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Tamara Kittelson-Aldred, MS, OTR/L, ATP specializes in complex seating and wheeled mobility and other technologies for children and youth with disabilities, through Access Therapy Services, LLC in Missoula, Mont. **See page 40.**

Jeffrey S. Baird, Esq. is chairman of the Health Care Group at Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. He represents pharmacies, infusion companies, home medical equipment companies and other health care providers throughout the United States. Baird is Board Certified in Health Law by the Texas Board of Legal Specialization. **See page 12** .

Don Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART). Clayback has more than 24 years of experience in the Complex Rehab Technology and Home Medical Equipment industries as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences. **See page 28**.

Ann Eubank, LMSW, OTR/L, ATP, CAPS is vice president of Community Initiatives for UsersFirst, a program of United Spinal Association. **See page 32.**

Michele Gunn, ATP, CRTS® is NRRTS president. She works for Browning's Health Care in Orlando, Fla., and has been a NRRTS Registrant since 1996. **See page 8.**

Wendy Koesters, PT, ATP is a physical therapist at the Ohio State University Medical Center. She shares her time in the Assistive Technology Center as well as treating neurologically impaired individuals in an out-patient setting. The AT Center allows her to evaluate, trial and treat adults with seating, positioning, skill training, and technology related needs. **See page 34.**

Michelle L. Lange, OTR, ABDA, ATP/SMS is an occupational therapist with 25 years of experience and former clinical director of the Assistive Technology Clinics of the Children's Hospital of Denver. She is a well-respected lecturer, both nationally and internationally and has authored seven book chapters and more than 100 articles. She is the editor of "Fundamentals in Assistive Technology, Fourth Ed." Lange is on the teaching faculty of RESNA and the University of Pittsburgh. She is on the RERC on Wheeled Mobility Advisory Board. Lange is a credentialed ATP, credentialed SMS and is a senior disability analyst of the ABDA. **See page 50.**

Tim Pederson is thedirector of The MED Group's National Rehab Network and National Orthotics & Prosthetics Network. **See page 20.**

Cindi Petito, OTR/L, ATP, CAPS is the owner of Seating Solutions, an outpatient private practice in Orange Park, Fla. She has more than 10 years experience in the area of complex seating and wheeled mobility, and assistive technologies. **See page 40.**

Katie Roberts, ATP, CRTS® is a NRRTS At-Large Board Member who works for Cimarron Medical Services in Stillwater, Okla. **See page 24.**

Dr. Richard M. Schein is a research scientist in the Department of Rehabilitation Science and Technology at the University of Pittsburgh. **See page 48.**

Dr. Mark R. Schmeler is an assistant professor, graduate faculty, and director of the Continuing Education Program in the Department of Rehabilitation Science and Technology at the University of Pittsburgh. **See page 48.**

Jill Wiele is a consumer advocate who attended CELA 2012. **See page 16.**

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If We Keep GIVING AWAY THE MILK, They Ain't Gonna *Buy the Cow*

Written By **Michele Gunn, ATP, CRTS®**

THE OTHER DAY, I HAD AN EVALUATION with a therapist I work with often. Once we finished looking at our client, we began chatting about other clients and catching up on things. She mentioned a case where she felt all alone in the process of choosing a stander for a client whose equipment provider felt that was her responsibility. She asked me if I had just been doing her a favor by coming out with trial equipment and helping determine what would work for our clients in common. I responded that "rehab" was a team sport and while I am not reimbursed for my time in the process, I am one of the players who make sure the equipment works for all parties involved. I have always wondered what would happen if I were removed from the equation. As funding gets tighter and sources look for ways to save precious dollars, will I ever be seen as a valuable player?

Why is it no one seems to understand the only reimbursement we realize is from the delivery of the equipment itself? Others on the team are getting paid for their time in the process. We only get paid for the piece of equipment. We know this, but no one else seems to understand. Clients and funding sources alike compare what we do to Internet providers, even when standing in their homes working after 5 p.m. on a Friday night. How many times have you had someone shop you to quote a product and after hours of work go purchase it on the Internet? Then when it shows up to the house in a box they call you to have you drive out to set it up for them. How have we let ourselves get painted into this corner, and is it too late to paint a path out?

I get many of my ideas for articles from what I read on our listserv, and this is a topic that has come up a lot lately. We are unhappy with the situation, but somehow feel powerless to do anything about it. A friend of mine calls this our social worker mentality. We want to help our clients in any way possible. This has somehow turned into doing everything necessary to include giving away free service, as well as items we are no longer able to get funded. A while ago, there was talk about what people were doing in different states for transit brackets. The replies varied by state with many providers saying they felt it was their responsibility to give them away if no one would pay for them to keep their clients safe. How did it become our responsibility to do this? If we continue to do these things for free, they will not be seen as having value. Ultimately, we will never get paid for providing them.

Do you think people would notice if we all stopped doing everything we do for free? Take for instance the loaner chair issue. When did we let ourselves become loaner chair providers? I am guessing this happened when clients no longer stayed in rehab long enough for their chairs to get processed. Patients get out sooner, and we have to go through more and more hoops, so the chairs take longer to fund. Enter the need for loaner chairs for the client to be discharged. Maybe there was a middle step with a rental for awhile, but that did not seem to last. There is also the issue that facilities expect the chair to be as close as possible to what is being recommended and this is seldom possible with rental type chairs.

How many of you get orders from these facilities saying a loaner must be provided upon discharge if you are going to be the provider? I am not even sure if this is legal, yet we see this every day. Think, then, of the time spent getting the loaner ready. The delivery is never smooth. Usually the time is hurried as no one really knows when they are going home until the last minute. Then once you get to the facility or home, no one is satisfied with the shape or quality of what you are providing at NO CHARGE. There is such a thing as looking a gift horse in the mouth! Now you are on the hook to service the loaner chair for free until the permanent chair shows up. If you do get to deliver the permanent chair, the loaner is never in the same shape as it left the office if it is even returned at all.

Why is it no one seems to understand the only reimbursement we realize is from the delivery of the equipment itself?

Then there is the issue of repairs and warranty service. Our industry is unusual in that suppliers do not get paid for providing warranty service from manufacturers. I am not

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...They Ain't Gonna Buy the Cow

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sure I understand why this is, but try to explain it to a consumer. Living in Orlando, we have an unusual amount of calls for warranty service from high traveler volume. They call the manufacturers of their chairs who then give them our number. We have not made any money providing their chairs and are now expected to do warranty service for free? Even if we charge for the labor, there is no way you are making a profit for providing this service.

This is one of the things about our industry that really makes me scratch my head. I am also lucky enough to be located in one of the first competitive bid areas. We are not a bid winner, yet we get calls all day long from clients who cannot get their chairs serviced from the companies who sold them. The reasons they give are endless. The company is no longer in business, no longer has a contract with that manufacturer, and won't come out to the home. It goes on and on. When providing regular service we are supposed to drive out to the client's home and are not allowed charge for it? There is a flat fee for labor on replacement items that do not give adequate time to perform the service? As far as I know, Medicare pays the highest labor fee a $14.05 a unit in Florida. Many other contracts are in the $9 area. At the highest of $56.20 an hour, someone is going to have to explain to me how they think their repair departments are making any money. At best, most break even and call it a PR expense.

I have limited room in my message, so this list is not inclusive. The reimbursement continues to drop while the list continues to build. Everything we do is expected to be covered in the amount we receive once we deliver and bill for a chair or repair and service. Still, there are those who claim we have no real value. If we all stopped this madness tomorrow would things change? You bet they would.

CONTACT THE AUTHOR:
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PROVIDING REPAIRS: There Is an UPSIDE.... and There Is a *Downside*

Written By **Jeffrey S. Baird, Esq.**

IN THE MOVIE "A PERFECT STORM," THE crew of the Andrea Gail was trapped in the collision of a nor'easter and a hurricane. The end result was ugly. Thank goodness George Clooney and Mark Wahlberg survived to make future movies. Rehab suppliers are caught in their own version of a perfect storm: (i) the Durable Medical Equipment (DME) industry is young; in its present form, it has been around for about 30 years (compare this to physicians and pharmacies/apothecaries who have been around for thousands of years); (ii) the DME industry grew up unregulated; essentially, the old HCFA (now CMS) did not pay attention to the DME industry until approximately the last seven years; (iii) until recently, it was easy to obtain a Medicare Part B supplier number and a state Medicaid provider number; there were no substantive background checks; (iv) because it was easy in the past to obtain a supplier number, a small (but visible) number of people came into the DME industry and blatantly committed fraud (e.g., Operation Wheeler Dealer in Houston); (v) the fraudulent acts of these few suppliers provided emotional "sound bites" for politicians who railed against health care fraud; (vi) Medicare is broke; it went broke serving 23 million of the "greatest generation;" now Medicare is facing a tsunami of 78 million "baby boomers" who are retiring at the rate of 10,000 per day and who will live to be 85 years old; (vii) as the government is inclined to do, it overacted; Congress passed laws and CMS issued regulations; (viii) one example of the government's overreaction is decreased reimbursement and more stringent coverage and documentation requirements; (ix) other examples are aggressive post-payment audits and prepayment reviews; and of course, (x) competitive bidding.

At this point in time, there are few artificial barriers to providing rehab equipment to patients not covered by a government health care program. This is not the case with Medicare beneficiaries. Power and manual wheelchairs, scooters, and related accessories are covered by the ill-advised competitive bidding program. 42 C.F.R. § 414.402, 404. What this means is that in 100 of the largest cities in the country, in order for a rehab supplier to have the right to provide wheelchairs, scooters, and related accessories to Medicare beneficiaries, the supplier must be awarded a competitive bidding contract. However, a rehab supplier that was not awarded a competitive bidding contract may nevertheless perform repairs on equipment previously provided by another DME company. Of course, the rehab supplier can provide repairs on equipment for commercially insured patients, and, generally speaking, the supplier can provide repairs on equipment in which the patient is covered by a state Medicaid program.

Therefore, the question becomes: Should the rehab supplier provide repairs to rehab equipment that the supplier did not initially provide? That is a good question and arguments can be made on both sides of the equation. The upside for providing repairs to equipment that the rehab supplier did not initially provide are: (i) the rehab supplier "stays in the game;" that is, the supplier has contacts/communications with the patient, the patient's family, and the referring physician; (ii) when the rehab supplier has multiple points of contact with patients, their caregivers, and referral sources, then referrals of patients (Medicare, Medicaid and commercial) will invariably come to the supplier; (iii) as discussed above, even if the rehab supplier is not awarded a competitive bid contract for wheelchairs, scooters, and related accessories, the supplier can nevertheless provide repair services; this will

> At the same time, there is a downside to repairing equipment that other suppliers have sold.

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Providing Repairs...

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provide cash flow to the supplier and allow it to stay in contact with the patient, the patient's family, and the referral source; and (iv) if the rehab supplier focuses on providing repair services, then this can be a niche that relatively few rehab suppliers fill.

At the same time, there is a downside to repairing equipment that other suppliers have sold. If the equipment somehow malfunctions, and if the patient is injured, then the patient and his attorney will "look all the way up the food chain" for damages. In other words, when a patient is injured by a piece of equipment, then the plaintiff attorney will assert a claim against the complete "chain of custody" for damages. *See Thompson v. Nat'l Seating & Mobility, Inc.* The rehab supplier is part of the "chain of custody." This chain includes the manufacturers of the component parts; the distributors of the component parts; the company that assembles the component parts; the distributor of the assembled product; the retailer of the product; and the company that provides repair services. From the plaintiff attorney's standpoint, each of the companies within this "chain of custody" may have contributed to the malfunction that caused the injury. Thus, even though the rehab supplier is only paid a minimal amount of money for the repair, the supplier may face liability (along with the other companies within the chain of custody) in the event of an injury. Liability can be based on one or both of the following theories: negligence and products liability.

NEGLIGENCE

The elements of negligence are the following:

- the existence of a duty on the part of the defendant to conform to a specific standard of conduct for the protection of the plaintiff against an unreasonable risk of injury;
- breach of that duty by the defendant;
- the breach of the duty by defendant is the actual and proximate cause of the plaintiff's injury; and
- damages to the plaintiff's person or property.

See 53 Tex. Jur. 3d Negligence § 56.

An employer is responsible for injury to a third party when its employee commits negligence while acting within the course and scope of his employment. An act of an employee is within the scope of his employment if (i) it was something fairly and naturally incidental to the employer's business assigned to the employee, and (ii) it was done while the employee was engaged in the employer's business with the view of furthering the employer's interest and did not arise entirely from some external, independent and personal motive on the part of the employee.

The elements necessary to prove negligent hiring and negligent retention are generally the same. This theory requires proof that (i) the employee was unfit, considering the nature of the employment and the potential risk to those with whom he would foreseeably associate; (ii) the employer knew or should have known that the employee was unfit; and (iii) the employer's negligence was a proximate cause of the plaintiff's injuries.

