



# Assistive Technology Summit Report

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December 4, 2019

*Every once in a while, a new technology, an old problem, and a big idea turn into an innovation.*

- Dean Kamen,  
American engineer, businessman, and inventor of the Segway and iBot battery powered wheelchair



From smart phones to self-driving cars, technology has transformed modern life, opening new doors and new possibilities. For people with intellectual and developmental disabilities (I/DD), technology holds the promise of expanding options for independent living, increasing inclusion in the community and workplace, and reducing costs.

NJCDD's mission is to address the needs of individuals with I/DD and their families through systems change and capacity-building efforts that promote self-determination, integration, and inclusion. The Council believes that assistive technology (AT) can promote greater independence and enable people with I/DD to perform tasks that they would otherwise be unable to accomplish or have difficulty accomplishing. Access to effective and appropriate AT is a crosscutting issue, with implications for the NJCDD's 5-Year Plan in all areas: self-advocacy, family training and information, direct support staffing issues, special education advocacy, employment, transportation, health and wellness, and housing.

### **Defining AT**

As defined in 1998 by the Federal Assistive Technology Act, "assistive technology" refers to: *Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. AT service is directly assisting an individual with a disability in the selection, acquisition, or use of an assistive technology device.*

Since the passage of that Act, our understanding and use of technology has broadened to include two subcategories of AT.

- *Enabling Technology (ET)* is the use of various forms of devices and tech to support a person with disabilities to live as independently as possible. These types of technologies include sensors, mobile applications, remote support systems, and other smart devices. Enabling technology can support a person in navigating their job and community, gaining more control of their environment, and providing remote support and reminders to enable independent living.
- *Remote Support (RS)* is an emerging service model that combines technology and direct care to help support people with developmental disabilities living independently. Using two-way communication in real time, such as home-based sensors, cameras, and other technologies, remote support allows an off-site caregiver to monitor and respond to the safety and needs of a person with developmental disabilities living in the community. Learn more here: <https://shelbydd.org/remote-support/>

For the purposes of this paper, the term Assistive Technology refers to the ever growing array of developments under the tech umbrella, including “enabling technology” and “remote support.”

Recognizing its importance, NJCDD organized a Summit on Assistive Technology. On December 4, 2019, leadership at the Council assembled a group of roughly 30 thought leaders—providers and consumers—in New Jersey’s I/DD system (see Appendix A). The goal for the day was to learn about ways in which AT can improve the lives of people with I/DD, and to look for ways to expand the use of AT in New Jersey. The day began with a presentation by three highly qualified national experts who have used AT approaches to transform their organizations and support for people with disabilities.

Guest experts who presented to the summit were:

- Nick Filarelli, *Program Director, Core Services of Northeast in Johnson City, TN*
- Jeff Ballenger, *Vice President, Supportive Housing & Family Services at Charles Lea Center in Spartanburg, SC*
- Ravi Dahiya, *Chief Program Officer at YAI in New York, NY*

The speakers set the stage for discussion by describing:

1. The importance of technology: why it matters and what it accomplishes;
2. How provider agencies that had been using little or no technology worked to integrate technology into person-centered planning;
3. Case studies in which individuals achieved greater independence and happiness through technology;
4. Obstacles and challenges faced when transforming service delivery to a more AT-centered approach;
5. How funding mechanisms work, so that providers are paid for services when technology is used to support individuals; and
6. Lessons learned thorough the Center for Medicaid (CMS) and State experiences.

### **Why AT Matters**

*“People with disabilities want a good life, NOT a lifetime of good services...”*

Following the morning presentations, stakeholders took part in a facilitated discussion concerning the future of AT as a strategy to address issues facing people with disabilities. The discussion began with a review of “why”—the reasons that moving the needle on AT in New Jersey is vital (see Appendix B). The conversation returned to the concept of helping people with I/DD “live a good life—one that is self-determined.”

Motivation for taking action on expanding AT fell into two general categories:

1. *Greater independence and opportunities for people with I/DD*
  - a. When individuals with I/DD can use technology that enables them to carry out a task without direct assistance from another person, they experience greater independence, individual control, and self-direction.
  - b. People with I/DD may be able to do tasks thought to be impossible, based on assumptions about their disabilities. This can open doors to employment and full participation in the community.
  
