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**Don Clayback** is executive director of the National Coalition for Assistive and Rehab Technology (NCART). Don has more than 23 years of experience in the Complex Rehab Technology and Home Medical Equipment industry as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences. **See page 26.**

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**Tom Rolick** is vice president sales North America for Permobil and is a Friend of NRRTS. **See page 18.**

**John Zona** is president of NRRTS and has been an RTS for more than 28 years, a NRRTS Registrant for more than ten years and an ATP, CRTS® for 12 years. Prior to serving as NRRTS President, Zona was an At-Large Board Member. He is employed by Lakeview Medical, Inc. in Auburn, Mass. **See page 8.**

# Are YOU in "Denial?"

Written By **John Zona**

*"The successful Complex Rehab Technology company makes a habit of doing what the failing company doesn't like to do."*
with apologies to Thomas Alva Edison

**JUST WHEN WE THINK THINGS CAN'T GET** any worse – they do. More restrictions; more unreasonable delays; more funding problems; all getting in the way of what we do best – providing much-needed Complex Rehab Technology products and services to people who require it to support their health, function and well-being.

The situation is out of control. How can funding sources, regulators and legislators turn a blind eye to how critical this technology is to the people who need it? Don't they see individuals are losing their jobs and Complex Rehab Technology companies are going out of business? How can they ignore access to this technology for Americans with disabilities is sliding down the tubes? How can the Complex Rehab industry and profession survive in this environment? Obviously there are more questions than answers.

The fact is there are a few thriving companies. Then there are other companies that are surviving. What do these organizations have in common? I'm not sure exactly, but obviously they are doing something right – more right than the companies that are going under.

There are solutions out there – the challenge is finding them and applying them to your service delivery model. NRRTS Registrants and Friends of NRRTS have a unique opportunity to speak with other people in the field and share problems and solutions. The NRRTS Listserv is a vehicle for discussing the problems we all face, give it another look. Sign up at NRRTS-subscribe@yahoogroups.com.

The bottom line is, as things get worse more companies will fail. More qualified people will be out of work. More Americans with disabilities will go without the technology they need. What do we do about it? We can fight every denial, down code or under payment through the appeals process – this may work sometimes, but is extremely resource intensive. This approach is a case-by-case solution that doesn't give us a stable and sustainable service delivery model. We can "give away" products that people need – that also doesn't give us a stable and sustainable service delivery model. We can beg, borrow and appropriate cushions, chairs, parts and accessories from manufacturers to meet individual client's needs –certainly neither stable nor sustainable.

Systems change is the only solution to the problems we, as an industry and profession, face. It starts with changes to the Medicare program – specifically adding a Separate Benefit Category for Complex Rehab Technology. You've heard it all before. Come to CELA. Visit your members of Congress on Capitol Hill. I hear you saying, "I can't afford to come to Washington. My company is barely able to make ends meet – there's no money for travel. I can't take time away from work."

OK, let's accept that premise. There is something meaningful, however, that you can do. Consumers, clinicians, suppliers and manufacturers from all over the country need to call their members of Congress to tell them about our situation and about the solution – a Separate Benefit Category for Complex Rehab Technology. Go to www.nrrts.org for additional information.

Our industry and profession are facing huge problems – we need huge numbers of people to be a part of the solution.

CONTACT THE AUTHOR
John may be reached at John.Zona@fallonclinic.org or 508.407.7711.

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QUALITY FOR LIFE

# Providing LOANER Chairs

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

## PROACTIVE STEPS TO AVOID LIABILITY

**IT IS A COMMON PRACTICE FOR COMPLEX** rehab providers to provide "loaners" to patients in one of two instances: (i) pending completion of a new power chair to be delivered to the patient, or (ii) to be used by the patient while his/her existing chair is being repaired. While this is a valuable service, the provider nevertheless needs to take proactive steps to avoid liability in the event that the patient is injured while utilizing the loaner. Liability can be based on 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.

An employer is responsible for injury to a third party when its employee commits negligence while acting within the course and scope of his/her 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.

### PRODUCT'S LIABILITY

"Product's 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/her: (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). 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 product cases, liability for misrepresentation is usually based on strict liability, but may also arise for intentional and negligent misrepresentations.

## CASES

In Gallo vs. Hunter's Ambulance Service, Inc. (CT 2007), the complaint alleged that (i) the plaintiff suffers from paraplegia, (ii) the plaintiff was injured by employees of the defendant, (iii) when these employees attempted to transfer plaintiff from a gurney on which he had been carried to his wheelchair, they "failed to provide the necessary and appropriate assistance to the plaintiff, resulting in his falling to the floor;" and (iv) as a consequence of the defendant's negligence, the plaintiff suffered serious and painful injuries.

In Shelby vs. Granbury Care Center (TX 2005), the complaint alleged that (i) the plaintiff was injured at Granbury Care Center while attempting to transfer a 300-pound patient, from his bed to a wheelchair; and (ii) Granbury Care Center was negligent in failing to assist the plaintiff in transferring the patient and in failing to provide adequate employees to care for Granbury Care Center patients.

In the Estate of Christopher C. Maria vs. Judson Center Inc. (MI 2006), the complaint alleged that (i) Christopher Maria was being transported from the bedroom to the bathroom when his wheelchair struck something, causing Christopher to fall out and land on the floor, (ii) Christopher suffered substantial injuries to his mouth and body, including losing eight teeth, which required repeated surgeries for bone grafts and dental implants, and (iii) defendant's failure to follow the plan of service regarding the mandatory use of Christopher's chest strap constituted negligence, gross negligence and willful and wanton misconduct.

In Robinson vs. Memorial General Hospital (NM 1982), the complaint alleged that (i) the plaintiff (a patient of the hospital) had been instructed by the surgeon not to put any weight on her right

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## *Providing Loaner Chairs*

*(continued from page 11)*

leg, (ii) the hospital employee refused to assist the plaintiff in getting into wheelchair, and (iii) the plaintiff was injured as a result of such refusal.

### PROACTIVE STEPS

When providing a loaner, the provider should take the following steps. These are designed to reduce the risk of liability under the theories of negligence and products liability:

- Inspect the loaner prior to delivery to ensure that it works properly.
- In a face-to-face meeting, show the patient and his/her caregiver how to use the loaner. Equally as important, the patient and caregiver need to be instructed on what not to do with the loaner.
- Have the patient (if applicable) and the caregiver sign a document confirming that they have received the instructions described in the preceding bullet.
- The provider's employee, who instructs the patient and caregiver on using the loaner, needs to have prior training. Such prior training needs to be memorialized in writing and kept with the provider's records.
- The provider needs to confirm with its liability carrier that the provider's liability insurance policy covers use of loaners.
- In the event there is an adverse incident involving a loaner, the provider should immediately take statements, take photographs (if feasible), and preserve evidence. The provider should also notify its liability carrier.

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*> This opinions expressed in this article are those of the individual author and do not necessarily represent the opinion of the National Registry of the Rehabilitation Technology Suppliers, its staff, board members or officers.*

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# Looking for the Next Hope

*Written By* **Randy Christian**

**IN THE FALL OF 1987, ROBERT "BOB" MELIA** took the plunge and became a research participant in the Miami Project. Launched by NFL Hall of Fame linebacker and legendary Miami Dolphin Nick Buoniconti and led by Dr. Barth Green, the project is dedicated to finding a cure for paralysis caused by spinal cord injuries. Buoniconti's passion for this cause was spurred by his son, Marc, who like his dad, was a football player and linebacker and aspired to play in the NFL someday. But, in the fall of 1985, Marc's dreams of making it to the pros ended while still in college. In the heat of a game, Marc lowered his head in textbook fashion to make a tackle. Unfortunately, the impact caused his spinal cord to sever, leaving him permanently paralyzed. Ironically, in the summer of that same year, Melia suffered a similar injury with much of the same consequence.

As someone who had recently suffered a debilitating spinal cord injury, Melia was an ideal candidate for the Miami Project. Its investigation into the life-changing damage caused by spinal cord injuries and commitment to finding a cure intrigued the world.

Melia's decision to move from his beloved Boston to Florida was relatively easy. With his family's blessing and the encouragement from friends, he headed south in search of ways to better navigate the challenges of his disability and learn from others who had suffered spinal cord injuries. The thought of warmer winters and the absence of New England ice and snow certainly provided a nudge in the direction of sunny skies and sandy beaches. Yet, the real "driving force" behind Melia's decision was the idea of being a part of what was to become one of the most intense efforts to find answers to the injury-induced paralysis.

"I wanted to make the journey to Miami. It had been two years since my accident. I had completed intensive in- and out-patient rehab, and I had reached a plateau in my recovery. You're always looking to get better. You never stop. You're always looking for the next hope," Melia said.

Involvement in athletics was a way of life for the Melia family. Melia's dad, a construction worker, was his and his brothers' No. 1 fan, and he did his best to never miss a game or even a practice session. Their mom, an emergency room nurse, was a dedicated fan, too. The boys' and their passion to excel on and off the field brought great joy to them both. They were living the American dream — watching their happy, healthy, physically-active boys grow into responsible, self-reliant young men. Yet, soon the fabric of this very close-knit family would be tested to the breaking point. Their dream became a nightmare.

"I was a two-sport athlete in college. Wrestling and lacrosse and training for them consumed a lot of my time," Melia said. "When I wasn't on the playing field, I was in the gym working-out, lifting weights, running -- whatever it took to get stronger and better. My brothers and I swam a lot, too. We were real 'water-babies.' We swam better at a young age than kids 10 years older than us."

It was summertime in New England. It was the time of the year when the thought of old-man-winter and his frosty breath was not even a fleeting thought to Melia or his brothers. The warmth of the summer sun beckoned everyone to the beach. Nineteen-year-old Melia was no exception. He had just finished a grueling workout at the gym and was ready for a plunge into the cool ocean water off the pristine Cape Cod beach.

Unfortunately, the impact caused his spinal cord to sever, leaving him permanently paralyzed.

"I'd really pushed myself at the gym that day and was really looking forward to a swim. My brother was with me. The water was great, nothing out of the ordinary. Suddenly, I was hit by this extraordinarily big wave. It twisted my head around the way you would wring out a dish

towel. I heard a pop," Melia said.

Almost immediately Melia lost control of his arms and shoulders as well as his ability to swim. Helpless, he was tossed around like a rag-doll, pushed to the bottom of the shallows of the beach and eventually washed ashore. His younger brother raced to his side, eager to help. It was obvious to both of them that something was very wrong. There was slight movement in his legs and arms, but it was clearly abnormal. The paramedics arrived soon and immediately placed Melia on a backboard, and rushed him to Boston's University Hospital.

> Sharp turns and life-changing obstacles don't befall those who are in great physical shape and play by the rules.

While in the ambulance, and for many days after arriving at the hospital, Melia believed his condition would improve. He kept telling himself it would all wear-off. He knew, in his heart, it was just a 'stinger' — a 'dead- arm,' such as taking a direct, hard hit in football.. But things didn't get better; they got worse. The swelling began to press against his brain stem causing paralysis from the chin down, which in turn, made it impossible for Melia to breathe on his own. For several weeks, Melia laid motionless, connected to a respirator that helped him breath.