One can sue an employer on the theory that its negligent training and supervision of the subordinates caused the misconduct. This theory usually requires proof that (i) the employer failed to exercise reasonable care in training or supervising the employee; and (ii) the employer's negligence was a proximate cause of the plaintiff's injuries

PRODUCTS LIABILITY

"Products liability" is the generic phrase used to describe the liability of a supplier of a product to one injured by the product. A plaintiff in a products liability case may have one of five possible theories of liability available to him: (i) intent; (ii) negligence; (iii) strict liability; (iv) implied warranty of merchantability and fitness for a particular purpose; and (v) representation theories (express warranty and misrepresentation). *See e.g., Tex. Civ. Prac. & Rem. Code Ann. § 82.001(2).* To find liability under any products liability theory, the plaintiff must show that the product was "defective" when the product left the defendant's control.

- Liability based on intent – A defendant will be liable to anyone injured by an unsafe product if the defendant intended the consequences or knew that they were substantially certain to occur. Liability based on an intentional tort is not very common in products liability cases.
- Liability based on negligence – See the discussion, above.
- Liability based on strict tort liability – To establish a prima facie case in products liability based on strict liability in tort, the following elements must be proved: (i) strict duty owned by a commercial supplier; (ii) breach of that duty; (iii) actual and proximate cause; and (iv) damages.
- Liability based on implied warranties of merchantability and fitness – If a product fails to live up to the standards imposed by an implied warranty, the warranty is breached and defendant will be liable. The plaintiff need not prove any fault on the defendant's part. When a merchant who deals in certain kinds of goods sells such goods, there is an implied warranty that they are merchantable.

"Merchantable" means that the goods are of a quality equal to that generally acceptable among those who deal in similar goods and are generally fit for the ordinary purposes for which such goods are used. An implied warranty of fitness for a particular purpose arises when the seller knows or has reason to know (i) the particular purpose for which the goods are required and (ii) that the buyer is relying on the seller's skill or judgment to select or furnish suitable goods.

• Liability based on representation theories (express warranty and misrepresentation of fact) – An express warranty arises where a seller or supplier makes any affirmation of fact or promise to the buyer relating to the goods that becomes part of the "basis of the bargain." Liability for misrepresentation may arise when a representation by the seller about a product induces reliance by the buyer. In products cases, liability for misrepresentation is usually based on strict liability, but may also arise for intentional and negligent misrepresentations.

From a cost-benefit standpoint, the question becomes: Is it worth it for a supplier to provide repairs on equipment that it did not originally sell?

There is another downside to consider. The Medicare contractors (DME MACs, CERTs, RACs, and ZPICs) are on steroids as they conduct post-payment audits and prepayment reviews. The intensity of audits and reviews has increased exponentially over the last two years. In a post-payment audit, the rehab supplier has been previously paid but is now required to produce documents that support the payment. *See generally Medicare Program Integrity Manual Ch. 3.* If the contractor concludes that the supplier's documentation does not support the prior payment, then the contractor will demand a recoupment. Id. In a prepayment review, the contractor will not even consider paying the rehab supplier until the supplier submits documentation that, in the eyes of the contractor, justifies payment. Id. So what does this mean to the rehab supplier that is performing repairs? If the DME company (that sold the equipment to the patient) is subjected to a post-payment audit and is hit with a recoupment demand on the basis of lack of medical necessity, then there is a risk that the recoupment demand may also apply to the rehab supplier that provided the subsequent repairs. Again, from a cost-benefit standpoint, the rehab supplier must determine if it is worth it for the supplier to perform repairs on rehab equipment it did not initially sell.

In short, there is no "black and white" advice on what a rehab supplier should do. As is the case in most aspects of its business, the supplier must conduct a cost-benefit analysis regarding the value of performing repairs on rehab equipment that the supplier did not initially sell.

CONTACT
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Branch Out with a Toaster Oven from MAINE to *Arizona*

Written By **Randy Christian**

NOT LONG AFTER JILL WIELE GRADUATED from the University of Iowa, she was invited to move to Maine. Yes, Maine; where the summers are muggy, humid and downright miserable, especially if you have no air conditioner. Winter can be charming too, if you're a polar bear. The average daytime temperature in the winter is 48 degrees. Fifty-eight inches of snow is pretty much a sure bet. Wiele is quick to sing the praises of Maine and says it's a beautiful state, just not the best place for someone to live who uses a wheelchair.

–

Had Wiele ever been to Maine before she made her move? No. In fact, the only time she'd ventured far from home, prior to moving to Maine, was when she flew to Washington, D.C., with her mom to attend an educational conference. Not only was it her first plane ride, but it was also her first time to fly with her electric wheelchair. She was genuinely excited about attending the conference, but was actually using the trip as a test flight for her move to Maine.

Just prior to her departure for America's northern most state, Wiele learned she and her friends would not be flying. So, with her wheelchair securely fastened on a trailer hitched to the back of her friend's car, Wiele and crew set out for Maine, sight unseen.

"After I graduated, I thought about getting my masters, but wasn't sure it would really help advance my career. I had this lingering fear that if I did go back to school, I'd get stuck and not branch out; so I moved to Maine," Wiele said.

By many standards, moving more than 1,400 miles away from home right after graduating college certainly constitutes "branching out." It was particularly bold for someone who had literally grown up in a wheelchair. Even for an able-bodied person moving somewhere you knew no one, except your travel mates, takes a lot of courage and an innate zest for life, but for Wiele it was much more. It was one more opportunity to prove to family and friends she could make it in this world all alone if necessary.

"It seems like ever since I was born I've had to prove people wrong. Because I was born with cerebral palsy, and the prognosis was not good, my parents were told that I should be put in an institution," Wiele said. "The experts said I'd never be able to talk, and I did. I'd never be able to sit-up or feed myself, and I did. I kept doing things I wasn't supposed to do."

–

In 1968 when Wiele was born, little was known about cerebral palsy compared to today. With a noted pause in her voice, Wiele indicated her parents did the best they could with knowledge available at the time. By accident, one of the more positive things Wiele's parents did for her was to treat her much the same as her three siblings. The lack of coddling forced Wiele to fend for herself as much as physically possible. It prepared her for a world that could be bitterly cruel at times, but also incredibly rewarding, especially for a young girl who was determined to defy the odds customarily associated with cerebral palsy.

Wiele began her schooling in a segregated environment composed only of kids with a variety of disabilities. It wasn't until her family moved to Iowa and she was "mainstreamed" that the environment changed radically. Now, she was in a school where she was the only kid in a wheelchair. It was a challenging circumstance for which Wiele was not fully prepared. For the first time in her life, Wiele was faced with the fact that she was very different than the other kids. She had a disability and far too often her young classmates reminded her of that reality.

> Wiele's parents treated her much the same as her three siblings.

The cruelty of young children can often be more piercing than that of an adult. Such was the case for Wiele. From fourth grade to her senior year in high school, Wiele

ABOVE: WIELE IN FRONT OF THE WHITE HOUSE AT CELA 2012
LEFT: WATCH WIELE WALK ON THE TREADMILL

endured a barrage of teasing, taunting and juvenile jokes leaving her with few positive memories of her school days and few friends. Fortunately, her college years were much different. After attending a junior college to, as Wiele says, "get my GPA up," she applied to attend the University of Iowa. She was accepted, but there was one catch – Wiele had not told her parents she had applied.

"I can remember when I got the letter that said I was accepted to the University of Iowa. I was really excited and my parents were shocked," Wiele said.

Not only was the University of Iowa relatively close to home, but Wiele knew it to be very wheelchair-friendly. It also had a respected social work program, Wiele's major, and there was a childhood connection to the university as well. Fond memories of attending what was called "Hospital School" at the University of Iowa when Wiele was a child were easily recalled.

At "Hospital School," kids with disabilities learned basic life skills. It was around the same time Wiele attended "Hospital School" that she had surgery at the hospital affiliated with the university. As fate would have it, a college professor was the doctor who performed one of her

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...Maine to Arizona

(continued from page 17)

surgeries years earlier. With a profound sense of joy Wiele said, "He remembered me." The physician's memory of Wiele thrilled her immensely. It was evidence someone cared.

Without any help or coaching from any disability advocacy group or an attorney, Wiele took on the insurance company by herself.

One of Wiele's college dreams was to join a sorority, but that was not to be. None of the sorority houses were wheelchair accessible. Undaunted, Wiele joined a co-ed service fraternity. It was a perfect alternative, especially since there was no fraternity house and no challenges associated with a wheelchair. Because the fraternity was service-oriented, it provided Wiele with opportunities to participate in fundraisers and awareness programs that benefitted a variety of worthy causes. One such event was a Rock-a-thon. The goal was to raise money and awareness for the plight of the elderly. All Wiele had to do was sit in a rocking chair and rock and rock and rock for hours and hours.

"Wow, a Rock-a-thon was perfect for me. I could sit there and rock. I don't remember how long I rocked, but it was a long time. It was fun and for a good cause," Wiele said.

After graduation in 1991, Wiele made her bold move to Maine. However, after realizing it wasn't the best place for a girl in a wheelchair to call home, she made another bold move to Arizona where there was no snow, but lots of sun and heat. Again, sight unseen, Wiele used her Maine strategy and carefully plotted her move to Phoenix. After saving a little money, Wiele called a travel agent who graciously helped her find ADA compliant living quarters in Phoenix. The travel agent also made sure Wiele had access to an airport shuttle that could accommodate a wheelchair. So, for several weeks after arriving in Phoenix, Wiele called the Roadway Inn "home."

"A funny thing about flying to Arizona is somehow they let me board the plane with a toaster oven. I cooked with that thing for quite while in the hotel room. I don't know how or why they let me take that toaster oven on the plane, it sure was a lifesaver," Wiele said.

Next on Wiele's agenda was to get a job, which was not easy. Keeping a job was even harder. Even though she made sure her employer clearly understood her limitations, ultimately her co-workers would complain, and tension was sure to follow.

"Oh, the supervisor would start out by telling me how good of an employee I was, but would finish with, 'This just isn't a good fit.' I had an idea who had complained. While I knew I had rights under the ADA, I wanted to avoid the possibility of a hostile workplace. Ironically, as I was leaving, the company began remodeling in order to become more accessible," Wiele said.

In the early 1990s when Wiele experienced her employment struggles, American with Disabilities Act workplace compliance laws had yet to make a significant difference in the lives of folks with disabilities. Times have changed as well as Wiele's willingness to defend herself. Today, Wiele does not hesitate to push the cause for those with disabilities.

Her unwavering tenacity is one of the primary reasons she is the proud owner of a new power wheelchair with a tilt system. When she submitted a request for her new wheelchair, the insurance company immediately denied her request, even though she met three of the five criteria as prescribed by her insurance company. Without proper review of Wiele's follow-up submittals, the insurance company continued to say "No."

Determined to prove them wrong, Wiele pushed her case all the way to the Ninth Court of Appeals in California. Without any help or coaching from any disability advocacy group or an attorney, Wiele took on the insurance company by herself.

"We were on a video conference with the judge in California. I made sure to let the court know that the insurance representatives chose to attend via phone rather than go down the street where I was speaking on video and meet me in person," Wiele said. The judge was further irritated when he found out they had never bothered to speak to Wiele's doctor. "They didn't have the pictures of the sores on my skin and feet either, but the judge had them," Wiele said.

In less than half an hour the hearing was over. Wiele had won. Her new wheelchair was ordered and quickly delivered, too.

Wiele's fighting spirit was welcomed with open arms at this year's CELA meeting in Washington, D.C. Her trek up Capitol Hill and meetings with congressional staff members certainly had an impact. Like so many other times in Wiele's life she was again motivated by her forever philosophy of, "I'm going to prove them wrong" by encouraging our lawmakers to do what is right. Wiele, like so many others who continue to conquer life in their own special way, is an inspiration.

From Maine to Arizona, her search for freedom and independence is a touching journey we all should gladly support.

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USING WHAT YOU KNOW...

A CONVERSATION WITH THE MED GROUP'S TIM PEDERSON

Interview By **Danette Baker**

ABOUT A YEAR AGO, TIM Pederson transitioned to a director's position with The MED Group, heading up the company's National Rehab and Orthotics and Prosthetics Networks. He was already a familiar face in the industry having served on the boards of organizations such as MAMES and the American Association for Homecare's Complex Rehab Mobility Council, but in recent months, he has worked aggressively on the Separate Benefit Category for Complex Rehab Technology (CRT).

DIRECTIONS recently had the opportunity to visit with Pederson and learn more about his new position with The MED Group.

HOW DID YOU BECOME INTERESTED IN THE INDUSTRY?

Back in 1986, I graduated with a degree in Healthcare Administration. This is right when the bottom fell out of the hospital market due to the Prospective Payment System coming online. This meant that there were a lot of more experienced people than me who were looking for entry level positions in hospital administration. After trying to compete for those jobs, I was advised to look at the supply side of health care, and that is where I got my opportunity.

I ended up working for Pat Cody at Wheelchair House in Englewood, Colo., back in 1993. This is where I first began to learn about CRT — even though we didn't call it that back then. Pat is a great teacher, and we keep in contact to this day.

