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HOME MODIFICATION DESIGN FOR WHEELCHAIR USERS

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in *every* ISSUE

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in *this* ISSUE

Theresa F. Berner, MOT, OTR/L, ATP, is an occupational therapist and is currently a Rehabilitation Team Leader at Ohio State University Medical Center. Berner is responsible for assistive technology and specialty programs and has her ATP certification. Berner is a clinical instructor in the Occupational Therapy Division of the School of Allied Health and serves on the advisory board. She has more than 17 years experience in seating and positioning and is very involved in the field. Berner has completed several presentations on seating and positioning and spinal cord injury both locally, nationally and internationally. **See page 36.**

Don Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART). Clayback has more than 23 years of experience in the Complex Rehab Technology and Home Medical Equipment industries as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences. **See page 30.**

Laura Cohen PT, PhD, ATP, RESNA Fellow, is the principal for Rehabilitation & Technology Consultants and executive director of the Clinician Task Force (CTF). The CTF is a leading group of clinicians from across the United States whose work involves providing clinically relevant information about seating and wheeled mobility device assessment and decision making to policy makers to ensure appropriate access for individuals with disabilities. Cohen is a second-level reviewer for a third-party payer reviewing DME requests in 21 states. She is a past chair and ex officio member of the RESNA Professional Standards Board, and works part time providing direct patient care in the Seating and Mobility Clinic at Emory Center for Rehabilitation Medicine. **See page 40.**

Judy Dexter is associate executive director of NRRTS. **See page 46**

Gerry Dickerson, ATP, CRTS® is NRRTS vice president. He works for Medstar, Inc. in College Point, N.Y. **See page 24.**

Ann Eubank, MSSW, OTR/L, ATP, is vice president of Community Initiatives for United Spinal Association. **See page 34.**

Erin Gildner is a consumer advocate who lives in Arkansas. **See page 16.**

Michele Gunn, ATP, CRTS®, is NRRTS president. She works for Browning's Health Care in Orlando, Fla., and has been a NRRTS Registrant since 1996. **See page 10.**

Brad Howard is an attorney at of Brown & Fortunato, P.C., who specializes in health care litigation and employment law. Howard graduated from the University of Texas School of Law in 1991, and he works closely with the firm's health care clients throughout the country. **See page 12.**

Sue Lebbens, MBA, OTR/L graduated in 1994 with her Bachelor of Science in Occupational Therapy from the University of Hartford. She also has her Master of Business Administration from Franklin University (2009). She is a licensed Parkinson's Delay the Disease exercise instructor and has her National Board of Certification in Occupational Therapy (NBCOT). Lebbens specializes in the treatment of spinal cord injury, stroke, parkinson's and brain injury. **See page 36.**

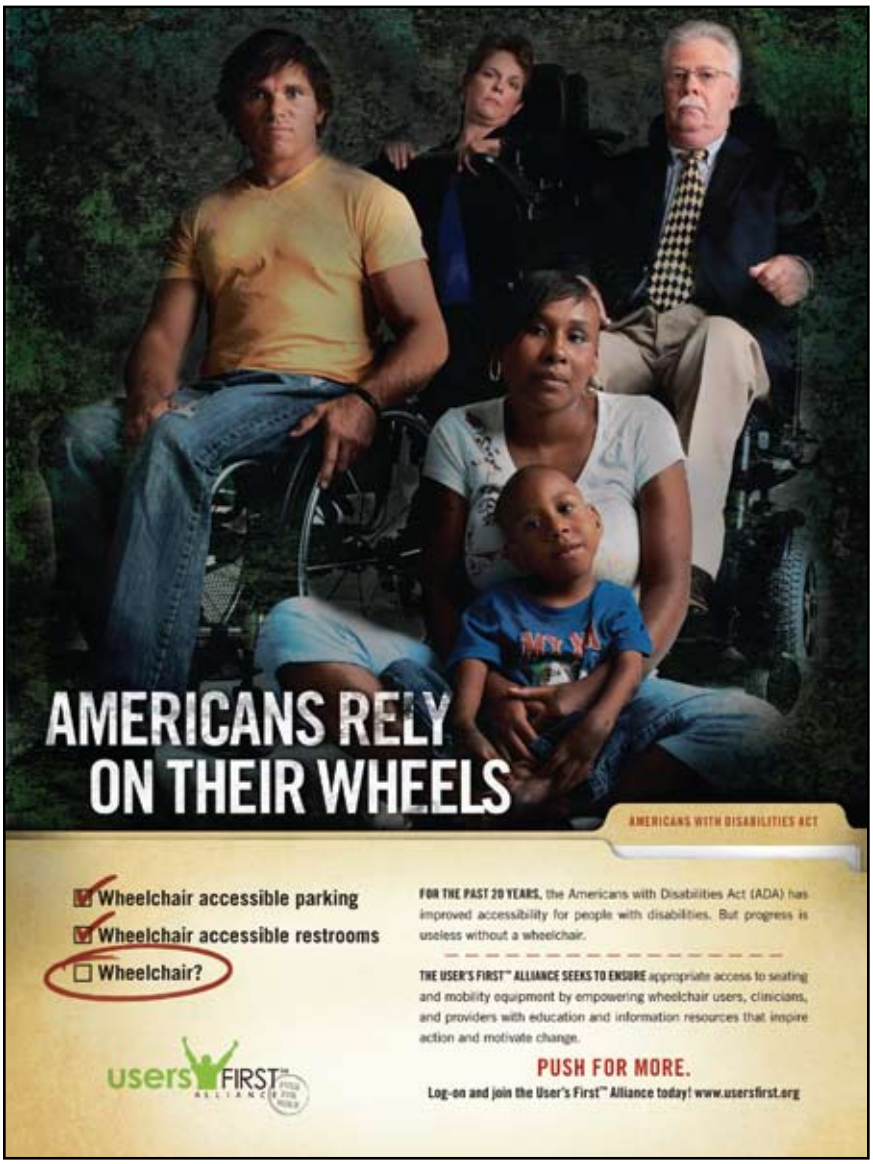
Amy Morgan, PT, ATP, is the pediatric and standing specialist for Permobil. **See page 48.**

Jessica Presperin Pedersen MBA, OTR/L, ATP, has been an occupational therapist for more than 30 years with an expertise in seating. She has been active in the development of the profession of seating, contributing clinically, educationally, and through advocacy. Pedersen was the first secretary of NRRTS and has been involved in RESNA, the Clinical Task Force, and AOTA. Pedersen and Jean Ann Zollars knew each other as young therapists sharing their experiences in therapy and seating. They've continued to learn from each other throughout the years as they've shared their passions in their professional growth. **See page 52.**

Cindi Petito, OTR/L, ATP, CAPS, owner of LOTTUS Designs and Seating Solutions, has been a private practitioner for 12 years, specializing in the area of mobility and complex rehab seating and home modifications. **See page 42.**

Gabriel Romero is director of sales and marketing for Stealth Products. **See page 22.**

Lorenzo Romero is president of Stealth Products. **See page 22.**



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Theresa Berner, MOT, OTR/L, ATP

ETHICS FOR ALL
Thursday, January 19, 2012 • 5:00pm-7:00pm Eastern
Simon Margolis, CO, ATP/SMS

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Tuesday, February 21, 2012 • 5:00pm-7:00pm Pacific
Barbara Crane, PhD, PT, ATP

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Thursday, February 23, 2012 • 5:00pm-7:00pm Eastern
Delia Freney, OTR/L, ATP

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Tuesday, March 20, 2012 • 5:00pm-7:00pm Pacific
Jill Sparacio, OTR/L, ATP

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Thursday, March 22, 2012 • 5:00pm-7:00pm Eastern
Theresa Berner, MOT, OTR/L, ATP

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Tuesday, April 17, 2012 • 5:00pm-7:00pm Pacific
Mary Shea, MA, OTR/L, ATP

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Cynthia Petito, OTR/L, ATP, CAPS

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Michelle L. Lange, OTR, ABDA, ATP/SMS

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Michelle L. Lange, OTR, ABDA, ATP/SMS

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POWER WHEELCHAIRS: *Using IR Transmission to Control Devices in the Environment*
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Jill Kolczynski, ATP

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Stephanie Tanguay, OTR

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Thursday, July 19, 2012 • 5:00pm-7:00pm Eastern
Mary Carol Peterson, OTR

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Tuesday, August 21, 2012 • 5:00pm-7:00pm Pacific
Pamela Wilson, MD

SEATING CONSIDERATIONS FOR CLIENTS WITH HIGH TONE
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Tuesday, September 18, 2012 • 5:00pm-7:00pm Pacific
Mike Babinec, B.A., B.S., OTR/L, ABDA, ATP

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Ann Eubank, OTR, ATP

GETTING IT RIGHT THE FIRST TIME: *Measurements*
Tuesday, October 23, 2012 • 5:00pm-7:00pm Pacific
Robert Lindholm, ATP

PATHOPHYSIOLOGY: *Osteogenesis Imperfecta (OI) and Arthrogryposis*
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Michelle L. Lange, OTR, ABDA, ATP/SMS

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Mary Ellen Buning, PhD, OTR/L, ATP

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Jill Sparacio, OTR/L, ATP

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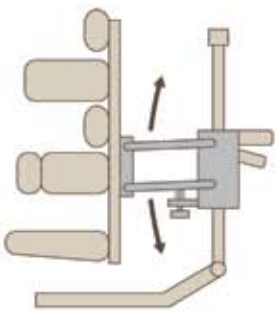
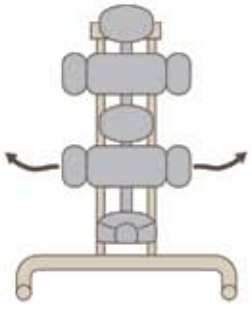


Dynamic vertical movement allows for stepping phase



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OUTCOMES

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

I AM GOING TO HAVE TO STAY ON OUTCOMES for a little while as there is a lot going on with this topic. Simon Margolis and Mark Schmeler presented at Medtrade in October the initial analysis from the pilot program we are running with the University of Pittsburgh. The data proves what we have been saying is true. There is significant improvement from the first FMA to the second FMA when we are involved with the wheelchair evaluation through fitting and delivery. It is there; we now have it in writing. Now the big question is: What do we do with it? How can we use the information to stabilize reimbursement so we can provide quality interventions for our clients? This will all have to be sorted out as we continue collecting the data to increase the sample size and range of information. Very exciting stuff!

This brings me to my client story for this issue. Michael has a spinal cord injury that left him paralyzed at the T3 level. Our company did his first ultra light wheelchair frame with seating shortly after discharge from rehab following his injury. I did not do it myself, but another colleague in our office had helped with a folding K0005. It was a good chair and served him well for the expected useful lifetime of the frame. It was only in the last year that the fastening points on the side frames and cross brace started to wear beyond repair. We got a prescription and made an appointment to meet at the clinic. Michael had little input regarding the first wheelchair and admitted he let the treating therapist at the time make most of the decisions during the initial evaluation. Now that he had several years under his belt, he knew a little more about what he liked and disliked in a wheelchair. We had a couple chairs there for him to try, and he settled on a rigid, mono-style aluminum K0005. Goals for the chair included shaving some weight, losing the cross brace to add efficiency in propulsion, and durability. We also changed his seat and back to address posture issues he was having.

