now this group in Nasca can help some of these people get a wheelchair and provide important maintenance and repairs."

Kittleson-Aldred provided this example of the memorable experiences the team has had in Peru:

A 17 year-old girl had juvenile rheumatoid arthritis and lived in a fairly remote village in the Andes. With the intention of getting her daughter to our wheelchair clinic her mother carried the girl on her back and walked three hours to catch a bus that, after a four- to five-hour ride would bring them to where our team was working. The girl was on our list to receive a wheelchair and we expected her on Wednesday, but she didn't come. On Friday, she and her mother showed up.

We learned that on Wednesday the mother had carried the girl to the bus stop only to discover they had missed the bus. She then turned around and carried her daughter back to the village and rested on Thursday. Friday, the mother got up very early and again carried her daughter on her back to the bus stop. This time they caught the bus and after another four-plus hours made their way to the clinic so the girl could be fitted for a wheelchair.

"Things are so different in other parts of the world," Kittleson-Aldred concluded. "These situations are beyond what we can imagine here." She emphasized that Eleanore's Project is always looking for creative individuals who "love doing CRT; enjoy teaching and mentoring others; are good team players; and like to think out of the box." If you are interested in knowing more, go to www.eleanoresproject.org.

CONTACT

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CRT UPDATE

COMPETITIVE BID PRICING FOR CRT WHEELCHAIR ACCESSORIES

WRITTEN BY: DON CLAYBACK

We have a limited window of time to resolve this major access threat and the solution depends on increased engagement by Complex Rehab Technology (CRT) stakeholders as we move through the remainder of this year.

Without specific Congressional intervention Medicare payments for accessories used with individually configured complex rehab wheelchairs will be inappropriately cut by 20 percent to more than 40 percent starting Jan. 1, 2016. This is a result of CMS violating the intent of existing Congressional legislation and inappropriately using Medicare Competitive Bid Program pricing for standard wheelchair accessories to cut payments for complex rehab wheelchair accessories.

If Congressional legislation is not passed to prevent this, there will be devastating consequences to people with disabilities who rely on complex rehab wheelchairs to meet their medical needs and maximize their function and independence. This will not only negatively impact Medicare beneficiaries, but also extends to children and adults with disabilities covered under Medicaid and other health insurance programs as well.

The positive news is that legislation to stop these cuts was introduced in August in the House of Representatives by Rep. Lee Zeldin, R-N.Y.. The legislation is HR 3229. Our collective task is to get as many co-sponsors on this bill and get it passed by Congress and signed by the president this year.

OUR COLLECTIVE TASK IS TO GET AS MANY CO-SPONSORS ON THIS BILL AND GET IT PASSED BY CONGRESS AND SIGNED BY THE PRESIDENT THIS YEAR.

To further highlight the need for passage of H.R. 3229, leading consumer organizations have sent letters of support to Congress. These organizations include the ALS Association, ITEM Coalition, Muscular Dystrophy Association, National MS Society, Paralyzed Veterans of America, United Spinal Association and VETS First. Be sure and share this in your Congressional discussions.

We need all CRT stakeholders and friends to contact their Representative today (and be persistent in their outreach) by following these simple steps:

1.) **Visit the dedicated website** at http://cqrcengage.com/access2crt/HR3229 to view the list of current co-sponsors to see if your Representative has signed on yet. You can also access helpful documents like the position paper and the House of Representatives and Senate letters that were sent to CMS on this issue.

2.) **Call your representative:** If your representative has not signed on, call his/her office using the link on the website. Just supply your home address and your Representative and the contact information will be identified. We have also provided simple talking points that you can use to make your request. While a phone call will be the most effective, you can also send an email. A template message is provided to use as is, or you can modify.

Special Note: As mentioned, a copy of the April House of Representatives letter to CMS is available on the website. Check to see if your representative was one of the 101 signers. These members should be particularly willing to co-sponsor H.R. 3229 since it was necessitated due to CMS' refusal to honor the Congressional request in the letter. Mention this in your outreach.

A national petition has also been created to get the attention of President Barack Obama . The petition calls for these cuts to be stopped. If we get 100,000 signatures the president is required to formally respond to the request. You can access the petition and a link to contact Congress at www.ProtectMyIndependence.com/LearnMore. This is one more vehicle we can use to elevate the awareness and urgency on this accessory issue. After signing the petition, be sure you also use the other link to email your representative.

In your Congressional outreach your follow-up to get a "Yes, I will co-sponsor" answer from your representative is critical. Additional emails and phone calls may be required. Remember Congress is a busy place. But we have seen proof that positive results will come from "polite persistence" with your Congressional offices.

CRT SEPARATE BENEFIT CATEGORY LEGISLATION

Given the urgency of the Competitive Bid Pricing threat which has a Jan. 1 deadline, resolving that issue has become our priority. However the "Ensuring Access to Quality Complex Rehabilitation Technology Act" (HR 1516 and S 1013) continues to be important to provide more comprehensive and longer-term improvements and protections. We continue to secure co-sponsors for this legislation and as of this writing stand at 146 representatives on HR 1516 and 12 senators on S 1013.

MEDICARE MISCELLANEOUS CODE REMINDER

As reported in the last column, CMS has proposed to make significant changes relating to HCPCS codes E1399 "Durable Medical Equipment, Miscellaneous" and K0108 "Wheelchair Component or Accessory, Not Otherwise Specified."

The CMS proposal is that the two HCPCS codes be split into a total of six codes for: (a.) DME or Wheelchair Component that Does Not Exceed $150 (paid in lump sum amount at a fixed rate), (b.) DME or Wheelchair Component that Exceeds $150 (paid on a capped rental basis for up to 13 months with rate caps), and (c.) replacement parts for DME or Wheelchair Being Repaired

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COMPETITIVE BID PRICING ...
(CONTINUED FROM PAGE 33)

(paid in lump sum amount based on contractor individual consideration). CMS indicated the coding and payment changes, once finalized, would be effective Jan. 1, 2016.

Industry comments were submitted and NCART met with CMS to express our concerns. We expect to see a CMS announcement on or about Nov. 1 as to what the final coding and payment changes will be.

THANKS FOR STAYING ENGAGED

We understand the frustration many CRT stakeholders are feeling with the access battles we are having to fight. But that is the unfortunate reality of today's changing health care system. The good news is we are developing Congressional champions who are willing to help us. We have built greater CRT awareness that provides a foundation to fight the current attacks to access and will hopefully minimize those in the future. Thanks for staying engaged as we work through the remainder of this year. Your continued advocacy and that of other CRT stakeholders is critical to our ultimate success.

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ORTHOPEDIC SURGERIES

WRITTEN BY: MICHELLE L. LANGE, OTR/L, ABDA, ATP/SMS

This issue of DIRECTIONS includes two articles about arthrogryposis, an orthopedic condition that often requires surgical intervention. A number of diagnoses may require orthopedic surgeries, including cerebral palsy. In cerebral palsy, the influence of increased muscle tone on growing bones can lead to orthopedic changes in various areas of the body.

TENDON LENGTHENING

Tendon lengthenings or releases are performed to increase range of motion in a specific muscle. Procedures are commonly done at the hamstrings, hip adductors and the Achilles tendon. These procedures may be done in combination with tone management strategies and other orthopedic surgeries.

OSTEOTOMIES

An osteotomy is a surgical procedure during which a bone is cut to shorten, lengthen or change its alignment.

