

**Event ID 743183:  
Mobility and Seating Assessments and Equipment Procurement**

Lisa: Ladies and gentlemen, thank you for standing by and welcome to the Disability-Competent Care Webinar Roundtable Series conference. At this time, all participants are in a listen-only mode. Later we will conduct a question and answer session. If you should require assistance on today's call or if you'd like to ask a question, please press star and then a zero. I would now like to turn the conference over to our host. Christopher, please go ahead.

Christopher Duff: Good afternoon or morning, depending on where you are. On behalf of the Lewin Group, I'd like to welcome everyone to this third of our 2014 webinar roundtable sessions on disability-competent care. Today, in particular, we're focusing on mobility device procurement. As Lisa stated, my name is Chris Duff. I'm a disability policy and practice consultant under contract with the Medicare and Medicaid coordination office at the centers for Medicare and Medicaid services. The Lewin Group has engaged myself and a few of our colleagues to provide technical assistance to providers working with adults with disabilities.

First, I'd like to introduce you to our platform for this presentation. If your slides are not advancing, please push F5 on your computer keyboard. Also please note a few icons. Two of them are circled at the bottom. The brown icon, third from the left, will open a chat window for participants to pose and discuss any topic related to the questions, the participants, and speakers.

The green icon of a file folder, third from the right, provides you access to resources for this presentation. The middle icon has two CCs in it, and that's for closed captioning. That will be available if you so desire. After a brief presentation, we will also open the phone line for participants to ask questions, as Lisa stated in the introduction.

This series will consist of eight webinars. The first four are being presented on Tuesdays in February, followed by a two-week break and then we will resume with the next four starting March 18. Last year we published a comprehensive disability-competent care self assessment tool describing disability-competent care in three key components--individualized care coordination provided by an interdisciplinary team, redesigned primary care delivery, and flexible long term service and supports. We followed that up with nine webinars focusing on individual components of disability-competent care. All of those webinars were recorded and are available along the pdf and the slides at the link on the slide now. We will also be recording these sessions and they will be available shortly.

We would like to solicit your opinion on this series, as well as past webinars and supplemental resources. Please take the time to complete our survey at the end of this webinar and send us your ideas for future topics and content. Content information is listed at the end of this presentation.

Our goal in this series is to be highly practical using experts in each topic area with organizational examples or first person stories to demonstrate key messages. The presentations will be no more than 20 minutes, allowing the remainder of time to explore questions and issues submitted by the participants. Beyond the chat feature, you can also submit questions and

comments at any time and the open phone line will allow you to submit questions verbally. We'll also be using instant polling to ask specific questions to help guide our presentation. To demonstrate this process, here is the first question. Is your plan or organization currently responsible for procuring mobility devices or specialized seating for your participants? Would you please choose your answer and then submit and we will review that in a minute.

Today we're exploring disability-competent practices related to mobility and seating assessments and procuring equipment. Our presenter will focus and will provide information about both the need for and the provision of mobility assessments and to help prepare you to meet the mobility needs of your participants so that they can live their lives as they choose.

As this slide shows, different individuals have different needs and rely on equipment in different ways. Historically, wheelchair use has often been driven primarily by what the participant's insurance will provide. Currently, those with only Medicare coverage only have access to chairs for the use within their home setting. These are commonly simple manual chairs. Those who need to rely on mobility devices throughout the day, both within and outside their homes, commonly rely on powered wheelchairs. Additionally, those with orthopedic or position limitations often commonly need specialized seating supports. Thus, it is clearly not one size fits all.

If we could look at the polling results, that would be great, if they are available. I see that it's very interesting. We were expecting that most of you would be familiar with Medicare benefits and less of the Medicaid, but it seems like many of you are already experienced in managing the benefit within integrated dual models and that's great, although 34% of you are not managing the benefit yet. One thing that Jean will be focusing on is what is the difference further on applying the Medicaid benefit and Medicare benefit and then doing so within integrated dual programs.

Today's webinar will be presented by Jean Minkel, Senior Vice President of Independence Care System of New York City. ICS has been a provider of managed long term care services and supports for close to 15 years. Jean, in particular, has been directly responsible for their overall rehabilitation service which includes equipment assessments, maintenance, and repair. She has been a lead in the development in the field of mobility assessments working closely with both RESNA and the MS Society in defining and delineating appropriate practice.