Michael is a man of few words. He did not have many negative opinions about the folding frame when I did the interview for the first FMA. I have done a few of these now and get excited when I go out to do the second interviews. When we started going over the questions, Michael did not share my excitement. He had had the new chair for several weeks at the time and said he did not see much of a difference. Only now he had one negative in that it did not fold the same as the other, so it would not fit into his friend's car. I was getting that sinking feeling. You know the one. I felt like I blew it big time. I had thought the chair would be a huge change for the better for him. Although a little deflated, I continued asking the remainder of the questions.

Funny thing about the FMA, the early questions talk about the chair usage within the home. It is not until the last page that we get into how it is used outside. Once I got to these, Michael's whole demeanor changed. Michael lives with his family in a very small apartment. He told me he went inside to eat and sleep. Otherwise, he was outside in the community. Now the answers were completely "agree," and he started talking about how much tighter the turning radius was, how much easier it rolled with one stroke and how the seating had relieved most of his lower back pain. For Michael, only time will tell about the chair's durability. He is one I hope to do follow up FMA's on to see if what we believe to be true is actually true. Yet, another way outcome measures will prove valuable to this industry.

So, last message I used the COMFORT word and now I said he used his chair OUTSIDE. What a rebel. Not happy with the status quo? Join me in the rebellion!

CONTACT THE AUTHOR:
Michele may be reached at mgunn@brownings.net or 407.650.9585.

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Working With COMPLEX REHAB Patients:

SOME LEGAL RISKS AND A FEW SUGGESTIONS

Written By **Brad Howard**

SUPPLIERS OF COMPLEX REHAB EQUIPMENT are susceptible to liability claims for issues they may not even foresee. The purpose of this article is not to outline every liability risk, because an entire issue of **DIRECTIONS** could not cover them all, but instead to address some of the legal theories commonly raised by plaintiffs and their attorneys in complex rehab litigation throughout the country. Although it will not be the focus of this article, I would like to address one case because it is representative in the sense that it includes several of the legal theories commonly leveled against companies and individuals that service the needs of complex rehab patients. I am not assuming any of the allegations in this lawsuit are true, and in fact the defendant adamantly denied them all. Instead, I merely intend to focus on what is alleged against the defendant, because any of you could be in court one day answering similar allegations.

ONE FINAL WARNING: This article may not make you feel much better, but hopefully it will make you a little more aware of both the risks you face in this industry and some proactive steps you can take in an effort to avoid liability.

Last year, a lawsuit was filed by a father alleging that his son, who was receiving wheelchair repair services, was killed by the defendant's negligence. In this lawsuit, the family sought damages in excess of $10 million. It is a catchy and very large figure, and perhaps that was one motivating factor for including it in the original lawsuit filing. Specifically, the lawsuit claims the defendant should be responsible for this individual's death, as well as other injuries and deaths caused by alleged negligent maintenance of wheelchairs in the past. The plaintiffs alleged two repairmen at the direction of the defendant provided wheelchair services for a young man in his home. They further alleged the repairmen failed to remove the young man from the wheelchair while they attempted to repair it and failed to disconnect the wheelchair's battery while the work was being performed. They claim the wheelchair "jumped" and caused the young man to get pinned under the table he was sitting at. The lawsuit claims the young man then began to have uncontrollable seizures and died.

The complaint filed in court by the young man's family included a very serious allegation stated as follows:

COUNT THREE-NEGLIGENT TRAINING, SUPERVISION, CONTROL, DIRECTION AND RETENTION

In this section of the complaint, the plaintiffs alleged the defendant "had a duty of ordinary care…to properly train, supervise, control, direct and retain the employees…with respect to the maintenance of their equipment. As a result of their breach of their duty of ordinary care, defendants injured the plaintiffs, and plaintiffs are entitled to damages" in the total amount of $10 million. The primary legal allegations necessary to support such theories include: that the supplier hired unfit employees, failed to exercise reasonable care to train or supervise the employees, and the employer's negligence was the reason for the bad result, such as an accident involving a client. In the referenced case, plaintiffs would likely argue the employees should have been trained to follow certain procedures, such as disconnecting the power source, ensuring the patient was transferred before the repair work was done, etc. They would likely claim the employer's failure to train the employees in such safety protocols caused the accident for which the employer is liable. The defendant would undoubtedly avail itself of any applicable defenses if, for example, the employees were in fact contractors under the control of a different employer, the patient's family failed to account for his transfer from the chair prior to the necessary repair (and perhaps the company was reluctant to transfer him since an accident there would arguably be their fault as well), unavoidable accident, etc.

Lawyers also commonly assert claims for liability when a patient falls during transfer.

Lawyers also commonly assert claims for liability when a patient falls during transfer. In one representative case, the plaintiff alleged, during a transfer, employees of the defendant, "failed

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Working With Complex Rehab Patients...

(continued from page 12)

to provide the necessary and appropriate assistance to the plaintiff, resulting in his fall to the floor." Other cases include allegations that a company should be legally responsible for "failure to follow the plan of service regarding the mandatory use" of protective equipment and failure to properly secure the patient.

Therefore, in some cases the plaintiffs claim companies should be liable for failing to train their employees, who allegedly allow accidents to occur, and in other cases the plaintiffs allege a company's failure to follow its own safety protocol is enough to make them liable when a client is injured during a transfer. Finally, I am aware of allegations that an employee can be liable for improperly touching a client during a transfer.

Sadly, even the best of companies find themselves in court defending their actions. The earlier case is a primary example of the fact that an unfortunate result can land your company in court, where it is up to you to prove you did nothing wrong. However, a company can take certain steps in an effort to ward off liability claims. First, it is imperative your company has safety procedures in place to address all foreseeable situations that could lead to accidents or other losses. Second, any company in the complex rehab industry must properly and regularly train its workforce to follow all safety procedures. Third, you should consider retaining an industry consultant to review your policies and procedures, as well as your training protocol, and advise your company about additional measures to prevent liability-causing accidents. Fourth, you should consider any potential liability scenarios to ensure your company operates safely. For example, do you screen your employees who will be driving as part of their work responsibilities? Do you have policies in place to ensure they will not be texting or attending to other company business while driving for you or attending to patients on your behalf? Finally, you should discuss your liability concerns with your insurance agent to ensure you have adequate insurance coverage to protect you in the event of an accident.

Lawsuits and liability claims are an inevitable part of the business environment for many companies, and even the best companies cannot reasonably anticipate every situation that may land them in court. But if you seek advice about issues that make your company vulnerable, properly train your employees, and ensure all company safety policies are reviewed and enforced, perhaps you will only have to read about lawsuits against others and never experience one up close and in person.

CONTACT THE AUTHOR:
Brad may be reached at bhoward@bf-law.com or 806.345.6310.

> These written materials are not intended to be legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only. The law pertaining to the issues addressed by these written materials may have changed since these written materials were submitted. The reader should consult his or her own attorney for legal advice.

The "BARN RAT'S" Battle to *Live Again*

Written By **Randy Christian**

OFTEN, WHILE REFLECTING ON CERTAIN chapters of our life written in our youth, the phrase, "There but by the grace of God go I," pops into our heads. A slight chuckle and nervous smile sometimes follow, but deep inside we know there is really nothing to smile or laugh about. We know we dodged the virtual bullet. Disgrace or even worse missed its mark. For reasons we may never know, we miraculously escaped the consequences of our risky behavior. Many times, a single blinding glimpse of our mortality is enough for us to see the light and change our ways. Unfortunately, for thousands of teenagers and young adults who drink and drive, they fail to escape consequence, and in a blink of an eye, become a statistic. Some survive and remain convinced they are invincible. Many have perished leaving family and friends mournful forever. Others live, but are changed in ways they could have never imagined.

"I remember the paramedics telling me everything was going to be OK. They were going to get me out of the car. It wasn't until I was laying on the gurney at the hospital I realized I couldn't feel my legs."

Erin Gildner always loved horses. At age 4, she rode stick horses she made with her neighbor in Arkansas. Their imagination took them and their wooden thoroughbreds through jumping courses and to luxurious horse shows. At age 6, she traded her stick pony for the real thing and saddled-up for her first riding lesson. From the moment her trusty steed trotted across an open field until her early teens, Gildner's life was dedicated to horses. Maggie, an Australian sheep dog, was also near and dear to her heart and was never far from her side.

When Gildner was 11, her dad got a new job. So she, along with her father and stepmother, moved from Arkansas to Florida. With the move came an addition to the family. Gildner's grandparents bought her a real horse. The Arabian filly named Seratima, better known as Sera, and Gildner were inseparable. Going on trail rides, participating in shows or just feeding, caring and loving her horse gave Gildner great joy and purpose.

She began to work at the stables while still in grade school primarily in exchange for boarding fees and riding lessons. Cleaning stalls was a less than glamorous chore, but she also had lots of fun riding horses owned by others who were unable to for a variety of reasons. It was great for the horses, because they needed the exercise, but it also helped advance Gildner's riding skills. She became a confident, competent rider and would often be asked to train "green" horses for those with lesser skills.

In the summer, Gildner's stepmom would drop her off at the stable early in the morning on her way to work. There, she'd meet other young girls who also loved horses. Together, they would clean the barn and saddles, as well as other chores, and then ride and ride and ride.

Regularly, the owner of the stable would have the girls clean themselves up and take them to lunch and a movie. For Gildner, and the self-proclaimed "barn rats," days at the stable were more like an equestrian summer camp than work. She was living a storybook life. Horses, dogs, sunshine, fresh air and lots of good friends graced her life, but things were about to change.

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> For reasons we may never know, we miraculously escaped the consequences of our risky behavior.

ERIN HOLDS HER SON HAGEN FOR THE SECOND TIME SINCE HIS BIRTH. *JULY 2004*

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The "BARN RAT'S" Battle to Live Again

(continued from page 16)

TOP: ERIN, KOEN, RYAN, AND HAGEN. *CHRISTMAS DAY 2010*
MIDDLE: ERIN AND HAGEN HOLD THUMPER THE BUNNY. *EASTER SUNDAY 2011*
BOTTOM: ERIN AND HER FAMILY. *FALL OF 2009*

"When I was in the eighth grade, I moved Sera to another barn. The friends I had at the new barn were younger, so they weren't my high schools friends. I gradually became more interested in being popular at school than in my horse and my "barn rat" friends. I had my first drink [of alcohol] when I was 16 years old," Gildner said.

She remembers very well the first time she got drunk. As she says, "It was not pretty." Her teenage drinking would lead to late nights and the customary hangover. Her throbbing head and aching body begged her to stay in bed and abandon her duties at the barn and the affection of her beloved Sera. It was not long before her riding days were over, and she sold Sera.

Parties, late nights and lots of drinking soon consumed her. It became more than a way of life; it was her life. The once stellar student was barely making it to class. She was chronically late. Most of the time, she was nursing the effects of her newly embraced risky behavior. Her grades were embarrassingly low, but by now the alcohol had quietly taken over and wickedly assured her this was the good life. The young girl who once had thoughts of attending the University of Florida was no more. Her replacement was a stranger to family and herself. Now, when Gildner wasn't drinking, she was thinking about drinking.