VDRO: A common osteotomy performed in children with abnormal muscle tone is a varus derotation osteotomy (VDRO), sometimes called a femoral osteotomy. As small children begin to bear weight, the hip socket (acetabulum) begins to form around the head of the femur. In children who do not bear weight, this socket remains rather shallow. Increased muscle tone in the hip adductors and internal rotators in conjunction with less desirable postures (such as the notorious "W" sit position) lead to rotation of the femur itself as it grows. As a result, the ball is rotated out of the socket and the hip subluxes or dislocates. In a VDRO, the femur is cut in one or more places and realigned, so the ball of the femur fits into the hip socket. VDROs are often performed on both sides (bilateral VDRO) and hardware is typically placed in the bone during surgery. Tendon lengthening (i.e. adductors) is commonly done in conjunction with this surgery. A leg length discrepancy is common after this surgery as the position of the femur in relation to the hip has changed.

THE CLIENT MAY REQUIRE A TEMPORARY SEATING SYSTEM TO ACCOMMODATE THIS POSITION, AS WELL AS A RECLINING WHEELCHAIR IF HIP FLEXION IS LIMITED POST-SURGERY.

THE SHAPE OF THE TRUNK WILL CHANGE DRAMATICALLY AFTER SURGERY AND THE CLIENT MAY SIT TALLER IN THE SEATING SYSTEM.

Pelvic osteotomy: This surgery is designed to create a better shaped socket or cup to hold the ball of the femur. This surgery may be done in combination with a femoral osteotomy. Specific procedures include Pemberton, Ganz periacetabular and Chiari osteotomies.

After these procedures, it is common to use casting (i.e. spica cast), bracing and/or other positioning to keep the hips abducted during healing. The client may require a temporary seating system to accommodate this position, as well as a reclining wheelchair if hip flexion is limited post-surgery.

FUSIONS

A fusion permanently connects adjacent bones to maintain alignment. This is most commonly done at the spine to correct spinal curvatures, but fusions can occur at other joints, such as the ankle or wrist, to reduce significant contracture and stabilize a joint.

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Jesse Cuellar
Artist

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ORTHOPEDIC SURGERIES
(CONTINUED FROM PAGE 36)

Spinal fusion is a major surgery and is typically delayed as long as possible to allow for maximum growth of the trunk. Many surgeons will only recommend this surgery if a curvature exceeds a certain limit, such as 50 degrees. Some clients are not a candidate for this surgery due to medical fragility. The surgery may be performed posteriorly (over the back), anteriorly (through the abdomen) or both. Part or all of the vertebrae are fused and often attached to the pelvis. Rods and wires are used to correct the curve(s) as much as possible and are attached to the vertebrae. The bones are then prepared, so bony fusion occurs over time.

The shape of the trunk will change dramatically after surgery, and the client may sit taller in the seating system. Many clients may have used a molded back before surgery to support and accommodate spinal curvatures. This back will no longer match the client's body contours after surgery. Hip flexion is typically limited after surgery to minimize forces between the pelvis and spine and so the seat-to-back angle may need to be opened or a recliner used during the post-operative time period.

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CLINICAL CORNER

ARTHROGRYPOSIS

WRITTEN BY: KAY ELLEN KOCH, OTR/L, ATP

OVERVIEW OF THE DIAGNOSIS

Arthrogryposis was first documented in 1841 by Adolph Wilhelm Otto in an article written in Latin. Arthro = joints, Grypo = curved, Multiplex = different forms, Congenita = present at birth.

The major cause of arthrogryposis is fetal akinesia or decreased fetal movements. Decreased movements may be due to fetal abnormalities (neurogenic, muscular, or connective tissue) or mechanical limitations to movement in the womb. Maternal disorders including infection, drug use, trauma or illness can also lead to decreased fetal movement. Sometimes nerve signals don't reach the muscles because of problems with the baby's central nervous system (CNS).

During early embryogenesis, joint development is almost always normal. As movement becomes limited or decreased, the joint becomes fixed. The frequency of arthrogryposis (Mankin, 2013) is about 1 in 3,000 live births in the United States. The causes of arthrogryposis are varied and not entirely understood, but are presumed to be multifactorial. In most cases, arthrogryposis multiplex congenita (AMC) is not a genetic condition. However, in approximately 30 percent of cases, a genetic cause can be identified. It is not uncommon in twins for one baby to have some form of arthrogryposis secondary to limited space in the womb.

In some cases, only a few joints are affected and the range of motion is nearly normal. In severe cases, many joints are involved, including the jaw and back. While there are many known forms, the most common is Amyoplasia (A = absent, Myo = muscle, Plasia = abnormal growth or development). No racial predilection has been described. Males are primarily affected in X-linked recessive disorders. Otherwise, males and females are equally affected. Arthrogryposis is detectable at birth or in utero using ultrasonography (see Picture 1).

PHYSICAL PRESENTATION AND LIFE SPAN EXPECTATIONS

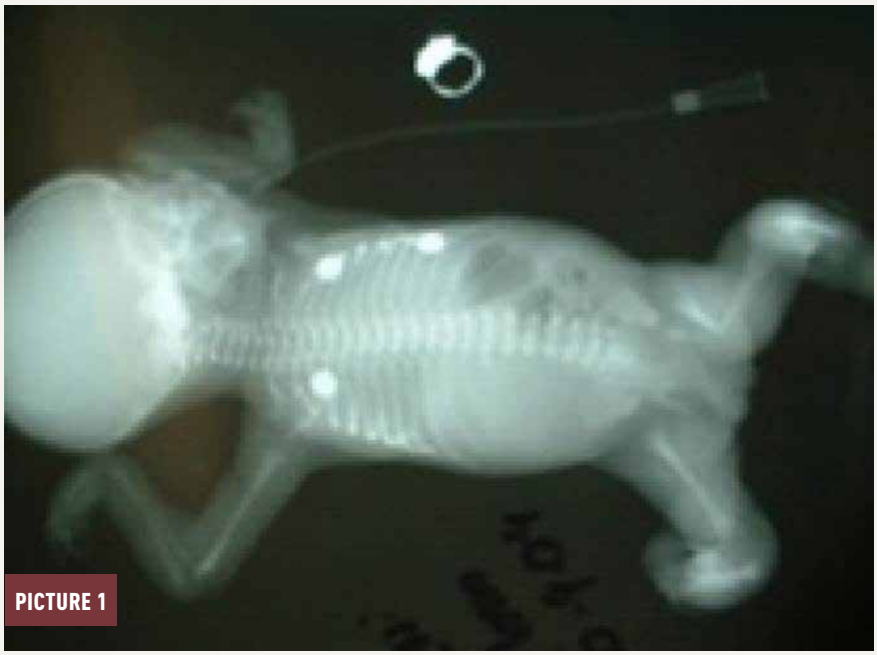
- Involved extremities are cylindrical in shape;
- Orthopedic limitations are usually symmetrical, and severity increases distally;
- Distal joints are affected more frequently than proximal joints;
- Joint rigidity and diminished range of motion may be present;
- The patient may have joint dislocation, especially the hips, and occasionally, the knees;
- Atrophy may be present, and muscles or muscle groups may be absent; and
- Sensation is usually intact, although deep tendon reflexes may be diminished or absent.

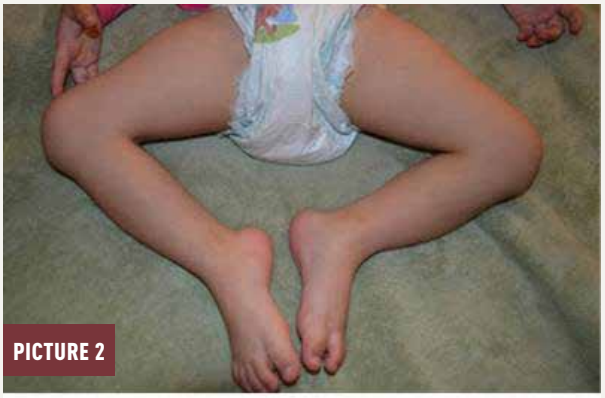
The individual's life span depends on the disease severity and associated malformations, but is usually normal, unless the nervous system and/or heart are involved. About 50 percent of patients with severe limb involvement and CNS dysfunction die in the first year of life. Scoliosis may compromise respiratory function which leads to early mortality.