Joining us as a discussant will be June Kailes who is one of the co-authors of this disability competency care assessment tool that I mentioned earlier. She has been a disability policy consultant for 35 years, working with a variety of health facilities and managed care organizations and government-related projects as a trainer, writer, researcher, and policy analyst. Now, I'll hand it over to Jean for her presentation and June for her comments.

Jean Minkel: Thanks, Chris. I appreciate the opportunity to share with folks both my passion for getting people the right piece of equipment that they need and the experience we've had over the last 15 years here in New York City. Regardless of how you come to the need for a mobility device, I thought it would be helpful to really give an overview of the process. It's absolutely critical to have an understanding of what's the individual need and matching that need to equipment recommendations. That takes part in a process usually involving an interview and

ideally a face-to-face with a clinician and a supplier to help particularly the long term wheelchair rider understand the functional capabilities if they had the right piece of equipment. When the equipment recommendation has been agreed to, there's the process of getting authorization for funding. Most mobility devices are covered by insurance and, as Chris said earlier, we'll talk a little more about the coverage policies and how they really drive the decision-making process.

Once the authorization is in place, the ordering and delivery process takes place. For some people with what we call complex rehab needs, the ordering may be from several manufacturers. It comes together by a supplier who does the assembly and then the delivery is back to the end user, ideally back with the clinician and the supplier who made the original recommendation. Following the delivery, the essential services include training on the use of the device, most often about the functionality of the wheelchair including maintenance, how to do routine charging, cleaning, everyday tightening of nuts and bolts, and ultimately information to the person on what their next steps are if they need a repair--what happens, how do they go about getting the repair initiated and ultimately paid for. Today we're going to focus on step one in the procurement process and next week we'll look in more detail at step two on the activities following the delivery itself.

As Chris mentioned, I am a physical therapist by background and have worked with a really innovative long term care program in New York City called Independent Care System. Fifteen years ago when our focus is on adults with physical disabilities living in the community, one of the biggest needs that our new members coming to the program brought with them was the need to get the right kind of equipment and be able to keep that equipment running. In order to facilitate the member experience to get the right piece of equipment, I see us invested in a wheelchair clinic environment that really focused on a consumer purchasing experience.

The slide on your left of the wheelchair is actually the entryway into our clinic and is designed to give people that car showroom feel so that they acknowledge that as a wheelchair rider our member has their own functional needs that they can visualize functioning in different chairs. The slide on the right illustrates the individual process in which we work clinician and a supplier with the member or the beneficiary directly because our experience is--particularly people who rely on wheeled mobility full time is--there are very individual needs that need to be understood and then ultimately a piece of equipment configured to meet those needs.

We've found that when people don't have the appropriate mobility devices, there is impact at health status, functional ability, and the level of participation. In our experience, particularly people with risk for pressure sore development either because of a lack of sensation or because of a lack of the ability to move themselves effectively, we have a high potential for skin breakdown. It's an area where knowledgeable access to the right equipment can greatly mitigate this incidence. Working with the person and identifying the type of cushion that can distribute the pressure over the surface area and establish how they can move their own weight around. It's a great way to prevent that pressure sore from occurring from the very beginning.

We talk about the lack of balance when you're sitting and if you don't have trunk control, sitting in a sling chair doesn't provide you the base of support. I always like to point out to able-bodied people an example of how to function with a very low base of support is try tying your own shoe

while standing on one foot. It's very challenging. Well, tying your shoe may be easy when you have a base of support, if you're trying to do it while standing on one foot, it's really challenging. Not having support when seated impacts somebody's ability to feed themselves, to access their activities that require both of their arms when they're relying on one arm to hold them up.

Long term wheelchair use has been shown to potentially lead to upper extremity dysfunction and pain, in particular, rotator cuff problems and carpal tunnel problems as a result of repetitive stress injuries from particularly propelling a chair that hasn't been optimally configured. We find a loss in function when there's increased falls. Someone may have been ambulatory. They have had a decline in their balance abilities. We hope they've avoided the fracture as a result of a fall, but they tend to restrict their own activities out of fear of falling or have out of a history of falling.

