

**GUIDELINES FOR THE PROVISION OF
ASSISTIVE TECHNOLOGY SERVICES
TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES
UTILIZING THE PARTICIPATORY APPROACH**

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
NEW MEXICO DEPARTMENT OF HEALTH



Revised:
February 2006

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
NEW MEXICO DEPARTMENT OF HEALTH

**GUIDELINES FOR THE PROVISION OF
ASSISTIVE TECHNOLOGY SERVICES TO
INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES
UTILIZING THE PARTICIPATORY APPROACH**

I. INTRODUCTION AND PURPOSE

This document has been prepared as technical assistance for the provision of Assistive Technology services to individuals with developmental disabilities being served by the New Mexico Medicaid Developmental Disabilities Waiver. Assistive Technology (AT) encompasses the evaluation of AT needs, acquisition of AT devices, customizing and/or maintaining AT devices, coordinating other services with use of AT devices, AT training, and technical assistance for others substantially involved with the AT user. The desired outcome of Assistive Technology services is to maintain, increase, or improve functional capabilities of individuals in the areas of communication, mobility, environmental control, cognitive enhancement, employment/volunteer work, leisure and daily life activities.

It is expected that providers of physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services will utilize these guidelines in the development of Assistive Technology supports and services. They will be useful to both current developmental disabilities Medicaid Waiver providers and other interested therapists. The guidelines also be helpful to community provider agencies and individuals served.

The Developmental Disabilities Supports Division (the "Division") recognizes and respects the rights of individuals with developmental disabilities to secure Assistive Technology services. Further, it acknowledges the responsibility of the individual's Interdisciplinary Team (IDT) to include a provision for such services, as warranted, in the individual's Individual Service Plan (ISP). The principles that guide the service delivery of Assistive Technology services are as follows:

- A. The purposes of Physical, Occupational and Speech therapy services are to:
 - 1. Identify, implement and train therapeutic strategies to support the individual, their families and staff in efforts to meet the individual's ISP vision and goals.
 - 2. Increase, maintain, or reduce loss of functional skills;
 - 3. Treat a specific condition clinically related to an individual's developmental disability;
 - 4. Support the individual's health and safety needs; and
- B. All therapy services are to be determined within the context of the IDT and are to be recorded in the ISP. Therapy services are to be provided in a manner that promotes self-advocacy.
- C. Therapy services and supports are to be developed and implemented using the "Participatory Approach." Developmental Disability (DD) waiver service providers must be familiar with this approach and philosophy. The "Participatory Approach" asserts that no one is too severely disabled to benefit from Assistive Technology and other supports that promote participation in life activities. The "Participatory Approach" rejects the premise that an individual must be "ready" or demonstrate certain skills before Assistive Technology supports can be provided. Assistive Technology services will be offered in a fashion that takes into account whatever cognitive or physical challenges are present currently in the individual's life. Use of a "readiness" or "candidacy" model is contraindicated and rejected in these guidelines.

- D. All persons' IDT members will support and embrace the concepts included in the implementation of the "Participatory Approach." To that end, all case managers, all providers, all applicable funding agencies, and other interested parties are encouraged to advocate that Assistive Technology be utilized to the fullest extent and not denied because of a mistaken belief that individuals are too disabled to benefit from Assistive Technology devices and services. Participatory Approach trainings and technical assistance are available to support all stakeholders in this approach.
- E. The therapist should develop strategies that include the use of Assistive Technology to support the individual's vision, desired outcomes and action plans as identified in the ISP. Related activities developed or identified by the licensed therapist that incorporate therapeutic methods and strategies are to be adopted by the IDT for implementation throughout all appropriate life activities by service providers supporting the individual.
- F. While it is understood that a portion of intervention may be a direct skilled therapy treatment, it is the expectation of DOH/DDSD that therapists providing services under the DD Waiver will practice an integrated model of therapy whenever applicable. This means involving the direct support individual(s) to the maximum extent possible in the implementation of therapeutic goals. The therapist will initially be very active in designing, implementing and training the therapy plan in all relevant settings. Once a plan is implemented, direct support staff is fully engaged and the individual with disabilities is doing well with the plan, wherever possible the therapist will reduce the direct hands-on hours with the individual and become more involved in the training and monitoring aspects of the therapeutic interventions. Therapy is a dynamic process and may have times of greater and lesser active involvement by the therapist depending on the needs of the individual.
- G. Therapy services to individuals receiving more than one therapy must be delivered in a collaborative manner.
- H. The incorporation of Assistive Technology into an individual's life will be done in a fashion that is as non-intrusive as possible. Therapy services shall be provided in compliance with the applicable NM Licensing Board/Practice Act regulations and in accordance with standards and guidelines established by the applicable National Association. Therapists are expected to follow the "Code of Ethics" as established by their National Association in addition to all DOH/DDSD policies and procedures including The DD Waiver Service Standards and the Policy and Procedure for Supporting People on the DD Waiver with Dysphagia/Risk of Aspiration.