Those days were particularly difficult for Melia and his family, especially his dad. "This may have been the toughest time for my parents, especially my dad. There he was, standing next to his oldest son, in a hospital bed, with all these tubes running out of him, on a respirator; and who, just days earlier, was lifting weights and fighting with his brothers. I couldn't talk either, so he was doing his best to read my lips. He was getting very frustrated," Melia said.

The fact that Melia's mom was an emergency room nurse was both a blessing and a curse. She knew many of the doctors and other medical professionals caring for her son and the ins and outs of the care he was receiving. There was no question in her mind that he was receiving excellent care. However, she was also painfully aware of the consequences that come with severe spinal cord injuries as well as many unknowns that come with them, too. The one thing she knew for certain — the road ahead for her son was going to be a long, difficult one, dotted with tears, sorrow and hopefully some joy.

Several weeks passed, the swelling subsided, the respirator was removed, and Melia began to breathe on his own. He regained enough strength and courage to begin in-patient rehabilitation. Little-by-little, he began to regain a bit of mobility in his shoulders and biceps. Every day he worked hard to make things right again. All the while, he silently remained in denial believing his paralysis would never be permanent. He was working equally as hard to convince himself that "things like this" don't happen to guys like him. Sharp turns and life-changing obstacles don't befall those who are in great physical shape and play by the rules. Melia was certain his inconvenient paralysis wouldn't last, even though his doctor's prognosis was to the contrary. After months and months of in-patient rehab, Melia was released from the hospital and sent home just in time for Christmas. His quest to regain additional mobility seemed to reach a plateau at the time and the reality of his limitations began to set-in.

"Over time, you begin to think a lot more about what the doctors were telling you. You don't want to believe it, but all of this is probably going to be permanent," Melia said. "I have to admit; I got angry and probably took my anger out on friends and family. I apologized to most of them, and those others, hopefully they know I wasn't myself at the time and have forgiven me."

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## Looking for the Next Hope

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Fortunately, Melia was already enrolled for the spring semester of college that was to begin just weeks after his return home. It turned out to be the best medicine for Melia at the time. His class work along with out-patient rehab kept his mind and body extremely active. Positive things began to happen both academically and physically. Melia slowly regained movement in his back, shoulders and arms. Now, for the first time since his accident, he began to do some functional things on his own. He had a new focus and attitude, not only on his college career but, also on life. It was certainly a different life than before the accident, but now it included hope.

An unforeseen ray of hope shined its light on Melia in August of 1988 when he was invited to participate in the Miami Project. The small world event that took him there is almost unbelievable, and at the same time, tragic.

"My friend Marita, who I went to college with my freshman year, knew the Buoniconti family. On Christmas Eve of 1985, a drunk driver ran a red light, hit Marita's car resulting in a debilitating injury. We were doing rehab at the same time, but in different cities. Marita told the Buoniconti family about me, and then I became a part of the Miami Project," Melia said.

While participating in the research of the Miami Project, Melia enrolled at Florida International University and received his Bachelor's Degree in Political Science, and then earned his Master's in Public Administration. Today, he is the coordinator for the Orlando Health System Spinal Cord Injury Network, overseeing the care for those learning to live with their new life. He is one of the leaders in the greater Orlando Spinal Cord Injury Network and serves as an advisory council member for the Department of Health's Brain and Spinal Cord Injury Program. Melia is proud of his academic and professional achievements, but he is most proud of his family. He, and his wife, Stephanie, have two wonderful children, Bobby and Annabella. Melia was recently elevated to the position of den leader for his son's Cub Scout den.

> No one has a crystal ball. No one has the ability to predict the future. But everyone has a special spirit inside themselves ready to help overcome whatever challenges may invade their life.

When asked if he could snap his fingers and change anything about his life — Melia's response was slow, yet thoughtful.

"You know, I think about that a lot. When I've had a tough day — when things haven't gone all that well — I think about if I hadn't gone to the beach. If I could change that one day, life would be so different, but I don't know if it would be better. Now, I have a great wife. I have great kids. I've had the opportunity to do some great things. Would I like to be more independent and have more money? Certainly. But at the end of the day, my bad days would be a lot worse if I didn't have what I've got today," Melia said.

No one has a crystal ball. No one has the ability to predict the future. But everyone has a special spirit inside themselves ready to help overcome whatever challenges may invade their life. It may take awhile to find that spirit, but wonderful things can happen, like mustering up the strength, courage and tenacity to keep looking for the next hope. Ask Bob Melia. It seems as though he may have found his.

CONTACT
Bob may be reached at robert.melia@orlandohealth.com.

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# Montana Tech, Tall Trees and a TRAGIC TWIST of *Fate*

*Written By* **Randy Christian**

**TOM ROLICK WAS BORN** and raised in the small rural town of Kane in the far northwestern corner of Pennsylvania, nestled in the beautiful, lush Allegheny Mountains. Kane was not only a great place to grow up, but the perfect location for his family's lumber business. Rolick and his brothers began working there at an early age. They all spent many hours in the thick forest cutting down, and then hauling trees to their mill. Everyone's hard work, helped make the family business a success, but it was also the kind of physical activity that prepared a young, talented high school football player like Rolick for the rigors of the gridiron. In fact, his football talent earned him a college scholarship.

After graduation, he headed to Butte, Mon., and the campus of Montana Tech University. Even though the prairie of Montana was far from Kane, it still had the feel of home for a very curious reason. Tech's coach was originally from Pennsylvania and made it an important and productive part of his recruiting efforts. With that in mind, it was no surprise to many at Tech, when Rolick and 22 other Pennsylvania freshmen arrived to play for the Orediggers football program. The small university and community was a great place to play a football and earn a degree in petroleum engineering. Rolick was successful at both.

After his playing days and graduation, Rolick landed a job with Marathon Oil in Wyoming. Not long after taking the job, tragedy struck the family. While working in the forest, Rolick's brother Bill was seriously injured when a large tree fell on him. The results of the accident were permanent paralysis. As expected, Rolick was devastated. He also knew the absence of his brother would have a negative affect on the family's lumber business. Without hesitation, Rolick quit his job with Marathon and returned to Kane to help not only his brother, but also his family.

"It's safe to say no one's family is prepared for an accident like Bill's. It was my first experience with someone with a disability like my brother's. I knew I needed to go back home. For the next six months, I worked at the mill and went with Bill to his rehab," Rolick said.

Gradually, Bill began to reclaim his life and was ready to move forward. He resolved himself to the fact he would, more than likely, spend the rest of his life in a wheelchair — and he did.

Assured that his brother and the family business would be okay, Rolick began to pursue other career opportunities. At the time the oil industry was on the "skids." Consequently, there were virtually no petroleum engineering jobs available. Knowing the job market was thin, Rolick was ready to take most any available job. He answered an ad for a Southern California company called Damaco. They needed an engineer's assistant and fortunately, he got the job. Not in his wildest dreams could he have imagined his new job would open a door of opportunity that would change his life forever.

"The only thing I really knew about Damaco was they needed an engineer's assistant, and I of course, needed a job," Tom said. "I went in for my interview and the first thing I asked was, 'What do you guys do?' Lo and behold, what they did was convert manual wheelchairs into power wheelchairs," he said. "I immediately thought of my brother. There was an instant connection and common interest."

> Not in his wildest dreams could he have imagined his new job would open a door of opportunity that would change his life forever.

If there was ever a scenario that accurately described a "twist of fate," Rolick's response to the Damaco help wanted ad has to rank as one of the best. Even though his brother's accident was tragic, it gave Rolick a glimpse into the world of the disabled and their dependence and independence linked to their wheelchairs.

For a young man with a degree in petroleum

> Even though his brother's accident was tragic, it gave Rolick a glimpse into the world of the disabled and their dependence and independence linked to their wheelchairs.

engineering and enough knowledge about wheelchairs to be dangerous, Damaco was the perfect place for Rolick to land. It was a small company at the time, allowing him to garner practical experience in a variety of areas. While there, Rolick spent a great deal of time in the service and sales department. Because the company's primary focus was adding power to manual wheelchairs, he also got his hands dirty in areas of production and assembly. He even became a production foreman. Rolick's three and one-half years at Damaco was, without question, the rock-solid foundation on which his successful career path was built. He is quick to point out that he learned more at Damaco than he did in his five years of college.

Rolick's next learning experience, after Damaco, was with Levo, a well-respected manufacturer of power stand-up wheelchairs. Rolick was brought on-board as their national sales manager, and during his tenure at Levo, his association with Permobil began. It wasn't long until that association became a new job and another significant career path move. Rolick was hired to be Permobil's West Coast sales manager.

Permobil's origin is Swedish and was founded more than 40 years ago by

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## ...Tragic Twist of Fate

(continued from page 19)

Dr. Per Uddén. His belief, everyone has the right to live a satisfactory life in accordance with their circumstances, was the driving force behind his quest to build power wheelchairs. Laboring in the basement of his home workshop, Uddén spent countless hours designing, engineering and building his first power chair. His gift for building power wheelchairs with unique technical features was soon recognized throughout Europe. His compassionate spirit and desire to make a difference in the lives of people with disabilities was much more encompassing than his ingenious inventions. He was passionate about empowering his company and its people to become engaged, effective advocates who were committed to making a difference for the disabled and their families.

Even today, Uddén's legacy is an integral part of the Permobil culture. In 1989, Uddén's son Göran, brought not only his father's remarkable wheelchairs to America, but also his life changing patient advocacy philosophy.

"The emotions that come with helping every disabled person are always there. Göran challenged us to be much more than just the emotional part of the equation. He encouraged us to be strong, positive patient advocates who contribute, not only our equipment, but also our knowledge and opinions to help find better solutions for our patients," Rolick said.

By his own admission, the Permobil philosophy, initiated a radical change of thinking for Rolick. It was the cornerstone of Permobil American and international success. Rolick believed he was no longer a guy who just had a job in the mobility industry, but instead a "lifestyle." He said he is constantly thinking and learning how to better serve the customer. He knows that doing the little things almost always reaps significant rewards for the customer and their family. Becoming involved with NRRTS and traveling to Washington, D.C., for CELA was embedded in his Premobil lifestyle, too. He has learned to step back and look at the "big picture" with regard to the patient's wants, needs, desires and dreams. Asking simple, yet critically important questions of every patient always yielded more individualized, tailored and beneficial solutions. The more Rolick lived the Permobil lifestyle as patient advocate and embraced its responsibilities and rewards – the more his appreciation for his work deepened.

> The emotions that come with helping every disabled person are always there. Göran challenged us to be much more than just the emotional part of the equation. He encouraged us to be strong, positive patient advocates who contribute, not only our equipment, but also our knowledge and opinions to help find better solutions for our patients."

"Being a Permobil sales representative or a representative for anyone in our industry is the best job in the world," Rolick said. "There aren't many jobs that allow you to put together a one-of-a-kind solution, using technologically advanced equipment and the knowledge of incredibly intelligent health care professionals and make a difference in the lives of so many wonderful deserving people."

Rolick now serves as vice president of North American sales for Permobil and is headquartered in the company's new U.S.A. Operations Center in Lebanon, Tenn., a suburb of Nashville. The 140,000 square-foot facility opened its doors in the Fall of 2010 and brought all aspects of the companies operations under one roof and location.