Ultimately, when someone can't get around where they want to get around, their ability to function to do what they want to do becomes greatly limited, whether it's going into the kitchen and getting your own drink of water or whether it's going and joining your family member at a social function, going to church, or a grandchild or child's athletic event. Not getting around in home or not getting around in the community, both have the impact of reducing someone's level of participation. What we see often with a decreased involvement is it's often the family member that points it out. "Two years ago we used to go to the park and we haven't gone there in the last eight or nine months." It's the slow self control of not exposing yourself in mobility activities because you're no longer as functional as you used to be. It tends to lead then to increased levels of social isolation. In impacting people's health, people's function, and people's level of participation we've found that paying very close attention to what wheel mobility options are available, and very inclusively involving the participant and beneficiary in that process has been key.

Part of determination of need is having a dialogue, having a conversation, really understanding what this person's needs are. There is a tool--the Functional Mobility Assessment that was developed by our colleagues at the University of Pittsburgh that serves as a great way to guide that conversation. It asks a series of ten questions regarding your current ability to manage your health care needs, get around your home, get around the community, and based on those answers we know where somebody is functioning in the device that they have today. Oftentimes we have to ask about their environment of use. Is their home accessible? Is their elevator accessible? Are all aspects of their apartment or their home accessible? Equally important are transportation issues. How are they able to get around in the community, going to medical appointments or going to other activities outside of the home? Transportation can greatly influence the appropriate mobility device that someone is going to be able to use in the community.

When we have an idea of what type of mobility device they're going to need and what environment they're going to be using it in, we often invite people into a clinic environment in order to do a seating assessment, to really look at their sitting balance and what are the postural support needs that they have. If they're in a sling chair that hasn't given them good support, has it resulted in a change in their skeletal alignment? Do they have a curve of scoliosis or are they just in need of lateral supports that help hold them up against gravity. We're always checking then back to skin integrity. Are they able to have feeling? Can they move themselves? The two

biggest risk factors for developing a pressure sore in the seated position is not having sensation and not being able to move. If someone has sensation but can't move themselves, then we look to those skin issues. Are they currently getting redness? Can we have a good cushion that distributes pressure? Can we offer them a method of relieving their pressure whether it's their own ability to lean side to side, or if that's not effective, are they able to use a power seating system to allow them to redistribute the pressure from their buttocks onto their back or other parts of their body?

Ultimately, there's a match here between the functional need and the individual product recommendation. I as a clinician can do a lot of the needs assessments with the member or the participant directly. Working with a supplier is essential in then taking those needs and translating them into product recommendations. For a clinician, there is a decision-making algorithm that we work through to best match function and product. For Medicare-only clients, this decision tree is even more restricted in that we're asked to ask these questions in the home only. The range of questions go, "Is this person ambulatory? If they are ambulatory, would a cane, crutch, or walker facilitate their ability to get around their home?" If a cane, crutch, or walker allows someone full access in their home and their Medicare primary, that's the device that will be chosen. Additional needs for the community aren't covered under the current Part B funding.

If we are looking more broadly at someone's totally functional needs, we can ask, "Does a cane, crutch, or walker allow them full access in the community?" I'd like to think can the person cross a crosswalk while the walk sign is up? Are they able to walk at a speed that's functional in a community environment? If that answer is no, is a manual chair an appropriate device? Could they self-propel, ideally, an optimally configured manual chair, at such a pace that they would be able to keep up with a walking person? To be functional, that manual mobility needs to be pain-free and without excessive exertion. If that answer is no, is a scooter an appropriate device? Can a scooter be accessible to their home? Do they have a place that they can store it and charge it? If a scooter doesn't provide the postural support or the person isn't able to use both of their upper extremities to control the scooter, then a power chair may be the most appropriate device for in-home and community use.

If all of those options don't work, we're asked, "Is there someone in the environment that could push this person? Is this person a candidate for dependent mobility?" This is an algorithm that's used really to refine the mobility needs in the environment that the person is most likely to be using the device.