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

Opening my own business was a risk back in 1998, but I learned a lot. Serving as chairman of American Association for Homecare's (AAHomecare) Rehab Council was a great experience as well. We managed to change the name from Rehab and Assistive Technology Council (RATC) to Complex Rehab and Mobility Council (CRMC) during my last year. Serving as president of the Midwest Association for Medical Equipment Services (MAMES) was also a great honor. MAMES continues to be one of the premier state associations in the industry. Joining The MED Group, initially as director of the Orthotics and Prosthetics (O&P) Network and later becoming director of both it and the Rehab Network is also a major milestone in my life.

Probably my most relevant milestone was helping bring the industry together as part of the group that created the Separate Benefit Category Steering Committee. This coalition brought together four industry organizations that sometimes have struggled to work together. I am honored to have been able to serve with the other members of the committee as a true industry coalition. We have achieved a level of unity that the industry has never seen. My hope is that the groups involved will look at this coalition as more than a single issue initiative. We are seeing much more industry coordination than ever before on all of the issues that we face.

WHO HAS BEEN INSTRUMENTAL IN THOSE ACCOMPLISHMENTS?

In starting my own business, a wise old friend who is now deceased was the one who was most instrumental. For chairman of AAHomecare's Rehab Council, Dan Meuser and Seth Johnson from Pride Mobility were the ones that really encouraged me to take this opportunity. At first I was quite reluctant, but I grew into the position and felt quite comfortable after a period of time.

For the MAMES position, several were instrumental. Carol Laumer from Rice Home Medical in Minnesota initially asked me to join the executive committee and get in line to be president. Lelia Wilkerson from Heritage Medical in Iowa, Barb Stockert from Sanford Healthcare Accessories in North Dakota, and, of course, Rose Schafhauser from MAMES were all instrumental in my acceptance.

I was also blessed with a great executive committee of my own while serving as president. Among the others that supported me were Gerald Sloan from Progressive Medical in Kansas, Greg Lord from Great Plains Rehab Services in North Dakota, Julie Weidemann from Palmer Home Medical in Iowa, and Jackie Semrad from Reliable Medical in Minnesota.

For the MED position, Wayne Grau and Jeff Woodham were instrumental in that. Having their confidence gives me encouragement to elevate our networks to show true value to our members.

Several people were instrumental in the creation of the Separate Benefit Category Steering Committee. I believe without the efforts of Gary Gilberti, Simon Margolis, Don Clayback, and Walt Gorski we would have fallen short. Margolis said it best early on in the process. He stated that we could put together a perfect benefit structure that is not workable, or we could put together a workable benefit structure that is not perfect. He said that he was willing to compromise to achieve a workable benefit. I think that single statement put everything in perspective for the rest of us, and the rest is history.

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...Using What You Know

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WHAT INSPIRED YOU TO MAKE THE MOVE TO THE MED GROUP TO HEAD UP ITS NATIONAL O&P NETWORK?

I think the challenge is what did it for me. I needed a change. My company was no different than the rest of the industry in that the challenges we faced were substantial. They certainly didn't need me on the payroll to do their work, and MED approached me about this project. A change in scenery is good for the soul.

WHAT ARE SOME OF THE MAJOR ACCOMPLISHMENTS HAVE YOU HAD WITH THE PROGRAM SO FAR?

The major accomplishment has been to help our members understand that providing orthotics and prosthetics is so very similar to providing complex rehab. The business processes are nearly identical in that we have credentialed personnel providing specialized services. Our members needed a guidebook of sorts to make this transition, and we created the MED Orthotics and Prosthetics Pathway program to give our members the guidebook

> Margolis stated that we could put together a perfect benefit structure that is not workable, or we could put together a workable benefit structure that is not perfect.

that they need. We broke the business into six different "pathways" that the member can choose from. It is a menu of choices, but they don't need to choose all of them. They can choose the services that they feel are most compatible with their business model, and we help them every step of the way.

Credentialing is vitally important to O&P stakeholders. Although it is also important to CRT stakeholders, the O&P credentials have been in place for a longer period of time. The American Board for Certification in Orthotics, Prosthetics and Pedorthics and the Board for Orthotist/Prosthetist Certification have positioned the certifications in O&P to be recognized as true clinicians rather than suppliers. I think one of the major accomplishments with our MED program was to help our members understand the specialized nature of the credentials. An ATP cannot take a few courses and become a certified O&P practitioner. It takes post-graduate work, internships, and a residency before a candidate can sit for the exam. Our members understand this better than they did a year ago.

WHAT CHALLENGES LIE AHEAD FOR THIS NEW PROGRAM?

I think some of the same challenges that we see with CRT are similar to the challenges that face O&P. Neither industry has done a good job of documenting outcomes of our services. This will be critical in the future as we fight not only to maintain but also to increase reimbursement. O&P now seems to be in the crosshairs for audits. The audits are finding more basic errors from these providers than from CRT providers. CRT medical policy is somewhat nebulous about medical documentation, while O&P medical policy is very clear on documentation standards. O&P providers have tended to be somewhat lax in gathering the required documentation. Since the providers have not been under this much scrutiny in the past, Centers for Medicare and Medicaid (CMS) is finding a target-rich environment right now. On the CRT side, we are asking for clearer documentation standards. The double-edged sword is that even with those clear standards, O&P providers are struggling in the area of compliance. CRT must not fall into the same trap.

HOW ARE YOU USING YOUR KNOWLEDGE OF THE SEPARATE BENEFIT CATEGORY WITH O&P TO HELP SHAPE ONE FOR CRT?

The steering committee has adopted the O&P benefit as a model for the CRT benefit. Given that the businesses are so similar, this was relatively easy to crosswalk. Using O&P as a model services two purposes: first, it is a radical shift from the current durable medical equipment model, and second, even though it is a dramatic change for providers, the model is familiar to CMS and other payers. It is also a precedent that can be cited. I don't think anyone would disagree that a complex power wheelchair for someone with a spinal cord injury is just as specialized as a custom prosthetic leg for someone who has had an amputation.

WHAT HAS KEPT YOU WORKING SO DILIGENTLY FOR THE SUCCESS OF THIS INDUSTRY?

The belief that we can do better as an industry has been a great motivator for me. I would like to believe that we can work together to create more opportunity for providers and clinicians in the industry. Right now many providers are questioning their future in this industry. Some are considering strategic decisions such as divestment. I'd like to change the environment to create opportunities in the business for providers that are smaller in scale similar to small O&P providers. An ATP who works for a smaller local provider can develop a true practice of CRT. If we continue to stabilize the industry, we will be able to create more opportunities for ATPs to have the experience of developing their practice with a smaller provider.

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

If I'm in my office, I routinely participate in two or three conference calls per day. I am also on the phone frequently with members of the National Rehab Network and the National O&P Network.

A great deal of my time is also spent creating content for our programs and services as well as developing the programs themselves. I enjoy the wide range of activities all in one position. I'm grateful for the diversity. I travel about 30 percent of the time, and I enjoy visiting our members and helping them with their businesses.

WHAT'S LIFE OUTSIDE OF THE 9 TO 5 LIKE FOR TIM PEDERSON?

I'm a husband and father, so my family is important to me. I like to support my wife in her activities — she likes to work with her horses and has begun to take them to horse shows. My son is an athlete. He plays hockey at the high school level, so we are on the road a lot for that. We also have a lot of family activity time. Living in the Black Hills is a blessing for us. We enjoy camping as a family during the warm months and other mountain activities during the winter months. When I have the time I like to work with our horses myself. I love to team rope, but it's a good thing I have a day job because I would starve if I depended on that for an income!

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Katie's BIG SPLASH in Stillwater

Written By **Randy Christian**

WE ALL HOPE TO RECOGNIZE THAT DEFINING moment God has planned for us. Sometimes it's an unanticipated event that stuns us into accepting a purpose for our lives that was unimaginable only seconds previously. Other times, it's a person whose inspirational life leads you to leaving the comfort of home in a quest to change the world. All too often we ignore those virtual nudges pushing us toward our defining moments. Some of us chalk them up to a bout with indigestion or those brief emotional boosts we get from reading an ancient Chinese Proverb someone posted on Facebook, but not Katie Mussett Roberts.

Her defining moment revealed itself when she was a junior in high school. Her nudge: an opportunity to help fellow classmates with disabilities. It was at that moment her passion to help others was ignited. It continues to burn brightly today.

Roberts had signed up to participate in a Peer Advocate program at her high school. She was just 17 years old. It wasn't a program many kids her age would even give a second look. Working with kids with disabilities, especially those your own age, was certainly not as glamorous as trying out for cheerleader or running for student body president. Roberts, of course, enjoyed doing all the things almost every teenage girl enjoys doing, but her DNA seemed to be coded in a way to allow her to feel comfortable helping people who couldn't always help themselves.

TOP AND BOTTOM: MDA ADULT RETREAT

Roberts and others who volunteered for the program helped with a variety of classroom activities, as well as used their best teenage wisdom to solve a plethora of problems that constantly cropped-up during the school day.

Dealing with a peer challenged with a mental or physical disability could, at times, be overwhelming for a high school kid. For Roberts, the notion of using her innate problem-solving skills and making the day a little brighter for her disabled classmates was inspirational. Being a part of that Peer Advocate program back in high school was clearly a defining moment for the young woman from Stillwater, Okla. Her sweet spirit of caring for others would guide her through doors of opportunity opened early and often in her young life.

As faith would have it, Roberts's next opportunity to engage her servant's heart would be with the Muscular Dystrophy Association. For several years she took on the duties of a camp counselor. For one week, during the summer, a group of campers descended upon the MDA camp and for that week Roberts was assigned a camper and assumed all responsibilities. Her primary responsibility was to see her camper had lots of fun all week long.

"Spending that week caring for one child, taking care of all of her needs allowed me to see how incredibly, incredibly hard it is to be the parent of a child with a disability. I felt fortunate to be able to take that burden off the parents' shoulders, even for just one week. I have great respect for those parents," Roberts said.

The collective goal of all the counselors was to ensure the phrase "I can" was present in the camper's experience. Whatever the kids wanted to do, Roberts and crew would move heaven and earth to make it happen.

> Her sweet spirit of caring for others would guide her through doors of opportunity opened early and often in her young life.

One of Roberts's campers wanted to jump off the diving board and into the pool 100 times. Yes, you read right – 100 times. So, over and over and over again, throughout the week of camp, Roberts secured the young girl in her arms, climbed the diving board ladder and plunged into the cool, clear, welcoming water of the swimming pool. As they made their way to the diving board for their final

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...Katie's Big Splash in Stillwater

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ABOVE: THE ROBERTS FAMILY: GARRY, SARA AND KATIE

RIGHT: MDA SUMMER CAMP - ROBERTS WITH CAMPERS AND COUNSELORS

jump, a gallery of anxious on-lookers formed around the pool ready, able and more than willing to celebrate a different kind of defining moment that was about to engulf Roberts and her precious camper. The last big splash was, in essence, a shout-out to all the other campers letting them know anything is possible with the love and help of wonderful, caring friends like Roberts and the other camp counselors. She remains a dedicated volunteer to many groups.

After graduating from high school, Roberts left Stillwater to attend Northeastern State University in Tahlequah, Okla., where she earned a bachelor's degree in speech pathology. Even though there is an abundance of job opportunities for folks with speech pathology degrees, Roberts felt it wasn't what she wanted to do with her life. So, with diploma in hand, she traveled down several new avenues that allowed her to gain the confidence and credentials to secure the job she enjoys today.

As it turns out, her days at MDA camp were not only rewarding because of her daily interaction with the campers, but several skilled volunteers provided invaluable mentoring as Roberts changed careers. Randy White, a highly regarded complex rehab professional, came to the camp on a daily basis to work on camper's wheelchairs and evaluate their seating and positioning needs. As Roberts said, "I'd ask him lots of questions and he'd answer them all." She also asked questions about the professional, as well as the educational requirements and experiences she would need to follow in his footsteps. At night, after all the campers were in bed, Roberts would carefully study all the empty chairs "trying to figure them all out."

She also took advantage of every opportunity to learn more and more about seating and positioning, from the experts, whether at the summer camps, the MDA Clinic in Oklahoma City, or the Oklahoma Assistive Technology Center. Her dedication and intense interest in complex rehab technology paid off when a job at Stillwater Medical Center became available. She applied and was hired.

Coincidently, a human resources department staff member at the Medical Center encouraged her to investigate the merits of becoming a NRRTS Registrant. Several doctors also recommended Roberts check out NRRTS. As she researched NRRTS, she discovered it was highly regarded by a myriad of rehab disciplines. She also learned being a NRRTS Registrant sent a strong signal to doctors and other rehab professionals of her commitment to the profession. It helped to distinguish her from those fly-by-night folks who were notorious for slapping a patient in the next available wheeled contraption with little to no regard for proper seating and positioning protocol. In 2007, Roberts became a proud NRRTS Registrant and currently serves on its Board of Directors.