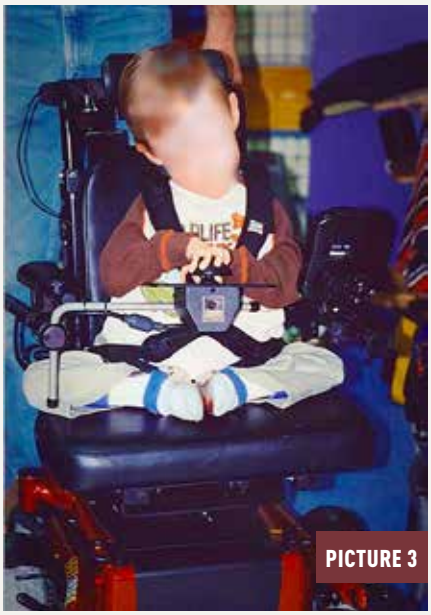
ORTHOPEDIC CONSIDERATIONS

Some joint limitations can be corrected and ambulation is possible. Interventions include a combination of surgical procedures and occupational and/or physical therapy for strengthening, range of motion, ambulation and ADL activities. Often, any recurrent joint limitations are addressed with splints

PROVIDING MOBILITY EARLY CAN DIMINISH LEARNED HELPLESSNESS AND ALLOW THE INDIVIDUAL TO BE AS INDEPENDENT AS POSSIBLE.







Picture 1: Ultrasound of a baby with arthrogryposis
Picture 2: Example of lower extremity involvement
Picture 3: Range limitations accommodated in seat and mobility base

and bracings. When indicated, night splints are prescribed. The parents are part of the team with home programs designed to assist with maintenance of range of motion and strength.

Most surgeries are performed early, often before the child turns 2 years old. The most common surgeries are to the bone or tendon transfers. Due to the heightened risk during anesthesia, whenever possible or needed, two surgeries may be combined. When the individual is older, osteotomies may performed when growth is completed.

When surgeries are not performed and joint rigidity and contractions occur, seating and wheeled mobility become the selected form for ambulation. A power wheelchair assessment may occur as young as 18 months.

As the child grows, the location and severity of orthopedic involvement can create unique seating challenges, particularly when surgical interventions are not provided (See Picture 2). For example, when there are fixed contractures and asymmetries in the hips, knees and ankles, creating an appropriate seating system that will support the individual and provide pressure redistribution requires multiple considerations (See Picture 3). One consideration is how to integrate this unique seating system into the mobility base.

SKIN/SENSATION CONSIDERATIONS

Sensation is intact, so comfort is a major consideration within the seating system, contrary to what funding sources may consider in their coverage criteria. Often, bony prominences resulting from contractures need to be addressed. Skin webs (pterygia) may be present across fixed joints. Skin dimples are common where movement is limited. Secondary to muscle atrophy, muscle mass and circulation is decreased. There may be a history of skin breakdown in these areas depending on the ability of the individual to do a weight shift or redistribute pressure.

BASIC SEATING AND MOBILITY CONSIDERATIONS

- Provide support;
- Accommodate/prevent orthopedic limitations;
- Increase functional mobility;
- Decrease fatigue;
- Anticipate change or growth;
- Protect skin integrity;
- Encourage independence in MRADLs;
- Enhance physiological function; and
- Consider future surgeries or other medical interventions.

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ARTHROGRYPOSIS
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SETTING GOALS

Most children born with arthrogryposis have normal intelligence but can experience developmental delays related to decreased mobility and exploration of their environment. Providing mobility early can diminish learned helplessness and allow the individual to be as independent as possible. Some individuals may be able to roll or scoot, however it is not uncommon for young children to be carried or placed in strollers, limiting independent mobility opportunities. Commercially available strollers do not provide adequate postural support either. A thorough mat assessment and evaluation with trial equipment is needed to determine the best technology solution for each individual.

THE TEAM SHOULD STRIVE TO:

- Encourage acceptance and exposure to mobility technologies;
- Educate the parents on product options, as well as the evaluation process;
- Encourage autonomy;
- Diminish learned helplessness by providing mobility options;
- Provide a safe, but less protective environment to promote independence; and
- Explore options and access to other technologies that will enhance independence and that can be operated from the mobility device.

SUMMARY

While there are many levels of physical involvement seen in an individual with arthrogryposis, the client we typically see for a seating and wheeled mobility assessment is the one who presents without surgical intervention. Considerations for accommodating contractures and decreased range of motion while providing postural support and access to mobility will continue to challenge the team's knowledge, creativity and problem solving abilities. The RTS/CRTS working together with the individual, their family, the therapist and equipment manufacturers will help provide the best outcomes for independence and function.

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REHAB CASE STUDY

MEET W.C. – MOBILITY MAGIC

WRITTEN BY: KAY ELLEN KOCH, OTR/L, ATP

Working in pediatric seating clinics in Cincinnati, Ohio, and Dallas, Texas, over the course of my career as an occupational therapist and ATP has provided me with an opportunity to evaluate a variety of children with diverse diagnoses. Most recently, I was able to work with some amazing CRTS®s and therapists in rural settings outside Atlanta, Georgia, while working for a complex rehab supplier.

In my role as education, training and accreditation manager, I was given the opportunity to assist many school based therapists in some of the most rural areas of the state as part of the seating and wheeled mobility evaluation and assessment team. Our complex rehab equipment company would assist with equipment trials, handled by our CRTS®s, for power mobility evaluations for the families who did not wish to make the drive "into the city" for their seating and wheeled mobility assessments.

There were advantages to evaluating these children with their school system therapists, many of whom were the only therapist the child had ever known. We were also able to meet in a setting familiar to the child and his or her family. We were able to better assess not only the environment the equipment would be utilized in, but could begin educating the families on the use, care and maintenance of the equipment from the first day of the assessment. Working closely with our manufacturer representatives allowed us to bring equipment to these rural areas for trials. It was rewarding to follow many of these children from their first independent mobility experiences to their second or third wheelchair. The team worked cohesively with the children and their parents providing ideas and goals for the equipment, the school therapist performing the mat evaluation and contributing valuable input, the CRTS® providing the equipment for trials in an overfull van and myself problem solving ideas for additional support or positioning and, when needed, with access to the mobility device being trialed.

BEFORE THAT, THE FAMILY CARRIED W.C. OR USED A COMMERCIAL STROLLER FOR HIS MOBILITY. W.C. COULD NO LONGER BE CARRIED EASILY DUE TO HIS WEIGHT. BY THE FAMILY'S CHOICE, HE HAD NOT RECEIVED ANY SURGICAL INTERVENTIONS AND NOW NO LONGER FIT INTO THE COMMERCIAL STROLLER.