When we've identified the type of device and the type of postural support systems that are needed, it's really important to be working with rehab specialists to help define those needs and work to translate them into product. Rehab therapists and rehab specialists tend to be occupational physical therapists, particularly therapists who have experience in rehab and working with people with long term needs. We often work most exclusively with certified rehab technology suppliers who are durable medical equipment suppliers who have specialized in rehab devices and the designated certified rehab technology supplier comes from passing the RESNA examination for an Assistive Technology Professional credential. This is a supplier who

has, if you will, taken the extra step to learn about highly adjustable configurable devices that are most appropriate for people with long term needs.

In order to get this type of an assessment, the plan, the person backing the acquisition of the chair may have independent contractors and therapists working with suppliers who work exclusively with their beneficiary pool or there may be in geographic areas specialty mobility clinics, wheelchair clinics often associated with major hospitals, major rehab hospitals, or children's hospitals in geographic areas of urban areas most often. In more rural areas, there may be a preferred relationship with--we have a technology supplier and a therapist. In more urban areas, there may be facility-based programs in which people are referred to. When we're looking at long term needs for wheeled mobility, it's not encouraged to use durable medical equipment suppliers who are working alone, particularly if they don't have rehab experience. There tends to be the concept, as Chris said earlier, that one size fits all and any wheelchair will do. Any wheelchair might do to transport somebody from point A to point B or department A to department B in a hospital, but as a mobility full time device, we really want to be sure that there is customization and knowledge of the options available to meet the needs.

Currently, when there isn't the fully integrated program, we have different funding sources with different criteria. Under the Medicare Part B, as I alluded to earlier, the benefit is focused on in the home mobility related activities of daily living. As a clinician, I'm asked to evaluate this person's mobility needs in their home. As a result, the devices that are available for in-home use only, tend to be lower cost because the demands for use in a home, particularly around power mobility, don't need to have strong motors and heavy duty systems if they're only being used inside. An in-home use chair, just by comparison, averages about \$2,500.

Under the Medicaid program, if the need has been medically justified, the environments of use are often inclusive of both home and community and the community-based needs often add to the need for greater durability, greater speed, and the ability to change one's position during the day. The average cost of a chair for indoor and outdoor use is about \$5,000 with any specialty items being added to that. In fully integrated plans, the plan will be responsible for providing medically necessary equipment without regard to the Medicare criteria in Part B as it stands right now.

Once the funding has been approved and, obviously, that's where the plan benefit will have impact on which devices will be funded under what circumstances, then the plan sends the authorization to the supplier. As I noted earlier, the supplier orders from the manufacturer. It frequently in rehab products may be more than one manufacturer. It's assembled and the clinic, if that's where the order came from, is notified that the device is ready for delivery. The rehab therapist will check out the equipment relative to the order. This is a step that has really improved the quality of the outcome where the checking that what was originally prescribed is what's actually being delivered and then inviting the beneficiary back to the clinic to have individual fitting to be sure that the configuration of the device meets the need as it was identified during the assessment process. At that time, it can be determined does this person need further training? Are they new to this type of mobility device or are they a seasoned and experienced user and know how to operate the device and know where to get information with regard to maintenance and repairs?

In summary--and I really want to be sure we have plenty of time for questions from the audience--it's been our experience as a managed long term care provider that the framework of looking at individualized seating and mobility has helped us have a positive impact on skin integrity, reducing pressure sores, maintaining skeletal alignment which also has an impact on that pressure distribution, allowing somebody maximum access in their natural environments, and increasing their ability to engage in really meaningful activity. Nothing makes my heart sing as when someone six or eight or ten months after receiving a device is either out in the community or comes to one of our member programs and says, "I was a shut-in. I didn't know what else I could do. Getting the right mobility device has opened the world back up to me."

We've also found that a really helpful question is to ask what can the person not currently do that they would be able to do with this new device. When you ask people that question, they give you wholehearted incredibly practical answers to why they need a particular device. Ultimately, an integration of the Medicare and Medicaid alignment through the dual advantage programs really, really help in eliminating some of the funding conflicts that are encountered every day by Medicare and Medicaid enrollees currently. With that, I'd like to open the floor for questions.

Lisa: Thank you. Ladies and gentlemen, if you wish to ask a question, please press star and then a zero on your phone. You'll hear an acknowledgement tone. An operator will then gather your name and further instruct you. Once again, for questions and comments, press star and then zero.

Christopher Duff: June, do you wish to start with some questions and comments based on what Jean said?