Her new career choice didn't help her addiction to booze. Working in restaurants provided easy access to free drinks when she completed her shift. Many times, the free drinks simply primed her for more drinks at another location. Each day became hauntingly predictable. She showed up late for work, completed a shift, and then started drinking again. On more than one occasion, a manager informed Gildner if it hadn't been for her charming personality, she would have been fired long ago. A serious night of drinking followed by a monstrous hangover would prompt Gildner to enact a "no call/no show."

"I'd just decide I didn't want to work there any more. Sometimes I'd been out too late the night before and didn't feel like going to work, so I just would not show up for work. I knew I could get a job at another restaurant so it wasn't any big deal," she said.

Desperate for change, Gildner moved back home with her parents and started back to school. She enrolled in Valencia Community College and was even encouraged to enroll in its honor program.

(continued on page 20)

The "BARN RAT'S" Battle to Live Again

(continued from page 19)

There was only one problem. Several of her classes were early in the morning, which of course conflicted with her late night drinking. It was standard practice for her to meander home two hours before she had to be in class, but on Sept. 11, 2001, the reality of her crumbling life hit her right in the face.

> It may sound crazy, but I'm grateful for my experiences.

"As usual, I was late to class, but on the way, the guys on the radio were talking about an attack on the Twin Towers of the World Trade Center. I went into the classroom and told everyone about the attack. They thought I was crazy, but soon they knew I wasn't," Erin said.

For Gildner, the collapse of the World Trade Center towers symbolizes her life. Like the towers, her life had been attacked. She recognized it was on fire and falling apart. It was time to try to rebuild her life, but she wasn't quit sure how. Ironically, her mother, who was in the Navy Reserves, was called to active duty due to the attack on New York City and was sent to Saudi Arabia. Gildner moved back to Arkansas to house sit while her mother was overseas. This seemed like an answered prayer that included working at Oaklawn Race Track hot walking horses. The job at the track required Gildner to be on time and at work early in the morning. She was clean and sober for the entire three weeks she worked at the track, but the itch for alcohol was too much. She quit the track job and found a new one at a restaurant.

The cycle of late nights, drinking and hangovers began spinning again, but it came to a screeching halt the night of April 10, 2002.

"I got drunk the night before and had promised myself I wasn't going to drink that night. I hadn't planned on going out, but my friends talked me into going to the restaurant where I worked. I had a couple of glasses of wine. I felt OK when I got in the car to go home and get $20 and return to pay my friend's bar tab," she said.

ERIN AND THE BOYS AT THE MEMPHIS ZOO.
SPRING BREAK 2011

Gildner was one mile from her mom's house when she lost control of the small red Saturn on a curve. The weather was good, but she was going too fast. She crossed the highway, missing oncoming traffic and then ran into a ditch coming to a stop on a rocky culvert. The little car flipped several times on its way to its final resting place, never hitting another. Fortunately, Gildner was wearing a seat belt. It saved her life, but it didn't prevent her from breaking the T-11 and 12 vertebrae. She was paralyzed from the waist down.

Five days after her accident, surgery was performed and the T-8 and L-1 were fused. Metal rods were placed in her back, too. Rehab began almost immediately, teaching her how to live and work without the use of her legs. She met many amazing people while in rehab who were living proof you can reclaim your life if you choose to.

Gildner also met Mack Welch, a caseworker for the Arkansas Spinal Cord Commission. He talked her into speaking to people attending DWI and DUI classes around the state. Her testimonial not only had an impact on those who attended the classes, but her on as well.

"I decided to get help for my problem with alcohol. I came from a family of recovering alcoholics and knew I couldn't beat it by myself," Erin said.

Not only did Gildner get help, but she hasn't had a drink in nine years. While attending her recovery program she met her husband, Ryan, who was also battling alcoholism. Both remain sober and are the proud parents of two young and rowdy boys.

Today, Gildner works for the University of Arkansas System and is a real-life soccer mom and member of the PTA. Her husband recently graduated with a bachelor's degree in geology and works for a natural gas company.

When asked if she could change anything about her life, Gildner was quick to answer. "Sure, it would be nice to walk again, but only if I could keep the life I have now. It may sound crazy, but I'm grateful for my experiences. It stopped me from destroying myself and started me on a new path. I know it was divine intervention."

Gildner's life, words and deeds are truly inspirational and have the ability to cause people to question or even stop their risky behavior. She also gives us reason to believe miracles do happen, and the grace of God is a consequence we hope never to escape.

CONTACT
Erin may be reached at emgildner@uasys.edu.

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Work is MORE Than a Way to Make a Living,

Written By **Danette Baker**

IT'S A WAY OF LIFE

GABRIEL ROMERO

LORENZO ROMERO

GROWING UP, GABRIEL

Romero had three older siblings he could look up to. He describes his older brother, Lorenzo Romero, as having been blessed with their father's mechanical aptitude. He worked in Brigham City, Utah, for Morton-Thiokol, the manufacturing company that built booster rockets for the space shuttles.

Like their father, Lorenzo also had a knack for seeing a need for something and then building it. Gabriel, on the other hand, always had a knack for technical things and was a natural salesman.

In 1999, Lorenzo and his business partner, Rucker Ashmore, designed and built an aftermarket headrest for those using wheelchairs. The Stealth Ultra became the cornerstone for Stealth Products Inc. The company, owned by Lorenzo, is now a multinational design and manufacturing firm specializing in aftermarket components for wheelchairs and has a reputation in the rehab industry for not only producing a quality product, but also for producing products of value to the consumer.

Although there were other headrests on the market, the Stealth Ultra provided options not available on the others – namely swing away facial pads offering relief for the client, alternative options for mobility and communication, and flexibility in transferring in and out of the wheelchair. The concept itself was novel; however, the real story of this company's success lies in the simplicity of its mission.

"We have tried to build a business model like an Erector Set," said Gabriel, director of sales and marketing. "We look at meeting supply and demand with our current product, but if there's a need we'll take what we have and build something new from it.

"We've become a company a therapist or wheelchair manufacturer calls up to meet the needs of their clients."

For the first few months, Lorenzo and his sister were Stealth's only employees. They worked in tandem for several months taking sales calls and manufacturing products before they hired the first employee.

About the same time Lorenzo launched Stealth, Gabriel began working for Adaptive Switch Laboratories, a manufacturer of adaptive switches for mobility, communication and computer access. Gabriel started in the repair department and worked his way into technical support and sales.

In 1999, Stealth Products was at the Medtrade show, Lorenzo's first time to attend. Gabriel was there as well, representing Adaptive Switch Laboratories.

"I'll never forget that day looking over at my brother's booth and seeing the great response he had with Stealth Products. He had a modest booth he had designed and built and was having good response from the industry," Gabriel recalled. "I remember thinking, 'That's where I want to be.' "

When Gabriel joined his brother at Stealth Products in 2004, the company was well established in the industry. To grow, however, he knew that meant focusing on getting a sales force educated and trained. The brothers have worked diligently during the course of about seven years to increase their internal sales force from two to 13 people at the company headquarters in Burnet, Texas, as well as add an independent representative in Europe. Burnet, Texas, is about 40 minutes northwest of Austin, Texas.

> Despite the stellar business acumen, Gabriel quickly points any success to the fact that they have remained true to their family values.

"What makes us unique," Gabriel said, "is that a lot of the products we design are originally for a small percentage of users."

Every wheelchair user needs a headrest, he explained, but not everyone considers those who need a headrest with switches or positioning pads. That's what makes their product unique. The Stealth

Ultra, for example, can be customized for the consumer, with switches for mobility or computer use, but also maintain its clean design.

Early on, Stealth Products was seen strictly as a headrest manufacturer but has diversified through the years adding a mobility base, which provides an alternative to the traditional umbrella-type folding stroller. The Lightening Stroller maintained the functions necessary for an adaptive mobility product, but introduced a look more in line with a traditional stroller, Gabriel said. Like the headrest, the product was developed to meet the needs of a particular consumer — parents whose children needed the rehabilitative support but who wanted to be able to stroll without the attention.

The same year, Stealth Products made another mark in the rehab industry with its LINK technology. Similar to the LEGO building block system, LINK technology provides the ability to position and articulate products not available by the traditional mounts in the industry.

"When brought to the industry, we also discovered it could be used for headrest supports," Gabriel said. "Once we did that, it made a huge impact, and we see it on a lot of manufacturer's order forms."

The company catalog provides a visual look at its growth. In the beginning, there were minimal models of the headrest, mechanical switches and a mushroom joystick on the front of a single sheet with a price list on the back. From there, Stealth Products has increased its product base to hundreds.

In 2008, Stealth Products embarked in the seating and positioning market and within the year had a full seating line encompassing hardware, seats, backs, upholstery and foams. Gabriel describes the 2008 product addition as one of the most aggressive moves the company has made since turning on the lights.

"It helped give us the reputation that this company is going to do things differently, out of the box, but with respect to the principles of the industry," he said.

Innovation is a word heard often at the Burnet headquarters. It's one of the things the company takes pride in as it encompasses not only developing new products, but also improving what they have. Their pricing has not increased since opening their doors in 1999. In fact, they have reduced manufacturing costs by implementing lean manufacturing principles, despite that they've added more than 100 employees to the payroll and continued to produce 97 percent of their products in America.

There is no greater satisfaction than seeing a product you created make an impact in someone's life.

"It is simple things like creating a jig that cut our process time on producing one item from 25 minutes to two," Gabriel said.

Despite the stellar business acumen, Gabriel quickly points any success to the fact that they have remained true to their family values. They are a tight-knit clan who works together and serves together. They established their business in the same small town they called home long before the company became successful. In addition, they recently completed building a neighborhood church, Jesus Christ the Living Rock, where Gabriel serves as a worship leader along with their father. Daily, the Romero brothers would leave work and drive across town for their "second shift" to build the church, modeling a work ethic they had see from their father.

"He would leave work and then go by and fix things at a relative's house," Gabriel said. "That was something he never said, but it was just understood, you don't walk by someone struggling without offering to help."

Gabriel came upon a young man at a trade show at Craig Hospital in Denver, Colo., and received great feedback on some laterals and accessories when he noticed the young man perusing the booths from his wheelchair. The man stopped to take a call on his cracked iPhone that lay in his lap. Inquiring as to what happened, Gabriel discovered the man kept his phone in his lap so he could reach it, but it kept getting bumped and had been dropped more than a few times.

Gabriel took one of the Stealth company cell phone mounts he had with him at the show and attached it to the young man's wheelchair and told him it was compliments of the company. The young man was surprised, but grateful, Gabriel said.

"There is no greater satisfaction than seeing a product you created makes an impact in someone's life."

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TINKERING and PUTTERING at My *Grandfather's Workbench*

Written By **Randy Christian**

GERRY DICKERSON HAS BEEN IN THE industry for more than 38 years. His memory of those years is absolutely remarkable. He is a virtual walking complex rehab encyclopedia with user-friendly finger tabs and comprehensive reference sections. The names of many of the industry pioneers and technical wizards are stored in his brain and set for quick retrieval. Names, dates, projects and places are easily shared and with a sense of reverence. The story of him and his youthful coworkers "burning the midnight oil" and loving every minute are warmly remembered. Designing, building and test-driving prototype wheelchairs would over time masterfully morph into some of the complex rehab equipment we see today.