II. SCOPE OF THESE GUIDELINES

These guidelines have been developed to more fully define the Division's requirements and expectations for Therapy Service Provision in the area of AT for persons being served by the N.M. Medicaid Developmental Disabilities Waiver.

These guidelines also contain requirements and expectations that pertain to providers of Community Living Services, Day Habilitation Services, and Supported Employment Services.

Case Managers should have knowledge of these guidelines to allow them to advocate for individuals served, to reinforce the concepts herein to the IDT, and to include provision for such services, as warranted, in the individual's ISP.

These guidelines should assist individuals, teams, and therapists to identify the Division's requirements and expectations in the area of AT but they should not preclude the provision of other A.T. Services that are not mentioned herein, but are identified by the therapist, the individual and the team as necessary for health, safety, or the attainment of ISP visions/desired outcomes.

Although these guidelines may refer to therapy documentation related to AT Services, they do not cover specific therapy documentation requirements. Therapy documentation requirements are specified in the current DD Waiver Service Standards and other related guidelines specific to the Service Standards.

These guidelines are driven by the concept of the "Participatory Approach to Assistive Technology" to which DDSD subscribes and presents to service providers and interested parties in various training venues. The
February 2006

roles of therapists go beyond issues of health and safety to include developing supports that enable individuals served to participate in life to the fullest extent possible. All individuals served should be provided with supports to interact physically and communicatively within their environment. The responsibility for implementing these principles extends from therapists and other providers to guardians, case managers, administrators, and those who make the funding decisions.

The N.M. DOH/DDSD "DD Waiver Service Standards" shall guide the provision of AT Services as outlined in these guidelines.

III. DEFINITIONS OF TERMS

Assistive Technology, like most professional disciplines, has its own terminology that is utilized in various portions of this document. Some of the more frequently used terms include:

- A. Assistive Technology (AT) Device** - Any item, piece of equipment, product, or system, acquired commercially (off the shelf), modified, or customized, that is used to maintain, increase, or improve functional capabilities of individuals with developmental disabilities. This term includes all items that are considered "adaptive equipment" as well.
- B. AT Service** - Any service that directly assists an individual in the selection, acquisition, or use of an AT device. This service includes evaluation of technology needs, acquisition of AT devices, customizing and/or maintaining AT devices, coordinating other services with AT services, AT training, and technical assistance for others substantially involved with the AT user.
- C. Augmentative and Alternative Communication (AAC)** – Supports and strategies provided by certified and licensed speech-language pathologists that function to compensate, temporarily or permanently, for severe communication disorders and consequently allow for greater participation in life activities.
- D. AAC System** - An integrated group of components including the symbols, high and low tech devices, strategies, and techniques used by individuals to enhance communication. The system serves to supplement any gestural, spoken, and/or written communication skills.
- E. AAC Symbol** - A visual, auditory, and/or tactile representation of conventional concepts (e.g., gestures, photographs, manual sign sets or systems, pictoideographs, printed words, objects, spoken words, and Braille).
- F. AAC Aid** - A physical object or device used to transmit or receive messages such as a communication book, board, chart, mechanical or electronic device, or a computer.
- G. AAC Strategy** - A specific way of using Augmentative Communication aids, symbols, and/or techniques more effectively for enhanced communication. A strategy, whether taught to an individual or self-discovered, is a plan that can facilitate functioning.
- H. AAC Technique** - A method of transmitting messages through a variety of possible means such as linear scanning, row-column scanning, encoding, signing, and/or natural gesturing.
- I. Communication System/Multimodal System** - An approach which utilizes the individual's full communication capabilities including any residual speech or vocalizations, gestures, signs, and aided communication.
- J. Voice Output Communication Aid (VOCA)** - Any communication device that produces speech. The speech may be digitized (digitally recorded) or synthesized (computer generated).
- K. Low Tech AT** - AT supports which are less sophisticated and are often readily available, easily fabricated, or require minimal modifications.