As a board member of NRRTS, Roberts was encouraged to attend CELA in Washington, D.C., which she did in 2012. It may come as no surprise to veteran CELA attendees that Roberts experienced a series of defining moments as she traveled the hallways of the congressional office buildings. She also learned meetings with elected officials and/or their legislative aides are somewhat like Forrest Gump's famous box of chocolates. They may look similar on the outside, but you never know what you'll find inside. Some staff members had loved ones who had battled physical or

mental disabilities. Others were attentive, but didn't have a clue. A few with whom they met late in the day fought-off the sandman as Roberts and friends made their pitch. Regardless of the level of engagement, Roberts left the Hill with a sense of how D.C. works ... or doesn't. She also left with a charming, euphoric sense of what it means to be a citizen of the United State of America.

"You felt like you did something great, but did it do any good? Will it make a difference? Did the people I meet with hear anything I said? I have no idea, but it's a very empowering thing to know that you can go up there and talk to somebody," Roberts said.

Her noble efforts at the 2012 edition of CELA will always be appreciated and rewarded with a mind-full of memories and many new, lifelong friendships. She has every intention of returning to D. C., but as Roberts moves forward with her career in her home state of Oklahoma, she is sure to impact the lives of many folks for years to come. Even with the avalanche of paperwork that seems to grow higher and higher each year, Roberts's love for helping people with disabilities seems unwavering.

Roberts is quick to point out she is one of the "new kids" on the complex rehab block. She knows it will take her many years to acquire the sixth-sense so many other rehab professionals who came before her gained through their never give-up attitude. They are truly the NRRTS pioneers who recognized their defining moments. They embraced their newfound purpose – "to help people with disabilities gain the freedom and independence they yearn for and deserve." It's Roberts's purpose, too and has been since she walked into a high school classroom as a Peer Advocate. Many, many people in Stillwater, Okla., are thankful that at the ripe old age of 17, Roberts recognized her defining moment.

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Separate Benefit for COMPLEX REHAB Technology Update

Written by **Don Clayback,**
NCART Executive Director

CALL TO ACTION FOR COMPLEX REHAB TECHNOLOGY

WE ARE MAKING GOOD PROGRESS ON OUR Separate Benefit Category legislation, H.R. 4378, the "Ensuring Access to Quality Complex Rehabilitation Technology Act." For those unfamiliar with the bill, it will create a Separate Benefit Category for Complex Rehabilitation Technology (CRT) within the Medicare program. This is similar to the separate category given to Orthotics and Prosthetics and will provide needed changes and safeguards to improve access for the people with disabilities who rely on this equipment and the related supporting services. Here's a review of where we are and what all CRT stakeholders can be doing to keep things moving forward.

H.R. 4378 WEBSITE

To provide current information and easy access to advocacy materials, we have created a dedicated SBC website at *www.access2crt.org*. This houses various documents and information, including most importantly a link that enables anyone to send an email to their congressman and senators asking for support. The website content includes:

- "Introduction to CRT" video (10 minutes) - Share this link with legislators and others to educate them on what CRT is, who uses it, why it's important, and how it's provided.
- Contact Congress link - This link will allow you to enter your zip code and email your representative and senators about the issue and your request to support H.R. 4378. Use the suggested message, or better yet personalize it from your perspective.
- National Petition link - After sending your emails, you can also sign the electronic petition that will be shared with Congress to show widespread support for the bill.
- Educational Material - View and share the summary of H.R. 4378, the position paper, the list of supporting national organizations, and other educational documents.

The website also houses a Co-Sponsor Scoreboard so you can see who has already signed on. This is the place to point people to so they can get engaged in our efforts. We will be updating this site regularly.

THE POLITICAL LANDSCAPE

As we enter the summer and move into fall, Congress is in election mode. This is a great time to be reaching out to your Members. Our task is to get every member of Congress educated on Complex Rehab Technology. If they are in the House, we need them signed on to H.R. 4378. If they are in the Senate we need them to help us get a "companion bill" introduced. If we can generate enough support (co-sponsors) over the next several months, we will be in position to push to have our bill attached to a larger piece of legislation when Congress comes back after the elections. It's a big goal, but for us to have a chance in that November/December window we need to be doing the hard work now through October.

CURRENT ACTIVITY WITH CONGRESS

Active discussions are continuing with many Member offices. We're happy to report that thanks to the persistence of dedicated CRT stakeholders, as of this writing we have 17 House Members officially signed on as co-sponsors of H.R. 4378. This group includes key members from the Ways and Means Committee, the Energy and Commerce Committee, and the Disability Caucus. You can view an up-to-date list of co-sponsors by state at www.access2crt.org. If your Member is not on this list, you know what your assignment is for next week!

Once you connect with your Member's office, a very good sign is if they have questions about the bill. Please feel free to contact me in those situations, and I will be happy to reply directly or to help you develop your own reply. One common question is "what is the cost of the bill?" Since the bill was just introduced in April, we do not have a Congressional Budget Office (CBO) score yet. The CBO is the independent office that provides Congress the "official" estimate of the financial cost of legislation. To obtain a CBO score we need to get more co-sponsors behind this bill so the CBO will make it a priority.

However to address this question in the meantime, the SBC Steering Committee hired a well-respected Washington, DC

To provide current information and easy access to advocacy materials, we have created a dedicated SBC website at *www.access2crt.org.*

economic consulting firm, Dobson and Davanzo, to use a CBO model and develop a score. Their report estimated the cost at about $5 million a year (or $56 million over 10 years). Based on that, we are asking co-sponsors to sign on with that assumption and recognizing the merits of the legislation. We know cost is a factor and will work to work with our co-sponsors should the CBO score come in higher. It's important to note that this cost does not factor in any of the savings that will result from people having better access to CRT. Better access will reduce the major health care costs that result from such things as development of pressure sores, progression of orthopedic complications, increased hospitalizations, etc.

Your Member is not officially a co-sponsor unless they contact Nicole Cohen in Congressman Joe Crowley's office to let her know. Nicole can be reached at 202-225-3965 or nicole.cohen@mail.house.gov. Be mindful of your Member saying they "support it and will vote for it" when it comes to the floor. While that will be helpful down the road, what we need is for them to officially sign on as a co-sponsor NOW so we can add their name to the bill. If they "support" it, signing on as a co-sponsor should be easy.

CALL TO ACTION

It's time to get a commitment from your Members in Congress. If you haven't made contact yet, start with an email and use the information at www.access2crt.org to inform them of the issues and the bill. But remember the email is only the START of the process. If you have already been in contact with your Member, don't be timid about pushing for support. If they are hesitant, find out why and what we can do to address the concerns. But after giving them a reasonable period of time to

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Complex Rehab Technology Update...

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analyze and consider the bill, you need to be politely persistent so they know this is important to you. Given the elections up ahead, Members will likely be more open to addressing the request of their constituents.

Getting legislation passed in Congress is a real challenge. H.R. 4378 will only get passed if enough Members of Congress hear from people in their home districts and states. We need thousands of people from across the country to contact Congress and tell them this issue is important and they need to sign on to this bill! Here are five simple steps everyone needs to execute:

- Step 1- Use *www.access2crt.org* to review the background material
- Step 2- Use *www.access2crt.org* to email your Members of Congress
- Step 3- Use *www.access2crt.org* to sign the National H.R. 4378 Petition
- Step 4- Follow up with your Members until they sign on to H.R. 4378
- Step 5- Spread the word and get others engaged in this advocacy

Let's build on the momentum we have created! We have developed a variety of tools to help in your advocacy efforts: *www.access2crt.org*, video, position paper, legislation summary, suggested email, CRT background information, etc. These can all be very helpful, but are worthless unless you and others take the time to use them with Congress. Unfortunately Members will not sign on unless they hear from you and others in your district. So please invest the time and let us know how we can be of assistance. Thanks for your active advocacy and for getting others engaged in our efforts.

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GRASSROOTS UPDATE: Being a PART OF THE MISSION *Every Day*

Written By **Ann Eubank, LMSW, OTR/L, ATP, CAPS**

THIS RESILIENT COMMUNITY OF CONSUMERS, clinicians, suppliers and manufacturers faced with denials, appeals, delays in payment and indiscriminate, arbitrary medical equipment policies continues to persevere. It is a privilege to be a part of a community that builds, provides and uses equipment that allows Americans to exercise the right to access their communities. The insurance industry may try to condition us to strictly think "medical necessity," but people who use mobility equipment, Americans, think meaningful life activities equal function. And, sometimes are offended when insurance companies, for example, do not deem the ability to reach kitchen cabinets to independently cook a meal "medically necessary." One would think eating is considered an essential element to being healthy. Regardless of these injustices, this community continues to challenge limiting polices.

Through collaboration and determination of everyday citizens, including all stakeholders, a bill addressing access to Complex Rehab Technology (CRT) has been introduced to Congress. This success embodies our community's ability to succeed in the face of great obstacles. To quote Thomas Edison, "Genius is 1 percent inspiration, 99 percent perspiration." Yes, sir, it's mostly hard work.

In 2009, the community leaders formed CRT workgroups and a steering committee and then began writing discussion papers detailing every aspect involving and related to CRT, which was published in March 2010. In January 2011, a formal proposal was written. This proposal was sent to a Washington D.C., law firm that edited it for acceptance on Capitol Hill. Then an economic firm scored it. This means they determined what financial cost is associated with the bill. Once this was done, our community leaders and workgroups met with their local representatives to find a sponsor. With relationship building and perseverance, Rep. Joe Crowley from New York agreed to sponsor the bill. His staff worked with the wording of the bill in order to actually introduce it to Congress. This process took about three years with lots of certitude.

CHAPTER EVENT IN KANSAS CITY

The CRT bill is a great idea, yet changing the status quo takes effort and patience. To quote Admiral Rickover, "Good ideas are not adopted automatically. They must be driven into practice with courageous patience."

Keep in mind we have more work to do. To increase the possibility of success more representatives are needed to sign onto the bill. This work happens locally. Meaning, as a community, when we bring our stories – the consumers' stories – to the representative's office in our state, it is a powerful and empowering act.

Many of the attendees of CELA – professionals, consumers and family members – reported feeling empowered. To have the freedom and means to visit members of Congress and tell your story is an awesome experience – a true American experience. Another powerful aspect of NRRTS is the opportunity for peer support. The community of professionals who faces similar challenges throughout the country is able to connect daily, if desired, for support and information. This support is crucial given the funding environment and changing business landscape. NRRTS also provides the opportunity for Registrants to speak out with their own individual voices. Having a voice and being heard is quite significant in today's fast paced world. This strong sense of community lends itself to mobilizing individuals to action. The success is evident.

As we move forward, spreading the word and soliciting support for CRT, consumer involvement is paramount. Consumer involvement is not dissimilar to NRRTS involvement. UsersFirst and United Spinal Association offer chapters and support groups nationwide. Much like NRRTS, the chapters and support groups discuss and offer information concerning various subjects that are important to the members. As a consumer organization, our members are generally interested in subjects related to living with a disability. Therefore, attaining the right wheelchair that works best in their lives is a hot topic.

The chapter network provides the structure for people with similar interests to gather, provide and receive support. Here, members learn about valuable resources, participate in supportive peer relationships and gain the opportunity to voice their needs and concerns. UsersFirst is an empowerment model. Meaning, through peer support, members choose what is most important to them and use the resources available to take action. UsersFirst provides education and support for members to take action locally to increase access to wheeled mobility.

As a consumer organization, our bottom line is service to people with disabilities and to contain costs. Our budget must focus on the programs that foster the empowerment necessary for members to consider themselves an advocate. People take action once they feel empowered.

> The CRT bill is a great idea, yet changing the status quo takes effort and patience.

The ongoing support of a consumer organization with a mission to serve creates a sustainable movement. Challenging discriminatory policies takes patience so it is essential UsersFirst and United Spinal provide the necessary structure and support to continue to engage members. Politics can be overwhelming to many Americans, yet through peer communication concerning wheels that work, the CRT message is disseminated.

Please be part of this daily mission, visit http://www.usersfirst.org.

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FINDING Your Passion

Written By **Wendy Koesters, PT, ATP**

CERTAIN PEOPLE COME INTO YOUR LIFE AND they make you re-evaluate your priorites: am I fulfilled with what I am doing, am I making an impact on people's lives around me, what is my next big challenge? Laura's case caused me to question all of these things and with the team that I work with, I know we helped Laura answer some of these for herself.

Laura was referred to our clinic in the spring of 2010. She had been a repeat patient of our clinic over the years due to pain and post surgical loss of function. She has neurofibromatosis causing tumors to grow in her central and peripheral nervous system. To preserve function and decrease pain she has undergone multiple cervical and lumbar laminectomies. She developed scoliosis due to lack of muscular stability post surgery. She underwent a hemipelvectomy on the right five years prior. She has dependent edema of left distal leg. Surgical transfers of bilateral ulnar nerves, a left arm tendon transfer of ECRL and FPL, along with a left median nerve dissection result in decreased grip and limited flexibility at elbow and wrist. She has dealt with ischial and coccygeal wounds post surgeries and upon referral had a stage I coccyx sore. She has chronic neck, back and worsening complaint of shoulder pain over the past year. Tumors present on her head caused hypersensitivity to touch at the back of her skull.