Warning: If you plan to have a conversation with Dickerson regarding his career in complex rehab, be sure to take a chair. A soft, comfortable one would be best, not because of a fear of the duration of the conversation, but you'll want to be relaxed and ready to savor every tidbit of information Dickerson will graciously share about the industry he loves. He has seen it grow from a tiny seed into a giant sturdy tree that provides support, comfort and hope for thousands of disabled men, women and children.

Today, at age 57, Dickerson is vice president for Rehabilitation Technology at MedStar Surgical in College Point, N.Y., but the truth is, his career started in his grandfather's basement. Most summers he would spend the day at his grandparents' house across town from his. Dickerson would follow his grandfather to the basement and watch and learn as he stood at his workbench and used all kinds of tools to fix-up discarded and broken birdcages. He would often give it to a friend or neighbor. His grandfather loved to repair most anything from tattered toasters to rusty radios. It was a time, unlike today, when things were not thrown away.

> In my early days, there was no such thing as complex rehab. It just didn't exist.

Dickerson's dad was a fixer-upper kind of guy, too. Both his dad and grandfather taught him the value, skill and virtue that came with being what is affectionately referred to as a tinkerer and putterer. They loved cutting, bending, drilling, twisting and turning nuts, bolts and screws this way and that. Hours later, what was once nothing would be a useful something that sure brought a smile to a true tinkerer, if no one else. Some people might consider it a curse to live with a tinkerer, but not Dickerson. He considers it a blessing. To this day, he uses the skills he learned at the foot of his dad and grandfather.

"I can remember going as a child with my dad to Barry's Hardware in Dover, N. J. He'd get what we needed to do stuff at the house. He loved to work around the house. Hang a door. Pull up the carpet. Paint this. Paint that. Take this apart. Put it back together. He just loved tinkering and puttering," Dickerson said.

Dickerson put those skills to use soon after he entered the world of rehab. His first job was with a local medical-surgical supply company, Area Medical, in Morristown, N.J. Immediately, Dickerson was fixing things up using the skills he'd honed at his grandfather's workbench. During this time, he connected with the Matheny Medical and Educational Center a short distance from his home. Matheny is a special school and hospital for children and adults with medically complex, developmental disabilities. Fortunately, the center offered Dickerson an opportunity to work on several projects that once again called on his tinkerer's skills. In short order,

THE QUINTESSENTIAL CHRISTMAS HOUSE

> The cool stuff, the remarkable stuff about our industry you learn from experienced people.

TOP AND MIDDLE: DICKERSON'S CHILDREN. HE ASKS, "HOW DID WE GO FROM HERE TO HERE?"

BOTTOM: JIMMY THE RACER AND HIS PIT CREW, CIRCA 1988

Dickerson became a partner in Area Medical and as he said, "The rest is history."

As Dickerson began to write his professional history, the history of complex rehab was being written. Little-by-little, project-by-project, new technology was being cobbled together to become the foundation for today's complex rehab industry.

"In my early days, there was no such thing as complex rehab. It just didn't exist. That's part of the reason why I'm so attracted to its history. We are directly connected to the first generation of people who were involved in the evolution of complex rehab. People like Doug Hobson and Elaine Trefler brought their work from Canada to the University of Tennessee in the early 70s," Dickerson said.

Even though Dickerson and his cohorts were far from Tennessee, they kept a close eye on the goings-on in Memphis. Back in their neck-of-the-woods, Dickerson took full advantage of his company's machine and electrical shop and worked tirelessly helping whoever needed help. If a customer had a wheelchair with a 15 inch x 16 inch base, but needed it to be wider, his crew had the tools and advanced tinkerer skills to get the job done in a day. After a day of applying their mechanical magic to the needs of grateful rehab customers, the boys would then work at night making landing gears for remote controlled model airplanes. Ironically, their night shift provided a virtual glide path into the fledgling complex rehab industry that was beginning to take flight.

Unbeknownst to Dickerson and gang, their development and uses of capacitive switches and fiber optic lights was slightly ahead of the industry

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Tinkering and Puttering...

(continued from page 25)

curve, thanks in part to his brother-in-law who was a bit of an electronic genius. The more they made things move in a smooth and steady manner, the more fun it was to come to work. The shop became a virtual Disneyland filled with the endless potential for making wonderful new attractions for their customers.

The combination of their blue-collar work ethic — and playful Jersey swagger — gave the young tinkerers the confidence to believe that if anyone has isolated movement and the cognitive skills to drive a wheelchair they could get them moving. It became theirs to drive passion to build the best. It also provided the boldness to instigate after-work parties that included young single female therapy students who lived in dormitories and provided therapy services at the Matheny School. In exchange for free food and a moderate amount of libations the young therapists would evaluate the design and maneuverability of the company's new creations. The goal was simple: find out if the stuff they made would work in the real world. Having fun was also a high priority.

"I dated a girl for a while with a spinal injury. We went to a Fleetwood Mac concert at Madison Square Garden. I'd get in her chair, then put her in my lap. I wheeled us right up to the front of the stage," Dickerson said.

The pace of the technological advancements began to accelerate, which added fuel to the fire of complex rehab. In a relatively short period of time, the evolution of the wheelchair went from the 40-pound unmanageable monsters to the ultra-light, easy-to-maneuver technology-laden wheelchairs that now help move thousands of people through the door to greater independence and more freedom.

The thrill of being a part of the technology advancements that changed the lives of truly wonderful people was more than enough to deepen Dickerson's love affair with his work. Whether it was an adult or a child, he had seen firsthand how the most elementary technology could make a monumental difference.

"Some of these folks have been my customers for 35 years. They came to me when they were 8 or 9 years old. They're in the third, fourth, fifth power wheelchair and now they're in their 40s," Dickerson said.

Even with the incredible advancements in complex rehab, the process to acquire new equipment seems to be harder. In some cases, it take months — and in others, years — for worthy people to receive the kind of complex rehab equipment needed in order to be the productive, employable, tax-paying citizen they desperately want to be. Dickerson has fought and won many funding battles. His more cherished reward is often the letters from many grateful men and women. As follows are a few excerpts from those letters:

"I am so grateful for what you have done for me."

"I would have never believed it possible for me to sit like a human being; kudos to you."

"I love my chair more than most things in life. Ha, ha, ha. "

"Thank you, I'm free. Thank God, I'm free at last."

"I'm free to see the world out there that's waiting for me. Thank you."

They are words and thoughts and feelings Dickerson will treasure forever and are a reflection of a career dedicated to service to others above all else. Dickerson has built a legacy that is honored and respectively envied by his peers. There is one question regarding his career that may remain unanswered forever. Where is the next Dickerson? Where is that young 20 something willing to pick up a tool and patiently follow and absorb wisdom of someone who has learned by doing?

"The cool stuff, the remarkable stuff about our industry you learn from experienced people. You see them thinking outside the box. You learn from them how to look at something and not see it the same way twice. It's truly a craft you learn over time. I'm not sure where that next generation of complex rehab craftsmen will come from. I wish I had an answer," Dickerson said.

(continued on page 28)

TOP: THE LAST CROSS COUNTRY MOTORCYCLE TRIP, OGALLALA, NEB. CIRCA 1975
MIDDLE: MR. AND MRS. DICKERSON
BOTTOM: WITH JACK AND BEAR, CIRCA 1976

Tinkering and Puttering...

(continued from page 27)

Maybe the answer is for us to help more young people, who seek to serve others, find their own personal workbench. It is special place where they can watch and learn how to use the tools of their father to fix a discarded birdcage, a rusty old radio and maybe even a wheelchair or two. Is it time to rekindle the wisdom and skills of the tinkerer-putter? Is it time to look back and learn how to twist and bend and turn nothing into something? If we do, perhaps the next generation of tinkerers will be inspired to try and make a wheelchair do things we have yet to imagine. I'd bet Dickerson would be willing to loan them his tools.

CONTACT
Gerry may be reached at gdcrts@aol.com or 718.460.2900 x.138.

TOP: WITH THE BOYS, BLOCK ISLAND, JULY 2009

MIDDLE: FAMILY GATHERING, SUMMER AFTER TAHOE

BOTTOM: MEETING WITH CONGRESSMAN CROWLEY. L-R CAROL NAPIERSKI, DOUG WESTERDAHL, JEAN MINKEL, CONGRESSMAN CROWLEY, BILL TOBIA AND GERRY DICKERSON

At Medtrade 2011, Dickerson was awarded the David T. Williams Advocacy Award by NRRTS and NCART. This annual award will recognize the accomplishments of an individual from the Complex Rehab Technology (CRT) industry who has demonstrated extraordinary efforts in advocating to protect and to promote access to CRT for children and adults with disabilities and serious medical conditions.

MICHELE GUNN, GERRY DICKERSON AND DON CLAYBACK

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Separate Benefit Category and COMPETITIVE BIDDING Updates

Written by **Don Clayback**

NOVEMBER 2011

THE PURSUIT OF A SEPARATE BENEFIT

Category (SBC) for Complex Rehab Technology (CRT) under the Medicare program got a big boost at the end of October. We received our first formal commitment from a member of Congress to introduce the legislation needed.

Rep. Joe Crowley, D-N.Y., has agreed to take the democratic lead in the House of Representatives and get the bill finalized and introduced. Crowley is a 12-year member of Congress and serves on the key Ways and Means Committee in the House. We have been working closely with the congressman and his staff and are very appreciative of his formal commitment to take this lead. It's important to note we are also continuing to pursue a republican lead so the legislation can enjoy bi-partisan introduction.

In announcing this development, there's an important lesson to share. Investing the time in telling and illustrating the CRT message (specialized products used by people with disabilities that require a high level of individualized service) does indeed pay off.

The congressman's decision was the result of a long-term "educational process" led by Gerry Dickerson, ATP/CRTS, and vice president at Medstar Surgical in College Point, N.Y. Dickerson has personally been educating Crowley on the challenges of providing CRT for many years through hosting a site visit at his business location, providing regular updates to Crowley's office, and attending his local fundraisers. Dickerson's personal efforts were supplemented with the involvement of representatives from the United Spinal Association and NCART. The collective investment of this time and energy paid off. We're happy to say when it comes to CRT, Crowley and his staff get it.

The good news is other CRT stakeholders are also spreading the CRT message throughout the country. Individuals and organizations are connecting with their members of Congress, their state legislators, their state Medicaid officials, and others. They're spreading the good word and creating a better understanding of CRT. This better understanding is critical to establishing and protecting coverage policies that give people with disabilities access to the CRT products and services they require.

As for our SBC legislation, this is the first of several critical steps in getting the bill introduced. Crowley and his staff will now be getting into the details. This will include more closely reviewing the draft legislative language, the related scoring report and other pertinent information. Input will be sought from the staff of the Ways and Means Committee, and from Congress's legislative counsel. Out of these activities will come the actual bill that will be introduced.

Once the legislative language is formally introduced, it will be assigned a bill number. 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 during this process, the legislation is forwarded to the Congressional Budget Office (CBO) for "scoring" to determine the "official" projected financial cost of the bill over a 10-year period. Finally, with enough congressional member support, the 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 on to the president for signing. Once signed, we have accomplished our legislative objective.