L. Medium Tech or Light Tech AT - AT equipment that uses moderately complicated mechanics and/or electronics.

M. High Tech AT - AT devices or equipment that incorporate sophisticated electronics and/or computers.

N. Environmental Controls - Devices that allow an individual to operate a wide array of electronic equipment using switch or voice activation. Lights, telephones, curtains, bed controls, and any other electrical device can easily be interfaced with an environmental control system. Systems may be hard wired, infrared, ultrasonic, or interfaced with the wiring of a building.

O. Therapy Services - Therapy services are provided by a licensed practitioner as specified by applicable New Mexico Licensing Board/Practice Act regulations. Therapy services, in the areas of physical, occupational, and speech as covered by the New Mexico Developmental Disabilities Medicaid Waiver program include evaluation, treatment, caregiver/staff training, and consultation, as necessary.

P. Physical Therapy - A skilled therapy service performed by a licensed physical therapist or by a licensed physical therapy assistant under the supervision of a licensed physical therapist. Services must be reasonable and proper and directed toward the diagnosis and management of movement dysfunction and/or the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, and conditions or injuries. Physical therapy services are often used in the provision of Assistive Technology.

Q. Occupational Therapy - A skilled therapy service performed by a licensed occupational therapist or a certified occupational therapy assistant (COTA) under the supervision of a licensed occupational therapist. Services must be reasonable and necessary to help an individual regain, maintain, develop, and build skills that are important for independence, functioning, and health. Occupational Therapy gives people the "skills for the job of living" necessary for independent and satisfying lives. Services typically include: customized treatment programs to improve one's ability to perform daily activities; comprehensive home and job site evaluations with adaptation recommendations; performance skills assessments and treatment; assistive technology recommendations and usage training; and guidance to family members and caregivers.

R. Speech-Language Therapy - A specialized therapy service performed by a licensed speech-language pathologist that involves the non-medical application of principles, methods and procedures for the diagnosis, counseling, and instruction related to the development and disorders of communication including speech fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal sensori-motor competencies. Speech therapy is also a skilled therapy service used when an individual requires the use of an augmentative communication device. Services must be reasonable and necessary to improve or maintain the individual's capacity for successful communication or lessen the effects of the individual's loss of communication skills AND/OR to improve or maintain the individual's ability to eat foods, to drink liquids and to manage oral secretions with minimal risk of aspiration of other potential injuries or illness related to swallowing disorders. These treatments will likely incorporate the use of Assistive Technology such as augmentative communication devices and adaptive eating equipment.

IV. AUGMENTATIVE AND ALTERNATIVE COMMUNICATION

Communication is a basic need and a basic right of all human beings. Severe communication disorders preclude individuals participating fully in life through communication. Even though some individuals may be able to produce a limited amount of speech, sign language, and gestures or communicate using facial expressions

and body movements, these expressions are inadequate to meet the varied communications needs to support inclusion in life interactions with a variety of communication partners. Augmentative and alternative communication (AAC) should be considered for individuals for whom speech and/or written communication are temporarily or permanently inadequate to meet all of their communication functions. A speech-language pathologist (SLP) with expertise in AAC is most qualified to guide the IDT in the identification, development, and provision of communication supports.

An effective communication system is comprehensive and includes all aided and unaided communication modalities used by an individual. Aided components include communication devices such as a VOCA, communication board, tangible symbol card, etc. Unaided components of communication are modalities such as facial expressions, gestures, sign language, vocalizations, etc. that do not require external devices. Each individual's communication system is unique and must be designed with this uniqueness in mind.

AAC aided communication supports exist in many forms. They may be low, medium/light, or high tech AT as described above. They may be purchased or fabricated. They may be integrated with other items of AT such as power mobility systems, environmental control units, computers, alerting systems, etc. They may have fixed locations or be portable. The selection of an appropriate communication system is based upon the individual, his/her abilities, and his/her definable needs.

AAC supports are best identified by a team of persons (which may constitute an IDT) that knows the individual served, his/her strengths and his/her interests. The team may include the individual served, family members, caregivers, day program/educational/job support staff, a speech-language pathologist, an occupational therapist, a physical therapist, behavior supports consultant, medical providers and other interested parties.

