

The Ups and Downs of Dependent Mobility Systems

By Andria Segedy

As the product has evolved, so has the name—from generic “stroller” to the more descriptive label of “dependent mobility system.” The challenge remains in the funding arena, which is more accepting of this type of system as primary rather than secondary mobility solutions.

“I refer to everything with wheels on it as a wheelchair—as a universal term,” explains Richard Dodds, technology projects coordinator, United Cerebral Palsy Associations, Washington, D.C. “The word ‘stroller’ conveys a shape, like the word ‘wheelchair’ conveys a shape. Some manufacturers make equipment that look like strollers, but have significant seating and mobility systems built into them. That same stroller wouldn’t be purchased by parents of a child who has no need for that significant seating system.

“I have a 13-month-old child and a portable stroller,” Dodd continues. “If he needed a positioning system, we’d buy a more expensive version [of the stroller] with more options as far as how his body would be positioned. [Would that be] a ‘stroller’ in the universal context, or a wheelchair designed specifically for children with disabilities? A ‘dependent mobility system’ can be used by an adult. ‘Stroller’ has the connotation of being a child’s device.”

A stroller is “something you buy at Toys ‘R’ Us to take your infant around in,” says Tom Whelan, product manager for pediatrics and positioning at Quickie Designs, Fresno, Calif. Quickie Designs last fall acquired Kid-Kart, a manufacturer of products that look like strollers, but can

accommodate sophisticated seating and positioning systems. The acquisition, Whelan says, was a recognition by Quickie Designs that people want a lightweight, transportable, primary mobility and seating system.

“We understand that early intervention is a huge issue in our industry,” he says. “The earlier we deal with seating issues, the fewer [problems we have in dealing] with involved people as adults.”

“We try to stay away from anything that sounds frivolous,” says Betsy McKone, OT, seating and mobility clinician at Packard Children’s Hospital, Stanford, Calif. A high-level system that accommodates advanced seating is usually identified as a multifunction dependent manual push chair, she explains, while a lower-level item might be defined as a lightweight backup manual push chair.

It’s easier to fund a lower-level system as a secondary mobility system if it supports a powered mobility product, she adds. “It all depends on the funder.”

What’s Available

The market is as high as \$12 million for dependent mobility systems as primary mobility and about \$7 million as secondary mobility, according to manufacturers. Popular products are those with more versatile functions, rehab professionals note.

A popular product in the San Francisco area is a system with multiple functions that transfer from highchair to dependent mobility system to car seat, McKone says. Parents need these systems not only for easy transportation for quick trips to the doctor, but also for getting up and down stairs inside the home, she adds.

“These chairs have become more popular,” adds John Phillips, pediatric products manager at Otto Bock Reha, Minneapolis. Otto Bock recently introduced the product McKone referred to. Higher-end dependent mobility systems “will accomplish what a pediatric wheelchair will do except letting a child push himself. These chairs have evolved so much.”

Another high-end system just introduced by Tumble Forms, a division of Sammons Preston, Bolingbrook, Ill., reclines, tilts and opens up to lie flat. Tumble Forms senior product manager Sue Garvin says that she has seen the prescription and funding of certain dependent mobility products vary by region and environment. In Southern California, there is a strong push to get children into wheelchairs earlier, while in Florida funding is more difficult and children stay in dependent mobility systems longer, Garvin says.

The purchase of a dependent mobility system over a wheelchair can often be an attempt to solve the child’s medical needs in seating while giving parents what they want aesthetically, explains Kurt McKenzie, president, Snug Seat, Matthews, N.C. The decision comes at a price, however. “To satisfy the parents with aesthetics, we scare off the funding source,” he said.

Kathy Riley, PT, CRTS, ATS, National Seating and Mobility, Mooreville, N.C., says she can satisfy the medical necessities of many children with a higher-end dependent mobility system. But lower-end units as secondary mobility systems “are harder to get funding for,”

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she says. The funding “depends on the primary disability [and] if there is a secondary medical condition like a cardiac condition where the child might be ambulatory for short distances but needs assistance for endurance.”