June Kailes: Sure, Chris. As we wait for some more questions to appear. Jean, your expertise and passion certainly shines bright. As a scooter user who lives in the world you described, I know how critical all of this is to our world of mobility, our health, and our mental health, and basically the quality of our lives. I've got a few questions. Is there a shortage of these certified rehab technology suppliers and what's the range of a good assessment cost?

Jean Minkel: June, with regard to the certified rehab technology suppliers, they are more bountiful in urban areas. They tend to be more bountiful in, frankly, states that have better Medicaid funding opportunities, so that you will see pockets where there are more choices, where there are less importance put on the funding of rehab devices. People go out of business and this is the type of business that will lose that certified supplier. There is in our resources at the end of the webinar here an association called NRRTS. We call it "narts", and it's a national registry of rehab technology suppliers, and it does show a state-by-state listing of those DME providers who have focused on rehab technology as their area of expertise.

I'd like to think, as we understand the conflict in the dual Medicare/Medicaid rules right now as the integrated programs eliminate some of those conflicts that we'll start to see more and more people go into this field as it is such a needed service, particularly with people with long term needs. Regarding the cost, the cost from the supplier standpoint is usually built into the cost of the equipment, so their time is built into their overhead in the equipment itself. The cost of the clinician working together--and I can't stress enough how important that team approach is--is it

tends to be in the \$150, \$200 range for a two-hour--sorry--a one-hour eval that may need to be over two sessions. It's usually in the \$200 to \$400 range, but when you consider it's \$200 to \$400 as an investment into a recommendation for a device for use in the next five to seven years, it's incredibly well worth it.

June Kailes: Good. Jean, I just have one more question and then I'll save the rest for later, but this integrated dual eligible benefit is really great news and kind of a dent in the restricted home problem that has been in effect for quite a while to the detriment of many older people. Besides us making that nice new dent in this world, is there anything else being done to correct the Part B advice issue--the home problem?

Jean Minkel: I know that several groups have been working at the legislative side in trying to get this customizable adjustable devices that are really designed for the long term user to be identified first as separate from durable medical equipment, to be really called complex rehab devices, and that these complex rehab devices be identified within CMS as a separate benefit category. There is legislation that's actually been introduced at both the House and the Senate to direct Medicare for separate benefit, specifically to address this concern that in the home is too restrictive for a beneficiary to rely on wheeled mobility all of the time. I see some other questions coming in.

June Kailes: There's a great question here from Judy at Access Living. "Is there research that documents the financial benefits for admission and other things--your visits and all--from personal disability and getting prompt quality equipment versus not getting the prompt quality that you need?" In other words, is there cost benefit analysis, if the chair costs so much?

Jean Minkel: Right. Another huge advantage of moving to an integrated plan is currently attempts to get those cost benefits have been really stymied by the fact that DME is covered by one benefit and hospitalizations and ER visits, etcetera have been covered by a separate benefit. Here at ICS, though not published, we have documented our pressure sore incidence among a high risk population--high risk is identified by the Braden Scale for pressure sore incidents--is less than 8% and we greatly attribute that to people getting the right chairs with the right postural supports with the right pressure-relieving capabilities within the chair. That percentage is about 5% or 6% less than the national average. I'm hoping that as we have the opportunity to compare claims data for re-hospitalizations and ER, that we will be able to show that the right equipment does have a positive impact on the bottom line.

Christopher Duff: If any of the participants here are aware of any research, it would be thing to be able to share in chat function, if you could. I think this might be a good time to ask another question that we have from Rachel at CareMore. "As a caregiver I have encountered many problems securing DME. The process is extremely frustrating and can become very convoluted." That's certainly very true. "Do you have any recommendations for recipients' and participants' involvement with the supplier and plan? Can you please repeat that and also when you use an acronym, make sure you say what it is."

Jean Minkel: Sure, so to answer the easy question first, the acronym is CRTS, and it stands for certified rehab technology supplier. As I noted earlier, a listing of those suppliers who are

certified is on the NRRTS--N-R-R-T-S--national registry of rehab technology suppliers' website, and the link is later in our slide deck here. With regard to resources in working with a plan and the supplier--no pun intended--the squeaky wheel gets the grease, and if your plan is not working with a provider who has the ability to offer adjustable configurable equipment, I'd give a call back and say, "Is there an out-of-network opportunity here or are there other suppliers that I can look to work with because a dissatisfied consumer is really important for both the plan to know and for the supplier to understand that individual needs are what we're trying to meet." I don't know if that helps.