Once the individual's AAC System is developed and provided, it is the responsibility of the IDT to ensure that it is available and maintained in working order whenever the system may be needed. For example, high tech systems must be charged according to the recommended schedule while low-tech systems must be maintained following repeated use. Batteries need to be kept on hand for many medium/light tech VOCA's. All members of the IDT must be knowledgeable regarding how they may support the individual to use specific operational techniques and strategies in conjunction with the communication system. All members of the IDT must also actively support opportunities for meaningful communicative interactions.

There are a number of factors to be considered regarding AAC system selection and design. They include:

- A.** Environments for living/communicating.
- B.** Chronological age-appropriateness of messages, materials, and activities.
- C.** Sensitivity to the individual's gender, cultural and linguistic needs.
- D.** Use during activities that are functional and purposeful.
- E.** The range of interactive messages for usage with a variety of partners.
- F.** Consideration for the perception of the communication system by others. It should present characteristics that enhance the perceived social standing of the user.
- G.** Reflecting the unique preferences, likes, and dislikes of the user. It should not be designed around or dedicated to requests for basic needs.
- H.** Focusing on interaction using abilities and supports that are currently in place. Communication should not be laden with instruction or contingent upon the acquisition of other skill practice such as crossing midline, pointing, page turning, etc.
- I.** Communication systems are composed of several modes and vary according to the environment, the situation, and the audience.

A communication system has three required components to meet the standards of the Participatory Approach. Persons who are not able to express themselves using a standard or conventional means of verbal expression commonly understood by unfamiliar listeners should have the following supports:

A. A Record of Current Communicative Behaviors/Communication Dictionary. This will include unique, atypical, and idiosyncratic acts which convey information to others regarding how the individual feels (emotionally or physically); his/her comments, requests, and complaints; and how the individual shares information. The behaviors may be purposeful or random, consistent or inconsistent, or emerging or well established. The record may take the form of a written communication dictionary or glossary, videotape, an audiotape, photographs, and the like. As a communication support, this record of current communication should be maintained as a part of the individual's ISP. If the team believes that the individual wants others to be aware of their current communicative acts and corresponding meanings, this documentation may be included in the ISP vision statements.

B. A 24-Hour Communication System. This is part of an individualized, integrated communication system. It is designed to support an individual receptively and expressively regarding issues that are frequently of concern in his/her life. This is usually a low-tech system, which must be portable and accessible from a variety of alternative therapeutic positions, as needed. For some individuals, it may be used as a backup to a more robust Voice Output Communication Aid (VOCA) or more sophisticated high tech system when it is unavailable because of necessary repairs or battery charging.

C. Interactive Communication Routines (ICR). These routines provide a structured context, availability of appropriate messages, and predictable and familiar interaction schemes to support substantive communicative exchange for individuals to interact with others regarding a specific area of interest or activity. The messages are scripted, and corresponding symbols are developed to support participation in the determined interaction/activity. Application of an ICR is not contingent upon a specific level of symbolic skill development. "Errorless choice-making" is one necessary component of ICR script design. AT supports from other therapy providers, I.E., OT, PT, are likely included in ICR design. Over time, a collection of ICR's may support an individual to participate in many areas of his/her life including activities of daily living, recreation, and educational/vocational pursuits.

V. ENVIRONMENTAL ADAPTATION AND CONTROL

Any environment in which an individual functions may need to be evaluated by an OT or a PT skilled in environmental access issues. The Environmental Evaluation and recommendations should consider access issues that pertain to the strengths and limitations of the individual and should address architectural barriers to function, safety hazards, vision and hearing impairments sensory processing dysfunction, and any environmental barriers to the individual's full participation in life. The Environmental Evaluation should consider the individual's ISP when prioritizing areas of intervention. The individual and family/support staff should be present for the evaluation whenever possible. The therapist should also consult with other members of the team regarding issues affecting their areas of service as applicable and must submit evaluation information as part of their annual documentation for each Environmental Evaluation completed. In addition, the evaluation should be updated when a person's physical environment or health/functional status changes, or as needed. Similar environmental issues should also be addressed when a person enters a new work or day program environment.

The evaluating therapist, the Case Manager and the Community Living Services Agency will follow procedures to engage supplemental funding for Environmental Adaptations such as provided by the DD Waiver funding for "Environmental Accessibility Adaptations Service" and other funding sources as applicable. In cases where the individual rents the home, structural home adaptations will need to be approved by and coordinated with the homeowner.