2. *Address workforce issues and reallocate resources*
  - a. When individuals with I/DD can rely on technology rather than staff people, it allows staff to be reallocated, so they are used more effectively and efficiently.
  - b. Shifting resources can help reduce waiting lists for services.
  - c. Assistive technology can allow providers to reallocate resources and become more efficient. Staff can be assigned to times/services for which they are truly needed.
  - d. Better use of staff resources could reduce waiting lists.

### *Olmstead: Is There a Right to Technology?*

The 1999 landmark US Supreme Court decision in *Olmsted v. LC* established that the unjustified segregation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act (ADA).

The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services.

In spite of this decision, most people with I/DD do not have equal access to the types of technology (e.g., communication devices, mobility devices, smart home, digital information) that could greatly increase their ability to live and work in the community. Advocates have asked if this is a violation of *Olmsted*.

University of Colorado's 2013 Coleman Institute Declaration of Rights (found at <https://www.colemaninstitute.org/wp-content/uploads/2017/01/TheDeclaration.pdf>) affirms "a commitment to equal rights for people with cognitive disabilities to access technology and information access." They call on leaders to ensure expanded public and private funding, and call on developers to use principles of universal design to ensure access and ease of use.

The declaration asserts:

*“...the vast majority of people with cognitive disabilities have limited or no access to comprehensible information and usable communication technologies, and that ensuring access to technology and information for the 28 million people with cognitive disabilities in the United States will create new markets and employment opportunities; decrease dependency on public services; reduce healthcare costs; and improve the independence, productivity, and quality of life of people with cognitive disabilities.”*

### **AT across the Nation: The Role of Medicaid**

While the use of AT in the provision of supports for people with I/DD is not yet widespread, there are islands of innovation. One of the major factors in the use of AT seems to be funding sources. That is, in states in which AT has been a funding priority, its use has expanded.

Medicaid is the first third-party payer to cover passive remote monitoring for home care. In a 2018 letter to members of Congress, (see Appendix C) CMS recognizes the need to deliver services in new and innovative ways, based on evolving technologies and recognition of the growing national shortage of direct service professionals (DSP). They seek to balance innovation and accountability by allowing states to include electronic monitoring devices as “medical assistance” under their state Medicaid plans under section 1915(c) of the Social Security Act under the general category of assistive technology and/or environmental modification services.

They may also consider other emerging technologies as long as states provide “adequate assurances in accordance with statutory requirements, such as they are cost effective, necessary to avoid institutional placement and are provided in such a way that assures protection of the health and welfare of the individual.” They must be designed to promote personal privacy and awareness of rights.

Some states have put into place innovative Medicaid waivers that specifically allow funding for remote supports and other forms of innovative AT. On the leading edge, Ohio, Minnesota, Maryland, West Virginia, Pennsylvania, and Washington have each written Medicaid waivers that allow Federal Medicaid dollars to be used for AT and were identified by guest experts as innovative models. (See Appendix D).

Guest speakers recommended ensuring that the New Jersey State Waiver use language to reflect the option to fund AT for:

- “Remote assistance”
- “Enabling technology designed to protect and promote health and welfare of individuals”

According to the Center for Connected Health Policy, 22 State Medicaid programs provide reimbursement for remote patient monitoring (RPM) through telehealth as of September 2019.

Two Medicaid programs (HI and NJ) have laws requiring that Medicaid reimburse for RPM, but at the time this report was written neither had any official Medicaid policy.

<https://www.cchpca.org/telehealth-policy/telehealth-medicaid-and-state-policy>

A 2018 report from University of Washington published by the *Journal of Medical Internet Research*, a peer-reviewed journal for health and health care in the internet age, found that two-thirds of the states cover location tracking and activity-monitoring sensors and one-third cover cameras, but only three states have specific service categories that allow them to track when they are paying for any of these technologies, impeding regulation and understanding of their use at the state and federal level.

### **New Jersey: Ready for Change**

The New Jersey system of services and support for individuals with I/DD is well positioned to make a shift to greater use of AT. In contrast to other states, New Jersey is densely populated and relatively small, making it easier to share resources and information. In addition, the network of providers is well-connected and experienced.