Christopher Duff: Yeah, and I'm loving all of these questions coming here, because every single one of them are exactly the kind of questions we have all faced for many years in the field. Rosemary said that she was informed by a medical provider that Medicare-funded power wheelchairs are not owned by you. You're renting it for a few years. Can you explain that?

Jean Minkel: Under Medicare certain products are under a rent-to-purchase option. It's not even an option. It's a rent-to-purchase plan, and it's a 13-month rental period. At the end of the 13<sup>th</sup> month, the beneficiary does then own that product. If during the 13 months, the person no longer needs the product, it will be picked up by the supplier, as it is the supplier's property under the rental agreement. During that 13 months, however, the repair and maintenance of that chair is the supplier's responsibility. The benefit is someone else should be repairing your chair in the first 13 months. At the end of the 13 months, it reverts to the beneficiary's ownership or at Medicare.

Christopher Duff: Thank you. That's one thing that we will be covering more next week is that whole issue of maintenance and repair. Again, related to this same issue, Elizabeth Leaf at ACL said, "Is there a timeframe a vendor has from the time the order is taken to the time the chair is delivered? If the chair is not what is requested--something is wrong with the order--is there a due process for the recipient and how long should it take?" Basically, it's about the timeframes for it.

Jean Minkel: Right. Great, great, great question, so the timeframe historically has been very closely related to how long does it take to get the funding in place. I'm going to answer the question. If funding is all in place, we use a metric of six to eight weeks from the time the manufacturer gets the order to when the assembled chair should be ready for us to deliver back to the beneficiary. Frequently that timeframe may be much, much longer because particularly power mobility under Part B today requires a face-to-face examination between the beneficiary and their physician and a whole host of paperwork that needs to be in place, documented, checked over, revised, sent back, so you may find that there is a three or four-month funding authorization period prior to the manufacturer even getting the order.

To answer the second question, if the product as ordered is not what is delivered, absolutely there's due process and the very first instruction to the beneficiary is don't sign for anything. Do not accept what you didn't expect. Then from our experience, the clinician that was working with that supplier needs to be the beneficiary's advocate and point out what was ordered and what was delivered. If there is a good working relationship, which you hope there is with a RTS--rehab technology supplier--there should be an exchange and a make-right, particularly if there is documentation to show what was recommended is different than what was delivered.

Christopher Duff: I think the process you're just describing is a classic example of why people with disabilities really benefit from having a care coordinator involved. If they're within an integrated model demo, a lot of these steps can be managed in a different way, a far quicker way, than having to go out to all of these external decision-makers because the plan itself can make the decision themselves, and so it can simplify it. Of course, if it is confusing to us as professionals working with these individuals, you can imagine what it's like with the recipient directly.

Jean Minkel: Absolutely.

Christopher Duff: Are there any questions on the phone line?

Lisa: Thank you. If you have provided your name to an operator and you have a question, press star and then 1. Otherwise press star and then 0 (zero) for questions.

Christopher Duff: While we're waiting to see if there are any questions on the phone line, why don't we push the polling question, if you would--the question about--it would be the second question. "Does your organization or program currently have a process in place for mobility assessments?" We're trying to get a sense of how many people do that. How many plan to do that internally, how many contract with external staff, or whether you just do it through DME vendors. While we're waiting for that answer, Jean, could you answer the question of--you talk about the team being involved--the wheelchair team of therapists, the consumer, and then what the consumer wants and a provider. Can you just talk a bit more about what are the consequences of not using a team--of just having the DME provider directly deliver it or just if we have the professional just working directly with the consumer?

Jean Minkel: Sure. At the very, very, very, very top level, many eyes make for the better outcomes. It's been my experience that when I'm with the consumer and I'm asking questions and I'm doing an assessment and I'm trying to gather a lot of clinical information, my supplier may be observing something different--non-verbal communication, a sense of pain, a sense of resistance--so it's a nice way where more than one person is gathering information. Secondly, as approachable as I try to be, beneficiaries are often concerned that this is an adversarial relationship. "I'm going to come in because I'm going to get what it is that I need." To really try and break it down and to say, "We're here to get you what you need," that's what we're all trying to work towards. Having multiple people be able to articulate the matching process can really help demystify the process and help the beneficiary really feel like this is part of the consumer experience.