ROAD TRIP

One day one of our rural school therapists, in a town about an hour and a half north of Atlanta, contacted us about evaluating a 5 year old who was new to her program. He was born an identical twin and had arthrogryposis. W.C.'s family had received a Convaid Cruiser for him when he was 3 years old from a local DME supplier who did not specialize in complex rehab equipment. Before that, the family carried W.C. or used a commercial stroller for his mobility. W.C. could no longer be carried easily due to his weight. By the family's choice, he had not received any surgical interventions and now no longer fit into the commercial stroller. The early childhood therapist had made some splints and provided a range of motion program, but W.C. still had contractures in his lower extremities and was non-ambulatory. The family was told the Convaid Cruiser was the best mobility option for him. The early intervention therapist and the family were not made aware of all seating and mobility options. The family told me that, at that time, the Convaid Cruiser met their needs as they rarely left the house with W.C.

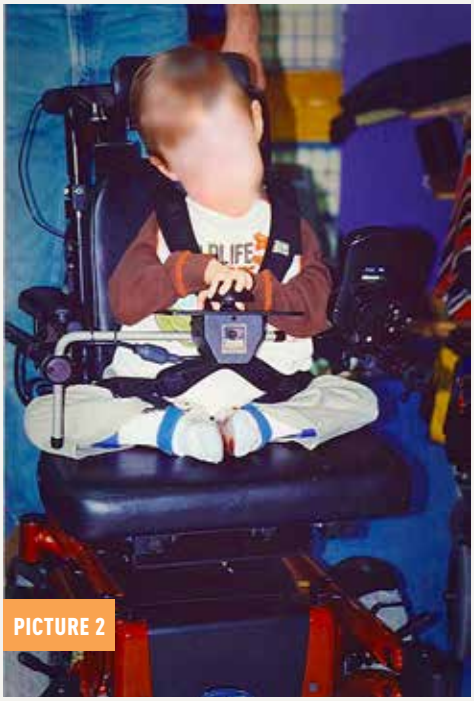
W.C.'s needs changed when he started school. He would try to scoot on the floor at school, but this was not functional mobility. The school therapist wanted to explore power mobility, but the family wasn't aware of this technology and wanted to learn more before any equipment was trialed. The

therapist had the family come to one of the first grade classrooms where another child who had cerebral palsy was independently using a power wheelchair to access the classroom, the lunch room and even participate in recess outside. This child was only one year older than W.C. and the family agreed to the assessment and equipment trial which was set up for the following month.

THE FIRST POWER WHEELCHAIR

The morning of our first equipment trial, the CRTS® packed his van with two power wheelchair options and some seating systems that could interface with these bases. W.C.'s hips were fixed in abduction, flexion and external rotation. His knees were flexed with fixed contractures and skin webbing present. His upper extremities also had fixed contractures, with his elbows in flexion. This position provided minimal stability and function for him as long as items were placed in midline. The therapist had suggested a midline mount joystick as W.C. was most stable with minimal distal movements.


PICTURE 1


PICTURE 2


PICTURE 3


PICTURE 4

Picture 1: Wheelchair used for trial for assessment

Picture 2: First power wheelchair

Picture 3: W.C. continued to grow and change

Picture 4: W.C. in second power wheelchair

Fortunately, we were able to adjust the seating on a power wheelchair and take W.C. out to the large school parking lot for his first trial (See Picture 1). His mom was there and the school let his twin brother out of class to see him try the power wheelchair. W.C. was able to drive all over the parking lot with his brother chasing behind him. At that moment, their mom commented to the team that she never thought she'd see the day where W.C. could outrun his brother. For his first power wheelchair, a Stealth Products mushroom joystick with midline mount was selected, with custom planar seating on top of an Invacare TDX -SP base (See Picture 2). The funding process required multiple submissions to Georgia

AT THAT MOMENT, THEIR MOM COMMENTED TO THE TEAM THAT SHE NEVER THOUGHT SHE'D SEE THE DAY WHERE W.C. COULD OUTRUN HIS BROTHER.

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Medicaid because his current Convaid Cruiser was only two years old, he did not have a 'change of condition' and had not 'outgrown' his current equipment. Finally, when a video was provided with another appeal, the recommended equipment was approved.

THE SECOND POWER WHEELCHAIR

Except for the usual batteries and some minor tweaking, the power wheelchair worked well for W.C. He was able to use the wheelchair at home and at the school independently. He enjoyed recess like the rest of his peers in his first grade classroom. When W.C. had entered 4th grade, it was time for a second power wheelchair. Due to his growth, and increased difficulty using the joystick with his hands, alternative controls were considered (See Picture 3). The contractures in his elbows made access and control of the joystick increasingly difficult. The team met to discuss the options. A head array was one option considered. Mom told us how W.C. could control a video game controller and wondered if one was available

FROM THE FIRST TRIAL IN HIS POWER WHEELCHAIR, THE FAMILY, THERAPIST AND SCHOOL NOTICED HOW W.C. CHANGED FROM A QUIET AND SHY CHILD TO A CHILD WHO WOULD INTERACT; ENJOY DISCOVERING NEW PLACES HE COULD ACCESS AND EVEN VOLUNTEER TO PARTICIPATE IN THE FLAG CEREMONY AT THE SCHOOL.

for a power wheelchair. Our CRTS discovered that an adapted video game controller was available and a trial was set-up. W.C. decided using his chin to drive gave him the best access to control the wheelchair (see figure 4). During the trial he was able to drive the demo wheelchair using this driving method all over the school and even out the door to the playground. The Quickie QM 710 base was chosen with custom planar seating and a Bodypoint Monoflex anterior trunk support. The base was chosen for its maneuverability indoors and outdoors. Upon delivery, the anterior trunk support needed to be adjusted to provide him the stability he needed to access the driving method.

THE MAGIC IN MOBILITY

From the first trial in his power wheelchair, the family, therapist and school noticed how W.C. changed from a quiet and shy child to a child who would interact; enjoy discovering new places he could access and even volunteer to participate in the flag ceremony at the school. W.C. and his twin brother have been able to explore their neighborhood together. Through the efforts of the team, with feedback from W.C. and his family, we were able to provide the best outcome and help W.C. discover the magic in independent mobility.

THROUGH THE EFFORTS OF THE TEAM, WITH FEEDBACK FROM W.C. AND HIS FAMILY, WE WERE ABLE TO PROVIDE THE BEST OUTCOME AND HELP W.C. DISCOVER THE MAGIC IN INDEPENDENT MOBILITY.

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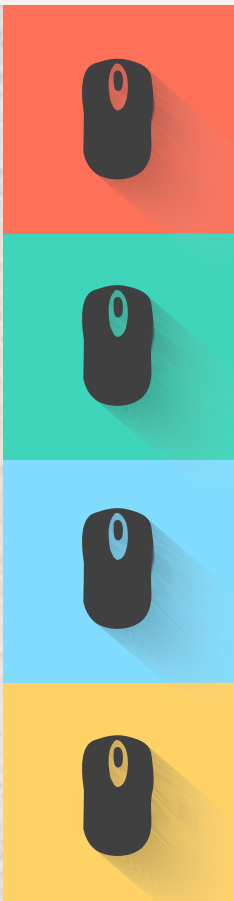

THE AMERICANS WITH DISABILITIES ACT: UNFULFILLED

WRITTEN BY: JENN WOLFF AND ALEX BENNEWITH

As the 25th anniversary of the Americans with Disabilities Act (ADA) celebrations come to an end, it's time to reflect on what it has done for the disabilities community and what still needs to be done.

In his speech on July 20, which marked the beginning of a week-long celebration in our nation's capital, President Barack Obama said, "Thanks to the ADA, the places that comprise our shared American life – schools, workplaces, movie theaters, courthouses, buses, baseball stadiums, national parks – they truly belong to everyone." The ADA has allowed people with disabilities to be active participants in their communities. Before 1990, many people with disabilities felt they had no choice but to stay at home, not necessarily because of stigma, but because we simply couldn't access places and things that were not accessible.