The Tennessee facility is the second largest in the Permobil family of international locations and the most technologically advanced. Its superior ADA design features have already caught the eye of others, as well as its investment in photovoltaic solar panel. Currently, it is one of the largest private systems of its type in Tennessee. When all panels are activated, they will provide 20 percent to 40 percent of the facility's electrical power. People from both the private and public entities have called and asked if they may tour the new operations center.

Rolick is very proud of the new company headquarters, but travel is a significant part of his duties. Airport and hotel rooms are sometime a nuisance, but sharing Uddén's legacy with the company employees and distributors in the United States, as well as Canada and Australia, easily overcome any travel woes.

Obviously, unbelievable technological advancements in the Permobil family of products have been achieved during the last 40 years. New features and capabilities are changing and enhancing lives of consumers daily. What hasn't changed is Rolick's appreciation for his "twist of fate" that turned a family tragedy into a lifelong passion for helping others to regain their freedom and independence.

CONTACT
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# PAST, PRESENT and *Future*

*Written By* **Danette Baker**

HIS **PAST** AS A CONSUMER AND ADVOCATE PREPARED HIM FOR HIS **PRESENT** ROLE IN THE REHAB INDUSTRY AND SERVED AS AN INSPIRATION TO MAKE THE **FUTURE** BRIGHTER FOR THOSE AROUND THE WORLD

**THERE WAS A TIME IN DALE HUFFMAN'S LIFE,** that his clients knew nothing about his past or why he had so much knowledge about durable medical equipment. His passion probably didn't make sense beyond him being a professional on the job.

That's what Huffman preferred. In fact, he made a conscious effort during his first five years with Advacare Medical Corporation to keep his personal life hidden from the consumer.

Huffman still prefers to keep his personal and professional life separate; but if the conversation takes a turn, he willingly shares about his experiences of dealing with government red tape or about using a particular piece of equipment. He's much more at ease now empathizing with his clients. "I realized that it's something I bring to the table, and I've discovered that most people respect the fact that I am a consumer too," he said.

Twenty-six years ago, Huffman's daughter suffered severe trauma at birth resulting in hypotonic cerebral palsy. At the time, he worked in the hospital's maintenance department, where his work hours were divided between painting walls and building therapeutic equipment. Tinkering, he said, was second nature. Even before his daughter was born, Huffman worked with a therapist at the post-acute head injury hospital building parallel bars and other equipment.

When she was only 6 months old, Huffman's daughter began attending a school that provided specialized care for those with disabilities. During that time, he learned how to build a seating box that would support her in an upright position. Before long, he was building customized seating systems for other patients, and the hospital provided a facility for his work. The therapists recognized Huffman's interest and suggested he attend workshops to learn more.

After a couple of years, the hospital census took a dive and Huffman's position was eliminated. That's when he joined Advacare Medical Corporation as a technician for their mobility and seating systems. Huffman then grew his profession and shared his talents with other medical supply companies in the Topeka and Kansas City areas. In 2006, Huffman found himself back with Advacare and has been with the company since. He works out of the Olathe, Kan., branch and provides services in and around the Kansas City area.

He rarely mentions to a consumer his past or the fact that he truly understands their struggles to achieve the independence many others take for granted, even though he's lived many of them.

After all, Huffman's daughter was born long before there was an Americans with Disabilities Act. In fact, he and his wife fought against suggestions that she be institutionalized. "Acceptance was a big issue back then," he said. "We feel like we were pioneers. She was the first child in our school district to be included in regular classroom education. We fought to have that happen. Now it's the norm."

The ability to empathize with consumers and the tenacity to advocate for their needs are strengths Huffman brings to the industry. "It's about what you do with your life experiences that make things better for everyone," he said.

That's why, for the longest time, he kept his personal life personal. "I didn't want my daughter to be my crutch. She has always been the happiest, sweetest child and truly the inspiration for what I do," he said. "What I came to realize is that by sharing our experiences, others are helped."

So every now and then, Huffman shares his personal insight. Sometimes it is the simple environment adjustments such as retrofitting room openings with pocket doors to provide more space to maneuver a power chair or helping a consumer understand how table height becomes an important element of the evaluation process. Other times, it's simply advocating on the consumers' behalves to ensure they get the equipment that's needed ... and that it gets paid for.

> "It's about what you do with your life experiences that make things better for everyone."

"Helping others is a type of therapy," Huffman said. "I find strength in focusing on helping someone else, because it doesn't allow me to focus on myself.

"I'm thankful everyday for what I can do, but frustrated that I can't do more," he said.

"I find strength in focusing on helping someone else, because it doesn't allow me to focus on myself."

That's why being a part of NRRTS is important, Huffman said. He became a NRRTS Registrant in 1996 and a year later was among the second group who sat for the ATP examination and was awarded the CRTS® designation. "I tell people two or three times a week they have got to be the ones who stand up," he said, "and that groups like ours are standing with them."

Huffman himself has worked as a lobbyist in the Kansas legislature for Families Together, a statewide organization serving families with children who have special needs.

He also is very active in the mission field, having made three trips to Guatemala and two to Peru, where his love for tinkering came in quite handy. Last August, Huffman took a team to Lima, Peru, to manage a seating clinic.

They saw 35 people in three days, fitting them with seating, positioning and wheelchair needs using the parts and pieces of equipment they were able to carry over with them. The clinic was held in conjunction with Centro Ann Sullivan del Peru (CASP). CASP was started in 1979 in Lima by Dr. Liliana Mayo-Ortega, who also holds an adjunct faculty position at the University of Kansas. Mayo-Ortega started the center with eight children, all with various disabilities, in her parents' garage.

The center, named for the teacher who worked with Helen Keller, now serves more than 300 people from newborn to age 46 from its headquarters in San Miguel, Lima, Peru. Its mission is to provide education and

*(continued on page 24)*

## Past, Present and Future

(continued from page 23)

vocation programs for those with disabilities so they, can live independent and productive lives.

The Huffmans' daughter made the trip to Peru in her manual wheelchair -- which they left behind for someone else's use. Huffman now is establishing a pipeline to get more equipment into the country. "It's fun because I don't have to worry about how it's going to get funded, just how we're going to get it there," he said.

His goal is to present at the International Seating Symposium in 2012, and recruit others to support Mayo-Ortega's efforts in Peru. These third world countries, Huffman explains, are progressively about where the United States was in the '40s and '50s.

But Huffman quickly dismisses any accolades about his efforts. "I've never really felt like a superhero or anything," he said. "I just happen to have found my calling."

And like so many others, he acknowledges the rewards far outweigh the paycheck.

" ...hugs, tears of joy, thank you cards... it's the best feeling when you lay your head down at night knowing that what you do truly makes a difference in someone else's life."

CONTACT
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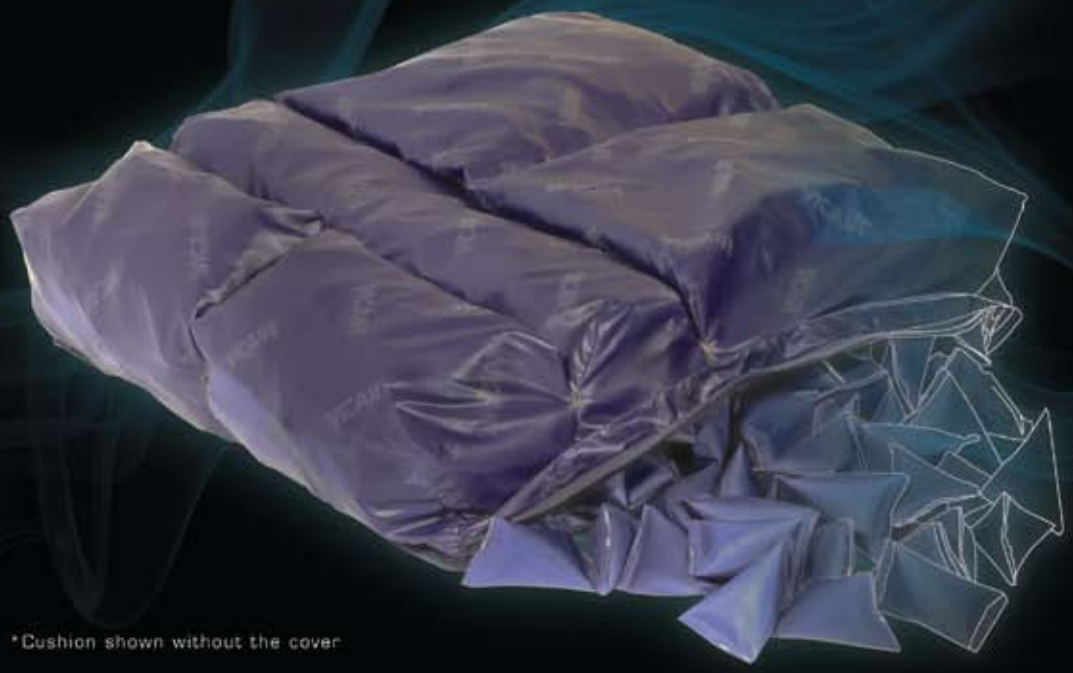

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# Separate Benefit for COMPLEX REHAB Technology Update

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

JANUARY 2011

## LOOKING FOR A GOOD NEW YEAR'S RESOLUTION?

We all know that for many people the start of a new year includes identifying resolutions for making things better. Lose weight, exercise more, eat healthier and give more hugs, are some of the more popular ones. Okay, give more hugs may be a stretch. But how about adding something new and exciting to your list? Something personal, something challenging, and of course, something life changing.

I've got just the ticket. Add "getting a Separate Benefit Category for Complex Rehab Technology" to your list. All in favor, raise your hand. Wow, that's what I like to see! Now that you've made that commitment, let's review what you need to do to help make that a reality.

The primary activities around the Separate Benefit Category initiative for the first part of 2011 will be on the legislative front with the focus on Washington, D.C. As of Jan. 5, 2011, we have a brand new Congress that will be in session for the next two years. Last November's elections brought about some big changes that resulted in new players and a change in the Republican and Democratic composition. The Republicans are now the majority party in the House. The Democrats retained the majority in the Senate, but with a drop in their numbers. And the key Congressional Committees for us, the Senate Finance Committee, the House Ways and Means Committee, and the House Energy and Commerce Committee have many new members.

Our 2011 objectives are to get legislation introduced, brought to a vote, and passed. While not a simple process, it's important to understand the basic steps.

Getting a member or members of Congress to agree to introduce the necessary legislation. This starts with sharing our Proposal Paper and the supporting draft legislation to prospective members and securing their commitment. Did someone say CELA 2011? More on that below.

The draft legislation may be modified by the member(s) and then sent to the legislative counsel in Congress so that it can be reviewed, edited and prepared for formal introduction.

Once the legislative language is finalized, it is formally introduced and assigned a bill number. A bill introduced in the House begins with HR followed by the bill number, while a bill introduced in the Senate begins with S followed by the bill number. The ideal situation is to have the bill introduced in both the House and Senate with both Republican and Democratic sponsors.

Upon introduction, the bill is referred to a committee of jurisdiction. This is when it is subject to additional detail review and when additional co-sponsors are sought.

At some point the legislation is forwarded to the Congressional Budget Office (CBO) for "scoring" to determine the projected financial cost of the bill over a 10-year period.

With enough congressional member support, the CRT Separate Benefit Category bill will be attached to a larger bill and be brought to the floor of the House and/or Senate for a vote. It needs to be passed in both chambers and then is sent to the president for signing. Once signed, we have accomplished our legislative objective!