Then lastly, things change so quickly that checks and balances, two people reviewing orders, being able to check back with the consumer themselves and say, "Did we get this right? Do you really need an 18-inch seat depth? I wasn't sure whether you were looking for the short armrest or the long armrest." If you are a one-man shop, it's very easy to miss those kinds of steps and then that's where, out of no intention of doing something wrong, the product that comes in is not the product that was expected. Teamwork just to make the whole process easier and to be able to demystify it for the beneficiary.

Christopher Duff: Thank you. I'm just going to show the poll results here. What we're describing as best processes, I know many of you have kind of found your own ways. There is no single right answer. I see that most of you have no process in place, and that's certainly understandable. Many of you just rely on the DME vendors. One of my experiences around just working with the DME vendors, they tend to spec out a chair that they carried which may not be the best chair for that individual, or they propose a modification that again may not be the best modification. Maybe someone else makes a different modification that would be better, so I think that's again bringing in a third party such as a certified rehab specialist is of great benefit.

A question that came in about loaner chairs, and I believe this was from Judith in Southwest Michigan. "Are there resources for used and reconditioned equipment for families to donate when a chair or other piece is no longer needed and for those who need to access the equipment they cannot get approval for by Medicaid or Medicare?" Lord knows, we've all been in apartments of people. You open up the closet and you just find all sorts of equipment sitting there. Jean, can you talk about what you're aware of and what you guys have come to address that in your practice?

Jean Minkel: Sure. The use of reuse or recycling is--it's just so critical, and to your point of you hate to see potentially very useful devices just collecting dust in closets or garages or basements. My experience is this is a very individual, by agency, by geographic area, by community--a Grassroots group has spearheaded the organization cleaning and distribution of reuse or recycled equipment. There are some great models. There is a terrific model down in Atlanta--Tools For Life. In New England there's something called NEAT--the New England Assistive Technology Marketplace--and these are examples of groups that have identified storage locations, have personnel that can do the cleaning and light maintenance, and have a way of--if you will--advertising what their inventory is.

We as a long term care support organization have embraced the need for loaner and recycled equipment. We have a loaner pool we manage ourselves that is part of our repair process that we can talk about tomorrow--I mean next week--but essentially it is an understanding that if you don't have access to your primary device, having access to a loaner is critical to maintaining your level of function and community participation. The biggest challenge to date is who is going to manage the storage and who is going manage the cleaning and distribution. I'm a firm believer of where there's a will, there's a way, and it's an area where a community coming together can meet the needs of that community.

Christopher Duff: It's really locally done is what you're saying?

Jean Minkel: Yes.

Christopher Duff: I think that the local centers for independent living in any community or the ADRC would have a sense of what's available. What we found was most useful was with non-motorized equipment. The motorized equipment tends to be really specified and with special seating capacity in them and they're really unique to an individual. For the simpler devices--manual chairs, a variety of different canes and crutches--that's where we found it to be the most useful.

June, do you have any further questions you wanted to follow up on?

June Kailes: Yeah, Jean, one more question related to your point in living in a shut-in world. Can you talk more about your experience and working with people who just value walking so supremely that they kind of deny the long term effects of their walking becoming less functional--that they're becoming very slow, unsteady, that they're falling frequently, and are just severely restricted--their world, their home life, their community life--kind of closing in. In spite of that, they fear using the device and how it may look to others. Can talk about that?

Jean Minkel: Yes. I appreciate that you noticed my passion and my love for being sure that people get around with the device that easiest for them. I've had to learn to check that passion sometimes and to really, in a sense of seek first to understand and really acknowledge that society sees the wheelchair as the symbol of disability, and particularly with people with progressive disabilities or perhaps have been aging with a disability who fought so hard to gain the function of ambulation. Losing that function has a big emotional tie.