The changes the ADA has made have made significant improvements in the lives of people in the disability community, as well as the able-bodied community. Two examples: closed-captioning allows deaf people and the hearing-impaired to enjoy televised news. Information and entertainment and is enjoyed by avid sports fans in sports bars across the country as well as our policymakers in Washington D.C., who rely on closed-captioning to keep up-to-date on Congressional floor activities. Curb cuts, put in place so that wheelchair users can traverse urban environments, are also of benefit to parents with heavy strollers, grocery-cart pushers and those who may need a cane or walker.

Sen. Tom Harkin, D-Iowa, chief promoter and supporter of the ADA and champion for disability rights, held prime speaking roles throughout the July celebrations. He focused many of his speeches on how the provisions in the ADA prohibit discrimination and ensure equal opportunity for people with disabilities in employment, state and local government services, public accommodations, commercial facilities, transportation and mandates the provision of assistive communication devices. Some of the changes the ADA has provided are now so integrated into our daily lives that it's difficult to remember the pre-ADA world. Although much of the physical environment is more welcoming to the disability community, the social environment including government and medical policies, need to be updated to enable people with disabilities to participate in society as fully as they wish.

What does it take for people with mobility impairments to have an increased chance to achieve those goals? Ensuring access to quality Complex Rehab Technology (CRT). When we, the users of mobility equipment, receive substandard equipment, it can potentially cause pressure sores or other health issues that cost the government money through increased insurance payments and lost taxes and cost us income from our jobs and loss of quality of life. People like you – the clinicians, the suppliers, the consumers, and other advocates – who all come together in a common voice around CRT, CRT accessories and the competitive bidding program, and support each other in advocating for change, know what needs to be done.

"THANKS TO THE ADA, THE PLACES THAT COMPRISE OUR SHARED AMERICAN LIFE – SCHOOLS, WORKPLACES, MOVIE THEATERS, COURTHOUSES, BUSES, BASEBALL STADIUMS, NATIONAL PARKS – THEY TRULY BELONG TO EVERYONE."

We need to celebrate the progress the ADA has made but need to continue to fight for equal opportunities, full participation, independent living and economic self-sufficiency which begins, for the community with mobility impairments, with access to the right wheelchairs and related accessories.

Thank you, Sen. Harkin and the generation that advocated for the ADA, for all you have done to promote equal rights for the disability community and thank you, NRRTS community for all your work in helping to improve access to CRT and the right wheelchairs in the fight ahead. Let's keep fighting! http://www.unitedspinal.org/advocacy-alliance/

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ICD-10 … HOW MUCH DOES IT AFFECT CRT?

WRITTEN BY: CLAUDIA AMORTEGUI, PRESIDENT, THE ORION CONSULTING GROUP, INC.

It feels like I have heard the "threat" of ICD-10 coming into effect for the entire health care industry for years. But each time it was mentioned, it was always something that would happen … eventually. As I write this article, it actually seems like it will truly take effect within the next couple days (if by some miracle it doesn't, just read this as a prelude to when it does).

As I talk to staff within the Complex Rehab Technology (CRT) provider community, it appears that most feel ready for the transition. They have updated systems and started having the conversations within their office and with the referrals. In my opinion, this change should not be a shock to any referral, as they also have to be prepared for the billing of their own services. Unfortunately, Medicare may have added some confusion by providing some "flexibilities" to certain physician services, but of course the DME sector does not have the same latitude. This difference may cause uncertainty with some of the referrals.

As the start date gets closer, the Medicare DME contractors (MACs) have prepared and published a "Dear Physician" letter explaining the requirements for the providers and explaining that there is no flexibility in the implementation of ICD-10 requirements and DME claims. Keep in mind that the ICD-10 diagnoses codes need to be used with any claim with a date of service (delivery date) of Oct. 1 and later.

UNFORTUNATELY, MEDICARE MAY HAVE ADDED SOME CONFUSION BY PROVIDING SOME "FLEXIBILITIES" TO CERTAIN PHYSICIAN SERVICES, BUT OF COURSE THE DME SECTOR DOES NOT HAVE THE SAME LATITUDE.

So what does this change mean to CRT claims?

The most obvious is the change in claim submission. The difficult part in the CRT world is making sure this happens with the appropriate claims, meaning at the right time. As we all know, CRT orders do not happen overnight and in most cases, do not even happen in the same month. With this in mind, providers need to make sure those orders that started a month or more prior to Oct. 1, have been adjusted to reflect ICD-10 codes versus the original ICD-9 codes tagged in their system. Does this mean that specific documentation must go back to the physician and/or therapist? No, not at all.

Medicare does allow the provider to convert the diagnoses codes if there is a direct crossover and/or if the clinical documentation provided allows you to determine the exact ICD-10 code – to the highest level of specificity. Be sure the staff understands that the referral does not need to physically write the ICD-10s on their documentation; it can be a written diagnosis description. You need to be certain your staff is aware of the requirements and comfortable enough to convert the diagnosis code if necessary, and if not, at least ask for assistance. You will also want to have a discussion with the referrals regarding the new diagnoses codes and the importance of exact descriptions that will allow you to make the conversion. If they do not provide such details (or the codes themselves), everyone loses due to the extra time needed to obtain the correct information.

Something else affected by this new requirement is the Seating and Positioning policy. We all have known that the list of qualifying diagnoses for this policy would have to be updated with ICD-10 codes. What most did not know, and in many cases have yet to realize, is that a change was made regarding coverage due to pressure wounds. This policy did include coverage of a specialty seat cushion for a client with any type of pressure wound or history of a pressure wound in the area of contact with the cushion. Under the updated policy, not all pressure wounds qualify. There has been no official notice that I have seen, however if you look at the new diagnoses list, you will see that Stage 1 pressure wounds are nowhere to be found. I admit, when I noticed this discrepancy from

the original policy/LCD, I was not necessarily surprised but it is a change that seems to have magically happened. In my opinion, this will not be a big issue for most CRT orders; however, it could affect those clients with the official non-qualifying diagnoses (such as rheumatoid arthritis), but with a Stage1 pressure wound that has allowed them to obtain a specialty cushion. Both ATPs and internal staff need to be aware of this change, as do the referrals. You want to be able to make an adjustment on an order during the evaluation and not after the fact.

If you take this policy change a step further, you will find that it could also affect some power wheelchair

> WHAT MOST DID NOT KNOW, AND IN MANY CASES HAVE YET TO REALIZE, IS THAT A CHANGE WAS MADE REGARDING COVERAGE DUE TO PRESSURE WOUNDS.

bases. How? The power wheelchair policy/LCD states that if a client only qualifies for a general use cushion, and if the selected wheelchair base has a corresponding captain's chair code, then you must provide the captain's chair model and not the sling/solid seat/back (or at least that is all they will pay for). This then becomes an issue on how to bill the claim, and if a free upgrade has to be provided. Margins have done nothing but shrink, so "giveaways" should not be commonplace. With all of this in mind, you need to be sure that everyone is aware of this change and the orders it could affect.

Be aware that all DME policies have been updated with a new date of

(CONTINUED ON PAGE 52)

ICD-10 ... HOW MUCH DOES IT AFFECT CRT?
(CONTINUED FROM PAGE 51)

DO NOT ASSUME YOU KNOW THE CHANGE BASED ON WHAT YOU HAVE HEARD. THE POLICIES MAY BE BORING, BUT THEY ARE THE FOUNDATION TO YOUR SUCCESS IN PROVIDING THE EQUIPMENT THAT WILL BE REIMBURSED. TIME TO START READING.