Per the DD Waiver Service Standards (reference current DD Waiver Standards), the Community Living Services (Residential) Agency for individuals in Supported Living is responsible to ensure in "areas for the usual functions of daily living, social, and leisure activities" that "adaptations will be available based on the unique needs of the individual."

The OT may recommend specific adapted bathing and personal care equipment needed for safety and function. The Division directs that the Community Living Services (Residential) Agency is responsible for provision and maintenance of adapted bathing and personal care equipment needed for safe and functional use under the above referenced DD Waiver Standard.

An individual's ability to access the environment as independently as possible may involve more than removal of environmental barriers or adaptation of the current environment. An individual should have access to an Occupational Therapist or other experienced professional for assistance in evaluation and use of appropriate technology for environmental control of preferred and needed devices/activities. This could include evaluation and training in use of devices from low-tech items such as reachers and large diameter handles, to higher tech devices such as those needed for remote switch access systems or telephone access needs.

Considerations may include identification of the individual's most reliable switch access site(s), basic functionality and cost-comparison of device options, portability and durability of the device, appropriate mounting of switches and items to be controlled, how various switches and devices might interface with mobility and/or communication systems, if the system can be expanded to accommodate future needs, as well as overall safety, ease of use and the individual's preference. The Therapist should consider the individual's ISP when prioritizing areas of intervention. Some systems such as access to a call device, access to the telephone might be considered priorities due to safety or medical issues. The Therapist should coordinate services with other professionals who may be utilizing switch access with the individual for communication devices, power mobility, or other purposes. If the Therapist does not have expertise in a particular area of Environmental Access that is an area of need for the individual, the Therapist should assist the team to identify other resources that might be of assistance in that particular area of need. The status of the individual's environmental access needs should be reviewed and addressed as part of the Initial Therapy Evaluation and as part of the Annual Therapy Re-Evaluation.

VI. POSITIONING FOR FUNCTION

If an individual is unable to maintain appropriate positioning independently to participate in activities throughout the day, the use of Assistive Technology should be considered. Evaluation of the need for and the prescription of positioning devices should be performed by an OT or PT. The therapist should consider the individual's present physical limitations, the benefits to be achieved by possible positions, and the variety of positioning technology available. Considerations may include an analysis of the potential to remediate impairments (such as limitations in range of motion or impaired pulmonary function) as well as to increase participation in functional activities. When Assistive Technology is used in positioning, the fit of the device and changes in skin condition should be assessed continually. Analysis of the practicality and ease of use of the technology, as well as safety during its use, should be completed by the prescribing therapist. Comprehensive instructions on the use and care of the technology should be provided to staff and/or family members who will assist the individual with the use of any positioning device. Periodic re-evaluations should be provided.

VII. SEATING AND MOBILITY

Individuals who utilize a wheelchair as their primary means of mobility should be evaluated relative to that wheelchair using a team approach. The team should include, at a minimum, the individual, a family member or support staff, a PT and/or OT, and a durable medical equipment (DME) supplier. When possible and appropriate, others such as a SLP, the teacher/day program provider/job coach, a technician skilled in equipment modification and a nurse may be included on the team. The team should consider the individual's medical history, life style, and ISP goals along with information from the evaluation when selecting a new wheelchair. The wheelchair evaluation should include a check of limitations in range of motion that affect seating, motor control, sensory impairments, skeletal deformities (and how flexible the deformities are), present skin condition and any history of skin breakdown, and functional activities in which the individual participates. Factors such as the need to integrate the wheelchair with other AT systems, the need to drive or be transported in a vehicle; home, school/work, and leisure environments; and the general setting in which the individual lives (rural or urban) should also be considered.

The team involved in selecting the wheelchair should clarify goals to be achieved with the use of the new wheelchair and seating system. These goals might include maximizing the individual's independence in mobility, maximizing the individual's independence in daily activities, maintaining or improving physical function and health status, preventing deformities and reducing the risk of secondary impairments, promoting optimal body alignment, preventing pressure areas, and assuring the individual's safety.

The wheelchair, both the mobility base and any seating system components, must be well maintained and clean. Damaged, worn, or missing parts require immediate attention from a qualified repairperson. Re-assessment by a qualified therapist should be carried out periodically or whenever there is a change in the individual's health or functional status.

VIII. SENSORY SUPPORTS

Vision and/or hearing impairments impact on all aspects of an individual's life from communication and mobility to competitive employment, recreation, and other daily activities. All individuals served will benefit from periodic evaluations of vision and hearing. When a professional evaluation indicates that the individual would benefit from a sensory aid in either or both of these areas, the professional should guide the IDT to procure, introduce, implement, and maintain the recommended AT support or refer the individual to that professional discipline that can provide such service.