As we move ahead, we will be working very closely with Crowley's office on these details and the creation of final legislative language that will form the text of the bill. In addition, as mentioned above, we will also be continuing to pursue a republican co-sponsor so the bill can enjoy bi-partisan introduction. So there's much work to be done, but we are happy to have cracked the congressional barrier by completing the first step in the legislative process.

COMPETITIVE BIDDING UPDATE

The Centers for Medicare and Medicaid Services (CMS) is still analyzing our request for CRT exclusions and other changes for round two within the newly created product category "Standard (Power and Manual) Wheelchairs, Scooters, and Related Accessories." As currently structured, this product category has major problems and requires immediate review and revision by CMS. We are continuing to communicate with CMS as they review the supporting information we have supplied and conduct additional research on the basis for our requests.

There also have been discussions held with members of Congress on this issue. As a result, Sen. Bob Casey, D-Pa., has sent a letter to CMS requesting the needed changes. Rep. John Larson , D-Conn., has also committed to writing a similar letter that will be sent shortly. We will be reaching out nationally for other CRT stakeholders to get their members of Congress to write similar letters to reinforce the need for these changes before proceeding with round two.

From the broader HME industry perspective, the American Association for Homecare and other HME groups are working to get legislation introduced to replace the current competitive bidding program with a "market based pricing" alternative. This alternative system would still provide savings to the Medicare program, but would do so in a manner that did not include the major flaws and weaknesses existing in the current competitive bidding model. This alternative proposal also includes language excluding all CRT items. You'll be hearing more on this in the weeks ahead.

QUESTIONS AND COMMENTS

A variety of documents related to our Separate Benefit Category initiative can be downloaded from the NCART (www.ncart.us) or NRRTS (www.nrrts.org) websites. If you are unable to do so, please e-mail me, and I will get them to you. 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, - US Rehab (elizabeth.cole@usrehab.com); Gary Gilberti, 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, National Rehab Network director, - The MED Group (tpederson@medgroup.com); and Paul Tobin, president, - United Spinal Association (ptobin@unitedspinal.org).

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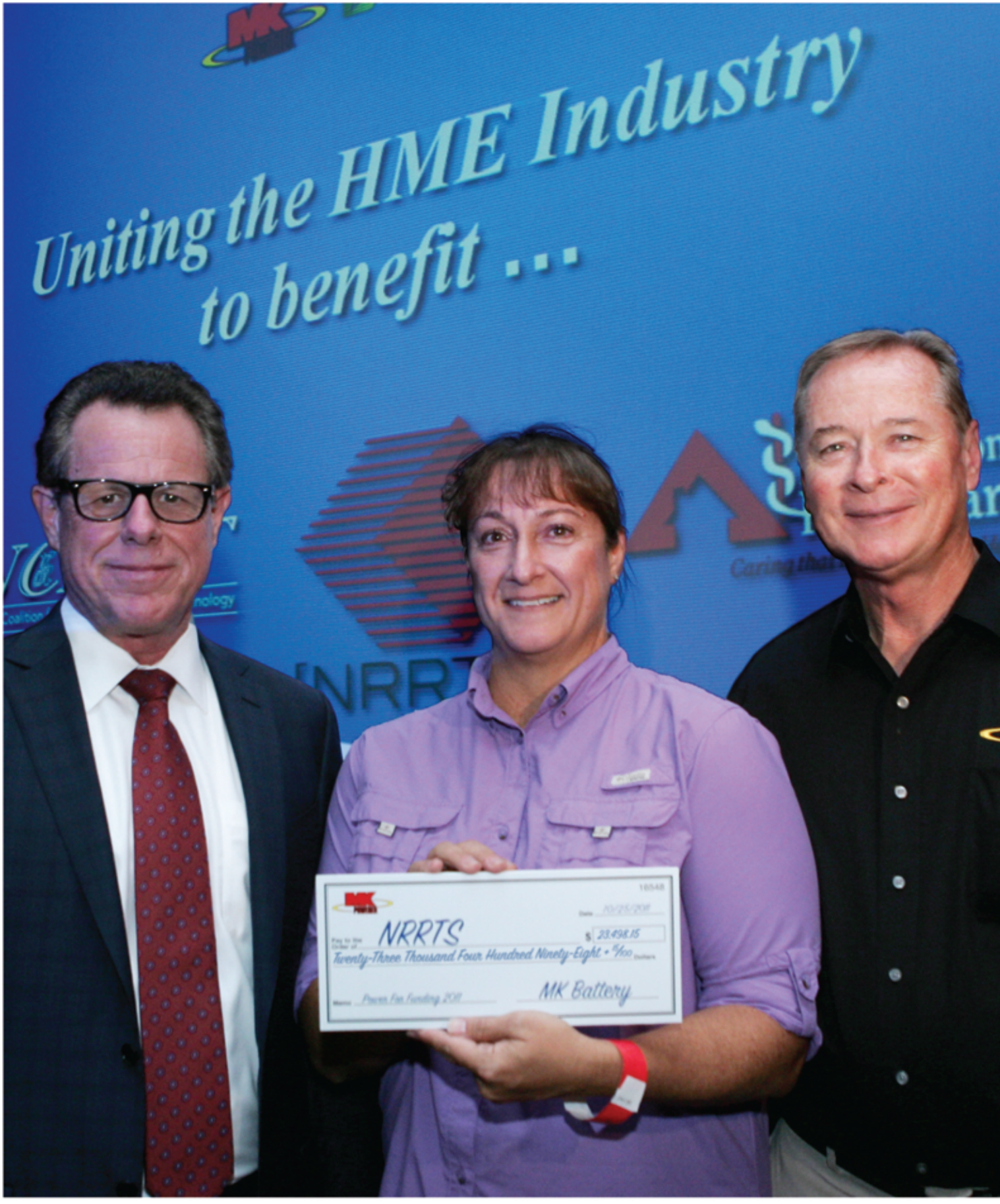
> *Visit www.ncart.us for more information.*



MK Battery's President, Mark Wels and HME Category Manager, Dennis Sharpe, present check to Michele Gunn, President of NRRTS

Power for Funding 2011 Raises Over $70,000

MK Battery, in cooperation with Medtrade, hosted the Power for Funding 2011 Networking Reception at the Omni Hotel in Atlanta on October 25th. As an inaugural event, it was very well attended and featured, in addition to a fine spread of food and refreshments, live music and a nostalgic slide show that took the HME industry on a fascinating walk down memory lane.

Proceeds were divided between NRRTS, NCART and AAHomecare. Thanks to MK Battery, Medtrade and all the sponsors who made this event possible.

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GRASSROOTS Update

Written By **Ann Eubank, MSSW, OTR/L, ATP**

HAVE THE CONVERSATION

I JUST RETURNED FROM IRELAND WHERE I was a guest of the European Seating Symposium. I mention this because the organizers, along with clinicians, suppliers and manufacturers from all over the world report similar funding challenges and the lack of consumer involvement we face here in the United States. I received the message that Europe is interested in the UsersFirst model. They asked me to explain the structure of UsersFirst, its successes, challenges and literally, the elements of such a movement.

UsersFirst is providing a service to consumers and professionals concerned with the lack of access to appropriate wheeled mobility. As we develop more outreach and education programs, we are fostering a true grassroots/consumer-run movement. There are specific reasons the model is working and continues building strength.

The subject of "consumer involvement" has filled more than one conference room during the last 10 years, and we come away with the central question of, "How does one engage the consumer in efforts to increase his or her access to wheeled mobility?" From this realization, three additional and vital questions emerged: 1. How does the consumer become aware of the lack of access?, 2. Feel as though participating will make a difference?, and 3. Find the means and structure to voice his or her concerns? These questions must be addressed to create and sustain a movement of people willing to voice their concerns about the lack of access to wheeled mobility – the lack of access to the freedom of movement.

To quote a famous community organizer, Saul Alinsky, "If people feel they don't have the power to change a bad situation, then they do not think about it." I have heard many industry partners ask, "Doesn't the wheelchair user understand what is at stake here? They are going to lose the opportunity to access their life!" The answer may be the typical wheelchair user does not move through her life identifying as a "wheelchair user." She might be identified with whomever she is: a worker, friend, student, mother, wife, etc.

This leads us back to the question, how does the consumer learn and care about such important issues that relate directly to freedom of movement? I suggest an answer — have the funding conversation with consumers. Inform the consumer there are a host of options on the market, yet the insurance company does not consider the device or option medical necessary, or that there is a cap on DME, or Medicaid or Medicare just competitively bid products and therefore service and choice of vendor and products has diminished.

At this point, the consumer may feel frustrated and even angry. These are powerful emotions and important to fuel a consumer movement. There will be more energy than apathy. We know what apathy looks like and that it possibly leads to less power for the consumer and more power for the third-party payer to continue slashing DME rates.

What can you do? You can help organize and connect the consumer with a structured organization that provides a space for people to voice their issues, a caring and educated staff to help guide them through the service delivery process of wheeled mobility and a legal staff to help challenge discriminatory policy.

Part of the organization's structure and an essential element in a consumer movement is the presence of a chapter network. UsersFirst has access to a national chapter network consisting of 24 consumer chapters and more than 37,000 members. All of these members and probably most Americans agree with the succinct mission of the UsersFirst cause: 1. Enroll people who care about access to appropriate mobility devices, 2. Educate people about the service delivery process, and 3. Challenge discriminatory policy.

> Have the funding conversation with consumers.

The essential element is the peer-support structure of the chapters. Chapter members and leaders are people who use wheelchairs. Each chapter sponsors multiple support groups and other types of member services. This is where change happens locally.

We now have the key elements of a successful consumer movement. If you are one of the many who believe in appropriate access to wheeled mobility and wish to partner with the growing voice of the consumer, you can do two things: 1. Have the funding conversation with the consumer, 2. Help connect the consumer with UsersFirst and all of its resources.

Here are ways you can become united and connected to support:

Tell your story at http://www.usersfirst.org/submit-your-story/.

Sign up to be counted as someone who cares about access to wheeled mobility at http://www.usersfirst.org/join-with-us/.

Stay connected through Facebook by "following " UsersFirst at http://www.facebook.com/UsersFirstAlliance.

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

It Takes a VILLAGE to Get a Chair...

Written By **Theresa Berner, MOT, OTR/L, ATP and Sue Lebbens, MBA, OTR/L**

OR A FEW CHAIRS

THE FOLLOWING CASE IS INTERESTING, because the patient in this story has crossed many paths of rehabilitation. He completed rehabilitation from two different programs in two different states. He has even acquired additional equipment within the five-year window. He used creative funding, and he invested his trust in good people. One can think: "the stars just aligned and it worked out," but we believe the strength of our industry is stronger than we may realize. This story also shows that complex rehab suppliers are necessary and best practice is from the integration of many different talented people sitting in different areas of our industry.