CELA 2011 is the kick-off for our pursuit of congressional support. At CELA 2010, we had a great showing and took the message of the Complex Rehab Technology (CRT) benefits and access issues to Washington, D.C. This year, on Feb. 17, CRT consumers, advocates and industry professionals will again be visiting the congressional offices for Phase Two of our campaign. This focuses on securing formal support to introduce and pass the needed legislation. So if you haven't signed up to attend CELA yet, visit the NRRTS website and get registered today.

To prepare you for CELA and beyond, we will be assembling a variety of tools for telling the CRT story and garnering the needed support. These tools will include CRT background documents, the Proposal Paper with the initiative details, and the draft legislative language. In addition, we are in the process of securing supportive letters from consumer and clinical groups that can be shared with your congressional representatives. These will be the informational documents for use during your in-person visits and subsequent follow up actions.

If you have not already done so, download a copy of the January 2011 Proposal Paper from the NCART (www.ncart.us) or NRRTS (www.nrrts.org) website. As the title indicates, this contains the most current information available. It will provide the details you need to know, and is a great document to share with others to begin your discussions.

Our 2011 plan should be viewed as a marathon, not a sprint. CELA is the kickoff event, but additional meetings and calls will be required to garner the level of congressional interest and support that we need. Our ultimate success will require the involvement of all CRT stakeholders: consumers, advocates, clinicians, suppliers, manufacturers and others. Through these combined efforts, the ultimate goal of improving and protecting access to Complex Rehab Technology products and services for individuals with significant disabilities and medical conditions will be achieved.

So, start 2011 with a commitment to be a part of accomplishing the industry's New Year's resolution of "getting a Separate Benefit Category for Complex Rehab Technology." Get yourself informed, gather the supporting documents and begin working to secure the support of your local representative and your two senators to pass the needed legislation.

To share questions, comments or suggestions regarding the Separate Benefit Category initiative please contact any of the project's Steering Committee members: yours truly at NCART (dclayback@ncart.us); Laura Cohen, PT, PhD, ATP, Rehabilitation and Technology Consultants (laura@rehabtechconsultants.com); Elizabeth Cole, director of clinical rehab services, U.S. Rehab (elizabeth.cole@usrehab.com); Gary Gilberti, ATP, president, Chesapeake Rehab Equipment (ggilberti@chesrehab.com); Walt Gorski, vice president, American Association for Homecare (waltg@aahomecare.org); Rita Hostak, vice president of government affairs, Sunrise Medical (rita.hostak@sunmed.com); Simon Margolis, executive director, NRRTS (smargolis@nrrts.org); Tim Pederson, ATP, president, West Med Rehab (tpederson@westmedrehab.com); and Paul Tobin, president, United Spinal Association (ptobin@unitedspinal.org).

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> *Visit www.ncart.us for more information.*

# Seating to Maximize Participation and OTHER Related Information:

## A CASE STUDY

*Written By* **Kevin Phillips, ATP, CRTS®**

**IMAGINE THAT YOU HAD TO DO EVERYTHING** you love sitting in one chair. Not one chair at a time…just one chair. Maybe it's not even a comfortable chair. Many families face challenges like this as they try to include children with disabilities in many activities that we take for granted. The Plasters are one of those families. They live near the coast of Southern California. With their three kids, they enjoy the lifestyle that the area offers — regular visits to the beach, as well as camping trips to the mountains and desert. These outings include their teenage daughter, Robyn, who has Type II Spinal Muscular Atrophy. Robyn has never been ambulatory. The weakness that limits her movement doesn't dampen Robyn's enthusiasm for outdoor fun and other activities with her family.

### A MOVE TO CUSTOM MOLDED SEATING.

Seating was a difficult challenge in all of Robyn's mobility systems, including her everyday chair. Robyn had "growable" rods incorporated into a spinal fusion at a young age. While the fusion stabilized her spine through the fused area, the upper and lower ends of spinal alignment were left at the mercy of gravity and positioning devices. Robyn had a variety of wheelchair mounted seating over the years, including planar, air flotation and off-the-shelf contoured systems. All of those systems allowed enough movement of her body away from midline for the development of deviations away from alignment in her spine at her lower spine and pelvis and neutral at her neck. [*See photo at top right on page 29.*]

In 2008, at the age of 15, Robyn reluctantly agreed to consider a full contact orthotic seating system. It was difficult to find the 'right spot' using off-the-shelf seating, and progressive deviation in the curvature at her neck was causing problems with function and fatigue. She had been leaning to the left through her trunk for years and compensating to the right with her head for balance. Those of us experienced in working with high functioning clients with a severe physical impairment know any change in equipment is traumatic even when the benefits are clear. We struggled for a year with refinements, such as how the system mounted to her Permobil C500 with tilt and full recline, the shape and firmness of the back and seat cushion, and how to preserve full recline with a custom orthotic system. It was a big learning curve for both of us.

It seems to be a widespread belief that kids with MD generally won't tolerate custom molded systems. They often prefer little or no contact and to use whatever they have for independent balance and function. Frequently, they will find balance by leaning on one elbow or balancing forward in an anterior pelvic tilt. The unfortunate result of little or no support for kids with low tone is the progressive collapse into destructive postures that ultimately limit or altogether prevent healthy posture and function. So many of those kids present as adults with more than 90 degrees of lateral flexion, or such a hyperlordosis they can no longer rest back on a back rest, and must either rest their ribcage on their thighs, or hang off a chest strap. The earlier we can encourage these kids to learn to rest with a healthy posterior tendency into seating that promotes upright, neutral spinal extension, the greater the likelihood they will maintain healthy spinal alignment throughout their lifespan. One therapist who specializes in children with Duchene's MD recommends full contact orthotic systems as soon as the child needs a power chair. Only time will tell if this strategy can help avoid some of the spinal misalignment that is so common at present.

In Robyn's case, she has a wonderful and persistent physical therapist by the name of Christy Malonzo at Precision Rehabilitation. Robyn and I had both tried to give up on the Ride system several times, but Christy knew what she wanted for an outcome and just wouldn't let it go. After almost an entire year, the kinks had been worked out and the seating system was comfortable. Once Robyn was able to develop new strategies to participate in the activities she enjoys, she was an immediate fan. With the increased core stability she gains from the seating, she has been able to improve her upper extremity function, as well as head alignment and control.

### RECLINE AND CUSTOM MOLDED SEATING

It seems to be a widespread belief that kids with MD generally won't tolerate custom molded systems.

Too many kids with progressive neuromuscular conditions who are seated from an early age emerge into their teens or early 20s with severe contractures in their hips and knees from a lack of regular change of body position. A 2005 review of the available research on ergonomics for seating in the office environment for able

TOP: POSTURAL EVALUATION AT PRECISION REHAB
(*NOTE: LEFT LEAN AND CORRECTION THROUGH NECK)*
BOTTOM: ROBYN WITH HER NEW RIDE SEATING ORTHOSIS

> Through the regular use of recline and power legs in combination with a regular stretching program, Robyn has full range at her hips, knees, shoulders, elbows and wrists.

bodied individuals came to this conclusion, "The only truly effective way to maintain a seated posture for extended durations is to continuously cycle through a range of natural, centered and healthful positions," (*review by Rani Lueder, 2005*). That statement is no less true for a person with a disability. "The concept of "dynamic sitting" is endorsed in the ergonomic field for individuals who use office furniture and workstations (*Kroemar, 1994*) and should undoubtedly be applied to wheelchairs as well, since many wheelchair users may not have the extent of dynamic movement as able-bodied office workers," (*RESNA position paper on Tilt and Recline*).

Robyn has been fortunate to have power seating that includes tilt, recline and power legs for most of her life. Through the regular use of recline and power legs in combination with a regular stretching program, Robyn has full range at her hips, knees, shoulders, elbows and wrists. The question was how would custom molded orthotic seating affect her ability to continue to move?

Since the advent of powered seating, problems associated with recline, shear and movement of the back support in relation to the user's torso have been recognized as a cause of potential risk of injury to users. In a 1997 article on the application of powered seating, the use of power recline with custom molded seating was given a "Not Recommended" indication with the comment, "The use of an aggressively contoured back in combination with power recline systems presents a problem. The offset of the axis of rotation of the seating system is not the same as the person's, therefore, when the person reclines, the backrest shears or moves relative to the person. This causes the back to no longer fit appropriately." (*David Kreutz*).

In the years that have passed, power seating technology has come a long way. The shear reduction mechanisms are more effective, and the custom molded back supports don't have to be so bulky, keeping the client closer to the pivot points on the seat mechanism. However, in current seating products, even with great improvement in the technology, the perception persists that a custom molded system with an intimate fit is not

*(continued on page 30)*

## ...Other Random Information

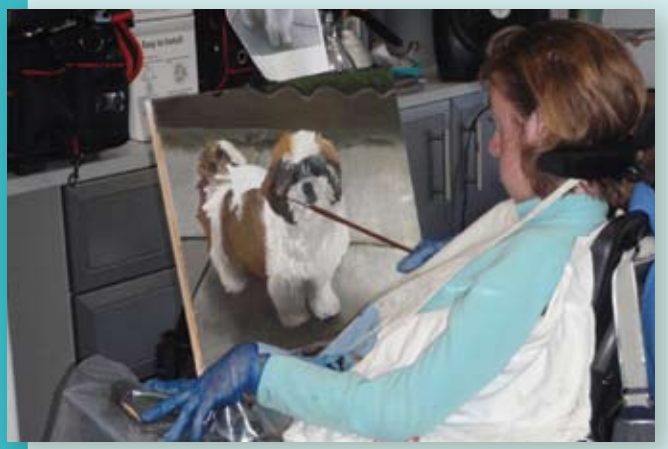
(continued from page 29)

advisable when used in combination with power recline. A recent article on recline included the statement, "For someone who has a molded seating system, recline is not generally advisable [...] As you recline, the contact with the mold does change. So it no longer matches the individual's body shape because you're changing the position it's being used in," (*Aug 2010, Mobility Management*).

The research based evidence available shows us that the health and functional benefits of dynamic positioning make it worthwhile to take another look at the combination of custom seating and recline. There is no question that caution must be used when an aggressive positioning interface is combined with dynamic positioning like power recline. For most clients, we teach them to limit the back travel to 20 degrees of recline to reposition their upper body for different functional tasks when the seat base is horizontal. When the seat is fully tilted first, then more recline can be used without shear or misalignment problems. The final fit, backrest travel and fit on the client's torso through the range of movement to be used must be reviewed carefully before the final system is released to the client. The safe use of the system must be combined with a diligent skin check and conservative 'break in' program, starting out with short sitting times that increase over the next few days. Over the last three years in our program, we have provided nearly 100 custom molded seat systems on power and manual tilt/recline combination systems with no skin trauma or shape misalignment issues related to the dynamic movement. It can be done.

> Robyn's situation was unique in that she is very sensitive to the firmness of the seating interface, and also was adamant that she be able to recline all the way to the 150 degree limit on her seat system.