An audiologist should provide the IDT with the appropriate diagnosis and recommendations for an individual served with a hearing impairment. A teacher of the deaf or hard of hearing may assist the IDT to develop functional and supportive and/or compensatory strategies, techniques, and AT systems. An SLP and an OT may be of some assistance to the team as well.

An ophthalmologist should provide the IDT with the appropriate diagnosis and recommendations for impairments of visual acuity and visual fields. An orientation and mobility trainer (OMT), a low vision specialist, and/or an OT may provide an evaluation and recommendations regarding use of functional vision, visual perceptual abilities, and/or mobility aids.

There are many low and high tech products and devices available for persons with vision or hearing impairments. It is important that the individual served be involved as much as possible in the decision making process regarding the selection of Assistive Technology supports.

Sensory Processing Disorders (SPD) affect a significant number of persons with DD and has a very high prevalence in persons with autism spectrum disorders. People with SPD misinterpret everyday sensory information, such as touch, sound, and movement. This can lead to behavioral problems, difficulties with coordination, oversensitivity to touch, extreme impulsivity, and many other issues. SPD or Sensory Integration Dysfunction should be evaluated and treated by an Occupational Therapist who has experience and coursework in these areas. The Occupational Therapist may assist the IDT in employing a variety of strategies such as sensory diets and environmental adaptations to help the individual organize his/her sensory system to respond functionally to environmental demands. Recommendations often include the use of Assistive Technology and environmental adaptations as needed.

IX. SELF-CARE AND DAILY ACTIVITIES

Many people with DD can benefit from the use of AT to assist them to participate more actively and/or more independently in self-care activities (eating, bathing, hygiene, etc), leisure activities, home management, cooking, community activities, social participation, and other daily activities. An OT should provide the individual and the team with comprehensive evaluation and treatment services in these areas. The OT should consider the individual's ISP when prioritizing areas of intervention. Services should include: trial of various AT devices that may assist the individual; recommendation of specific AT devices; assistance with appropriate sources to obtain recommended devices; training for the individual and support staff on use and maintenance of devices; and training on recommended adapted methods and safety precautions appropriate to use. The individual and family/support staff should be as involved as possible in decisions regarding AT devices and use. Residential

and Day Habilitation settings must have appropriate procedures in place to ensure proper care, maintenance and sanitation of personal AT devices such as eating, personal hygiene, and bathing equipment as applicable.

X. VOLUNTEER WORK AND EMPLOYMENT

The Developmental Disabilities Supports Division (DDSD) considers opportunities for meaningful employment and volunteer opportunities in integrated settings to be a high priority for persons served. Environmental Adaptation and Assistive Technology can be powerful tools to assist the individual to experience greater independence and success in these areas.

It is the policy of the DDSD that “The individual’s interdisciplinary team will ensure that all appropriate supports and services are identified and utilized for the individual” and that ...”reasonable accommodations are made for the individual at a job site”. (Reference the DDSD Policy on “Access to Employment”). Therapists are directed to evaluate individuals served at their work or volunteer site to determine if AT supports are recommended in these contexts. Evaluations should be updated when the person’s work or volunteer situation changes and as part of the Therapist’s Annual Re-Evaluation. If AT supports are recommended, the therapist should provide services in coordination with the individual, the team, Supported Employment Services and job coach, the employer/volunteer site supervisor, and DVR (as applicable). Recommendations should assist the employer; Supported Employment Services and DVR (as applicable) determine the extent of “reasonable accommodations” needed.

AT Services should include: recommendation of environmental adaptations, trial of various AT devices that may assist the individual; recommendation of specific AT devices; assistance with appropriate sources to obtain recommended devices; training for the individual, appropriate job/volunteer site personal, job coach and/or support staff on use and maintenance of devices as well as recommended adapted methods and safety precautions appropriate to use.

If the IDT determines that an AT Evaluation and/or Work/Volunteer Site Environmental Evaluation is needed and the appropriate therapy discipline is not represented on the team, the IDT will make a referral for the appropriate therapy evaluation. In general, a physical therapist would evaluate the individual for functional mobility, endurance, seating/positioning, and other physical needs. A Speech Therapist would evaluate the individual for communication and certain cognitive needs. A Behavioral Support Consultant would evaluate the individual for behavioral support needs. An Occupational Therapist would evaluate the individual in areas of specific work activity performance and perform a Work / Volunteer Site Environmental Evaluation.