Oct. 1, 2015. Medicare has added some new standard language to all policies that does not pertain to the ICD-10 change. There is a paragraph that refers to Medicare not assuming payment of an item that had previously been covered by another funding source. For example, if a client had received a K0005 manual wheelchair from another funding source, when it is time for a new chair do not assume that Medicare will automatically cover the same level equipment. This is a conversation that should be had with your clients at the beginning of an evaluation.

The changes discussed above should be a lesson to make sure you and the company staff read the new updated policies. Do not assume you know the change based on what you have heard. The policies may be boring, but they are the foundation to your success in providing the equipment that will be reimbursed. Time to start reading.

CONTACT THE AUTHOR

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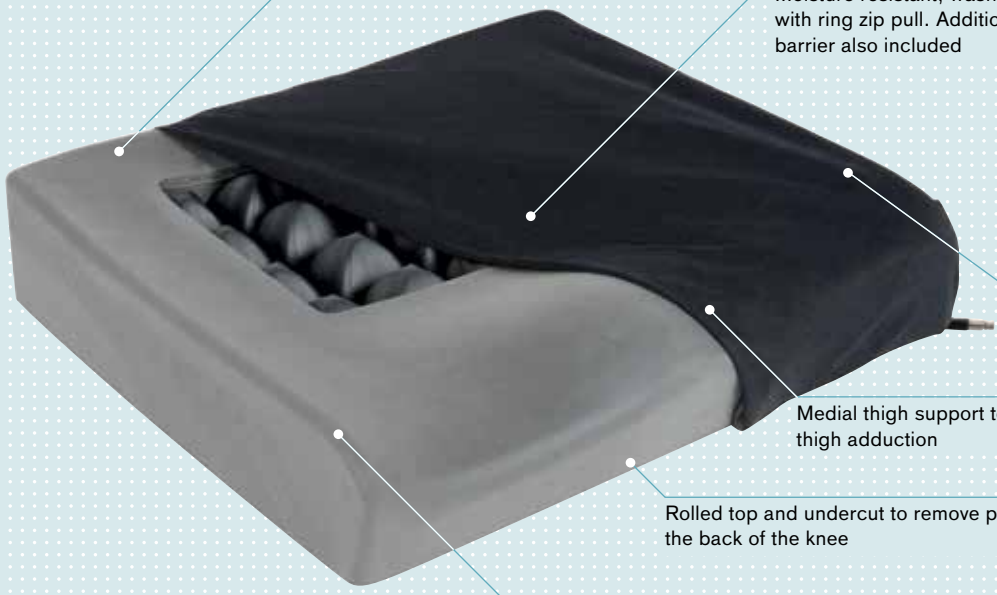
ottobock.



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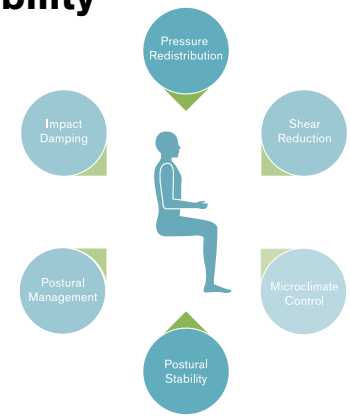

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NEILSEN FOUNDATION AWARDS GRANT TO CTF TO DEVELOP WHEELCHAIR TRAINING PROGRAM FOR CLINICIANS WORKING WITH INDIVIDUALS WITH SPINAL CORD INJURY

WRITTEN BY: LAURA COHEN PHD, PT, ATP/SMS

The Craig H. Nielsen Foundation awarded a one year grant of $49,000 to Barbara Crane PhD, PT, ATP/SMS, Associate professor of physical therapy at the University of Hartford, and Lauren Cohen, PhD, PT, ATP/SMS, executive director Clinician Task Force to develop and deploy a seating and wheeled mobility (SWM) training curriculum for entry level physical therapy (PT) and physical therapy assistants (PTA), and for continuing education for practicing clinicians.

This project supports the Neilsen Foundation's mission in the area of rehabilitation – specifically in the area of assistive technology – by providing for a nationally unmet need in the area of education/ training of physical therapy and physical therapy assistant students in the application of wheelchairs and seating for individuals with disability, including those with spinal cord injury (SCI). Providing appropriate education and training for entry-level clinicians will help improve the quality of services available in the area of SWM evaluation, prescription and training nationwide for individuals with SCI. This will enhance the ability of persons with SCI to obtain optimal assistive technology solutions to meet their needs in mobility, pressure ulcer prevention, and general health and wellness. Assistive technology has become increasingly complex with literally hundreds of products available to persons with SCI. However, this increase in availability of assistive technology devices has been accompanied by a decrease in a knowledgeable base of clinicians who can appropriately provide optimal services in the application of assistive technology for persons with SCI. This project aims to address the lack of knowledgeable practitioners through development and dissemination of appropriate pre-professional training materials best suited to meet this need.

For the purposes of this project, the University of Hartford will partner with the World Health Organization (WHO), the Clinician Task Force and the American Physical Therapy Association (APTA) Neurology Section. By design, WHO "Wheelchair Service Training Program (WSTP) materials were developed to build capacity for wheelchair service delivery in lesser resourced settings around the world. For this project, the WHO has agreed to partner with us to share experience and in-kind support to repackage and augment the WSTP materials for entry-level PT and PTA professionals in the United States. These materials will be replicable for use with other healthcare professional entry-level educational programs in the future for preparing the interdisciplinary SWM service delivery team caring for individuals with SCI such as occupational therapists, physicians and physician extenders. The Clinician Task Force – a national group of SWM subject matter experts (SME), and the APTA Neurology Section will partner to customize and disseminate the training materials.

The main purpose of this project is to develop module designed for use by entry-level PT and PTA programs. Development of a "plug and play" SWM module readily available for use by academic entry level PT and PTA programs will increase the likelihood students are exposed to a minimal standard of SWM knowledge and skills in the practice of SWM evaluation, prescription and training.

Results of a 2015 survey of 167 U.S. PT (n=76) and PTA programs (n=91), showed that only 22 percent of PT programs and 33 percent of PTA programs have a dedicated required course or module on SWM. On average, SWM classroom content is reported to be 11 hours (PT) and 7 hours (PTA) respectively. Survey respondents indicated overwhelming interest in using a pre-packaged SWM module in existing PT (94.7 percent) and PTA (98.9 percent) curriculums.

PURPOSE & OBJECTIVES

The purpose of this project is to increase the capacity of entrylevel PT and PTA professionals to provide quality basic level wheelchair service delivery to individuals with mobility impairments (SCI/D).

OBJECTIVES:

1) Increase the number of wheelchair users with SCI who receive a wheelchair that meets their needs;

2) Increase the number of wheelchair users with SCI who receive training in the use and maintenance of wheelchairs and how to stay healthy in a wheelchair;

3) Increase the number of PTA and PT students trained in basic level wheelchair service delivery;

4) Achieve greater integration of wheelchair service delivery within rehabilitation services.

5) Increase the number of PTA and PT academic programs that utilize the training program.

DELIVERABLES

A suite of materials will be developed based on the design criteria identified through stakeholder focus groups. Materials will include participant and trainer resources, and the plan is to include:

- Self-paced (asynchronous) pre-class preparatory assignments (reading, videos, exercises);
- Web-based learning modules;
- Structured laboratory activities (lesson plan, lab activity, grading rubric);
- Equipment list for laboratory sessions (number of items needed per student, resource list to arrange for loaner equipment from manufacturers and local suppliers); and
- Course test items to assess learning.

We will be seeking support from NRRTS Registrants to assist with this effort.