The story begins with a 19-year-old college student, Ian, suffering from a spinal cord injury. Ian is introduced to us during the outpatient rehabilitation phase and came to our clinic after completing his inpatient rehabilitation out of state. One of the first fears that go through a clinician's head is, "I wonder what they ordered, and I hope it is correct." Any clinician working in inpatient rehabilitation is experiencing the challenges of predicting the needs of an individual and his or her recovery. Insurance requires us to assist a client in making a decision on what equipment will be used when he or she leaves the hospital, although medicine and science is giving us hope of continual recovery.

This is not a unique situation, and we have all been there when we end up supporting a chair that exceeds the needs of a client or the chair doesn't quite meet the needs we predicted. All we can control is our investment in evidence-based practice to lead us into predicting recovery, collaboration with all team members to understand abilities and weakness, and partnership with our clients to help them understand their choices. Once we have accomplished this, we send the clients on their way with the hopes the complex rehab supplier can fill in the gaps that may have been missed. This all becomes more complicated when the individual we are carefully putting the pieces together leaves the state to go home or comes to us from a program far away. It is in these scenarios that we reach to our network of entrusted clinicians, suppliers and manufacturers and use all resources to help achieve a common goal.

Ohio State University was the recipient of an amazing clinic's work in starting the process of equipment integration. From June 2010 to the fall of 2011, Ian worked with a team of professionals that integrated his plan from inpatient rehab at Shepherd Center in Atlanta, Ga., to skilled care in Columbus, Ohio, which then brought him to his home, and he came to outpatient therapy at The Ohio State University Medical Center. Ian has an incomplete C5-C7 spinal cord injury as a result of a diving injury while on vacation. By the time he completed his inpatient rehabilitation and was ready to come home to Columbus, he was well on his way to a network of guardians who would ensure the equipment choices would allow him access to the world any other 19-year-old would need. Throughout the next 17 months the team of experts helped him identify the best mobility equipment that included a Group 3 power chair with a pressure relief cushion, an ultra lightweight manual chair with a different pressure relief cushion, and a set of power-activated, power assist wheels for his manual chair. If not for the collaboration of a lot of individuals, his story would not have had the success we will demonstrate.

The first leg of the journey was shown when Ian explained to us that he was given several choices in equipment and educated on the aspects of what features the equipment would have. He was introduced to several complex rehabilitation suppliers of which two had locations in Ohio. He chose the best Group 3 power chair that would meet his needs and was given a loaner chair to us use when he came to Ohio. He arrived at our clinic explaining how the cushion he had was not quite meeting his needs as he had expected. After contacting the Ohio based ATP of the Complex Rehab Supplier they quickly switched out the cushion that was agreed upon. We learned that the communication between the Atlanta branch and the Ohio branch allowed for seamless continuum to carry out the equipment choices.

Ian then shared with us that he was planning on purchasing an ultra lightweight manual chair so he could go places with his friends that the power chair simply could not access. It was important to him to have this equipment, and he felt he understood his options. Before the rehabilitation team could get with the supplier, Ian had already made an appointment with an ATP and ordered a chair of his desire. Here comes the second panic of a trained clinician: "If I wasn't there when you ordered it out how do I know it was correct?" While we were waiting on the arrival of the equipment Ian entrusted our advice on selecting a cushion that he could be more independent in completing his transfers. His team carefully trialed multiple cushions, analyzed the pressure mapping studies and then made a decision on the cushion that would best meet his needs. A few months later the chair arrived, and it fit Ian just fine. It was evident that the ATP had knowledge and skills required to order the ultra lightweight


IAN AND ONE OF HIS THERAPISTS.

chair to the required specifications. This is something that would not have been achieved if Ian went onto a website an ordered the equipment off of a checklist.

The next hurdle was he was not as independent as he imagined in the ultra lightweight chair. His therapy team introduced the power-activated, power assist wheels. After a brief trail of the equipment it was clear that the technology was what he needed. The challenge became that his primary insurance provided the power chair, and he self-funded the manual chair. How would the team receive procurement to fund the power-activated, power assist wheels? Although funding could have become a barrier the technology was needed so further investigation was required.

The network of team members who worked with Ian continued to grow. The therapy team enlisted our rehab engineer to complete propulsion analysis using the Smart Wheel in our clinic and sought out the social workers and case managers to begin investigating available funding. While these pieces were put together for a solution Ian had some training that needed to be completed and the clinical team began incorporating the propulsion training during each visit and working on the section of the equipment that would meet his needs. Ian then participated in manual wheelchair propulsion indoors and

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It Takes a Village...

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outdoors, accessing ramps, curb cutouts, and obstacle courses. He worked on maneuverability, wheelies, thresholds, and uneven terrain so that he could return to a college campus and be able to hang with his peers in the community. All these tasks are fully reimbursed through therapy intervention and following of CPT code rules.

Ian's challenge was that the chair needed to be sensitive enough to match his ability, be able to be specially programmed for his left and right side, and be able to navigate hills for use on his ramps. These are all careful details that could accomplished in therapy sessions rather than unreimbursed individual visits from a supplier. In order to have the technology for training during therapy, the team contacted the manufacturing representative for assistance and guidance. The representative came in for a few sessions, trained the clinicians on the programming options and then served as a resource for the team when his skills were needed.

Ian was able to be successful and independent with his ultra light manual wheelchair and set of programmable power activated power assist wheels. He received a new skin protection pressure relief cushion that he could transfer on and off as well as complete good pressure relief, and he still had his Group 3 power chair that he used when activities matches his needs. He used a combination of state and private funding, fundraising dollars from private donations, and is now beginning to work with the vocational rehabilitation program for all additional needs.

With the use of the above equipment, Ian is able to continue living at home, assists with coaching his high school lacrosse team, drives his van, and has returned to college. He is very active and has many options of equipment to support his lifestyle and needs. If it was not for the team of therapists and complex rehab suppliers in two different states, the manufacturers' representatives of all trial equipment, the rehabilitation engineers, social workers, case managers, rehab counselors, funding agencies, and one strong-willed 19 year old, the story may not have been the same.

A day does not go by without seeing a story about what challenges lie ahead in our industry. We all have to keep in mind that as long as our collaboration and strength continues, it may take a village to get the best equipment, but at least we can continue to see all of us stick together and persevere to do the right thing.

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An Update From The CLINICIAN TASK Force

Written by **Laura Cohen, PT, PhD, ATP**

THE CLINICIAN TASK FORCE (CTF) IS

comprised of a national group of 45 leading seating and mobility practitioners, primarily physical and occupational therapists, whose work involves providing wheelchair seating and mobility services to individuals with disabilities. This task force was formed by clinicians concerned about ensuring policies surrounding wheeled mobility coverage and that coding and payment provide adequate consumer access.

In the fall of 2004, a stakeholders meeting was held in Chicago to discuss issues that were impacting access to complex rehab technology. It was during this meeting stakeholders recognized the need for a strong and separate clinical voice. The CTF was formed out of a need for a viable forum to gather the opinion and recommendations from the leaders in the clinical community, formulate position papers and responses, and submit them to policy makers, government officials and Congress in a timely responsive manner.

The mission of the CTF is to advocate for professionally sound, clinically based public policies that ensure individuals with mobility impairments have appropriate access to seating, positioning and mobility products and services.

The CTF continues to work on our defined priorities.

CTF PRIORITIES:

Secure Separate Medicare Benefit Category for Complex Rehab Technology. Support from the clinical community, especially those experienced in the field of wheeled mobility and seating, brings meaningful credibility to this initiative. This is particularly important in efforts to have Congress approve this legislation. CTF representatives are involved through the steering committee, coding and coverage committees, as well as the supplier standards committee. The voice of the clinical community is present for each of the critical components of this important effort.

Work with APTA and AOTA to define professional standards and continued competencies in the practice area of CRT to ensure a prepared clinical workforce to meet the public need for CRT services. CTF members are actively working with leadership within the APTA and AOTA to define professional clinical practice in the area of seating and wheeled mobility through the development of an AOTA Practice Document and Revision to the APTA Guide to PT Practice. Used by academic programs, practicing clinicians and policy makers, these documents will guide those interested in developing their seating and wheeled mobility expertise, inform curriculum to prepare the next generation of clinicians, and influence policies for coverage and payment for clinical services.

Develop a CRT resource toolbox for clinicians and identify a sustainable long term dissemination plan to reach the largest numbers. The CTF recognizes that there continues to be a scarcity of clinicians capable of fulfilling the clinical role in the CRT multi-professional team. Our intention is to create a CRT resource toolbox that will prepare clinicians for appropriate evaluation, thorough documentation, presentation of policy requirements and resources to keep current, etc. More details will be shared as the plan is formalized.

Develop a long-term strategy to address evidence based practice policies impacting coverage and payment for CRT. Payers are increasingly denying access to technologies such as standing equipment and seat elevation. They are pointing to a lack of clinical evidence to demonstrate the products are effective in treating illness or injury. It is vital that appropriate levels of evidence be established for CRT products. The same levels applied to pharmaceuticals cannot be applied to devices. The CTF in collaboration with NCART and others is submitting a two-year grant proposal to identify appropriate standards for scientific evidence that establish the efficacy of CRT interventions as a basis for medical insurance coverage policies.

Engage APTA, AOTA and other professional organizations in advocating for consumer access to CRT for individuals with disabilities. The voice of the clinical community lends significant credibility to the separate benefit initiative and CRT issues. As a direct result of the work of the CTF, this year, we are pleased to report tangible progress with the unanimous passage of CRT motions within the Representative Assembly of the AOTA (representing ~40,000 members) and the House of Delegates of the APTA (representing ~77,000 members). These are the

Payers are increasingly denying access to technologies such as standing equipment and seat elevation.

highest policy-making bodies of these associations and the first occasion bringing attention and formalizing policies related to CRT issues. Both organizations have indicated support for legislation for a Separate Benefit Category for CRT. We also continue to work with other organizations, such as the American Academy for Cerebral Palsy and Developmental Medicine (AACPDM), American Academy for Physical Medicine and Rehabilitation (AAPMR) and prestigious rehabilitation, academic and research institutes to obtain additional support.

IN CLOSING:

We all know the challenges to CRT are growing and the support and involvement of an active CTF can bring the clinical voice to bear on key CRT issues. Funding for the Clinician Task Force is provided entirely through voluntary donations. To NRRTS and the other manufacturers and suppliers who have provided financial support to the CTF in the past, thank you. Your support has enabled us to make significant accomplishments. As you plan for 2012, please consider a pledge to the CTF. Contact me for additional information.

We look forward to working together with all CRT stakeholders to build on the progress we currently have, see successful passage of CRT legislation, and continue to fight the good fight!

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Written by **Cindi Pettito, OTR/L, ATP, CAPS**

HOME Modi

As the number of individuals with disabilities grows, home accessibility needs have been heightened. It is estimated approximately 15.1 percent of Americans (41.3 million) will have at least one type of disability, and within that group, half (22.7 million) will have two or more types of disabilities.