If DVR and/ or Supported Employment Services are involved with the individual, the therapist must coordinate with DVR and/or Supported Employment Services when providing evaluation and therapy services.

XI. INTEGRATION INTO NATURAL ENVIRONMENTS

AT supports are designed for use in all appropriate settings throughout an individual’s daily routine. Individuals served should have access to supports such as augmentative communication devices, environment control units, mobility systems, and other devices that allow persons to participate both communicatively and physically at all appropriate times throughout the day. Devices must be kept in good condition, including the availability of power sources (e.g., batteries). All providers are responsible for the appropriate maintenance, availability and utilization of all AT devices across settings.

The Division strongly suggests that Community Living Services (Residential) Agencies and Day Habilitation Services establish appropriate policies for the maintenance of an Assistive Technology Inventory of each individual’s personal AT devices.

XII. FUNDING OF ASSISTIVE TECHNOLOGY SERVICES

Therapists should refer to the Therapy Service Standards issued by the Division for information regarding how to bill for their services in the area of AT. Therapy services are funded through the DD Waiver; with one exception, it does not fund AT devices, products and systems. The DD Waiver may pay environmental modifications.

XIII. FUNDING OF ASSISTIVE TECHNOLOGY DEVICES

It is not possible to list all funding sources of AT devices in this section since financial resources are constantly changing. Many items of AT may be funded through the individual's medical funding source including, but not limited to, personal medical insurance, Medicaid and Medicare. DVR may also provide funding in cases where the device is work related.

The Assistive Technology Expense Fund is a State funding source that may be accessed by any New Mexican with developmental disabilities. As part of the shift to the "Participatory Approach to Assistive Technology" and in keeping with directives of the Division regarding AT supports and services this fund was established to support the purchase of low-to-light tech AT, the expenses incurred when fabricating AT supports and maintenance of Assistive Technology devices. This is a modest effort to encourage the development of low-tech augmentative communication systems, environmental control systems, and parts and repair for mobility or positioning systems not funded by other sources. Examples of AT expenses that can be funded include materials required to fabricate augmentative communication systems, replacement batteries, environmental control switches, trays and pads for seating systems, etc. The funding guidelines state that the Assistive Technology device must be utilized during meaningful and functional activities. The devices funded do not include "therapy materials" that are used in preparation for functional participation, nor for teaching skills nor for educational purposes that are the responsibility of the local educational agency. Payments from the fund may not exceed \$250 per individual per year.

XIV. SAFETY AND LIABILITY ISSUES

All AT must be designed and implemented in a manner that precludes any type of harm when used by the individual. This means that switches, electronic equipment, and similar items are manufactured in a way that protects against electrical shorts, fires, explosions, and electrocution (e.g., by meeting Underwriters Laboratory standards). It also means that the equipment must be properly positioned so that the individual served does not experience personal discomfort or exacerbation of existing conditions. Manufactured items must reflect construction standards that protect against bodily harm and death. Individuals served using AT must be protected at all times in terms of their ability to use these devices safely.

XV. ADDITIONAL CONSIDERATIONS

It is a theme throughout these guidelines that individuals served have a right to participate in the interactions of everyday life. In order to do so, individuals served require various supports offered by licensed therapists and other support staff in the area of AT. Relative to that right, as examples:

- A. The availability of AT equipment must not be withdrawn as part of any intervention for challenging behavior.
- B. AT equipment is not to be used for entertainment, exploitative or other inappropriate purposes by non-consumers.
- D. Consumers who use AT devices clearly deserve to have them available in all settings, in well-maintained and clean condition.

XVI. THE APPROPRIATE USE OF TRADITIONAL THERAPEUTIC INTERVENTIONS, WHICH MEET THE NEEDS OF INDIVIDUALS SERVED

The adoption of the “Participatory Approach to Assistive Technology” provides a conceptual framework whereby providers embrace the notion that no one is too disabled to benefit from AT services. The Participatory Approach also offers technical information on how to deliver certain AT services. Acknowledgment of the primacy of the Participatory Approach by the Division, however, does not preclude its support for and funding of other aspects of OT, PT, and SLP services when clinically indicated. Licensed therapists must use professional judgment in determining a therapeutic course of action. Therapists are also expected to utilize the directives/input from physicians and other professionals in the delivery of their services.