(CONTINUED ON PAGE 56)

NEILSON FOUNDATION AWARDS GRANT ...
(CONTINUED FROM PAGE 55)

The expected outcome of this project is knowledge translation to elevate the entry-level education of SWM knowledge and skills for current and future PTs and PTAs. The intention is that the sustainability of this project will occur naturally once the materials are incorporated into the education programs, as they will essentially be "permanent" aspects of these academic programs and knowledge can be updated via continuing education provided via the APTA or through other organizations whose mission involves providing on-going or continuing education opportunities for practicing clinicians.

The ultimate effect of this will be to enhance the quality of care provided to persons with SCI. Optimizing provision of SWM technologies will help support optimal health, wellness, and quality of life as well as maximizing activity and participation for persons with SCI.

The Craig H. Neilsen Foundation is dedicated to research and programs to improve the quality of life for people living with spinal cord injury. The Craig H. Neilsen Foundation was established in 2002 to award grants to a broad spectrum of charities, including those that benefit spinal cord injury efforts. Today, with assets of approximately $500 million, the foundation is primarily dedicated to funding extensive research, education and quality of life programs for improving the lives of people affected by spinal cord injury.

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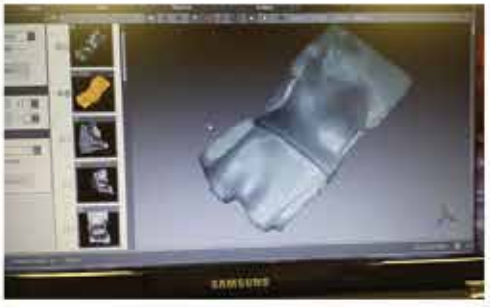

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RESNA

THE INS AND OUTS OF DISCLOSURE

WRITTEN BY: ANDREA VAN HOOK

Imagine this scenario:

You are a licensed medical professional (PT, OT, SLP) and a RESNA-certified ATP employed by a supplier or manufacturer. You are introducing yourself to a new client, so you say:

"Hello, I'm Mary Smith. I'm a physical therapist working for XYZ Medical. Today I'm going to evaluate you for a new wheelchair to see what works best for you."

Seems pretty straightforward, doesn't it? Except you've just violated the disclosure guidelines for the ATP designation.

RESNA's Code of Ethics and Standards of Practice state that an ATP is required to disclose their role, their employer and the capacity in which they are engaging in the provision of assistive technology or assistive technology services in all forms of communication, irrespective of their formal education, license(s) or additional credentials. This includes direct and written communication, advertising, signatures, and other forms of identification.

THE BASIC RULE IS THAT THE ATP, WHO IS THE AUTHOR OF THE DOCUMENT, MUST BE LISTED FIRST. ANY ADDITIONAL OR SUBSEQUENT SIGNATURES (SUCH AS THE DOCTOR'S) SHOULD BE LISTED UNDERNEATH THE AUTHOR SIGNATURE WITH A CONCURRENCE STATEMENT THAT SEPARATES THE TWO SIGNATURE LINES.

So in this scenario, an introduction that would fully meet the ATP disclosure guidelines would be:

"Hello, I'm Mary Smith. I'm a certified Assistive Technology Professional working for XYZ Medical. Although I am also a physical therapist, I am here today to work with your therapists and physician as the supplier. My role is to match the features of the technology recommended by your medical team to the specific products available. I will be ordering the equipment for you and seeking payment from your insurer. Do you have any questions?"

There are two standards of practice, #4 and #17, which provide guidance on disclosure. They are:

- Standards of Practice #4: Individuals shall not willfully misrepresent their credentials, competency, education, training and experience in both the field of assistive technology and the primary profession in which they are members. Individuals shall disclose their employer and the role they serve in the provision of assistive technology services and devices in all forms of communication, including advertising that refers to their certification in assistive technology.

- Standards of Practice #17: Individuals shall be truthful and accurate in public statements concerning their role in the provision of all assistive technology products and services.

The most common written communication is the letter of medical necessity. The basic rule is that the ATP, who is the author of the document, must be listed first. Any additional or subsequent signatures (such as the doctor's) should be listed underneath the author signature with a concurrence statement that separates the two signature lines. The letter should be on the author's company or facility letterhead, or clearly disclose the company or facility which employs the author. Here's an example of what that would look like:

Should you have any questions please contact me at [contact info]. Thank you very much for your cooperation and assistance.

_____ _____

Steve Clinician, OTR/L, ATP — Date
Acute Care General

I certify with my signature that I concur with the recommended equipment submitted by Acute Care General. It is my opinion that these items are both necessary and reasonable for the patient's well being in reference to this patient's medical condition and accepted standards of medical practice.

_____ _____

Jane Doe, MD — Date

Business cards and e-mail signatures can get tricky. With a license, educational degree, certifications, and registrations, that can mean a lot of letters after a person's name. The rule of thumb is: license, education, certification(s), and/or registrations. The information should also clearly indicate the individual's employer. Here's a sample business card:

Mary Smith, PT, PhD, ATP, CRTS®
Assistive Technology Professional
Certified Rehabilitation Technology Supplier®

XYZ MEDICAL

123 Main Street — 800-5551212ph
Anywhere, USA 12345 — 800-555-3434 fax
msmith@xyzmedical.com

In today's team-based healthcare environment, it can be very confusing for clients to understand who is responsible for different aspects of their care. By clearly disclosing your role and how you interact with other members of their care team, you can help consumers better understand their assistive technology, and also better understand how to communicate with you.

Communicating the value of your certification

THE RULE OF THUMB IS: LICENSE, EDUCATION, CERTIFICATION(S), AND/OR REGISTRATIONS. THE INFORMATION SHOULD ALSO CLEARLY INDICATE THE INDIVIDUAL'S EMPLOYER.

As everyone who works in the field knows, it is frustrating how little many consumers and even medical professionals know and understand about assistive technology. Certified professionals can help by proactively educating, whenever they get the chance, about the value of certification. Some tips:

- Don't get upset if a client, doctor, or employer doesn't know about certification. In a Newsweek poll a few years ago, 29 percent of Americans didn't know Joe Biden was vice president of the U.S. So the fact that someone doesn't know what the ATP is shouldn't bother you at all.

- When meeting a new person, always describe your certification and what it means. Be ready with a little elevator speech about your certification, and trot it out whenever you meet someone new. Just assume they don't know. If they do know, they'll tell you.

- Explain to clients the benefits of working with a certified professional. Use RESNA's consumer education brochure to educate clients about certification. Explain that it provides certain consumer safeguards, and that you are duty-bound to follow a code of ethics and standards of practice.

- Explain your credentials and your certification to medical

(CONTINUED ON PAGE 60)

THE INS AND OUTS OF DISCLOSURE
(CONTINUED FROM PAGE 59)

professionals. Let medical professionals know you passed a rigorous exam to become certified, and that you keep up with changes in the field and new technologies through continuing education.

• Explain the acronyms! Always use "certified Assistive Technology Professional" for "ATP" and "certified Assistive Technology Professional and Seating and Mobility Specialist" for "ATP/SMS." It's a mouthful, but you can't expect anyone, especially clients, to know the acronym.

We're here to help! On the RESNA website, we've just established a new section for certified professionals, with links to common documents and helpful resources. Just go to www.resna.org and visit the certification section.