Robyn's situation was unique in that she is very sensitive to the firmness of the seating interface, and also was adamant that she be able to recline all the way to the 150 degree limit on her seat system. The support system on the Ride custom seat includes a raised 'cantle' on the back of the cushion to provide enhanced posterior-



TOP: DRESSED FOR HALLOWEEN
MIDDLE TOP: IMPROVED CORE SUPPORT MAKES PAINTING EASIER
MIDDLE BOTTOM: BOWLING WITH HER SISTER
BOTTOM: FIRST TIME IN THE SAND

IN HER POWER BEACH CHAIR

READY TO HIT THE DUNES

lateral pelvic support, taking the load off the bony prominences. This shape effectively prevents more than a few degrees of recline. To overcome this limitation, Joe Bieganek, the founder of Aspen/Ride, made a hybrid Ride Cushion with a soft cantle by using the firm proximal thigh support from the custom Ride and the soft cantle from a Ride Forward, and then put a layer of reticulated foam over the entire base to give it a softer feel. The end result is that Robyn can safely use the full range of powered seating on her chair, and still benefit from the aggressive positioning that comes from the orthotic seating.

## SEATING FOR ACTIVITIES OUT OF THE WHEELCHAIR

The improvement in the seating on her wheelchair had made a dramatic improvement for Robyn, but a big seating problem remained. There are many activities that Robyn enjoys participating in that cannot be performed in her everyday wheelchair. The Ride system was now working great in her everyday wheelchair, but it must be mounted permanently to the wheelchair and can't be used in other activities outside of her wheelchair. When on outings, Robyn uses a power beach chair, an Omegatrac power chair for off-road camping use, an adaptive bicycle pedaled by family, and is the passenger in a Razor 4x4 off road ATV. Besides those devices, there are a range of activities that do not include a "chair," such as sitting on the sand at the beach, during which she needs to sit to enjoy. For Robyn to be comfortable, safe and functional in all of these activities, she really needed a transportable solution that could replicate the orthotic seating that could easily be moved to a variety of surfaces. A year ago Robyn was provided with an Aspen Seating Orthosis (ASO), a fully-integrated portable version of the Ride Custom Seat and Ride Custom Back. The ASO is not wheelchair dependent, and makes it possible for Robyn to sit wherever and on whatever she wants.

The improvement in the seating on her wheelchair had made a dramatic improvement for Robyn, but a big seating problem remained.

The first picture her mom sent me came with the note, "We went to the beach on Sunday even though Robyn had no wheels. Her seat was her chair in the sand and she built sand castles with her cousins." Since then, the family has sent several pictures of Robyn enjoying lots of activities that are facilitated by her portable seating orthosis, which are included here. The norm for custom seating has been, for the most part, produced and funded for attachment only to a wheelchair. As awareness of the possibilities for adapted participation in more activities of normal daily living with portable custom seating becomes widespread, wouldn't it be nice if every kid had access to this kind of technology and participation for the experiences that facilitate physical, social and cognitive growth and development?

*(continued on page 32)*

## ...Other Random Information

(continued from page 29)

### OUTCOME MEASURE SURVEY

I thought the outcome was great, but it doesn't really matter what I think. What did Robyn think? Robyn was one of the first participants in a pilot run of a Custom Seating Outcome Measure Survey that was developed as a collaborative project by Lori Knott, OT, and Jen Birt, OT, of Manitoba, Canada, and myself. The survey asks questions about customer satisfaction across a range of seating factors, such as skin integrity, pain, effect on posture, heat, moisture, function, etc. The questions are answered on a six-point scale from "completely agree" to "completely disagree" (similar to the FEW), with six being the most positive response to the factor.

Robyn reported gains in many areas, with no loss of function, no skin issues and no decrease in outcome scores in any area. She reported an incremental one point improvement in stability and comfort, and larger gains in the areas of posture, fatigue and positioning. The problems with swallowing due to poor neck positioning went away with the new seating. She reported a gain from a two in her old system (mostly disagree) to a six (completely agree) in her new system on the question. "I am able to stay in the right spot in my seating equipment." Her mother noted that the number of times she needs to reposition Robyn in the seat decreased from 15 times a day to twice. Her score for the question on fatigue ("Sitting up in my seating equipment does not cause me to feel fatigued") for the old seating was four (slightly agree) due to the constant loss of position, and is now a six (completely agree) in the new seating.

At present time, about 20 sites across the United States and Canada have volunteered to participate in the Custom Seating Survey in an effort to gather further objective data on the value and outcomes of custom seating. Two of those sites are supplier business. The remaining sites are clinical settings such as rehab clinics, hospitals, etc. There will be great value to all suppliers to have objective outcome data. The act of measuring outcomes helps to justify funding, improve our practice standards and internal process and validates the quality of work we are doing. If any of you are currently a Ride custom seating provider, and wish to participate in the survey, please contact me by e-mail.

CONTACT THE AUTHOR
Kevin may be reached at kphillips@abilitycenter.com or 858.541.0552 x 107.

TOP: DESERT DOGGY TRANSPORT SERVICE
MIDDLE: CHILLIN' AT THE CAMPSITE
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# HOW TO WRITE A CASE

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**Please contact Amy Odom at aodom@nrrts.org or 806.722.2322.**

Case studies are an invaluable record of the clinical practices of our industry and profession. While case studies cannot provide specific guidance for the management of successive clients, they are a record of clinical interactions and possible applications for other clients. Case studies also provide valuable teaching material, demonstrating both typical and unusual presentations which may confront the practitioner.

Quite obviously, since the overwhelming majority of clinical interactions occur in the field, not in teaching or research facilities, it falls to the field practitioner to record and pass on their experiences. However, field practitioners generally are not well-practiced in writing for publication, and so may hesitate to embark on the task of carrying a case study to publication. These guidelines are intended to assist the relatively novice writer in efficiently navigating the relatively easy course to publication of a quality case study. Guidelines are not intended to be proscriptive, and so throughout this document we advise what authors "may" or "should" do, rather than what they "must" do.

# E STUDY

## WRITE YOUR CASE STUDY

• Construct a template, in your mind or on paper, which will be the guide throughout the writing process. This will improve how the document looks, feels and reads. Consistency in these three items is key to a good case study.

• Draw your reader in with a unique title. It should attract the reader and make them want to read more.

• Begin writing the paper. Start by identifying the problem that is being addressed in the case study.

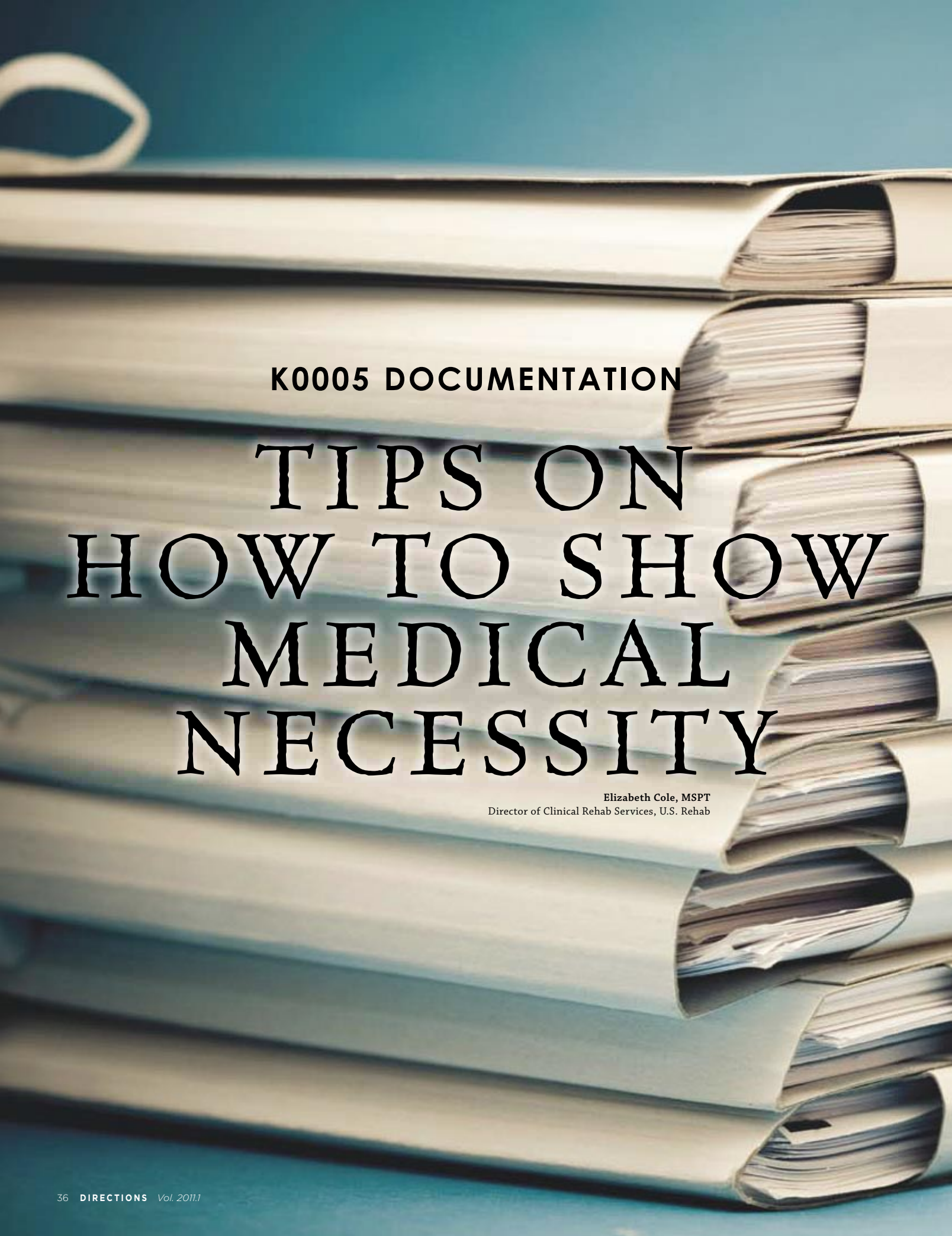
• Explore the problem, including cause and effect. Give as much background as possible on other solutions that were attempted.

• Discuss the solution you selected and/or how this problem was specifically addressed. Tell what methods were used in determining your solution.

• Describe benefits of the approach you chose. Tell how the benefits might impact other individuals with similar presentations. Discuss the limitation of your approach.

• Use before and after photographs to document your solutions.

• Utilize the general-to-specific-to-general approach. This is the approach to use because it draws the reader in, demonstrates a specific example, and then shows how it applies to the group as a whole. It also shows the reader how they can address their own problem this way.



## K0005 DOCUMENTATION

# TIPS ON HOW TO SHOW MEDICAL NECESSITY

**Elizabeth Cole, MSPT**
Director of Clinical Rehab Services, U.S. Rehab

An ultra lightweight (K0005) manual wheelchair can provide numerous benefits for many individuals with permanent complex disabilities. However, documentation requirements for a K0005 can be stringent as evidenced by a recent rise in negative determinations on ADMCs. How can you make sure that the documentation is as complete and informative as possible? What should be included to demonstrate medical necessity and justify the need for the K0005? What can you do if you do not feel that the documentation is sufficient?

As with all other MAE, the documentation must first demonstrate the need for manual mobility in general. This should include a description of the mobility limitation and specifically why this person is unable to carry out his/her daily activities in a timely and safe manner using a cane or walker. This could be due to decreased or absent muscle strength, abnormal tone, poor motor control and coordination, decreased balance and stability, decreased range of motion (ROM), pain, cardiac or respiratory compromise, etc. The documentation should be specific about these limitations and how they restrict the individual's capacity for functional and safe ambulation.