Kentucky Medicaid doesn't recognize the term “dependent mobility system,” says Dennis Yurt, Grogan's Healthcare Supply, Lexington, Ky. That state's Medicaid classifies all Convaid models as “strollers,” and you can't call it a youth wheelchair, he explains. However, the state classifies Kid-Kart products as a youth wheelchairs.

“Parents should push for a secondary

system,” Dodds stresses. “There's a place for strollers flow-end dependent mobility systems], but not as a long-term solution.”

In Glendale, Calif., Rob Morgan of Continental Hospital Supply calls these devices “pediatric postural positioning systems.” As secondary mobility systems, “they are generally paid by family members. There is no funding unless there is an extreme case.

“We might get funding for a real involved CP client with a power chair,” Morgan says, “and if the family doesn't have a van or any way to transport the child to the doctor. Then you might get funding for it. You can build justification for it along those lines.”

“No one mobility system is going to fit all the needs of the family,” says Sue McLaurin, PT. She makes funding decisions under the Title V program sponsored by the Division of Maternal and Child Health, North Carolina Department of Environment, Health and Natural Resources. “The choices have to be good choices,” she says. There are times when we realize, based on assessment, that because of the varied environments this child would function in, we would consider having a primary and secondary system. But it has to be well thought out up front.

“It's difficult for us to fund it, but we have been known to do it. It depends on the care plan that actually identifies all the factors that are relevant to use of the chair and promotes mobility and the needs of the family lifestyle.”

Dependent mobility systems vary in price and capabilities, from basic sling back and seat at just over \$400 to sturdy, growth-adjustable,

positioning-capable at up to \$2,500. Rehab professionals agreed that the value to parents and funding sources in purchasing a dependent mobility system over a growth-adjustable pediatric wheelchair ultimately depends on the child's and caregiver's long-term needs.

The low-end dependent mobility system initially was designed to meet the parent's or caregiver's need for a portable system that was durable enough to take the force of pressure from a child with a disability, notes Roger Galka, vice president of seating and mobility, Convaid Products, Palos Verdes, Calif.

As managed care and price-conscious payer sources started cost-cutting, strollers were upgraded to meet the positioning needs of growing children, yet remained more lightweight than a pediatric wheelchair. While funding sources rarely pay for a secondary mobility system, rehab professionals agreed that parents still want the lower-end dependent mobility system for convenience.

The more economical sling-back dependent mobility system remains more a convenience item for parents, notes Yurt. “You can get one that still has fairly good support, with a seat and back, maybe adjustable-height foot rests, so the child isn't just slumped in a stroller. But it's still easy to fold, and Mom can throw it in the car and go.”

“Even if a therapist says, ‘I want this child in a wheelchair all his waking hours,’ that's not going to happen,” noted Galka. “If Mom wants to go shopping or to church, she'll use something more convenient.”

“The challenge is not in the label, but in defining the medical need for the product, adds Whelan. “We still have funding sources that won't pay for a rigid chair because they think it's a sport chair. The core issue here is the right product for the right person for the right reason.” |

Tie-Down Standards Apply to Strollers

New draft standards for wheelchairs that are secured in a motor vehicle using a four-point tie-down system are expected to be announced in November, according to Lawrence Schneider, PhD. And strollers, or dependent mobility systems, are within the scope of those standards, he adds.

Sled-impact tests for companies that make dependent mobility systems are taking place at several test sites, including the University of Michigan's Transportation Research Institute, Ann Arbor, where Schneider works.

“Part of the motivation of these companies is related to the fact that the standards are getting close to being completed,” he adds. The purpose of the standards is to get wheelchair manufacturers to address their end of the problem. Manufacturers need to begin to dynamically test their chairs to see if they are strong enough to hold up to the test, to put attachment points on the chairs, and to make it clear where those points are, he explains.

These standards for mobility systems to have tie-down points are being developed by the Subcommittee on Wheelchairs and Transportation, also known as SOWAT, within the ANSI/RESNA Wheelchair Standards Committee. That committee developed J2249 SAE, the standards for wheelchair tie-down and occupant-restraint systems for use in motor vehicles, Schneider explains. Along with his university, committee members are represented by the University of Pittsburgh and the University of Virginia, Charlottesville.

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