CONTACT THE AUTHOR

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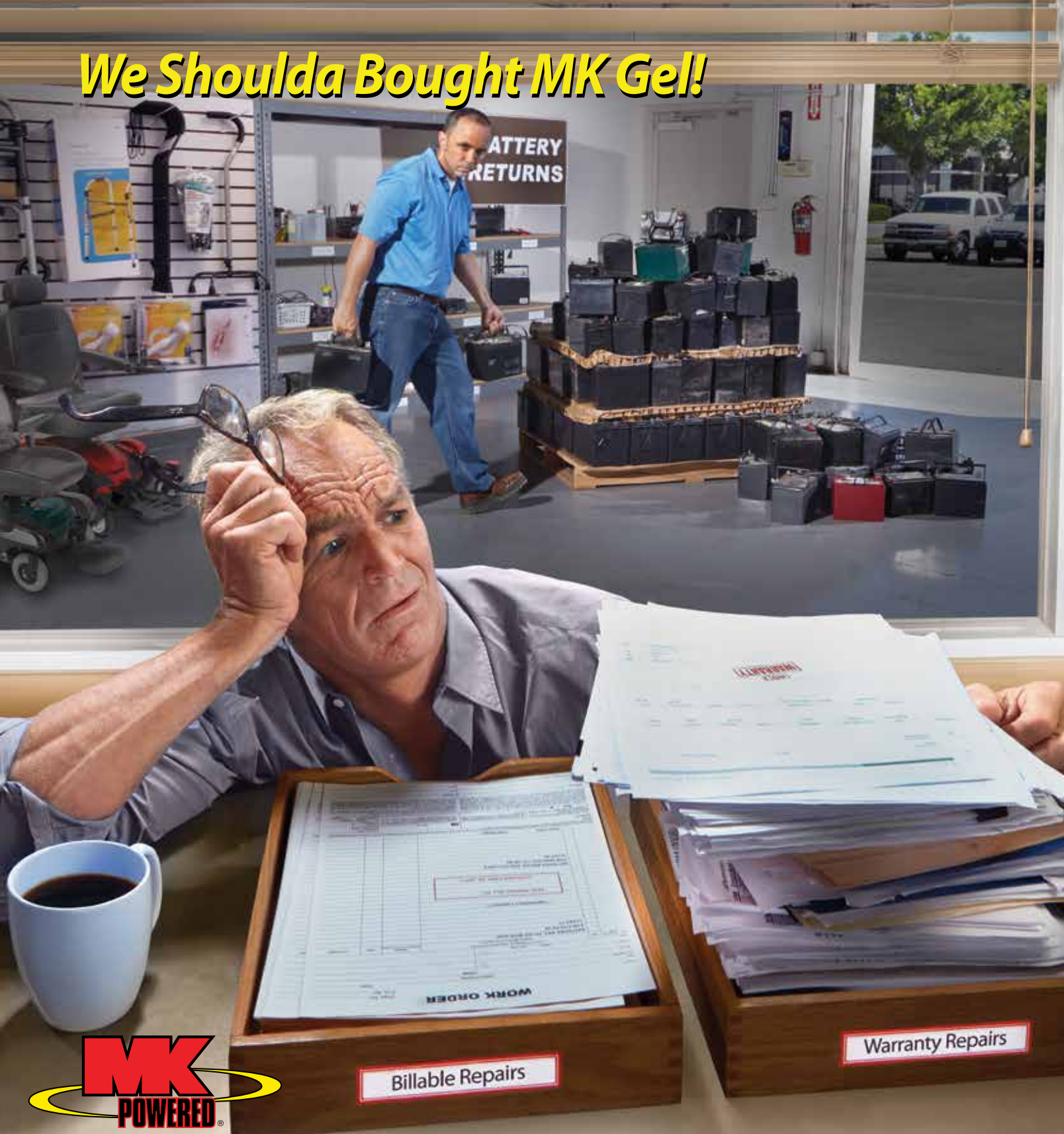

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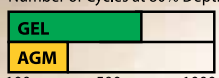

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Jack Badger, RRTS®
The Medical Store
1225 Airport Pkwy
South Burlington, VT 05403
Telephone: 802-864-0908 x.115
Fax: 802-862-6482
Registration Date: 9/21/2015

Bryan Benton, RRTS®
Allcare Pharmacy and Healthcare Services
112 South Oxley Dr.
Lyons, GA 30436
Telephone: 912-526-3200
Fax: 912-293-3350
Registration Date: 8/3/2015

Ilan Michael Breiner, ATP, RRTS®
A&A Medical Supply
8221 E Washington St
Chagrin Falls, OH 44023
Telephone: 440-543-4645
Fax: 800-849-7365
Registration Date: 9/15/2015

Nicholas Dodson, ATP, RRTS®
National Seating & Mobility, Inc.
3936 NW Urbandale Dr.
Urbandale, IA 50322
Telephone: 515-270-1522 x.204
Fax: 515-270-4914
Registration Date: 8/17/2015

Robin Grider, ATP, RRTS®
Presidential Conversions
2887 N College Ave
Suite B
Fayetteville, AR 72703
Telephone: 479-521-8433
Fax: 479-521-7771
Registration Date: 8/11/2015

Sean Kiepert, ATP, RRTS®
National Seating & Mobility, Inc.
6773 Industrial Parkway
N. Olmsted, OH 44070
Telephone: 419-357-6060
Toll Free: 423-551-8231
Registration Date: 9/16/2015

Rich Krause, RRTS®
Aspirus Home Medical Equipment
5450 Stewart Ave
Wausau, WI 54401
Telephone: 715-847-2545 x.52059
Fax: 715-847-2188
Registration Date: 9/3/2015

Michael Provines, ATP, RRTS®
Numotion
2315 Bob Wallace Ave SW
#G
Huntsville, AL 35805
Telephone: 256-705-4646
Fax: 256-705-4569
Registration Date: 9/21/2015

CRTS®

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential.

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Scott P. Dyson, ATP, CRTS®
Hudson Seating & Mobility
Warwick, RI

Jeff Kersey, ATP, CRTS®
Care Medical
Athens, GA

Rob Kriebel, ATP/SMS, CRTS®
Custom Mobility, Inc.
Largo, FL

Jose Lopez, ATP, CRTS®
Numotion
Worcester, MA

William C. McKeon, ATP, CRTS®
Hudson Seating & Mobility
Franklin, MA

Brian Perkowski, PT, ATP, CRTS®
National Seating & Mobility, Inc.
Wall Township, NJ

Michael F. Peterlin, ATP, CRTS®
Numotion
Brooklyn Heights, OH

Daniel Pino, OTR, ATP, CRTS®
Numotion
Chattanooga, TN

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 JULY 29 THROUGH SEPT. 27, 2015.

For an up-to-date verification on Registrants, visit www.nrrts.org, updated daily.

David Bechtel, Newport Beach, CA
Cory Brant, ATP, Gainesville, FL
David Bruinsma, ATP, Altamonte Springs, FL
Keith C. Burkholder, ATP, Carlisle, PA
Thomas Bursick, ATP, Sewicklely, PA
Jeremy Chung, San Carlos, CA
Melvin Chung, San Carlos, CA
Phyllis L. Edwards, ATP, Norfolk, VA
Mark Frazier, ATP, Tempe, AZ
Guy F. Joyce, ATP, Hudson, NH
James M. Kibler, ATP, Ft. Myers, FL
Aaron S. Lauver, ATP, Milton, PA
Ben Memmott, ATP, Carlsbad, CA
Mark Nice, ATP, Harrisburg, PA
Mark Sigeti, ATP, Buffalo, NY
Nathan A Smith, ATP, Fairfield, NJ
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NSM National Seating & Mobility
permobil
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SUNRISE MEDICAL
ROHO
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AEL Adaptive Engineering Lab
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Columbia MEDICAL — Solutions for Daily Living
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