Laura is a neurologist but had to discontinue practicing due to advancing medical difficulties. She had used a rear wheel drive power chair due to weakness after cervical and lumbar surgeries for multiple years but had transitioned to a manual Quickie Titanium for ease with transportation — driving with roof chair lift on a sedan with hand controls. She reported discomfort with sitting ever since the hemipelvectomy and had moved from use of a 2-valve Roho to a Roho Quatro high profile. She reported feeling like she was sitting on a "golf ball" at her coccyx. Balance within the seating system with mild dump and an adjustable tension back support was also an issue. She had found that by inflating the right half of her Roho to accommodate her obliquity assisted with stability but further compromised her comfort at her tailbone. Her propulsion

(continued on page 36)

" THE CUSHION CHANGED MY LIFE. I CAN NOW SIT FOR LONG PERIODS OF TIME WITH COMFORT. IT HAS GIVEN MY LIFE BACK TO ME," SAID LAURA.

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...Finding Your Passon

(continued from page 34)

ability had declined in the past year from one mile in fall 2009 to 10 minutes in spring 2010. Pain also limited her sitting tolerance to 10-15 minutes. Laura stated that her life had become very "narrow" with limited community access and even for completion of self care. She was able to live independently but had to increase reliance on family and friends for assist with cleaning her home and grocery shopping.

The Assistive Technology Clinic that I work at relies on the expertise of the treating therapist, patient-chosen vendor and rehab engineering. I definitely benefited, as did Laura, with this team collaboration. During the next eight months, the team would work closely with Laura challenging us to meet her changing needs along the way — surgery for more tumor removals, joint pain at shoulders and left leg, and skin breakdown. We utilized objective measures to assist with documentation for funding sources and decision making for equipment. The Smart Wheel, pressure mapping, plus Kirby's skills checklist with manual and power wheelchair propulsion were used as well for modifications as needed to the equipment. Orthopedic treatment with physical and occupational therapy also assisted in her achieving optimal functional ability with self care, transfers and propulsion as recommended by the treating therapist in the team.

The initial plan for equipment took into account her presentation with a wound and inability to pressure relief effectively or frequently (postural asymmetry and extremity/ trunk weakness), shoulder pain, plus she was an ineffective propeller. The Smart Wheel demonstrated that she was a successful propeller for short distances but with increased arm strain to complete. Long distance propulsion in community was limited with asymmetric arm strength and ROM. The Smart Wheel numbers in comparison to norms demonstrated her as an unsuccessful propeller out of the home — via stroke length and force production. Pain and inability for community propulsion had her pursuing power mobility. We completed a trial mold for back and cushion support to determine client's tolerance to and effect on pain. She was excited and wanted to pursue. The vendor was most familiar with a specific type of molding process and implementation. The client's preference for type of molding system changed when we invited her as a case study at a training program at our facility for this manufacturer. She was so pleased with the feel — the "golf ball" was gone" that as a group we decided to pursue this molding system for her power wheelchair. Laura still required the manual wheelchair for independent driving with her roof chair lift and requested ordering a new manual wheelchair with the same lightweight custom seating for back and cushion. She was fortunate to be able to self fund the manual wheelchair for community and insurance funding for the power wheelchair for use at home and outdoor in area of her home.

Multiple fittings and "tweaking" for both power and manual wheelchair seating systems were completed per client request

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ORIGINAL WHEELCHAIR WITH AIR CUSHION AND SLING BACK. EQUIPMENT DID NOT PROVIDE ANY STABILITY AND CAUSED POOR SITTING TOLERANCE WITH SIGNIFICANT PAIN.

...Finding Your Passon

(continued from page 37)

and with one month follow ups to determine independence and efficiency with mobility, transfers, pressure relief, and self care (reach, balance, etc.). The results for Laura exceeded her initial goals for pressure relief and increased sitting tolerance. She had the energy and ambition to pursue a new dream: kayaking. Utilizing her cushion she was able to kayak class II and III rapids in the Smoky Mountains with First Descents. This organization provides adventure opportunities outdoors for cancer survivors. In a phone conversation with Laura, she told me that she had an "addiction to kayaking ... the high lasts for months." She is planning kayaking tours in other national parks and in a river with a dam close to home.

Laura's case was unique for the fact that she was able to secure two seating systems to assist her within home and community with the fluctuating needs that she has depending on tumor growth/location and surgery recovery. But, our team staying persistent with trial of equipment to secure appropriate pieces and appropriate measures to justify the need for each incremental change in fitting, can be carried over into every case. The end result for Laura is her ability to pursue a passion that a year prior she had never thought possible and on a personal level for me, reaffirm my passion in what I get to do each day with my team.

CONTACT THE AUTHOR:
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POLICY STATEMENT on *CRT Ratified*

BY AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA)

Written by **Cindi Petito, OTR/L, ATP, CAPS & Tamara Kittelson-Aldred, MS, OTR/L, ATP**

CLINICIAN TASK FORCE (CTF) ACTIVITIES focus on protecting and improving access to Complex Rehab Technology (CRT) for people with disabilities. Since 2004, the CTF has served as the clinical voice to policy makers on CRT issues that require specific input and attention from a clinical perspective.

The CTF has worked to elevate the visibility of CRT and its provision within the American Occupational Therapy Association (AOTA) and American Physical Therapy Association (APTA) that together represent more than 120,000 clinicians. To increase the awareness of CRT within the clinical community, our members work with AOTA and APTA member leadership and staff to increase awareness of CRT consumer access issues and identify mechanisms to build capacity and better prepare the workforce to practice in this area. We believe that with increased understanding of the issues, their assistance in efforts to protect access should improve. These organizations can collaborate better and at a higher level if they truly understand the issues.

Under the leadership of Cindi Petito and Tamara Kittelson-Aldred, a CTF workgroup recently achieved a major accomplishment – ratification of an AOTA CRT Policy Statement. This success is a culmination of a multiyear effort, countless hours of volunteer time, and two separate attempts to introduce motions to the Representative Assembly of the AOTA in 2006 and again in 2010. Most recently, in October 2010, the process of drafting motions for submission to the 2011 Representative Assembly (RA) of the AOTA began.

The RA represents the highest governing body of the AOTA. Motions passed by the RA become official policy of the organization. Learning along the way and working with AOTA volunteer leadership and staff, we crafted motions that would both address our concerns and have a good chance of being adopted. We learned drafting motions, such as legislation, is an iterative process that requires patience, persistence and compromise. Over a period of seven months, two separate motions were crafted and introduced to the RA for a vote at the Annual AOTA Conference in April 2011.

By design, we intended our two motions would lead to creation of AOTA official documents to support a Separate Benefit Category for CRT. We were thrilled when both motions passed with overall positive support.

The first motion called for the development of a Specialized Knowledge and Skills Document on Complex Seating and Wheeled Mobility in Occupational Therapy Practice. This document is currently being written and is expected to be completed within the year. Once ratified it will define the knowledge and skills necessary for OTs to provide ethical, competent OT services related to CRT. These types of documents may be used by academic programs, educators, and clinical programs to develop curriculums to ensure clinicians are prepared for the future of CRT.

The second motion called for the development of a Policy Fact Sheet on CRT. Twelve months later, this document has been ratified and adopted by the AOTA. We are proud to be a part of obtaining AOTA's official support for H.R. 4378 "Ensuring Access to Quality Complex Rehabilitation Technology Act of 2012." The full text of the Policy Fact Sheet can be viewed under Advocacy Highlights on the AOTA website, *http://www.aota.org/News/AdvocacyNews/AOTA-Issues-Policy-on-CRT.aspx*.

The Policy Statement (Fact Sheet) on CRT includes information on the importance of therapists' role in assessing a beneficiary's need for CRT as well as providing fitting and training to ensure optimal use of the devices.

This document will be used by AOTA's Public Affairs officials, staff and members to:

- Educate OTs about public policy barriers placed on their patients' access to funding for appropriate complex rehabilitation assistive technology.
- Educate Congress, legislators, key committees, regulators, CMS contractors and other payers on a state and federal level about policy barriers to appropriate CRT and access to related OT services.
- Educate government public policy makers on coverage and payment policy barriers, and promote changes specific to CRT and related OT services.
- Advocate for changes to government third party payment policy, targeting CMS for Federal action and State Medicaid programs for State action.
- Advocate for changes to private third party payment policy makers.

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Policy Statement...

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Regarding H.R. 4378, Tim Nanof, AOTA's director of Federal Affairs states:

"This legislation, driven by the needs of beneficiaries and practitioners as seen in the field, will improve the quality of complex rehabilitation equipment and devices while improving beneficiary quality of life through enhanced access to occupational therapy expertise."

The Policy Statement concludes with a recommendation:

"Congress should pass legislation to establish a new Separate Benefit Category for CRT and services within the Medicare program. The legislation should recognize the complex and customized nature of the technology required to meet the medical and functional needs of individuals with disabilities and complex medical conditions. In addition the law should specifically recognize the full spectrum of qualified services necessary to the provision of high quality and effective care, including occupational therapy. In particular AOTA urges Congress to pass the Ensuring Access to Quality Complex Rehabilitation Technology Act (H.R.4378)."

The CTF work to obtain support for CRT legislation from clinical stakeholders and increase the clinical workforce capacity for CRT related services continues. Today we celebrate progress toward this end!

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Written by **Danette Baker**

Minimal INVESTMENT, **MAXIMUM** PAYOFF

NRRTS Registrants' contributions important component of outcomes study

When Def Leppard took the stage at the Tampa Bay Times Forum in June, Doreen Pender was in the crowd. The 45-year-old has followed the group since high school and has been to more than a half dozen of their concerts. Multiple sclerosis (MS) has made it more difficult to do the things she enjoys, Pender said, and the Florida heat and humidity would have made the walk into the Forum impossible. Yet, there she was, singing along to the likes of "Pour Some Sugar on Me" and "Rock of Ages," thanks to her new Invacare Ultralight MVP.

"The old chair would have never made it," Pender said. "It was supposed to only last five years, and I had it for 10."

Thana France, ATP, SMS, CRTS®, a seating and mobility specialist with Browning's Health Care in Orlando, Fla., worked with Pender recently to replace her first – and only – wheelchair, an Invacare Ultralight Action Xtra.

Pender described how a wheelchair had given her back much of the independence she lost with the rapid progression of MS. "I was stubborn and refused (to use a wheelchair) at first. I went from walking without assistance to using one cane and then two."

Simple household activities, such as doing the laundry, became a challenge, she said, explaining how "doing laundry" meant dragging the laundry basket full of clothes through her apartment by a belt she had woven through the sides.

"Now I can do laundry like it should be done. I can sit the basket in my lap and wheel myself around. I can do the dishes and go into my kitchen and get things myself. I even wheeled myself around at the market recently when John (her husband) drove me there," she said. "With my new chair, it's easier to wheel and the brakes work; I feel more stable moving around in it."

For complex rehab suppliers and providers, like France, success stories such as Pender's are common. They know their work is making an impact, but there has been an absence in its significance beyond themselves and their clients.

Until now.

Through the Outcome Measures Project, a joint effort between NRRTS and the University of Pittsburgh, the results France achieved with Pender have become part of a nationwide database that will eventually provide rich, scientific statistical results and serve as the basis for recommendations regarding Complex Rehab Technology, said NRRTS Executive Director Simon Margolis.

"In the past, we've gone on this gut feeling or used our own past successes to determine if what we do works," he said. "There is a growing movement in the health care arena in general toward requiring statistical data as evidence. We, as an industry, have been behind in gathering this; but for suppliers and providers, having this type of information and being able to present it in scientific language will validate the services and care they provide that is creating appropriate outcomes for their patients."

In March 2011, NRRTS entered into a one-year partnership with the University of Pittsburgh for the pilot study.

"We were looking for some way of actually, in an objective manner, determining whether what our Registrants were doing was appropriate and be able to develop more outcome-based practices as a result," Margolis said.

France, a NRRTS board member and veteran in the industry, was part of the initial group that contributed to the study, which is being conducted by a team at the University of Pittsburgh's School of Health and Rehabilitation Sciences, Department of Rehabilitation Science and Technology led by Mark R. Schmeler, Ph.D., OTR/L, ATP, and Richard M. Schein, Ph.D., M.P.H. The study utilizes the Functional Mobility Assessment tool, created by Schmeler, assistant professor and director of the school's Continuing Education Program. The tool is a questionnaire-type survey designed to measure the effectiveness of the equipment to produce patient-centered outcomes and be easily administered by anyone who works with the patient, Schmeler said.

France completed 15 assessments in the pilot study – Pender being one of them. France's initial interest came from being in on the initial development of the study and from a conviction that such data is crucial for the industry to move forward.

"I have felt from the beginning that it was very important for us to prove that what we do is worth something," France said. "Every other industry measures what they do. Ours never has, so there is no way for us to know for certain if we have made an improvement. I know personally about my work, but there has been no method of tabulating it along with that of others to really get a good picture of all of our efforts.