The documentation must then verify the medical justification for the K0005 ultra lightweight wheelchair and this is obviously where the "rubber hits the road." To do this, it should identify what the wheelchair must provide to allow that person to perform all activities of daily living (ADLs) and instrumental activities of daily living (IADLs) safely and in a timely manner. What activities both inside and outside of the home does the individual need to complete, and what environments are involved? What features are needed for this individual to carry-out these activities today as well as tomorrow and the next day without medical compromise, pain, undue fatigue or other harmful effects? What are the consequences if these features are not provided?

OK, so we all know the features of the K0005 and how they affect the performance and orientation of the wheelchair. The K0005s are the lightest in overall weight of the manual wheelchairs. The lighter weight reduces the forces needed to propel the chair which reduces the forces transmitted through the upper extremity (UE) joints. The fully-adjustable axle plate provides forward positioning of the rear wheel to bring the wheel closer to the individual for increased access to the handrim, improved UE dynamics and increased ease of propulsion. The more forward position also puts more of the person's weight over the drive wheels and less weight over the casters and decreases the overall length of the wheelchair. These features make the wheelchair more maneuverable, more accessible and easier to propel.

The multiple vertical adjustments of the rear wheel allow us to add increments of fixed tilt in the frame for an orientation in space other than vertical. The adjustable seat-to-back angle or the ability to add a squeeze seat on some of the K0005s provide multiple degrees of fixed recline or closed seat to back angles for alternate positioning and postural assist. The multiple seat widths and depths and back heights allow us to tailor the wheelchair dimensions to each person's individual body size.

But how do these features address a medical need for the individual? Yes, some of these features make the wheelchair easier to propel and more maneuverable, while others help the person maintain an upright posture. But how exactly does this affect the individual's medical status and health. What are the consequences of not providing these features? Let's look at each of the features and how they might benefit that individual.

## FIXED TILT IN THE FRAME AND ALTERNATE SEAT TO BACK ANGLES

How does the change in orientation in space and/or the addition of an open or closed seat-to-back angle affect the individual? In some cases, poor endurance and/or poor strength and control of the trunk, pelvic and lower extremity muscles prevent the individual from maintaining a stable and midline posture when in an upright wheelchair frame orientation with a standard 90 degree seat-to-back angle. Consequently, he/she slides into an abnormal posture such as a posterior pelvic tilt, increased lumbo-thoracic kyphosis and cervical hyperextension. This can result in skin breakdown, respiratory and digestive compromise and neck pain. In some cases, the poor postural stability experienced when positioned in a vertical orientation forces the individual to use the UEs for balance rather than for function, limiting the person's ability to complete certain ADLs. A specific angle of tilt or a specific seat-to-back angle could provide the necessary postural assist to allow the individual to avoid these harmful postures and their medical consequences, as well as allow him/her to use the UEs for activity rather than for stability.

In the examples above, we have identified what the K0005 provides (a specific angle of fixed tilt or a specific seat-to-back angle), why the person needs these features (to maintain an upright and stable midline posture), and how this affects the individual's function and health (prevents physiological compromise from poor posture, maintains skin integrity and increases ability to complete ADLs).

## FORWARD REAR WHEEL POSITION

For some individuals, decreased muscle strength, motor control, increased tone and/or ROM limitations in the upper extremities prevent the person from fully accessing the handrim of the rear wheels for propulsion when they are located in the standard rearward position. In addition, the shoulders are forced into excessive extension and elevation during each stroke. Because of this poor positioning of the UEs, attempts to propel throughout the day result in stress and damage to the shoulder joint, as well as pain in the shoulder, elbow and/or wrist. In some cases, the individual will not even attempt to access the rear of the handrim, but will instead utilize a very inefficient arcing method of propulsion using just the front of the handrim.

Either method of propulsion described above can cause repetitive strain injuries in the UE joints, resulting in structural damage and pain. Studies have shown this damage is increased with poor UE positioning during propulsion and that these injuries result in the need for costly medical interventions and loss of function. The pain, compromised joint integrity and musculoskeletal damage in the shoulders, elbows and wrists can significantly decrease the person's ability to use the upper extremities not only for propulsion, but also for all other ADLs. And the increased effort required by the poor UE positioning during propulsion can result in increased fatigue and decreased ability to perform all required ADLs throughout the day. In the worst case scenario, this will result in decreased independence, the need for assistance from a caregiver and/or the need for power mobility. In many cases, a specific forward position of the rear wheel that provides the UEs with more access to the handrim, a more efficient stroke pattern and improved UE positioning during propulsion can eliminate or reduce the pain and damage.

The forward position of the rear wheels also decreases the overall length of the wheelchair, which increases its maneuverability. For some individuals, this can make the difference as to whether or not they can access certain locations within their typical environments, especially when tight turns or corners are involved. This can significantly affect their ability to complete all required activities throughout the day.

Again, the documentation should identify the feature of the K0005 (rear wheel positioning), why the person needs this feature (increased access to the rear wheel for increased ease of propulsion, improved UE dynamics and improved maneuverability), and how this affects the person's function and health (decreases the structural damage and pain in UE joints, allows continued use of UEs for ADLs and independence, and allows access to the environment for completion of all ADLs).

## IMPROVED WEIGHT DISTRIBUTION AND DECREASED OVERALL WEIGHT

How does the deceased weight and increased efficiency of propulsion of the wheelchair affect the individual? Numerous studies have documented that stress to the UEs is common among long-term wheelchair users who are repeatedly propelling their own weight plus the weight of the wheelchair throughout the day. This stress increases with increased time spent in propulsion and with increased forces required during propulsion. For some individuals, the lighter weight and increased ease of propulsion provided by a K0005 reduce or eliminate this damage to the UEs from the repeated movements required by propulsion. As above, this preserves the integrity of the UE joints, preventing pain, structural

damage and ensuing loss of independence. In addition, if less energy is required to propel the wheelchair, then more energy is available for completion of ADLs. All of this allows the individuals to maintain independence in performing all required daily activities.

## MULTIPLE SEAT AND BACK DIMENSIONS

To medically justify multiple seat dimensions, we must be able to identify what the ramifications of improper dimensions might be. For example, for some individuals, a seat width that is too wide will allow the person to slide into harmful postures. These abnormal postures can, in turn, lead to skin breakdown, respiratory compromise, problems with swallowing and/or digestion and so forth. They can also impede the use of the UEs for functional activities and for propulsion. Similarly, if the seat depth is too short, the legs are not well supported in position and there is insufficient weight bearing by the femurs. This too can lead to poor postures and their physiological ramifications, as well as development of skin breakdown. Similar results occur if the seat depth is too long or the back height is too low or too high. For some individuals, a very specific seat width, seat depth and back height are needed to preserve optimal posture, prevent skin breakdown and allow functional use of the extremities for all daily activities.

These are just a few examples of the features of the K0005, what they can provide and how they could affect the ability of the individual to complete daily activities in a safe and timely manner without harm. The specific needs of each individual and the consequences if these needs are not met may be different for each person. Therefore, it is critical to relate the benefits of the K0005 specifically to that person and his/her individual needs. The documentation must demonstrate that the features of the K0005 are medically necessary in the home (and outside the home, as appropriate).

However, no matter how well the above information is documented, there is one more critical component in the justification for a K0005 and that is to document why these needs cannot be addressed using a K0004. What is it specifically about the K0005 that meets the individual's medical needs? Why isn't a K0004 sufficient? Is it that the specific seat to back angle or specific angle in space is not available on a K0004? Is it that the specific position of the rear wheels is unachievable on the K0004? Is it that the specific seat width and depth are not available on a K00004? Are there features on a rigid chair that are medically necessary, however there are no rigid K0004 frames? If this is not documented, the K0005 will be denied as not medically necessary since there is no indication that the individual's needs within the home cannot be met by the K0004.

In summary, the documentation should:

- Identify and justify the need for manual mobility.
- Identify features on the K0005 that are needed. Be specific about why they are needed in terms of that individual's medical health and ability to complete all required activities throughout the day in all typical environments. Include a list of all activities both in and out of the home but make sure the features of the K0005 are medically necessary inside the home.
- Document the detrimental effects if these features are not provided.
- Document that these features are not available or achievable on a comparable K0004 and why a K0004 is not sufficient.
- You could also include results from scientific studies that support the need. An excellent resource is the Consortium for Spinal Cord Medicine publication "Preservation of Upper Limb Function Following Spinal Cord Injury: A Clinical Practice Guideline for Healthcare Professionals" which can be found on the Paralyzed Veterans of America website (www.pva.org).

What then are the alternatives in situations when you just do not feel that the documentation is going to "fly?" At that point, it might be time to put the problem in the beneficiaries' court and do the claim unassigned, allowing them to assume the financial risk. The beneficiaries can also sign an ABN allowing them to pay the difference between the K0004 and the K0005 (just remember that with this option you will need to bill the K0005 on a rental basis, listing the K0005 as an upgrade and the K0004 as the product that is "medically necessary"). Perhaps it is at this point that we need to involve the beneficiaries themselves in the fight and urge them to let their voices be heard wherever appropriate.

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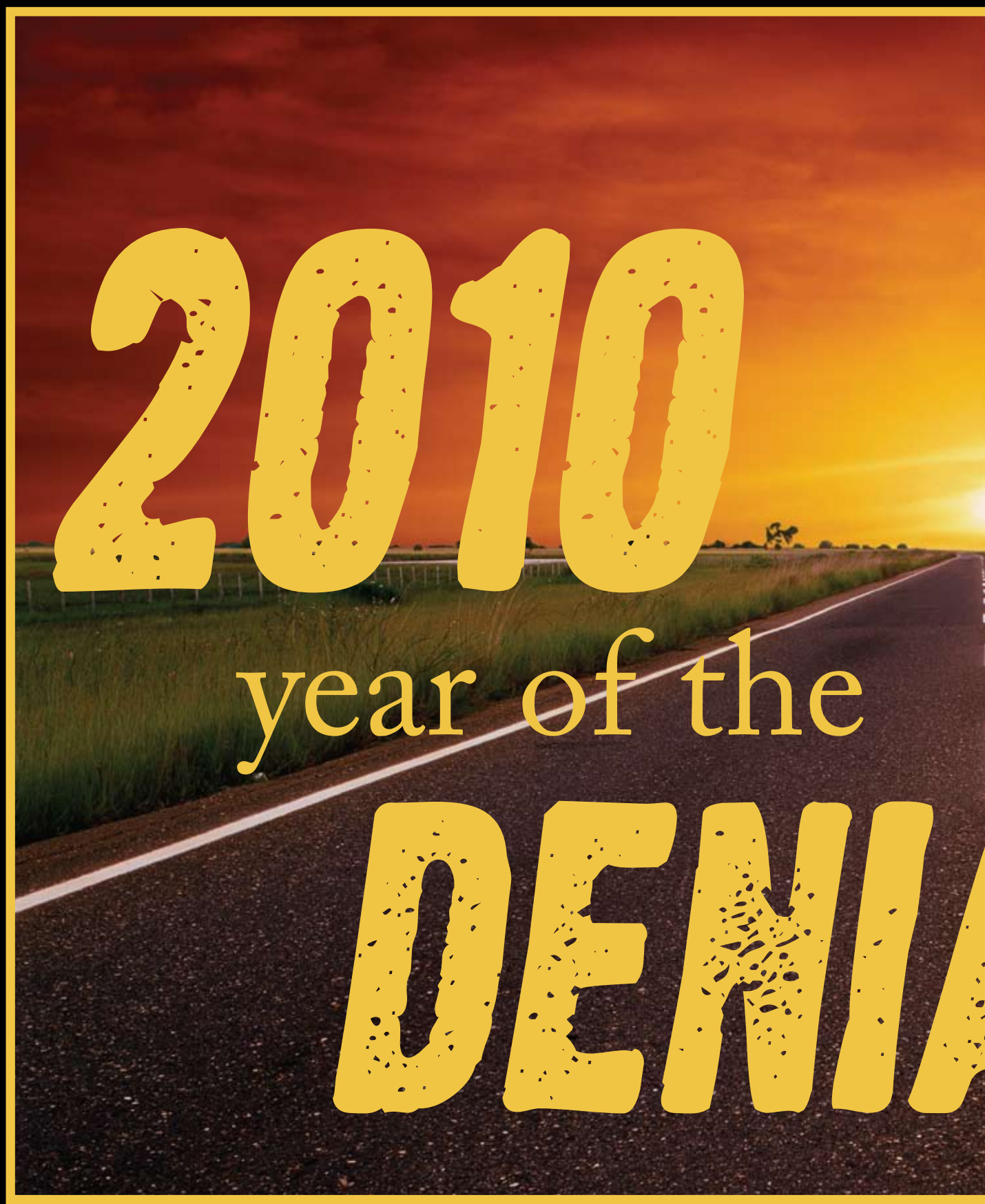
2010
year of the
DENI