The home modification (HM) service delivery model uses a team approach that spreads across both health care and housing sectors. This team usually includes the home dweller, family and caregivers, construction and building professionals, health care professionals who are often occupational therapists, architecture and interior design specialists, referring agencies, and funding sources.[1]

When completing HM recommendations, it is important to consider design and aesthetics inside and outside the home. There are several design concepts and terms used globally to describe accessibility. Universal Design (UD) is used primarily in the United States. According to RL Mace Universal Design Institute, UD is the design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.[2] In Europe, Design for All (DfA) ensures environments, products, services and interfaces work for people of all ages and abilities in different situations, under various circumstances, and without adaptation.

fication

Design For Wheelchair Users

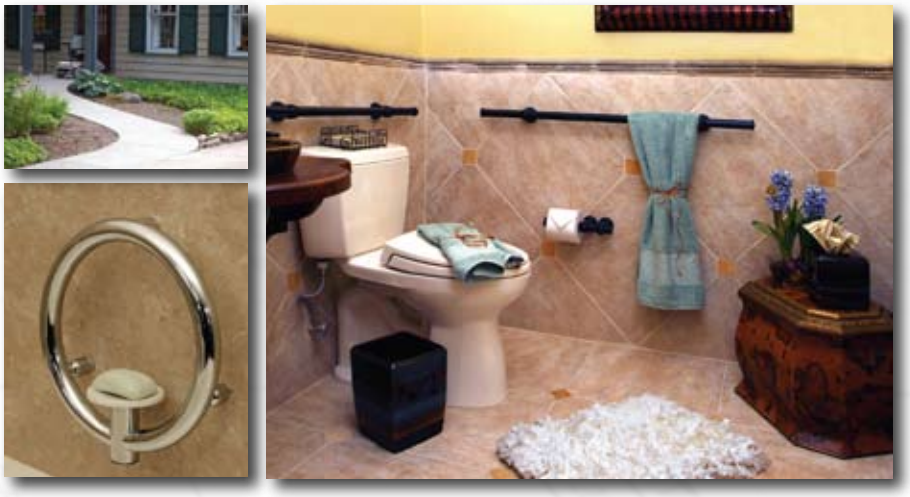
As wheelchair specialists, providers and manufacturers, we are mindful wheelchair and seating products and recommendations are cosmetically pleasing and attention is centered around seeing the individual, not just the wheelchair.

GREAT GRABZ
CREATIVE GRAB BARS

In UD, there are seven principles to describe characteristics which make designs universally usable:

1. Equitable Use
2. Flexibility in Use
3. Simple and Intuitive Use
4. Perceptible Information
5. Tolerance for Error
6. Low Physical Effort Universal Design grab bars by Invisia
7. Size and Space for Approach and Use

Inclusive Design (ID) evolved in the United Kingdom and is used in the United States. It includes ideas and holistic concepts I like as an occupational therapist. The British Standards Institute (2005) defines ID as the design of mainstream products and/or services that are accessible to, and usable by, as many people as reasonably possible without the need for special adaptation or specialized design.[3] For example, compare a home with steps and a wheelchair ramp to a home with a sloped entrance and no steps. While designers had good intentions with the ramp, it forces individuals in a wheelchair to take a separate route and it looks like an afterthought. By contrast, the sloped entrance allows anyone to enter the home without accommodation. ID is a process that results in inclusive products or environments



TOP LEFT: INCLUSIVE DESIGN: SLOPED LANDSCAPE RAMP ENTRANCE WITH NO STEPS
BOTTOM LEFT: GREAT GRABZ CREATIVE GRAB BARS
RIGHT: UNIVERSAL DESIGN GRAB BARS BY INVISIA

which can be used by everyone regardless of age, gender or disability. It expands its complex concept to include race, income, education, culture, and society, and relies on a holistic understanding of the responsibilities between those who shape environments in relation to those who populate it.

The term Universal Design has evolved from Barrier Free Design, Accessible Design, Transgenerational Design and Adaptable Design. It is now considered to be synonymous with Design for All and Inclusive Design.

Most clinicians and HM professionals in the United States use the Americans with Disabilities Act (ADA) standards. The U.S. Department of Justice adopted the revised ADA standards in September 2010, which will become mandatory in March 2012. These guidelines are in place to ensure accessibility to places of public accommodation and commercial facilities by individuals with disabilities. However, ADA requirements do not extend into the home environment, and are not standards that can be enforced by code specifically for ADA. While these standards are used as a guideline for measuring the home environment, measuring the individual and their abilities in their wheelchair within the home will maximize independence, health, and well-being. It is also important to prevent "minimal compliance practice" when using ADA standards and making HM recommendations. Minimal compliance practice can lead to creating environments that look institutional and can create barriers for others who reside in the modified home.

As wheelchair specialists, providers and manufacturers, we are mindful wheelchair and seating products and recommendations are cosmetically pleasing and attention is centered around seeing the individual, not just the wheelchair. These same concepts should be applied when making HM recommendations and creating design ideas to meet individual needs. The accessibility design then becomes disguised within the environment, and the disability becomes invisible.

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2. Mace, R.L. The RL Mace Universal Design Institute. www.udinstitute.org/whatisud.php

3. British Standards Institute (2005) British Standard 7000-6:2005. Design management systems - Managing inclusive design - Guide

Cindi will be presenting a NRRTS webinar on **April 19, 2012** from 5:00pm to 7:00pm Eastern that focuses on home accessibility. Please see page 8 in this issue of **DIRECTIONS** for more details on registering.

Getting to the "POiNTS!"

Written by **Judy Dexter**

NRRTS is committed to raising the bar for its Registrants to help assure consumers receive appropriate Complex Rehab Technology equipment and services. NRRTS recognizes that a CRTS® operates at a higher standard than other rehabilitation technology professionals. NRRTS also recognizes that many Registrants are involved in activities outside of direct patient contact and associated paperwork, appeals, etc. It is time to acknowledge those who pursue these other activities and assure that all CRTS® also maintain this level of involvement in the Complex Rehab Technology and disability community.

The Points System includes, but is not necessarily limited to, the following:

- Board participation, e.g., NRRTS, RESNA PSB, NCART, national or local disability/CRT related organizations (1 point)
- CELA (Continuing Education and Legislative Advocacy) - requires attending the Capitol Hill visit(s) in addition to any educational programs attended (4 points)
- Educational presentation(s) (does not include in-service) at ISS, CELA, RESNA, Abilities Expo, Medtrade, local OT/PT chapters, other conferences (1 point)
- Legislative Activities - e.g., on-site visits, call-in day, visit with local legislatures, involvement in fundraising activities, etc. (2 points)
- Complex Rehab Technology manufacturers' (non-CEU) training programs (1 point)
- Attendance at NCART events (2 points)
- Outcome Measures - 4 outcome measures administered and submitted (2 points – max 4 points)
- Published Complex Rehab Technology article or case study (1-2 points)
- Volunteer/advocacy in the Complex Rehab Technology or disability community (2 points)
- Other Complex Rehab Technology related activities as awarded (determined by the NRRTS Review Board)

Starting with NRRTS renewal dates in January of 2013, CRTS® Registrants will be required to present the following;

- Completed Renewal Application
- Proof of continuing employment at a Complex Rehab Technology company
- Documentation of participation in 10 contact hours (1 CEU) of continuing education approved by IACET, the University of Pittsburgh or other authorizing agency recognized by NRRTS and RESNA.
- Documentation of participation in activities listed in the NRRTS Points Program (4 points are required for renewal)

Reminder: NRRTS Registrants with the CRTS® credential must begin participation and documentation, during 2012, of the Points System activities listed above.

For additional information please visit www.nrrts.org/points.

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INDEPENDENT MOBILITY Can't Afford To *Wait*

Written By **Amy Morgan, PT, ATP**

LATELY, THERE HAVE BEEN MORE AND MORE situations in which young children are being denied power mobility based on their age. Besides the fundamental flaws with this type of denial, approval of a DME device is required to be based on medical necessity and not age. However, we as providers often don't know how to best respond to a denial like this. We realize the importance of independent mobility for a child's development, but it is difficult to articulate that justification to a funding source in an appeal letter. Even worse, we do provide appropriate justification only to get the same negative decision. Here are some important facts to remember if you are faced with a denial based on age:

Denying a DME device based on age is discriminatory and courts have ruled that age, as a sole criterion, is unreasonable because it is wholly unrelated to medical necessity. *(See Estaban v Cook, 77 F. Supp. 2d 1256 ; Hunter v Chiles, 944 F. Supp. 914).*

The evidence is compelling and clearly shows there is a critical link between independent mobility and overall development (visual perceptual skills, cognition, and psycho-social skills. *(See RESNA's Position on the Application of Powered Mobility for Pediatric Users, Assistive Technology 2009 Winter; 21(4): 218-226).*

ANDREW, A 2-YEAR-OLD BOY IN A PLAYMAN ROBO

All people, regardless of age, have the inherent right to move themselves independently in their environment. Mobility, especially at a very young age, is initially more about the foundational learning experience that will later help them efficiently move from Point A to Point B.

Children are protected under EPSDT. Furthermore, the primary purpose of State Medicaid programs is to help a recipient attain or retain the capability of independence, *42 U.S.C. § 1396.*

Paragraph 14,571 of the Medicare and Medicaid Guide states children shall be provided with care that "maximizes the capabilities of the individual and minimizes the effects of people with disabilities"*See also: Detsel v. Sullivan, 895 F.2d 58 (2nd Cir. 1990).*

Funding sources may say kids need to wait until they are older and have developed certain skills for "safety" prior to having access to power mobility, or they will require the child to demonstrate skills in the power wheelchair that are not age appropriate, and therefore is not a reasonable standard. In actuality, children NEED independent mobility first in order to explore and develop the visual skills, cognitive skills and problem solving skills, which are required for them to demonstrate such skills. Additionally, the sensory experiences associated with independent mobility allow a child to learn fundamental concepts about the world. These are all skills children without mobility impairments naturally develop through exploratory play. Let's take a look at typical infant/child development from a global view of exploration:

1-3 months old – Babies are beginning to develop head and neck control. This is essential to provide a stable base for their eyes to explore the world visually.

4-5 months old – Infants begin to roll over (initially by accident) and they quickly realize rolling actually can be functional for them. It allows them to begin their physical exploration of the world.

6-7 months old – "I can sit by myself! And the world looks quite different when I am upright." Sitting helps kids start to realize different perspectives of our world.

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Independent Mobility...

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8-10 months old – Watch out Mom and Dad! Your child is constantly on the go crawling and cruising around the furniture.

10-15 months old – By this time, children are interested in making mobility faster, more efficient, and more stimulating! They prefer to walk over crawling.

15-18 months old – Little climbers are on the prowl. No longer can you put forbidden items up on tables, because your climber will find a way to get to it. Problem solving is at its prime in this stage.

19-24 months old – Mobility continues to get faster and children begin running and jumping, exploring on the playgrounds more independently. Most of all, kids are beginning to show their strong will and determination to be as independent as possible. They test their boundaries (and their parents), which continues throughout their childhood and teenage years.

Unfortunately, some children are born with different abilities and challenges which keep them from achieving motor milestones at the expected time. Does that mean that they should miss out on all the experiences other children get from independent exploration? It shouldn't...which is why clinicians seek ways to allow children to experience independent mobility as early in life as possible, so they can continue to develop cognitive, visual and social skills mobility provides, all the while working on other therapeutic motor skills (even walking).