"Every other industry measures what they do. Ours never has ..."

"There have been so many funding cutbacks and restricted access to various pieces of equipment that are important to (patients') lives that I want to see changed. I truly believe this is one way to make that happen."

France's patients have been very willing to do their part as well. Pender said France worked pre-assessment into the initial evaluation process, which didn't cause any disruption in the level of care.

"She basically just asked a few questions," Pender said.

After delivery of Pender's new Invacare Ultralight MVP wheelchair, France administered the post-assessment with a simple phone call. "It was real easy for us," Pender said, adding that she agreed to participate in the study out of respect for France and to help improve the quality of care for others.

David Hughes, ATP, CRTS®, president of Able Mobility, also found the study to be easily administered.

"It took less than five minutes in the evaluation and an even shorter amount of time for the post-assessment and to send the form into Judy (Dexter, associate executive director at NRRTS)," he said.

Hughes said they did conduct some of the post-assessments during delivery of equipment, but believes truer representation came by waiting a few weeks after delivery of the equipment.

"It's like when you get a new car," he said. "It's really special and everything seems great those first few thousand miles. But when you get the chance to actually take it out on the road and really give it a drive and get to experience all of the features fully, the experience is quite different. The same applies to the wheelchair; the actual measurables come when people experience the real increase in their ability to accomplish new tasks."

Hughes said having worked closely with Schmeler and Schein for the last 12 years as a supplier for the university's rehab clinic, he was aware of the usefulness of the data they were trying to amass.

In fact, Able Mobility has conducted assessments with their clients for years, but used the data more as a way to measure business benchmarks, he said. "The data that comes from this study will give us another measure of how we are doing from a different perspective than how we've looked at it before."

The initial goal was to have 50 cases submitted by NRRTS Registrants, who were exclusive participants in the pilot study, said Schein, researcher scientist/VA-PRC AT and project coordinator at the University of Pittsburgh's School of Health and Rehabilitation Sciences, Department of Rehabilitation Science and Technology. About a month after the pilot study concluded in March, there were close to 200 case studies submitted, he said.

"Even with this initial data, we were able to come up with some hard numbers that confirmed what we have known intuitively for years (see page 48 for details about study results) and identify some trends," Schein said.

According to Schein, having NRRTS Registrants participate helped create a larger database from which conclusive analysis can be drawn that will allow not only for nationwide comparisons, such as disparities and trends, but also for specific regions.

One of the initial results of particular interest to Hughes suggests 1-800 wheelchair companies are targeting a number of consumers. A high number reported receiving their first equipment through companies heavily marketed via television, Schein said, but this population also has a high rate of abandonment, "which is not good for outcomes."

Having NRRTS partner with the university has provided a wealth of data, that Schein hopes will continue in the second phase. The more data they can assemble in the database, the greater the analysis for projecting trends, disparities and best practices.

"I can start looking at real discreet versus global outcomes for a very specific diagnosis," said Schein. "Features that before Medicare might consider a luxury, we can pull a sample from the database with a common diagnosis, say MS, and provide the evidence-based research to quantify that piece of equipment as a necessity."

In June, NRRTS entered into a second contract for the study, and Hughes and France have committed to participate. For Hughes, the decision was simple. More data can bring more information upon which to base solid outcome measures.

"Ultimately, I hope that there will be enough data to be disseminated to Medicare so we can finally address this elephant in the room and solidify the case for Complex Rehab Technology once and for all," Hughes said.

France agreed and also noted she views the minimal time it takes to conduct the assessments as an investment with huge potential for dividends.

"The University of Pittsburgh has an outstanding reputation in the community, and they were able to develop such a study that will be acknowledged and accepted, which will be critical.

"My participation, and that of NRRTS Registrants, is such a small thing that will make such a big difference," she said. "The time it takes to conduct the assessments and fax them in is a pretty insignificant amount of time to potentially move this industry forward; I think that's a very small investment for very large payoff."

PARTICIPATING IN THE OUTCOMES MEASURE PROJECT

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Written by **Mark R. Schmeler & Richard M. Schein**

PRELIMINARY NUMBERS

The University of Pittsburgh and National Registry of Rehabilitation Technology Suppliers (NRRTS) have for the last year collaborated on an outcomes measurement pilot project anchored around the standardized Functional Mobility Assessment (FMA) questionnaire. Both parties wanted to explore the feasibility of a uniform data collection system to assess the effectiveness and functional outcomes of products and services provided by NRRTS Registrants.

To initiate the project, a uniform/minimum data set has been identified and included elements such as year of birth, diagnoses, geographic location, living situation and type of mobility device. Uniformity in outcomes management allows for comparability of results over time and across providers, mobility devices, regions, diagnoses, and many other variables. Analyses can be used to develop or support best-practices, as well as demonstrate the effectiveness of devices and services for different populations.

During the last year, 11 NRRTS Registrants representing 16 states have entered Time 1 data on 134 cases into the Online Outcomes Measurement Database. Further, of those initial cases, 86 of them have Time 2 data. The purpose of Time 1 is to capture the user's assessment of their current mobility equipment, and Time 2 is to capture the user's assessment of their new mobility equipment no less than two weeks post-delivery.

Preliminary reviews of the data is interesting, but more so confirms much of what was somewhat known intuitively. Of the 138 cases of people who need complex rehabilitation, the following diagnoses were most prevalent:

- 24.63 percent
  Spinal Cord Injury
- 14.18 percent
  Multiple Sclerosis
- 9.70 percent
  Cerebral Palsy
- 7.46 percent
  Stroke/CVA
- 4.48 percent
  Amyotrophic Lateral Sclerosis

At Time 1 most individuals were using a group 3 power wheelchair (25.93 percent), K0005 manual wheelchair (16.30 percent) and K0004 manual wheelchair (11.85 percent). Also at Time 1, a majority of the devices were from one specific manufacturer. At Time 2 there was an even higher percentage of people using group 3 power wheelchairs (57.14 percent), fewer K0005 manual wheelchairs (13.10 percent), and no K0004 manual wheelchairs. The devices at Time 2 were also more evenly distributed across six different manufacturers.

Comparing Time 1 and Time 2 data across individual's Functional Mobility Assessment (FMA) scores, there was a significant difference across each of the 10 items (i.e. effectiveness, comfort, health, operate, reach, transfer, personal care, indoor mobility, outdoor mobility, and transportation) and total FMA score. The items that had the greatest change from Time 1 and Time 2 were comfort, health, and daily routine.

The preliminary numbers have yet to be analyzed more scientifically; however, the pilot has demonstrated the process is feasible. More NRRTS Registrants entering data and larger numbers of cases in the database will give results more scientific credibility and allow for specific analyses. The reality is that much of health care coverage and policy is going to be data driven and NRRTS Registrants, clinicians, consumers, and other stakeholders now have an emerging process to meet this demand.

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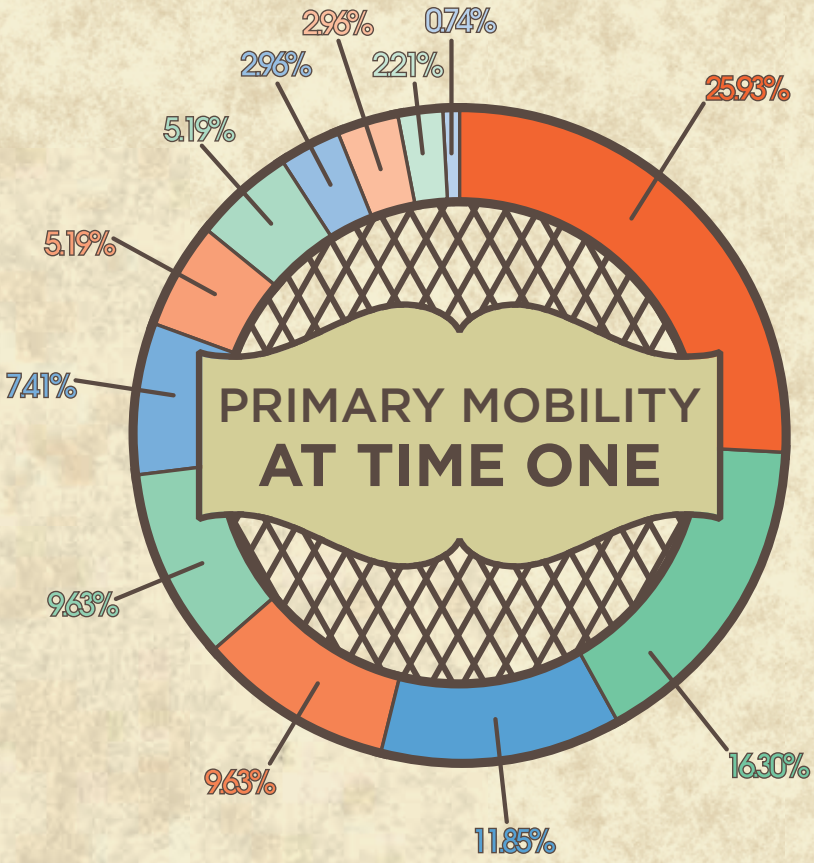
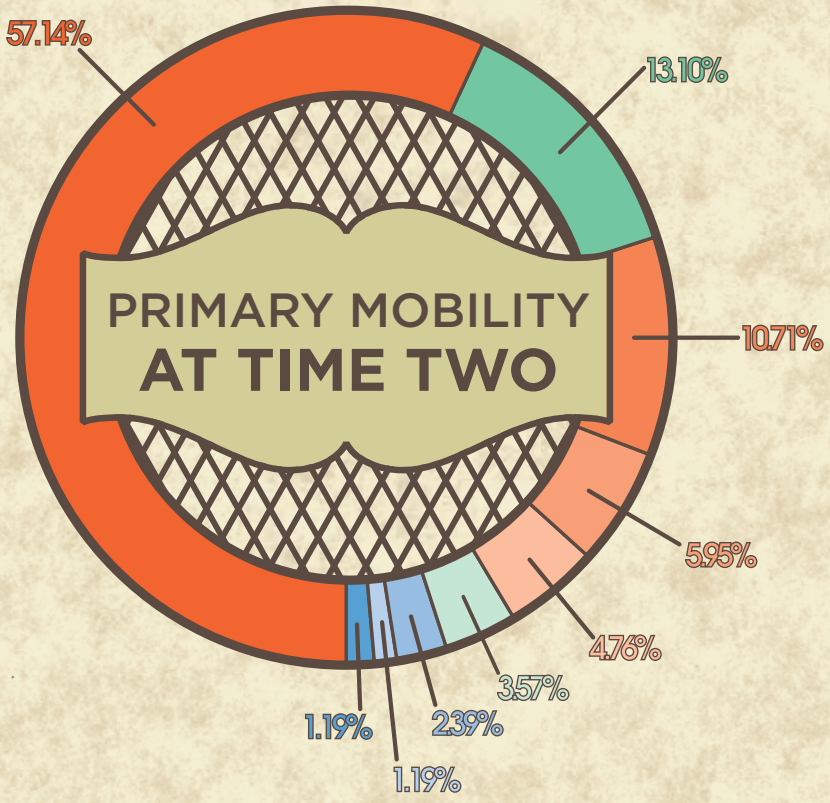


25.93%	GROUP 3 POWER WHEELCHAIR
16.30%	K0005 MANUAL WHEELCHAIR
11.85%	K0004 MANUAL WHEELCHAIR
9.63%	GROUP 2 POWER WHEELCHAIR
9.63%	WALKER
7.41%	K0001 MANUAL WHEELCHAIR
5.19%	GROUP 4 POWER WHEELCHAIR
5.19%	CANE
2.96%	OTHER
2.96%	TILT-IN-SPACE MANUAL WHEELCHAIR
2.21%	SCOOTER
0.74%	K0009 MANUAL WHEELCHAIR

57.14%	GROUP 3 POWER WHEELCHAIR
13.10%	K0005 MANUAL WHEELCHAIR
10.71%	GROUP 2 POWER WHEELCHAIR
5.95%	GROUP 4 POWER WHEELCHAIR
4.76%	TILT-IN-SPACE MANUAL WHEELCHAIR
3.57%	SCOOTER
2.39%	OTHER
1.19%	K0009 MANUAL WHEELCHAIR
1.19%	K0004 MANUAL WHEELCHAIR



Clinical Indicators: POWER vs. Manual Wheelchairs

Written by **Michelle L. Lange, OTR, ABDA, ATP/SMS**

GABRIEL IS A YOUNG ADULT WITH osteogenesis imperfecta (OI). He has a manual and a power wheelchair, both of which he uses independently. Why does he need two mobility bases? In Gabriel's case, as with many wheelchair users, a combination of factors led to utilization of more than one mobility base. Gabriel is able to self-propel an ultra lightweight manual wheelchair for short distances over smooth, level surfaces. He cannot propel longer distances, over varied terrain or up slopes due to poor biomechanics, decreased muscle strength and decreased endurance. His OI has resulted in contractures and short stature. Due to limited range and small upper extremities, his biomechanics are poor and it takes quite a bit of effort to move short distances. Due to the extent of the contractures and his muscle strength, as a result his endurance is low. He uses a power wheelchair for longer distances and negotiating a non-level, non-smooth world. The power wheelchair requires far less effort, both in terms of strength and endurance. So why does Gabriel even need a manual wheelchair? Well, besides providing a back-up to the power wheelchair, the manual wheelchair provides independent mobility within the home. Gabriel's home is not accessible, so he uses the manual wheelchair indoors and the power wheelchair out in the community.