While very diverse, the state's overall wealth strongly supports access to technology. Cellular coverage and Wi-Fi are available in virtually every part of the state. Among other strengths of New Jersey's service system, as identified by stakeholders:

- Providers are willing to take risks and try new approaches.
- There is good legislative support.
- There is a well-organized self-advocacy and family support system.
- New Jersey has embraced person-centered planning.
- There is a strong connection in New Jersey between NJCDD, the Boggs Center on Developmental Disabilities, and Disability Rights New Jersey.

New Jersey's Community Care Program and Supports Program within the NJ Comprehensive Medicaid waiver specifically allows assistive technology as a DDD-funded service. The definition includes reference to "remote monitoring" but does not define that term. New Jersey rules define AT to include both *devices* and *services*:

*"AT is an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: (A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (D) ongoing*

*maintenance fees to utilize the assistive technology (e.g., remote monitoring devices); (E) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the Service Plan; (F) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and (G) training or technical assistance for professionals or other individuals who provide services to, or who are employed by participants.” (See appendix D for more details)*

**Challenges and Barriers**

The stakeholder group shifted its attention to the challenges in New Jersey, exploring potential obstacles and barriers to the expanded use of AT. Challenges were identified at three levels: the Individual/family/caregiver level, the agency/provider level, and the statewide system level.

**Individual and family level**

Comments from participants included:

*“Is this really enough support?”*

*“What if it doesn’t work?”*

*“Access to AT may only be as good as the support coordinator’s interest in it.”*

Barriers/challenges identified by stakeholders include:

Fear: Will this work? What if my loved one gets hurt?
Reliance on support coordination for information and “gatekeeper” function of support brokers.
Turnover and support coordination results in turmoil.
Funding: Most people with disabilities have limited resources.
Funding: Medicaid waivers do not easily fund technology.
Training: Direct care support professional turnover—for example, if one DSP leaves, the technology may leave with them.
Frequent updates and upgrades to technology are needed. Who does it, and how is it funded?
Continuity and generalization: How will it follow the person from one setting to another?

Provider agency level

Comments from participants included:

*“What if we get sued?”*

*“How does this get funded?”*

*“How can we train staff to use this equipment?”*

*“What if staff don’t want to use technology?”*

*“Families and staff need a virtual experience. They need to see it in action.”*

*“Are we truly ready to listen more and honor the individual needs instead of using a readiness model?”*

Barriers/challenges identified by stakeholders include:

Liability/penalty.
Staff training.
Resistance from family and staff.
Providers still have a “parental/protective” approach to decision-making.
There is no place to pilot-test technology.
Funding.
Some providers may not want to change.
Still a health-based model.
Some people don’t understand technology and how it can be used.

Systems level

Comments from participants included:

*“It is hard to put a price tag on people with disabilities and what it costs for them to become more independent.”*

*“How can we shift from a system that ‘protects’ to one that honors the dignity of risk?”*

*“In the current system, access to disability services implies poverty—tech, even smart phones—can be expensive.”*

*“Does NJ’s waiver even fund this?”*



Barriers/challenges identified by stakeholders include:

There is a maze of conflicting and limiting regulatory and licensing issues.
New Jersey service system is heavily siloed.
Funding through Medicaid is not aligned with person-centered planning.
Up-front costs can be prohibitive—would need grants or demonstration projects.
Technology must come through a DDDC-qualified provider.
Not enough information about social determinants of well-being.
Medicaid is currently billed based on person-to-person services, not services more broadly.
The system was created for those with a temporary disability.
Continued vision has to come from the state.
Our vision: full access to transportation technology resources allows self to make mistakes.
Decrease barriers.
Increase incentives for innovation.
Increase incentives for employment.
Building wealth elevates the value of persons with disabilities.
Increase flexibility and adaptability.
Demystify the use of assistive technology division.