In summary, we can't afford to wait to give kids independent access to explore their world. We need to do all we can to give them the independent mobility experiences their peers are having daily so they can achieve maximum function. If you are facing challenges with funding for pediatric power mobility devices, here are some tips to help improve the likelihood of approval:

Contact the Users First Alliance for support throughout the appeals process at http://www.usersfirst.org. Users First seeks to improve access to mobility equipment for people who need it. By being aware of discriminatory denials, the organization can potentially help make positive changes to poor funding policies.

Seek legal counsel through your state's protection and advocacy department:
http://www.acf.hhs.gov/programs/add/states/pas.html.

Contact the manufacturer of the equipment being requested to see if they can offer any guidance through the appeals process.

If necessary, the family can contact local news authorities and share their story. The agency may choose to publish a story on the discriminatory denial.

When challenging any equipment denial, it is important to remember funding sources should be held accountable for their policies to ensure appropriate access for all people. Often times, guidelines are being used to make arbitrary decisions that are not based on evidence or good standards of care. If we don't challenge negative decisions, our funding climate will never change and people will not have equal access to the equipment they need. It is critical we hold fast to our professional recommendations, and help empower families to advocate on behalf of their child and hold funding agencies accountable for their policies and decisions they make.

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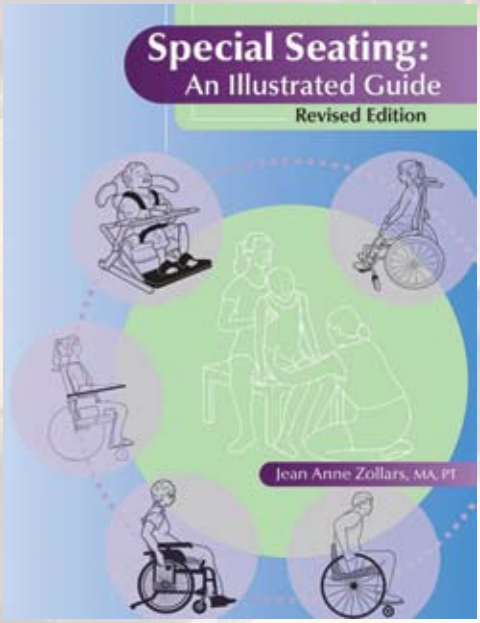
SAVANNAH, AN 18-MONTH-OLD GIRL WITH SMA TYPE 2, USING A K300 PS JUNIOR.

SPECIAL SEATING: An *Illustrated Guide*

Written By **Jessica Presperin Pedersen MBA, OTR/L, ATP**



The revised edition of *Special Seating: An Illustrated Guide* written by Jean Anne Zollars MA, PT, is now available. Zollars, being the listener she is, was able to hear our pleas to re-publish her 1996 book, which provided us with a pictorial method of teaching skills for assessment and intervention of postural and seating needs. Zollars' method of focusing on the person in a hands-on approach explains to all why the complex process of procuring a seating system can never be reduced to a simple phone call, mouse click or a flip through a catalog.

Zollars uses everyday language supported by drawings to show the process of a seating assessment and possible intervention approaches to meet physical, functional and participatory goals of the person and others in his or her life. Her easy-to-read style of writing is much appreciated as she provides a forum for learning difficult material that marries the art and science of wheelchair seating. She has added references to support her writing and complied with the ISO Standards created by the RESNA Standards Committee on Wheelchair and Related Seating (2008 edition) when describing intervention ideas.

The more than 350-page book is divided into six sections with an appendix of forms. More than 100 pages takes the reader through the steps of an assessment explaining the hows and whys when gathering this critical information. Zollars respectfully demonstrates how one's hands and body are able to "feel, sense and observe" how the person being evaluated responds to the support provided or the gravitational changes occurring when the person is guided in different positions. This is followed by design ideas separated into parts of the body, allowing for specific explanation as to how an individual might respond to that type of intervention. Zollars then takes the reader through the difficult step of putting it all together. A chapter on seating and mobilty guidelines for specific conditions is a new addition and provides the reader with insight on which considerations may be a priority for individuals with several diagnoses including cerebral palsy, traumatic brain injury, spinal cord injury, multiple sclerosis or spina bifida. Lastly, personalized case studies illustrate the depth of possibilities.

This book is highly recommended for occupational and physical therapists, rehabilitation technology suppliers, designers, engineers, students wishing to pursue these professions, people with disabilities, and anyone wanting to understand the assessment and recommendation process of wheelchairs and seating. It is a welcome addition to the seating clinician's library.

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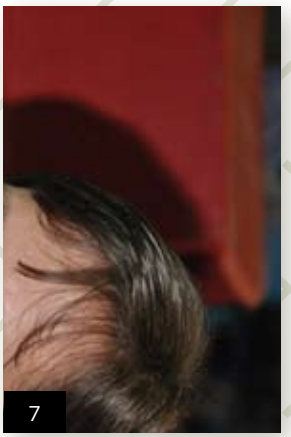
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1. NRRTS OPEN LUNCH MEETING

2. DON CLAYBACK AND RITA HOSTAK PREPARING TO PRESENT.

3. ANDREW DAVIS AND SIMON MARGOLIS AT NRRTS BOOTH

4. JOHN ZONA AND GERRY DICKERSON AT NRRTS BOOTH

5. MIKE BARNER VISITING WITH AN ATTENDEE.

6. WEESIE WALKER AND BRIAN COLTMAN VISIT OVER DINNER.

7. ANDREW DAVIS

8. GERRY DICKERSON VISITING WITH AN ATTENDEE.

9. MIKE NADEAU VISITS WITH AN ATTENDEE.

10. GERRY DICKERSON SHOWING HIS DAVE WILLIAMS AWARD.

11. MIKE NADEAU SCOPING OUT THE REHAB PAVILION.

12. BOARD MEMBERS VISITING WITH AN ATTENDEE.

13. DON CLAYBACK ANSWERING A QUESTION DURING THE NRRTS OPEN MEETING.

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14. MICHELLE MCMAHON ENJOYING A DRINK DURING A BREAK.

15. WEESIE WALKER VISITING WITH AN ATTENDEE.

16. INDIVIDUALS WAITING TO GET THEIR LUNCHES DURING THE OPEN MEETING.

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17. INDIVIDUALS ENJOYING LUNCH.

18. NRRTS BOARD MEMBERS ENJOYING THE MEETING.

19. MK POWER FOR FUNDING PRESENTATION

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Congratulations to the newest NRRTS Registrants. (Sept. 21 through Nov. 11, 2011)

John W. Burke, ATP, CRTS®
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2700 Lord Baltimore Dr.
Baltimore, MD 21244:
Toll Free: 800-777-6981
Fax: 410-298-1642
Registration Date: 10/5/2011

John Rocco Faiola, RRTS®
Hudson Home Healthcare
92 Bleachery Ct.
Warwick, RI 02886
Telephone: 401-562-0039 x.10
Toll Free: 800-321-4442 x.10
Fax: 401-732-5444
Registration Date: 10/19/2011

Marcel J Farnet III, ATP, CRTS®
National Seating & Mobility, Inc.
5515 Pepsi St. A&B
Harahan, LA 70123
Telephone: 504-729-6233
Fax: 888-283-1364
Registration Date: 10/11/2011

Charles Henry, ATP, RRTS®
Hudson Seating & Mobility
470 Wildwood Ave.
Suite 4
Woburn, MA 01801
Telephone: 781-897-6100 x.521
Fax: 781-933-0777
Registration Date: 9/26/2011

James L. Keating, ATP, CRTS®
ATG Rehab
2200 Norcross Parkway
Suite 200
Norcross, GA 30071
Telephone: 678-291-6855 x.106
Fax: 678-233-0144
Registration Date: 11/8/2011

John Michael Morris, CRTS®
Home Health Depot
105 Krispy Kreme Dr. #3
Bloomington, IL 61704
Telephone: 309-662-4606
Fax: 217-303-8081
Registration Date: 9/26/2011

Mahmoud Salarkia, ATP, RRTS®
Sarah Medical Equipment,Inc.
2632 Lincoln Blvd.
Santa Monica, CA 90405
Telephone: 310-396-5258
Fax: 310-396-5358
Registration Date: 11/7/2011

Willis Smitherman, ATP, CRTS®
Dothan Brace Shop
1240 East Main St.
Dothan, AL 36301
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Fax: 334-794-6741
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Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. Names listed are Sept. 21 through Nov. 11, 2011

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Lynn Bates, OT, ATP, CRTS®
Huntsville, AL

Brock Beasley, ATP, CRTS®
New Braunfels, TX

John W. Burke, ATP, CRTS®
Baltimore, MD

Marcel J Farnet III, ATP, CRTS®
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Bobbi A. Mackedanz, ATP, CRTS®
Brooklyn Park, MN

John R. Minnick, ATP, CRTS®
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John Michael Morris, CRTS®
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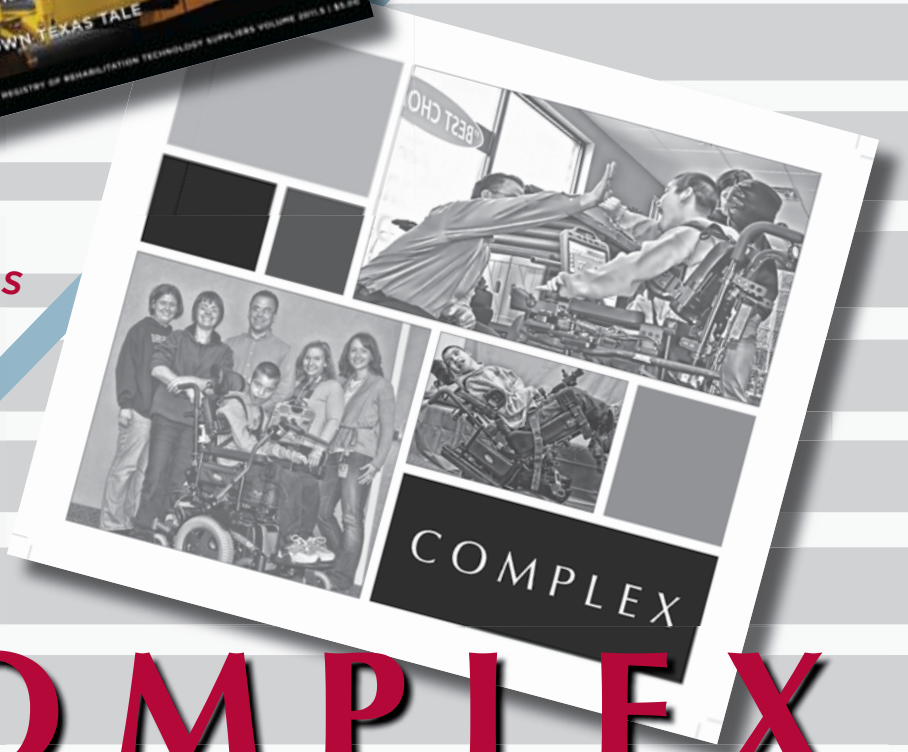

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FORMER NRRTS REGISTRANTS

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 Sept. 21 through Nov. 11, 2011. For an up-to-date verification on Registrants, visit www.nrrts.org, updated daily.

Trey Bradford Baton Rouge , LA
Teri L. Hively Balaton, MN
Chris Kieliszewski Traverse City , MI
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