MANUAL WHEELCHAIRS: CLINICAL CRITERIA FOR EFFICIENT SELF-PROPULSION

If you are assessing a client for independent wheelchair mobility, it is essential to determine whether to order a manual or power wheelchair. If a manual wheelchair is indicated, many bases are available to best meet an individual's needs. The following are clinical indicators for efficient manual wheelchair self-propulsion:

1. Efficiency: this is a combination of effort and speed.

a. Effort/Fatigue/Distance: If a client can propel, but only with great effort, then propulsion is not efficient. Functionally, the client may be too fatigued to participate in mobility related activities of daily living (MRADLs) or to propel more than short distances. Fatigue is a big deal. Clients with MS or autoimmune conditions may lose function (temporarily or even permanently) if pushed past a certain fatigue level. Muscle fatigue can lead to increased muscle tone in clients with neurological disorders, such as cerebral palsy, as the body tries to compensate for those tired muscles. Clients with decreased cardiopulmonary function should not exert themselves to a level of fatigue as the heart may be overtaxed and respiratory status compromised.

b. Speed: Great effort typically results in decreased speed. Speed is important for a variety of functional tasks. Crossing the street is a prime example. If the client takes too long to move from point A to point B, MRADLs may be affected and school and work tasks compromised.

2. Body mechanics: one drawback of long term manual wheelchair use is repetitive stress injuries of the shoulder. Clients who otherwise could continue using a manual wheelchair may have to switch over to power solely because their shoulders are so deteriorated. Proper set-up of the manual wheelchair and propulsion training can decrease risk of future damage. If a client is unable to use an efficient stroke pattern, as in Gabriel's case, propulsion efficiency decreases (increased effort and decreased time) and repetitive stress risk increases.

3. Terrain: only a small portion of our environment consists of smooth, level surfaces such as linoleum hallways. Many homes have carpets of varying naps and thresholds of varying heights. Propelling over carpet and over thresholds requires considerably more strength than propelling over a smooth and level surface. Outdoors, the challenges increase. Terrains now include cement and asphalt (which may include cracks and potholes) and grass. Although a variety of tires are available, no manual wheelchair does well in gravel, sand, snow and ice. Propelling over varied terrain, such as sidewalks, requires more strength and endurance than smooth and level surfaces.

> As the push for a Separate Benefit Category for Complex Rehab Technology moves forward, we all must be ready to play hard.

(continued on page 52)

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...Power vs. Manual Wheelchairs

(continued from page 50)

4. Slopes: slopes include ramps, driveways and curb cuts. Curb cuts have a fairly gentle slope, but ramps are not always compliant with the American with Disabilities Act and require quite a bit of strength to go up, to prevent rearward rolling and to prevent undue acceleration when going down.

5. Non-accessible situations: some manual wheelchair users are able to pop a wheelie to get up and over curbs and other obstacles. This is an important skill to increase independence in the community. Very few power wheelchairs can manage curbs.

If the client cannot self-propel a manual wheelchair efficiently (effort and time) and under required everyday circumstances (terrain and slopes), a power wheelchair may be indicated.

POWER WHEELCHAIRS: CLINICAL CRITERIA FOR EFFICIENT MOBILITY

In reality, a power wheelchair is always more efficient than a manual wheelchair as less effort and time is required. So why not order power wheelchairs for everyone? Physiologically, self-propulsion does provide some cardiovascular work, which is a good thing for most people. Funding realities – manual costs less. Accessibility – the world is inaccessible enough to manual wheelchairs, but power wheelchairs require even more accommodation. A manual wheelchair can often be carried up stairs, if necessary. A power wheelchair weighs about 300 lbs! A manual wheelchair can sometimes be folded or otherwise disassembled and placed in a trunk or the back seat of a car. A power wheelchair generally requires an accessible vehicle. Socially, people using manual wheelchairs are viewed as more "able" than a power wheelchair driver.

GABRIEL

The following are clinical indicators for efficient and independent power wheelchair mobility:

1. Cognitive: if a client understands how to use a manual wheelchair, but cannot do so efficiently, they should be able to use a power wheelchair. If you are not sure if the client understands the task, assess mobility skills and provide mobility training to develop skills, as indicated.

2. Vision: vision (acuity and perception) requirements vary from manual to power wheelchairs. In a manual wheelchair, the client's hands are on the wheels or rims. If the frame contacts something, such as a wall, the client will feel this more so than a power wheelchair driver. This provides additional feedback that can compensate for impaired vision in a manual wheelchair. Also, the manual wheelchair will only "bump" a wall, whereas a power wheelchair may literally begin to "climb" a wall, depending on how it is programmed. Many power wheelchair drivers have low vision and do well in familiar environments, particularly indoors. Outdoors is more difficult due to lighting and varied terrain, such as gravel and curb drop offs. I have worked with clients with no vision who drive a power wheelchair, typically using a cane in one hand and driving slowly. Depth perception does not develop until independent mobility occurs, so if the client has had no previous independence at all, it may take a few weeks for this skill to mature.

3. Motor: a manual wheelchair has significant motor requirements. Large bilateral coordinated upper extremity movements are used. Motor requirements for power wheelchair driving are quite different. The joystick is the most common access method. A variety of non-proportional access methods are available, as well.

4. Other factors:

a. Power seating: after choosing a power wheelchair, lots of specific features are available to meet an individual's needs. One feature is power seating, including tilt, recline, elevating legrests, seat elevators and standers. A key difference in manual and power wheelchairs is independence in this area. Although some of these seating features are available on manual wheelchairs, the client can rarely control the feature independently. Power wheelchairs provide independent control.

If a client cannot self propel a manual wheelchair efficiently or use a power wheelchair safely and independently, a manual wheelchair for dependent mobility (i.e. caregiver propulsion) may be indicated.

When evaluating a client for a wheelchair, it is important to determine whether a manual or power wheelchair will provide the most efficient and appropriate mobility for an individual's needs. Even clients who can self-propel may benefit from a power wheelchair for increased independence and efficiency.

CONTACT THE AUTHOR
Michelle may be reached at michellelange@msn.com or 720.333.2661,

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2012-2013 BOARD OF DIRECTORS

PRESIDENT (2011 - 2013)

Michele Gunn, ATP, CRTS®

I have been honored this past year to serve as your president. The NRRTS board has been and continues to be very active on your behalf. DIRECTIONS is one of the leading publications in our industry. This year CELA ushered in HR4378 to recognize Complex Rehabilitation Technology as a separate benefit through CMS. We have extended our Outcome Measures Project with the University of Pittsburgh for another year. Data collected so far proves that we are an integral part of the rehab team leading to positive outcomes for our clients. As a benefit to our Registrants, NRRTS' offers webinars that provide the education needed to maintain credentials. Even with the never-ending road blocks we somehow continue to take these steps forward as an industry gaining recognition for the work that we do. I have always enjoyed being part of NRRTS and have been a Registrant since 1996. I am very committed to my service on the board. Thank you for the opportunity to serve, and I will do my best to continue the advancement of our profession.

PRESIDENT ELECT (2012-2013)

Mike Osborn, ATP, CRTS®

I have been working in the HME industry for more than 18 years. I received my ATP in 1997 and have been working as a CRTS® since 2001. I am proud to be a part of such a hard working organization. I have been fortunate enough to take part in all five of the CELA events in Washington, D.C. We have seen major strides during the past five years in the awareness of NRRTS and what we do as Certified Complex Rehab Technology Specialists. The next step is to make the past five years mean something. With the new Separate Benefit Category now on the table in HR4378 we need to increase our voice on the legislative level. We have reached a place of not only changing lives each day with the work we do but also have an opportunity to change the Complex Rehab Industry in the future. It is an exciting time for NRRTS and for each of us. I am honored to be nominated as president elect and will do all I can to lead NRRTS and promote and represent CRTS and what we stand for.

VICE PRESIDENT (2012-2014)

Gerry Dickerson, ATP, CRTS®

The challenges continue. Some days it seems that everything we try to do for our consumers is slowed or stopped by a rule, a regulation or some mysterious, unseen demon working against the proper intervention.

Working together, telling anyone who will listen, promoting our profession, our benefit to the end user and the benefit to the funding source, is something we all need to do every day.

Efforts to obtain our champion for the Separate Benefit Category required endless hours of extra effort, but in the end it was all worth it. Now the challenge is to continue to push for additional congressional support so that the bill will become law.

The staff and Board of Directors of NRRTS are at the forefront of this effort.

CELA is more successful every year. This year we had a tangible bill - HR-4378, Ensuring Access to Quality Complex Rehabilitation Technology Act of 2012. DIRECTIONS magazine is the premier journal for our profession. Case studies and outcomes all "raise the bar."

More work is still ahead of us. In fact, the hard work is just beginning. I look forward to my continued work with the great community of NRRTS.

SECRETARY (2011-2013)

Leslie Rigg, MS, ATP, CRTS®

I have been a NRRTS Registrant since 1994 and a CRTS® since 1997. As co-owner of ATS Wheelchair and Medical, I am actively involved in ordering, fitting and obtaining funding for rehab equipment. Despite a busy schedule with my business, I have always felt it important that my work extend past my small business to include my community, the industry and the people we serve. I have provided service to NRRTS for the past 12 years in a variety of roles. I currently serve on the DAC Executive Committee and extend my service to the DAC Rehab A-Team. I also serve on the NCART Board. I remain committed to NRRTS and the mission of raising the level of expertise in the field of rehab technology.

We are at a time where now, more than ever, NRRTS must stand and be heard as a leader in the industry. NRRTS has made great strides in educating funding sources and consumers, as well as promoting and developing the expertise of individuals in the registry. There is much more work to be done. Continuity within NRRTS as well as committed leadership is critical to preserve and strengthens the mission of our organization.

TREASURER (2012-2014)

Elaine Stewart, ATP, CRTS®

I am honored to be part of an organization that works diligently to provide educational opportunities, supports the Certified Complex Rehab Technology Specialists, and is an active voice in our government supporting our profession, HR4378. I believe providing the proper information and education to our clientele and funding sources is imperative, so that the proper technology and service is provided to meet their functional needs. As an organization, being proactive is important more now than ever to assure our clients continue to be serviced appropriately and that our profession has a place in the medical model.

I have been providing rehab equipment for more than 25 years and have been a NRRTS Registrant and a CRTS® since 1996. I am a board member of the Association of Indiana Home Medical Equipment Services, which actively represents the industry's views to the state and federal government agencies and legislative bodies for Indiana.

I have seen this industry change many times in my 25 years, and I am driven to provide my clients with the proper technology to be functional within their abilities. After providing technology that is functional and effective, a smile from a family member or client is priceless; that's a profession to be proud to be a part of.

REVIEW CHAIR, DMAC A (2012-2014)

Carey Britton, ATP, CRTS®

I began my career in DME in 1992 after purchasing an existing franchise of Amigo Mobility Center in Fort Lauderdale, Fla. Within a year, it was obvious that we could benefit our customers more by becoming a specialist in the field of seating and mobility. We quickly added seating and positioning services, powered wheelchairs and other specialty equipment into our product line.

I was born and raised in upstate New York and have been living in South Florida since 1988. In addition to complex rehab technology (CRT), I am very involved with my family and photography. I currently hold several board positions in both my professional life and my personal life; giving me the knowledge and experience to help represent my peers. I believe NRRTS is a fine organization, and in the past few years has grown to become a leader in assistive and rehab technology.

In 2010, I was honored to take a position with NRRTS as a director, making our industry better. I believe that I can continue to make a difference and look forward to two more years of listening, learning and lobbying for our wonderful industry. I believe we need to take a moment out of every day and realize that what we do is very noble and impacts the lives of others.

In 2012, I celebrate my 20th year providing CRT, and although we are faced with many changes, I remain passionate and committed to making a difference.

Anyone can sell a product, but it takes an artist to craft a solution.

REVIEW CHAIR, DMAC B (2011-2013)

Mike Nadeau, ATP/SMS, CRTS®

I have been a NRRTS Registrant since May 2002 and a CRTS® since 2005. I have specialized in the field of seating and mobility for more than 28 years. I have been employed by Hudson Home Health Care since 1985 as a rehab technology supplier. I am a frequent lecturer throughout New England on various rehab equipment topics including manual and power wheelchairs, standing frames, and pediatric equipment. I also lecture at numerous New England colleges and universities to students of physical and occupational therapy. I am eager to continue serving on the NRRTS Board, so we can continue the momentum.