2010 is all wrapped up, and I am calling it the year of the denial. Not just your everyday denial but the blatant, "I don't care what I write or if it's legal" denial. The type of denial you scratch your head over or can't wait to show a colleague because the language being used is so absurd. But unfortunately most denials are not pursued by the beneficiary. The path of least resistance is to simply give up.

To try and educate on beneficiary rights, as well as for providers for that matter, is a daunting task. It can get very technical fairly quick. Find an advocate to help navigate the waters. It could be the manufacturer, provider, social worker, the protection and advocacy network, or even a non-profit such as Users First that is dedicated to getting HME equipment funded for the beneficiary.

Education on denials is crucial. People with disabilities are the least educated and poorest minority in America. It's up to us to point to an advocate or to resources that will fight for the beneficiary. You may want to take on the role yourself. So what are some steps when you get a type of denial that makes no sense?

1. Gather all the information you can. There is always one side, the other side and the truth. This will include the evaluation, LMN, product being described, doctor's script, funding source, etc.

2. What is the funding source where the denial originated? Is it Medicare, Medicaid, Medicaid HMO, private insurance, vocational rehabilitation? Each funding source has separate rules and regulations attached to each to govern their policies, programs, and procedures. Learn the dos and do nots on what ties a funding source's hands.

3. Does the denial follow regulations? National Coverage Determination, Local Coverage Determination, Title 19, state Medicaid DME handbooks, state Medicaid plans with the 1115 waiver, and private insurance handbooks. It sounds a bit overwhelming, but there are resources available to guide through the funding waters. Denials can be successfully challenged.

4. Appeal. There are several levels of appealing a denial. The simplest is a straight appeal usually filed within 30 to 45 days (denial will state). Your appeal should attack the specific language used to deny, which is usually related to medical necessity. Use language found in the funding sources own regulations and apply to reinforce why the product should be approved.

5. A next step in dealing with Medicare or Medicaid is to take your appeal to an Administrative Law Judge (ALJ). Cases taken before an ALJ are quite successful. When appealing with private insurance ask for a peer-to-peer review. This option allows the rehab professional to have the case reviewed with the insurance company's medical director. Also, make sure the company carrying the insurance is not self insured. If self-insured the company can override the insurance company's denial.

6. If it is clear the rights of the beneficiary are being trespassed on, there are resources to be called upon to assist in the fight. Every state has a protection and advocacy network dedicated to protecting the rights of people with disabilities. They will try to mediate first and sue second. It is free to the beneficiary. The National Coalition of Assistive Rehabilitation Technology (NCART) and Users First will also have available attorneys to help with denials that need appealing.

There are too many variables to predict an outcome of an appeal. The above steps are simply guidelines and resources to help with the process. Beneficiaries need assistance, and we as advocates or representatives need to be educated on their behalf. Fight the good fight, and let's get more approvals than denials!

CONTACT
Darren may be reached at darren.jernigan@permobilus.com or 800.736.0925 x406.

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# A FOCUSED and Transparent Mission

*Written By* **Ann Eubank**

**THIS IS THE FIRST OF A SERIES OF ARTICLES** in **DIRECTIONS**. To begin the series, this article will introduce Users First Alliance (UFA) by defining its mission, discussing its history and by introducing the board members and the executive director. Future articles will focus on specific cases where UFA will detail the steps to engaging consumers and clinicians in self-advocacy. Additionally, the articles will disclose the organization's ongoing activities. This transparency is an attempt to foster a united message that all stakeholders can embrace including consumers, clinicians, manufacturers and suppliers.

The focused mission of UFA states: Users First Alliance seeks to ensure appropriate access to seating and mobility equipment by empowering wheelchair users, clinicians and providers through education and information resources that inspire action and motivate change.

UFA offers education to bring clarity to the advocacy process. There is a gap in knowledge, as most stakeholders do not have special training in advocacy. The swift pace of the health care system does not often allow for the necessary time to educate consumers on the service delivery process of wheeled mobility. Users First Alliance seeks to offer this education through social media, publications, education materials, online education, live presentations and a presence at consumer conferences.

UFA history has evolved since being introduced in 2007 as an LLC by three companies: The ROHO Group, TiLite and Permobil. The market feedback was positive regarding the message, but the structure was not conducive to a fully-collaborative venture.

The industry has clearly called for consumer involvement, yet there has been no focused vehicle to bring the voice and the face of the wheelchair consumer forward. The community of consumers, clinicians, suppliers and manufacturers is frustrated with the eroding reimbursement and health care policies that limit access to appropriate wheeled mobility. Users First Alliance strives to harness this collective frustration into a united voice. There are certain key elements necessary to become a viable and trusted vehicle.

One of the essential elements is transparency so all stakeholders have the opportunity to assess the organization's mission and structure. UFA was approved as a 501c3 nonprofit from the IRS on Nov. 15, 2010. It means the organization is tax-exempt and can receive tax-deductible contributions. The status also regulates the nonprofit from endorsing any product. The organization must comply with federal regulations and focus its efforts on education. The IRS application was lengthy and inquired about every aspect of the organization including the board members and the executive director.

The board of directors of UFA consists of seven people, six of whom use a wheelchair. The by-laws are written to protect the board from becoming corporately weighted. The board majority is made up of community members. Below is list of the current board members.

- Andrea Cooper, JD (president) assistant commissioner rehabilitation services for the state of Tennessee
- Tim Gilmer, editor United Spinal Association
- Darrell Gwynn, president of Darrell Gwynn Foundation member of the International Drag Racing Hall of Fame
- Todd Hatfield, executive director National Wheelchair Basketball Association
- Darren Jernigan, councilman Nashville Metro government, director of government affairs, Permobil Inc.
- Josh Anderson (treasurer), director of marketing TiLite, LLC
- Jacqueline Klotz (secretary), corporate event & marketing specialist, The ROHO Group

> There is a gap in knowledge, as most stakeholders do not have special training in advocacy.

The current executive director of UFA is Ann Eubank. Ann has been a national educator since 1996 and currently provides education seminars for Permobil,

Inc. Eubank does not receive a bonus or commission from her current employer, nor has she received a salary from UFA. Eubank achieved a master's degree in social work in May 2010. She was enrolled at the University of Tennessee full-time since 2008. Eubank spent over $100,000 of personal income to pursue a degree in social work to better understand the community of people with disabilities. During her studies, focusing on policy and social movements, Eubank was inspired to help develop UFA into a strong entity to empower people to navigate the complicated service delivery process of wheeled mobility. She believes all of the essential elements are present to collaborate and create a strong united voice. With this voice, as a community, we may be able to effect positive policy change.

Users First Alliance spoke to over 1,000 people in 2010, has 2,500 members and 933 fans on Facebook. The organization receives daily requests from clinicians and consumers asking for education materials and guidance.

UFA is inclusive in nature and is guided by social work ethics including challenging social injustice and the importance of human relationships. UFA welcomes feedback from all stakeholders and is committed to honestly receiving that feedback.

The current strategic plan includes: 1. Increase membership to show government officials how many people care about this issue, 2. Form committees so the organization is advised by the stakeholders, 3. Provide the much needed evidence showing the benefits of wheeled mobility, and 4. Provide education materials.

A personal note from the executive director: I am more interested in doing the right thing than being right. Thank you to everyone who took the time to voice their concerns and interests to me. For more details, to share ideas, questions or concerns, please feel free to contact me.

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# PRESSURE Ulcers

*Written By* **Laurie Rappl, PT**

**PRESSURE ULCERS ARE ONE OF THE MOST** common health hazards one faces when life dictates the use of a wheelchair rather than feet for mobility. Our feet and legs are beautifully designed for weight bearing and sustained mobility, not our bottoms and arms. But our bodies and our culture have always demanded mobility, and so home medical equipment was born.

HME and the services of the NRRTS Registrants are undoubtedly helpful to both prevention and treatment of pressure ulcers. As sexy as equipment can be, and as much as we want to put our problems off on a device or a pill or a doctor or therapist, the patient bears the major responsibility in pressure ulcer prevention.

There's no getting around it.

If you are providing equipment — seat cushion, wheelchair, mattress, overlay, padded toilet seat — you are remiss in not providing another voice in telling the patient and caregivers, "Use this equipment responsibly, don't expect it to do everything to prevent pressure ulcers." The more people impress this on equipment users, the better chance of the message getting through.

How can the users help themselves to prevent pressure ulcers?

1) Vigilance. Make it a habit. Pay attention to all of the times that their insensate areas are contacting something. Legs lean against supports for footrests or side rails on beds. Buttocks on seat cushions. Heels on mattresses. Outside of the foot on the floor of the car when legs frog out. Buttocks sliding on sliding boards. Buttock ring on commode seats. Catheter tubes on legs. Pants binding around the top of thighs. The back of shoes cutting into the Achilles/heel area. Check these areas constantly and change the pressures frequently. Be vigilant. Make it a habit.

2) Check the skin everyday — twice a day if you can. A quick visual check is all it takes. You should be terrified that something is happening that you don't know about. All you need is one experience with skin breakdown and the long process to heal it to know why I use the word "terrified."

Look for redness (or worse yet for blue, purple or black). If you press your finger firmly on the reddened area and remove your finger, the spot under your finger should appear white then quickly change back to red. If it just stays red, tissue is damaged. Keep all pressure off of that area and protect it until the redness disappears.

3) Quit smoking and quit drugs. One cigarette decreases blood flow by 50 percent for one hour. Your tissue can't handle the pressure.

4) Keep your skin clean, balanced in moisture and free of cuts and abrasions.

5) Toenails can cause all kinds of problems. Perhaps you need a regular pedicure (*you can skip the nail polish if you want*) to get your nails trimmed correctly and prevent nail problems.