Our method is really, first of all, to engage in a dialogue and ask about where are they getting around and where would they like to be getting around and really acknowledge that there is a value for ambulation. As I always say to people, "The four steps you take in your bathroom could be the easiest way to manage you're a.m. morning routine without ever having wheels in the bathroom, but four steps outside your front door or back door don't get you too far into the community. Frequently family members and caregivers can really contribute here as to what it is that they've stopped being engaged in.

I've used the experience of can we get a rental piece of equipment just to introduce it. Somebody doesn't have to feel that they're making a five-year purchase decision, but if access to a scooter or a properly configured manual chair or a power chair maybe that has--we call it a captain seat. It looks more like an automobile seat than a wheelchair. If they have the chance to use a device, what's the experience. It's very interesting. Those who have been struggling with mobility will often come back and say, "I fought so hard to keep the old way, but now I have so much more energy in the day. I can engage back in the activities that brought me joy in my life. I can be with the people that I like to be with." It takes a bit of humility to say, "That which I hung onto for such a long time was really now causing more of an impairment. Embracing the next device has let me get back to being more functional in my environment," but it's gentle. It's very gentle.

Christopher Duff. Thank you. I can take one more question before we close this, but first of all I wanted to review with you the resources we've referenced. I would just specifically refer to slide 21. We've listed several resources that were connected or available on the RESNA website. That's rehabilitative engineering and assisted technology of North America on slide 21 and that includes a directory of credential providers that you look up the local provider. It also has a provision guide and a couple of videos showing how the evaluation is done, so you can actually see what's involved in it.

Then there is another link here which has a listing of professionals in your area, again, who have passed the RESNA exam, and then a couple of more consumer-centered pieces--one from

UsersFirst Mobility and the second from the MS society. I would encourage you to check up on those.

Then I'm going to combine a couple of questions we've received and the first part of the question is how is--and this is for Jean--how is a member's need for a mobility device identified? Then secondly, does your organization have a process in place for initiating and getting this to go from the need to the equipment?

Jean Minkel: Yes. The identification of need--we as a New York State managed long term care program, offer care coordination. That's the core of our business and part of that care coordination is every 180 days every member has a functional reassessment. During that reassessment, the nurse and/or the social worker can identify has there been a change in function? Should this be something that's introduced? Or the beneficiary themselves can initiate saying, "I'm having more repair problems. I think it's time that I look for a new device," or, "I've been having falls. The device I'm using now isn't serving my needs in the community so we take need identification from the beneficiary, family, caregiver, and the nurse assessment social worker care coordinator. It could be anyone in that array. Frankly, sometimes it's our wheelchair technician who identifies that, "We're on our last legs here and they really should get a new chair."

With regard to the process, at ICS we do have a very well-scripted process where the need is identified through the care coordinator and a therapist is then assigned to contact that person directly. The therapist might be at an external facility. For example, we have a model spinal cord center here in New York City. Our spinal cord folks are well connected to that center. We give them referral to go to that center for that wheelchair assessment. People that aren't well-connected--we assign them to therapists within the ICS staff here, so we have on-staff clinicians to do this process. We will go with a home visit if somebody has never had a mobility device, or we invite them to our clinic to see the products that are available commercially since the last time they got a device. Then we track that process right from needs assessment to equipment prescription to funding to ordering to delivery to training.

Christopher Duff: Thank you. While I do the final wrap-up, I'd like to call everyone's attention to the link for the webinar participant survey. If you could take a minute or two to fill that out, that would be very helpful and we'll inform how we produce these and try to meet your needs going forward. Next week at this time we'll be exploring issues related to the use of the provided equipment. This time we focused on how do you get people the right equipment, and next time we're going to be focused on the delivery of the equipment, the training and the use of the equipment, maintenance of the equipment, and repair and issues related to all of that.

Thank you, June and Jean, for your help today. Jean will continue with us next week and we will have Mary Lou Breslin join us again as a discussant as she did in an earlier webinar. Everyone who has signed up for this webinar will receive notice about future webinars, tools, and other resources we are able to provide. I would like again to thank both the speakers and all of you for attending and look forward to your continued support across the country as you try to meet the needs of people with disabilities. Thank you very much.

Jean Minkel: Thank you.

Lisa: Ladies and gentlemen, that does conclude the conference for today. Thank you for your participation and for using AT&T Executive Teleconference. You may now disconnect.