REVIEW CHAIR, DMAC C (2012-2013)

Keith Jolicoeur, ATP, CRTS®

I started my career in 1990 working for a large O&P/DME company in Flint, Mich. After a few years working as a delivery, warehouse and orthotics tech, I found myself applying skills toward becoming an RTS and have done so since 1993. As with many of us in this industry, this career as a seating specialist found me versus me finding it.

I have been an ATP/CRTS® with United Seating & Mobility in Springfield, Mo. since 2003. Although what we do as rehab technology specialists can be challenging at times, it also can be rewarding. I am proud to be part of industry that, given the many obstacles, still prevails to help those who deal with many challenges of their own.

REVIEW CHAIR, DMAC D (2012-2014)

Katie Roberts, MS, ATP, CRTS®

I have been a NRRTS registrant since 2007 and a CRTS® since 2009. I am relatively new to this field, but nonetheless I share the desire and understand the importance of moving our industry forward. I started my education in speech pathology where I began to learn about assistive technology. Through other jobs and volunteer work, I have always been involved with people with disabilities and technology. I have worked for our local hospital-based DME for the last seven years. At Cimarron Medical Services, I work on a multi-disciplinary team within the hospital and throughout the community to evaluate, provide, and educate patients for appropriate rehab and assistive technology equipment.

I am honored to be a part of an organization that is working so hard to make sure our industry not only survives but is also able to continue to help those in need.

AT-LARGE DIRECTOR (2011-2013)

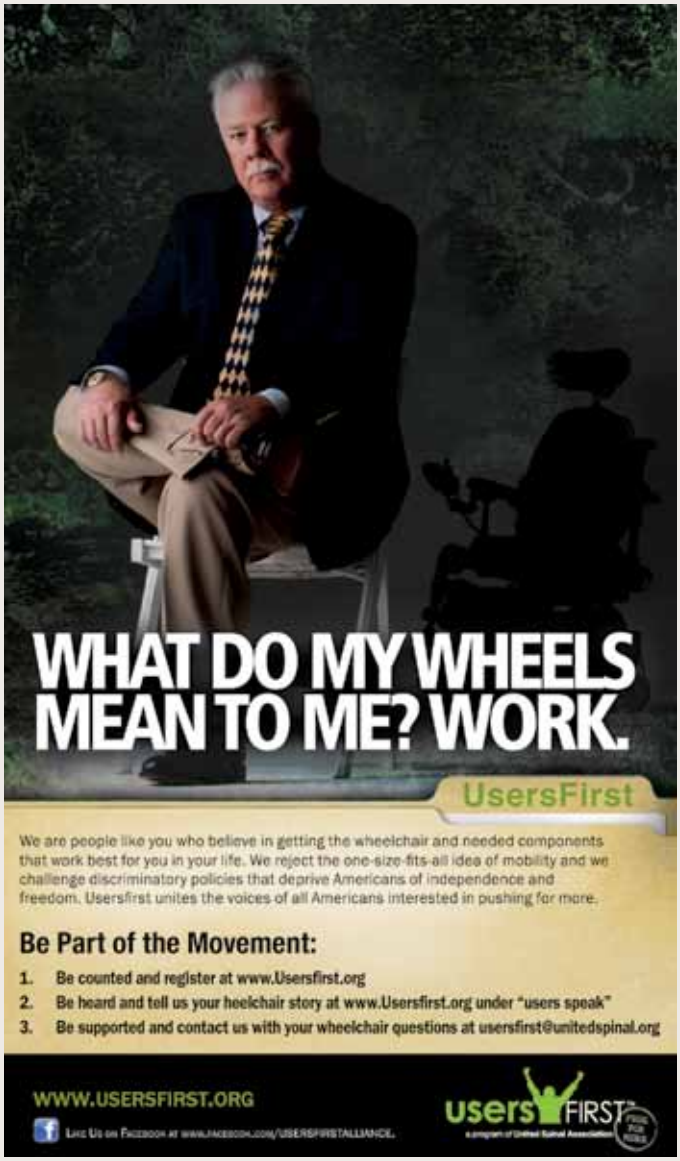
Mike Barner, ATP, CRTS®

I have 24 years of home care services experience, primarily focused on the provision of complex rehab. I have been employed with University of Michigan Health System (UMHS), Home Care Services since August 1997 and currently serve as operations manager for the Wheelchair Seating Service. Before UMHS, I was employed at Apria Healthcare. I have been a NRRTS Registrant since 1996 and an ATP/CRTS® since 1997.

AT-LARGE DIRECTOR (2012-2014)

Thana France, ATP/SMS, CRTS®

I am an ATP/SMS and a CRTS® and work for Browning's Health Care in Orlando, Fla. I have been in the medical industry since 1984, but have been working in rehab for 18 years. I believe we are at a critical crossroad for our industry; if each of us does not make the time to actively participate in the passage of the Separate Benefit Category now, we may not have an industry to serve. We owe this to ourselves and those we serve to make the Separate Benefit Category a reality. I am excited to continue working on the NRRTS Board as an at-large member and working with everyone to move our industry as well as the recognition of the value of CRTS® forward.



AT-LARGE DIRECTOR (2011-2013)

Michelle McMahon, ATP, CRTS®

I have been an active NRRTS Registrant since 2004 and an ATP/CRTS® since 2007. I have enjoyed serving on the NRRTS Board of Directors for the past five years. I am the president and CEO of Frontier Access & Mobility Systems in Cheyenne, Wyo. I continue to be active within the rehab industry, and I serve on various committees within my community and local government. I am a firm believer in NRRTS, and I am proud to be a part of the work that they do. I look forward to seeing our numbers grow, and I am confident we will continue to make strides in educating and reaching those in the rehab community.

AT-LARGE DIRECTOR (2012-2014)

Toby Bergantino, ATP, CRTS®

I have been a NRRTS Registrant since 1994 and an ATP/CRTS® since 1997. I grew up in this industry and have been involved with DME and rehab equipment since 1975. I have enjoyed working on past boards or committee's for the Connecticut Multiple Sclerosis Southwest Chapter, Connecticut Spinal Cord Association, Muscular Dystrophy Association, Sail Connecticut Access Program and Rotary International. I have had the opportunity to brainstorm many ideas regarding clients' needs with other ATPs within our ATG Rehab organization and realize there are many ways we can do the same within NRRTS. It will be an honor to serve NRRTS because it's the one strong rehab organization.

NEW REGISTRANTS

Congratulations to the newest NRRTS Registrants. (May 9 through July 10, 2012)

Emily Cotton, ATP, RRTS®
Tri County Mobility
310 Pine Street A
Goleta, CA 93117
Telephone: 805-967-0070 x.103
Fax: 805-967-4770
Registration Date: 6/4/2012

David Duarte, Jr., ATP, RRTS®
All Star Medical
6894 Alamo Downs Pkwy.
San Antonio, TX 78238
Telephone: 210-767-8004
Fax: 210-767-8024
Registration Date: 6/1/2012

Zane Jacobs, ATP, CRTS®
A & A Home Health Equipment, Inc.
221 Hwy 1 South
Greenville, MS 38701
Telephone: 662-332-0772
Toll Free: 800-748-9047
Fax: 662-335-1702
Registration Date: 5/14/2012

Charles Moye, RRTS®
Integrity Medical
1001 Walton Way
Augusta, GA 30901
Telephone: 706-855-8988
Fax: 706-955-8029
Registration Date: 6/28/2012

David Munroe, RRTS®
Holland Medical
374 North Centerpoint Road
Portland, TN 37148
Telephone: 615-650-8000 x.140
Fax: 615-226-3887
Registration Date: 5/17/2012

Chris Rogers, RRTS®
A & A Home Health Equipment, Inc.
3607 Memorial Parkway
Huntsville, AL 35801
Telephone: 256-881-6262
Fax: 877-888-0657
Registration Date: 6/11/2012

David Rowland, ATP, RRTS®
Alliance Rehab
109 Capanella
Sikeston, MO 63801
Telephone: 573-481-9695
Toll Free: 800-813-1656
Fax: 573-481-9924
Registration Date: 6/28/2012

Nathan A Smith, ATP, CRTS®
Hudson Seating & Mobility
10 Plog Road #2
Fairfield, NJ 07004
Toll Free: 800-321-4442 x.341
Fax: 973-575-1677
Registration Date: 6/16/2012

Coilin Speth, ATP, RRTS®
National Seating & Mobility, Inc.
14231 Seaway Rd. E-2
Gulfport, MS 39503
Telephone: 228-868-9544
Fax: 228-868-9558
Registration Date: 6/14/2012

David St. Louis, ATP, RRTS®
National Seating & Mobility, Inc.
525 N Peters Ave.
Fond du Lac, WI 54937
Telephone: 920-933-3855
Fax: 888-740-9340
Registration Date: 6/8/2012

John C. Stull, RRTS®The Wheelchair Shop, Inc
1332 Upland Dr
Houston, TX 77043
Telephone: 713-468-0696
Toll Free: 877-468-0696
Fax: 713-468-1517
Registration Date: 5/31/2012

in *deepest* SYMPATHY

ASHLEY S. SPEICHER

NRRTS extends it deepest sympathy to the family of Ashley S. Speicher, who died unexpectedly June 2, 2012, after her extended and courageous battle with heart disease. Speicher attended CELA 2012 as a consumer advocate. Please reference **DIRECTIONS, VOL 3 OF 2012** to read her full story.

CRTS® CREDENTIALS

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. Names listed are from May 9 through July 10, 2012.

Jeff Bour, BA, ATP, CRTS®
Carelinc Medical
Grandville, MI

James Brown, ATP, CRTS®
Wright Filippis
Lansing, MI

LeeAnn Cormany, ATP, CRTS®
Horizon HomeCare Supplies
Roanoke, VA

Albert W. DeLoach, ATP, CRTS®
First American Drugs
Valdosta, GA

Jeffrey Freehill, ATP, CRTS®
United Seating & Mobility
Indianapolis, IN

Zane Jacobs, ATP, CRTS®
A & A Home Health Equipment, Inc.
Greenville, MS

Michelle Marchand, ATP/SMS, CRTS®
ATG Rehab
Tacoma, WA

Ben Memmott, ATP, CRTS®
Access Medical
Carlsbad, CA

Thomas Ouimette, ATP, CRTS®
National Seating & Mobility, Inc.
Chicopee, MA

Michael Petz, ATP, CRTS®
Alliance Seating and Mobility
Mobile, AL

Tracy Don Schenck, ATP, CRTS®
United Seating & Mobility
Sheridan, CO

Kip W. Smith II, ATP, CRTS®
National Seating & Mobility, Inc.
Wichita, KS

Nathan A Smith, ATP, CRTS®
Hudson Seating & Mobility
Fairfield, NJ

Kort St. John, BS, ATP, CRTS®
CareLinc Rehab
Grandville, MI

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not. Names included are from May 9 through July 10, 2012. For an up-to-date verification on Registrants, visit www.nrrts.org, updated daily.

Donald C. Bates Tuscaloosa AL
Dennis Bishop Manchester GA
Raymond Bockover, ATP Tyler TX
C Michael Braun Asheville NC
Jim Conwell, ATP New Braunfels TX
Robert Deichert, ATP Torrance CA
Vincent Fels, ATP Earth City MO
Richard Friedman, ATP Hialeah FL
Kenneth Frye, ATP Lynnwood WA
Ryan Gorospe Campbell CA
Robert Houston, ATP Wilsonville OR
John L. Kaiser, ATP Houston TX
Jason Oravec, ATP Springfield OR
Tim Perkins, ATP Wilsonville OR
Kevin Roth, ATP Redmond OR
Michael R. Sivori, ATP Louisville KY
Shelly Torres-West, ATP Grand Prairie TX
Todd A. Truax, ATP Canton OH

CORPORATE FRIENDS [CFONS] OF NRRTS

As Corporate Friends of NRRTS, these companies recognize the value of working with NRRTS Registrants and support NRRTS' Mission Statement, Code of Ethics and Standards of Practice.

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The MED Group — Connecting Partners, *Delivering Results*™
MK Powered
National Seating & Mobility
permobil
Sunrise Medical
the ROHO group — shape fitting technology
Snug Seat — nothing compares to a smile!
TherAdapt
U.S. REHAB

> CFONS

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Columbia Medical — Solutions for Daily Living
Convaid — Advanced Seating & Mobility
EasyStand
FMS Frank Mobility Systems, Inc.
Hudson Seating & Mobility — Providing Technology for Independence
Innovation In Motion
Metalcraft
Motion Concepts
ottobock
Prairie Seating Corporation — Custom Contoured Cushions
Prime Engineering
PRM — The Power of Precision
Quantum — Life Beyond Limits
Aspen Seating — Ride
rifton — Products for life from people who care.
Stealth Products
Supracor
The Comfort Company
Therafin Corporation
Thomashilfen North America
Ti
United Seating & Mobility — Putting lives in motion.
Varilite

> AFONS

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GAMES — Georgia Association of Medical Equipment Services
Midwest Association for Medical Equipment Services
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NEMED
TMPC
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UCP Wheelchairs for Humanity

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