Appendix A: CHECKLIST FOR REFERRAL FOR ASSISTIVE TECHNOLOGY/THERAPY SERVICES

Referral for Assistive Technology support from one or more therapies may be indicated when the individual:

- has a wheelchair
- has a problem with his/her wheelchair, i.e. wheelchair is in poor condition; does not fit and/or does not meet the individual's needs.
- needs assistance with positioning for function, i.e. to improve the use of hands; to prevent skin breakdown; to interact with the environment; to improve breathing.
- wants to increase his/her mobility, i.e. in a wheelchair; using a cane or walker; improve gait.
- wants to maintain or improve function, i.e. for range of motion; for controlling movements; for dealing with high muscle tone; for a particular skill; for cardiovascular function.
- wants to eat more safely, i.e. is experiencing symptoms of aspiration; needs techniques for managing food/liquid/saliva orally; needs techniques to assist with swallowing; is refusing to eat/drink orally.
- wants to return to oral eating/drinking and PCP will permit.
- wants to improve oral sensitivities, but not oral eating.
- wants to communicate more effectively with others, i.e. does not speak and does not have an alternative system which permits participation through communication; wants to develop an alternate system of communication / AAC; wants assistance using an AAC system (access, vocabulary); speaks, but is difficult to understand; speaks, but words do not make sense; speaks, but has limited ability to express ideas; wants to develop functional literacy skills; wants to communicate in written form.
- wants to improve cognitive functioning, i.e. organizational strategies, sequencing skills, short-term memory, problem solving and/or adaptive strategies for functional activity.
- wants to improve self-care skills (ADL's), i.e. eating or drinking, dressing, grooming, toileting, bathing.
- wants to improve functional fine-motor skills, i.e. manipulating objects needed for daily activities, work or leisure tools, etc.
- wants to improve home living skills, i.e. shopping, money management, using public transportation, etc.; has difficulty with accessing home, work, day program or school environment, i.e. can't use dials, can't control leisure equipment, can't control lights, can't access faucets, needs assist to access home appliances, can't use work tools, can't take notes, etc.
- needs modifications to use wheelchair in daily environment, i.e. doors widened, bathroom adaptations, ramps, safety adaptations, etc.
- seems to have difficulty with processing sensory information, i.e. needs large personal space; over or under sensitive to touch, or sound, or auditory, or visual stimulation (all or one); has various self-stimulation or self-injurious behaviors that may be connected with poor sensory modulation; rocks body, spins around, avoids movement; bangs body, hits self, bites self.
- wants to improve visual-motor or visual perception skills, i.e. needs help moving around furniture; gets frustrated trying to find things in a drawer or in a visually busy environment; has problems visually attending, tracking, etc.; needs adaptations for visual impairment.
- needs hand splints to maintain range of motion for hygiene; increase ability to grasp; maintain hand function.
- wants to improve hand coordination or manipulation skills.

Appendix B: Integrating Assistive Technology Supports into the ISP

Assistive Technology support services and devices will be well integrated into an individual's life when the philosophy of the Participatory Approach to Assistive Technology and the Therapy Standards are applied consistently across settings. The following examples of "excellent" versus "poor" integration are provided as an illustration of appropriate service delivery practices and outcomes.

Excellent Integration of AT:	Poor Integration of AT:
•Therapies are provided to all individuals who require supports in order to participate more fully in their lives.	•Therapies are provided only to persons who demonstrate readiness or skills development needed to participate in their lives.
•Therapies support participation in life and/or daily activities and facilitate participation in special interest areas (hobbies).	•Therapies apply to activities performed in the therapy session only.
•Therapies provide practical strategies, techniques and ongoing training which assist caregivers with current and ongoing activities.	•Therapies are used <u>only</u> in contrived or newly introduced activities.
•Therapists interact regularly with caregivers.	•Therapists work directly with the individual and do not discuss activities, strategies, techniques, and supports with caregivers.
•Materials/devices, which support the individual in his/her daily activities at home, employment, recreation and leisure are readily available to the individual at all times.	•Materials/devices, which support activities, are kept by the therapist and used in therapy sessions only, until a minimum level of skill development is attained.
OUTCOME: •The individual is involved in meaningful age appropriate and culturally appropriate activities with the support of assistive technology.	OUTCOME: •The individual has no meaningful activities. He/She sits in front of the TV without interaction or active participation.