### **Solutions and Recommendations**

*(Note: Items marked in **bold face type** were suggested roles/action items for the Council)*

#### Individual/Family

In order to address challenges/barriers at the individual/family level, the following strategies were suggested:

1. **Fund pilot programs to showcase success.**
2. **Create model homes.**
3. **Oculus.®**
4. Engage DVRS.
5. Supplement support coordination.
6. Education and exposure to technology in order to address fears of families/consumers/DSPs.
7. Ensure that individual goals in habilitation service plans include technology solutions.
8. **Ensure that there is a statewide/regional resource for AT information, e.g., a hot line or “Geek Squad.”**
9. Make sure that individuals/families who opt for technology have less risk; create a “safety net so they can back out of innovative tech approaches if it’s not working.”
10. Training and direction to support coordinators and service providers to more directly encourage individuals to use technology.

11. Start use of technology early (in schools) and in the person’s life, so they grow up with tech solutions.
- 12. Share success stories about A/T.**
13. Put systems in place to keep technology updated.

#### Agency/provider

In order to address challenges/barriers at the agency/provider level, the following strategies were suggested:

1. Get everyone in one place—fire marshals, building inspectors, regulators, etc.—and make sure we have a conversation about integrated policy and procedures.
2. Increase and expand communication.
- 3. Demonstration projects and collaboration.**
4. Share innovations and lessons learned across agencies.
5. Engage Boggs Center to establish continuity of training related to AT across DSPs.
6. Educate with an emphasis on natural supports.
7. Develop agency-wide technology plans based on end goals.
8. Ensure the technology is part of all systems, not just an add-on.

#### Statewide System

In order to address challenges/barriers at the system level, the following strategies were suggested:

- 1. Research funding systems/mechanisms/waivers used successfully in other states** (see Appendix D).
2. Build partnerships.
- 3. Get statewide leadership “at the same table” to align policies, practices, and incentives toward AT.**
- 4. Educate and engage lawmakers elected and appointed officials.**
- 5. Collaborate with and learn from other states.**
6. Bring in the private sector and private funding sources.
7. Collect data on costs, outcomes.
8. Study and report on outcomes at the individual and organizational level.
9. Explore *Olmsted* as a tool for change—is there a right to technology?

## Appendix A Attendees

Thomas Baffuto, *The Arc of NJ*  
Jeff Ballenger, Charles Lea Center  
Paul Blaustein, *Chairperson, NJCDD*  
Edyta Zak-Burns, *Eden Autism Services*  
Anthony Camuso, *Enable, Inc.*  
Kyoko Coco, *Family Support Coordinator, NJCDD*  
Brenda Considine, *Considine Communication Strategies*  
Ravi Dahiya, *YAI*  
Michael Decker, *Eden Autism Services*  
Nick Filarelli, *Core Services of Northeast Tennessee*  
Steve Gruzlovic, *DDLS*  
Jake Jones, *PILOT Services*  
Naomi Leibowitz, *Disability Rights New Jersey*  
Venessa Lombardo, *Advancing Opportunities*  
Leslie Long, *The Arc of Cape May*  
Linda Lucas, *The Arc of Essex*  
Andrew McGeady, *NJCDD Council Member*  
Colleen McLaughlin, *The Boggs Center*  
Gary Michman  
Rebekah Novemsky, *Family Support Liaison NJCDD*  
Kevin Nuñez, *Vice-Chairperson, NJCDD*  
Meghan O'Sullivan, *At Home Technologies*  
Richard Olson, *DRNJ Board*  
Nancy Price, *NJ Division of Developmental Disabilities*  
Jade Pollock, *New Jersey Perinatal Cooperative*  
Jason Ray, *Simply Home*  
Diane Riley, *Supportive Housing Association of NJ*  
Valerie Sellars, *NJACP*  
Racheal Tait, *Eden Autism*  
Deborah Wehrlen, *Housing Consultant*  
Mercedes Witowsky, *Executive Director, NJCDD*

## Appendix B Why it matters

When asked WHY the issue of AT for people with I/DD is important, attendees responded:

- Enabling technology can assist my son to have more control over his environment and his life, enhance his self-image, and increase his happiness
- To explore AT as a way to address the workforce crisis
- To see how we can help individuals live independently with technology, but ensuring we have the right supports in place to avoid/limit liability
- To advance creative innovation opportunity for quality of life
- Integration and inclusion
- Independence for individuals
- Recognizes that the DSP workforce shortage will never be adequately resolved; need to explore alternatives and technology as one critical part of the solution
- To determine better ways to foster independence
- To learn about impact of technology on the DD population
- Empowerment and choice
- Improve the lives of the individuals we serve
- Empowering every person to live their best life
- Make sure we are honoring what consumers want and listening to their dreams
- Help people with I/DD live their dream life
- See through the clouds so we can better serve our community
- Introduce or educate people on more technology
- Help with transfers
- Live the best life
- Make sure kids are introduced to tech
- Have tech well-funded
- Understand Tech – lack understanding leads to reliance on legacy system
- Don't focus on the barrier, focus on what needs to happen and how we can get there
- Address DSP workforce issues
- Increase independence and individual control
- Increased control
- Honor and listen to consumers
- Demonstrate impact, better serve our community
- Reduce waiting list
- Shift resources and become more efficient
- Level the playing field
- Deal with physical transfers

Appendix C

Letter from CMS on AT in Medicaid, May 2018



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAY 17 2018

Administrator  
Washington, DC 20201

The Honorable Donald M. Payne, Jr.  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Payne, Jr.:

Thank you for your letter supporting greater incorporation of technology in the delivery of services to people with disabilities under home and community-based service (HCBS) programs and in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). We agree that technology can play an important role in services for individuals with disabilities.

The Centers for Medicare & Medicaid Services (CMS) permits states to include electronic monitoring devices as “medical assistance” under their state Medicaid plans under section 1915(c) of the Social Security Act (1915(c) HCBS waivers) under the general category of assistive technology and/or environmental modification services. Ohio, Indiana, Maryland, West Virginia and Pennsylvania are several of the states where such services have been approved. CMS reviews a state’s proposal to use this technology as it would for other HCBS services under section 1915(c) of the Social Security Act (the Act). CMS may consider other emerging technologies as long as states provide adequate assurances in accordance with statutory requirements, such as they are cost effective, necessary to avoid institutional placement, and provided in a way that assures protection of the health and welfare of the individual.

With regard to the institutional option for individuals in these 1915(c) HCBS programs, if ICF-IIDs choose to supplement resident supervision with electronic monitoring, they must ensure that the monitoring is implemented in a manner that promotes health and safety. It also is important to avoid conflict with regulatory provisions designed to promote personal privacy and awareness of rights.

We recognize the need to deliver services in new and innovative ways based on the evolving availability of technology and the realities of the direct service worker shortages. Together with you and our state partners, CMS will strive for the right balance between innovation and accountability in the provision of needed services to Medicaid beneficiaries including the use of payment models such as shared savings where appropriate.

Thank you for sharing your thoughts. We look forward to continued conversations on ways to more effectively provide Medicaid services. In addition, CMS encourages providers who are interested in utilizing specific technologies to have discussions with their State Medicaid Agency on ways to move forward. If you would like to discuss this further, please contact our Office of Legislation at 202-690-8220. I also will provide this response to the co-signers of your letter.

Sincerely,  
  
Seema Verma

## Appendix D Funding

**The Center for Connected Health Policy has identified 22 state Medicaid programs** that provide reimbursement for remote patient monitoring (RPM) through tele health as of September 2019.

<https://www.cchpca.org/telehealth-policy/telehealth-medicaid-and-state-policy>

**Medicaid Becomes the First Third-Party Payer to Cover Passive Remote Monitoring for Home Care: Policy Analysis –**

A 2018 report from University of Washington, and published by the *Journal of Medical Internet Research*, a peer-reviewed journal for health and health care in the internet age.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5842322/>

**Waivers Across the Nation (State by State)**

<https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/state-resources-map>

**1915 (c ) Waivers by State**

<https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/1915-c-waivers-by-state>

**CMS Innovation Center:**

<https://innovation.cms.gov/>

### STATE-SPECIFIC MEDICAID WAIVERS

#### **Indiana Waiver**

<https://www.in.gov/medicaid/files/ddrs%20hcbs%20waivers.pdf>

Electronic Monitoring, page 82 –97 (CIH Waiver only)

Electronic Monitoring (surveillance system and on-site response) includes the provision of oversight and monitoring within the residential setting of adult waiver participants through offsite electronic surveillance. Also included is the provision of stand-by intervention staff prepared for prompt engagement with the participants and/or immediate deployment to the residential setting.