6) Eat and drink a healthy diet. Guidelines are readily available.

7) Keep your wheelchair in good working order. Find out what that means from the supplier and make sure it happens.

8) Don't slide on sliding boards. Try to lift and sit rather than dragging the skin — under the pressure of the body weight — across the board.

9) Many medications affect the skin. Corticosteroids, nicotine, anti-coagulants, antibiotics, beta-blockers (some heart medications), drugs for rheumatoid arthritis, immunosuppressives, Cox 1 and Cox 2 inhibitors, and aspirin — the list is long and surprising.

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# GONE but Hopefully not Forgotten

*Written By* **Dan Lipka**

## GREETINGS TO MY OLD FRIENDS IN NRRTS!

I miss you! I cannot believe it has been three years since I made a career change. It seems like only yesterday I was going to wheelchair clinics, trying to adjust to all of the changes with mobility and seating codes and all the other policy changes that the industry has faced. Although I miss my networking with NRRTS, RESNA and NCART, I can't say I miss all the headaches and stress that went along with all these changes.

I am now working as a sales representative for a growing speech generating device (SGD) company called Tobii Assistive Technology Inc. I cover Ohio and Michigan, as well as portions of Pennsylvania, and Northern Kentucky. It's an area of assistive technology that has always been an interest of mine, and it's not that much different than seating and mobility. In fact, when I worked for Miller's, we were a reseller of these kinds of devices.

Because this is a much smaller industry, it's also not under as much scrutiny by CMS and state Medicaid systems. There's still a very close interaction with clinicians, but it's more often speech and language pathologists than it is OTs or PTs. There are still challenges with funding, but they are more related to very tight budgets and a general lack of understanding on what these systems do than because of concerns for fraud and abuse.

SGDs have only been covered by Medicare for some 10 years. Most, but not all, Medicaid programs and commercial insurances also cover SGDs. Coverage requires a very detailed and extensive evaluation performed by a speech pathologist as well as a physician's prescription, in much the same way that most complex rehab equipment is provided. So it's very time consuming and can be frustrating for the people that need this kind of HME.

Tobii ATI is well-known in this industry for developing the best eye gaze access technologies that can be used for accessing speech generating devices. By that, I mean all the person needs to do is look at items on a screen, much like a computer screen, to type words or select phrases. It's an absolutely amazing development in a technology that has been available for many years, but has not been very dependable or usable. I compare it with the difference between using a basic non-programmable joystick with a head array system on a power wheelchair. Due to the developments in eye gaze, people who were never able to access a communication device can now speak to their family, caregivers or medical professionals about their care or their daily needs.

In fact, I work with a number of people who can even access e-mail, surf the Internet, change the channels on their TV or make cell phone calls with their devices. So in spite of some of the challenges, the results can be amazingly rewarding! If you are

*(continued on page 48)*


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## Gone but Hopefully not Forgotten

(continued from page 46)

interested, check out www.tobiiati.com. You'll see a host of people using these devices in the 'User Stories' area.

> I am now working as a manufacturers' sales representative for a growing speech generating device (SGD) company called Tobii Assistive Technology, Inc.

On a more personal note, I am now the proud grandfather of three wonderful grandchildren — two girls and a boy. I find it odd to have grandchildren already, but it is so much fun playing with them, spoiling them and then giving them back to their parents when they get cranky.

Some of you may know that I am an avid skier and have been teaching adaptive skiing to people with disabilities for more than 20 years. During the last 10 years or so I have had the opportunity to volunteer with the Veterans' Administration/DAV Winter Sports program. This is an amazing event that includes some 300+ disabled vets and some 500 volunteers from across the United States. The program includes teaching adaptive skiing, sledge hockey, fishing, snowmobiling, scuba diving (in a heated pool of course!) and a host of other activities. It is an awesome event that is very humbling.

Last winter we had a visit from the most celebrated and accomplished alpine skier in U.S. History, Bodie Miller. I happened to be in the right place at the right time and got a chance to take a run with him. It was an easy run on a intermediate slope, but what a thrill! Something I'll never forget. I have always felt that when you volunteer you get back 10 times more than what you put in to it. I think this time I got a little more!

I do lurk on the NRRTS listserve once in a while, and I love reading DIRECTIONS. It's a great resource, and it is the best way for me to keep in touch.

CONTACT THE AUTHOR
Dan may be reached at Dan.Lipka@tobiiati.com or 330.620.1040.


TOP & MIDDLE: JULIA WHO IS 6 MONTHS
BOTTOM: ALAINA WHO IS 4 AND MAX WHO IS 3½
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## NEW REGISTRANTS

**Congratulations to the newest NRRTS Registrants!**
**(Nov. 13, 2010 through Jan. 17, 2011)**

**Jason Chavez, ATP, CRTS®**
United Seating & Mobility
4815 Hawkins NE
Ste A7
Albuquerque, NM 87109
Telephone: 505-338-6100
Toll Free: 888-815-9997
Fax: 505-341-9245
Registration Date: 11/24/2010

**Gary Chung, RRTS®**
Mobility Equipment Inc.
955 E San Carlos Ave.
San Carlos, CA 94404
Telephone: 650-596-7358
Fax: 650-596-7335
Registration Date: 1/6/2011

**Rafael Ibarra, RRTS®**
Alliance Seating and Mobility
4540 Atwater Court
Suite 104
Buford, GA 30518
Telephone: 678-677-4562
Registration Date: 12/17/2010

**Michael Jackson, ATP, CRTS®**
United Seating & Mobility
415 E Northtown Rd
Kirksville, MO 63501
Telephone: 660-665-2899
Fax: 660-665-3477
Registration Date: 12/1/2010

**Laura M. McAliley, ATP, CRTS®**
Chair and Equipment Rentals and Sales, Inc.
800 Central Ave.
Charlotte, NC 28204
Telephone: 704-333-8431 x.11
Toll Free: 800-333-8431
Fax: 704-333-5506
Registration Date: 1/4/2011

**Jarrod Rowles, ATP, RRTS®**
Black Bear Medical
275 Marginal Way
Portland, ME 04101
Telephone: 207-400-8040
Toll Free: 800-577-1365 x.140
Fax: 207-871-0590
Registration Date: 12/14/2010

**Daniel L Stephens IV, RRTS®**
Mobility Solutions
1001 E. Cooley Dr. STE 104
Colton, CA 92324
Telephone: 909-824-2185
Fax: 909-824-0958
Registration Date: 1/3/2011

**John Mark Tandy, ATP, CRTS®**
United Seating & Mobility
4815 Hawkins NE
Ste A7
Albuquerque, NM 87109
Telephone: 505-338-6100
Toll Free: 888-815-9997
Fax: 505-341-9245
Registration Date: 12/3/2010

## 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 Nov. 13, 2010 through Jan. 17, 2011.**

**Jason Chavez, ATP, CRTS®**
United Seating & Mobility
Albuquerque, NM

**Michael A. Deadrick, ATP, CRTS®**
Chesapeake Rehab Equipment
Ashland, VA

**Eric Hardy, ATP, CRTS®**
Midwest Respiratory & Rehab
La Vista, NE

**Ramey House, ATP, CRTS®**
Mobility Medical, LLC
Tupelo, MS

**Michael Jackson, ATP, CRTS®**
United Seating & Mobility
Kirksville, MO

**Ryan A. Martin, ATP, CRTS®**
National Seating & Mobility, Inc.
Houston, TX

**Laura M. McAliley, ATP, CRTS®**
Chair and Equipment Rentals and Sales, Inc.
Charlotte, NC

**John Paull, ATP, CRTS®**
National Seating & Mobility, Inc.
Chicopee, MA

**John Mark Tandy, ATP, CRTS®**
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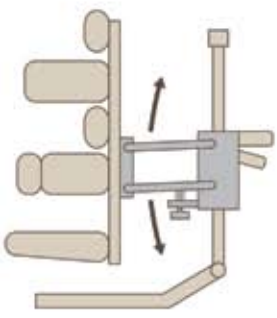
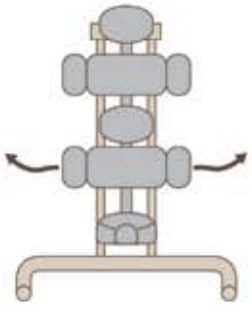


Dynamic vertical movement allows for stepping phase



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We are always available for your comments and suggestions.

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## FORMER NRRTS REGISTRANTS

**The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not. Names included are from Nov. 13, 2010, through Jan. 17, 2011. For an up-to-date verification on Registrants, visit www.nrrts.org, updated daily.**

David Bechtel, Newport Beach, CA

Ilan Michael Breiner, ATP, Cleveland, OH

Elizabeth Rafter, ATP Berkeley, CA

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**AUDITS – A FOUR LETTER WORD – HOW TO PREPARE FOR AND RESPOND TO DME MAC AND ZPIC AUDITS**

Tuesday, February 8, 2011 · 5:00pm to 7:00pm Pacific
*Jeff Baird*

**STANDING**

Thursday, February 10, 2011 · 5:00pm to 7:00pm Eastern
*Amy Meyer, PT, ATP*

**WHEN CONSIDERING MANUAL WHEELCHAIRS, WHY DO DESIGN AND WEIGHT DISTRIBUTION MATTER?**

Tuesday, March 15, 2011 · 5:00pm to 7:00pm Pacific
*Stacey Woods, OTR*

**VISION AND MOBILITY**

Thursday, March 17, 2011 · 5:00pm to 7:00pm Eastern
*Teresa Plummer, M.S., OT, ATP*

**ROLLABILITY**

Tuesday, April 19, 2011 · 5:00pm to 7:00pm Pacific
*Jim Black and Lois Brown*

**LOOK ME IN THE EYE**

Thursday, April 21, 2011 · 5:00pm to 7:00pm Eastern
*Leslie Johnson Fitzsimmons, PT, ATP*

**BACK TO THE FUTURE OF COMPLEX REHAB**

Tuesday, May 17, 2011 · 5:00pm to 7:00pm Pacific
*Julie Piriano, PT, ATP*

**EARLY INTERVENTION OF POWER MOBILITY**

Thursday, May 19, 2011 · 5:00pm to 7:00pm Eastern
*Maria Jones*

**SEATING FOR FUNCTION**

Tuesday, June 21, 2011 · 5:00pm to 7:00pm Pacific
*Michelle Lange, OTR, ABDA, ATP*

**OUTCOMES**

Thursday, June 23, 2011 · 5:00pm to 7:00pm Eastern
*Dr. Mark Schmeler*

**PELVIC CONTROL**

Tuesday, July 19, 2011 · 5:00pm to 7:00pm Pacific
*Allen Siekman*

**PRESSURE SORE MANAGEMENT**

Thursday, July 21, 2011 · 5:00pm to 7:00pm Eastern
*Darren Hammond*

**TOPIC & SPEAKER TBD**

Tuesday, August 16,2011 ·5:00pm to 7:00pm Pacific

**TOPIC & SPEAKER TBD**

Thursday, August 18, 2011 · 5:00pm to 7:00pm Eastern

**TOPIC & SPEAKER TBD**

Tuesday, September 20, 2011 ·5:00pm to 7:00pm Pacific

**TOPIC & SPEAKER TBD**

Thursday, September 22, 2011 · 5:00pm to 7:00pm Eastern

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