Personal emergency response system; page 106-107

Emergency Response System (PERS) is an electronic device that enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's telephone and programmed to signal a response center after a help button is activated. The response center is staffed by trained professionals.

#### **Minnesota Waiver**

Assistive Technology:

[https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_002426](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_002426)

Remote Supports - Individual Home:

[https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-298717](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-298717)

Remote supports- Supported Living:

[https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-298717](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-298717)

### New Jersey Waiver

AT on pages 88-90

<https://www.state.nj.us/humanservices/ddd/documents/community-care-program-policy-manual.pdf>

### New York Waiver

An Assistive Technological device may include an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or to improve the functional capabilities of the waiver participants. AT service is a service that directly assists a waiver participant in the selection, acquisition, or use of an assistive technology device. This service will only be approved when the requested equipment and supplies improve or maintain the waiver participant's level of independence, ability to access needed supports and services in the community or, maintain or improve the waiver participant's safety.

[https://www.health.ny.gov/facilities/long\\_term\\_care/waiver/nhtd\\_manual/section\\_06/assistive\\_technology.htm](https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/assistive_technology.htm)

### Ohio Waivers

OH Self Empowered Life Funding (SELF) (0877.R01.00) – Provides participant-directed homemaker/personal care, residential respite, participant-directed goods and services, participant/family stability assistance, support brokerage, **assistive technology**, career planning, clinical/therapeutic intervention, community inclusion, community respite, functional behavioral assessment, group employment support, habilitation - adult day support, habilitation - vocational habilitation, individual employment support, non-medical transportation, **remote supports**, transportation, waiver nursing delegation for individuals w/ID and DD ages 0 - no max age.

OH Level One (0380.R03.00) – Provides community respite, habilitation - adult day support, habilitation - vocational habilitation, homemaker/personal care, specialized medical equipment and supplies, **assistive technology**, career planning, environmental accessibility adaptations, group employment support, home delivered meals, individual employment support, informal respite, money management, non-medical transportation, participant-directed homemaker/personal care, **remote supports**, residential respite, transportation, waiver nursing delegation for individuals with ID/DD ages 0 - no max age.

<https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descriptor-Factsheet/OH-Waiver-Factsheet.html>

### Oregon Waiver

The Oregon 1915 (K) Waiver for Community First State Plan specifically covers backup systems to ensure the safety and well-being of individuals, electronic devices, and assistive technology to provide security and replace the need for direct interventions, allowing the individual to self-direct their own care and maximize independence.

<https://www.oregon.gov/DHS/SENIORS-DISABILITIES/KPLAN/Documents/1915-K-Option-State-Plan-Amendment.pdf>

### Wisconsin Waiver <https://www.dhs.wisconsin.gov/publications/p02256.pdf>

(HVBS Waiver/Children's long term supports program)

Assistive technology and communication aids are items, pieces of equipment, product systems, or services that increase, maintain, or improve functional capabilities of children at home, work, and in the community. The assistive technology and communication aids service directly assists the child or youth in the selection, acquisition, or use of an assistive technology device and/or communication aid. Allowable devices and services assist a child who has hearing, speech, communication, or vision impairments by increasing, maintaining, or improving the child's functional capabilities. The devices and services help the child to effectively communicate; decrease reliance on staff; increase personal safety; enhance independence; and improve social and emotional well-being

Adaptive aids (page 19); Assistive Technology and communication aids (page 27)

Personal Emergency response system

The personal emergency response system (PERS) service secures an immediate response and access to assistance in the event of a physical, emotional, or environmental emergency. A PERS uses a community-based telephonic, global positioning system, or other electronic communications device to provide a direct electronic communications link between the child or youth and emergency responders.

**Wisconsin Guide to Remote Electronic Support:**

<https://www.dhs.wisconsin.gov/publications/p0/p00692.pdf>



**Resources:**

Remote Support:

<https://shelbydd.org/remote-support/>