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Assessing Assistive Technology Service Delivery in the Ohio County Board of Developmental Disabilities System



OCALI

Report by the Assistive Technology &
Accessible Educational Materials Center
Ohio Center for Autism and Low Incidence

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Ohio
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Introduction

Evaluators from OCALI's (Ohio Center for Autism and Low Incidence) Assistive Technology and Accessible Educational Materials (AT & AEM) Center conducted a study of the 88 Ohio County Boards of Developmental Disabilities (CBDD) in order to gauge the system's capacity for providing assistive technology (AT) services and supports. This mixed method study consisted of two parts, 1) a survey of the 88 CBDD's current AT service delivery practices, and 2) interviews with five select CBDDs for the purpose of differentiating AT barriers and supports for high self-rated and low self-rated CBDDs. It was anticipated that high self-rated CBDDs would identify more AT supports and fewer barriers, thus indicating a higher capacity for AT service delivery and low self-rated CBDDs would report more barriers and fewer supports thus indicating a lower capacity for AT service delivery. The different but related questions addressed in the two parts of the study were:

- (Part 1: AT Survey) What is the self-reported prevalence of relevant practices for providing AT services and supports?
- (Part 1: AT Survey) What are the self-reported supports available within the CBDD system to allow for AT provision?
- (Part 2: Interviews) What are the commonalities in AT service provision of high-self-rated and low-self-rated county boards?
- (Part 2: Interviews) What are the differences in AT service provision of high-self-rated and low-self-rated county boards?

Methods

A statewide survey of CBDDs was the first part of a mixed method study of the practices that CBDDs use in their efforts to provide assistive technology (AT) supports and services to people with developmental disabilities. The second part of the study involved focus group interviews with staff, family members, community members, vendors, and individuals with disabilities. The focus groups consisted of CBDDs with high and low self-ratings of AT service delivery as determined through the survey administered in the first part of the study.

This section of the report describes the procedures the OCALI evaluators used to select participants, the instrument and procedures they used for collecting information from participants, and the methods they used to analyze the data. It concludes with a brief discussion of study limitations.

Part 1 – AT Survey

Participants

Four fact-finding sessions were conducted in collaboration with Arc of Ohio and Ohio Self-Determination Association-Project STIRS to help better understand the AT concerns of those providing and receiving AT services through the CBDDs. Additionally, an invited group of stakeholders participated in a final fact-finding session to review the findings of



other fact-finding sessions and to offer additional input. Participants in the fact-finding sessions included individuals with developmental disabilities, family members, direct service providers, administrators, and other relevant stakeholders. Efforts were made to include participants who represented ethnic, socioeconomic, and regional diversity across the state.

Instrumentation

The information obtained from the fact-finding sessions was reviewed and a survey was developed for CBDD superintendents with questions to determine their general knowledge of AT, as well as AT supports and practices. The survey questions developed were then vetted by the external evaluator who made minor revisions to the formatting and wording of items.

The final version of the survey instrument contained 16 questions including questions on demographics, general knowledge, assessment, implementation, and monitoring and evaluating AT use and supports such as training and funding (see Appendix for survey questions).

Data collection

The evaluation team used SurveyMonkey to disseminate the online survey and collect responses. A link was sent to CBDD superintendents on September 15, 2017. Follow-up requests were sent between 10/10/17 and 11/7/17. To facilitate responses, the evaluation team provided paper copies of the survey instrument to County Board staff members who requested it and conducted the survey via telephone survey for a few others. Surveys were completed from September 15, 2017 to November 7, 2017. Ninety-eight respondents participated, representing responses from all 88 counties.

Data analysis

The first step was to clean and organize the data. Data was then reviewed and further organized by the external evaluator. The external evaluator analyzed the data using the Statistical Package for the Social Sciences (SPSS)--one of several industry-standard software tools for performing statistical analyses of quantitative data. The evaluation team also recoded data from some questions using a midpoint split. For each of the 10-point scales, responses were divided into two groups, on either side of the midpoint (5.5) of the scale, scores between 1-5 and scores between 6-10. The percentage of participants falling within each group was then calculated. For the Likert scale questions, the responses were assigned a percentage for each group (strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree).

Limitations

A few limitations were noted related to the survey process and potential outcomes. There were more respondents than Ohio counties, indicating that some counties provided multiple responses. The selection of the respondent who completed the survey was at the discretion of each CBDD superintendent. As is common with survey



participation, some respondents dropped out and did not complete the survey, therefore the number of respondents (N) is noted for each question. When analyzing the data of 10-point scales, 2 groups were identified using a midpoint split of the scale. This midpoint split resulted in two 5-point scales which compared groups agreeing to those disagreeing. By using a midpoint split or by comparing agrees with disagrees, some details may be obscured. The reason to do so was to clarify results. Finally, the surveys were a self-assessment of knowledge and practices. When using a self-assessment, sometimes it is difficult for respondents to recognize what they may or may not know, particularly if they possess limited knowledge about the topic.

Part 2 – Focus Group Interviews

Participants

Following the collection of survey data via an online survey that was completed by staff at all 88 CBDDs, the OCALI evaluation team analyzed results. They constructed an omnibus score by summing responses to key survey items and positioned this score as an indicator of overall AT capacity. For the focus-group interviews, the team then selected three County Boards with high self-ratings and two Boards with low self-ratings. The five County Boards in the sample had AT capacity scores either in the top 15% or the bottom 15% of the sample. Selection was also attentive to geographic location within Ohio with selected CBDDs in the, northeast, northwest, and southwest parts of the state. Additionally, diversity in terms of race, culture, socioeconomic status, and first language of the individuals served by the five CBDDs was considered in the selection process.

The superintendents of the selected CBDDs were then asked to assemble a team of individuals to participate in the interview session with the OCALI evaluation team. Because of the nature of the CBDD interviews, purposive sampling was used since individuals participating in the interviews would need a strong knowledge of AT and the AT services within their CBDD. The samplings included CBDD staff members, parents, outside service providers, caregivers, vendors, and AT users. Teams ranged in size from two participants to 18 participants.

Instrumentation

The OCALI evaluation team developed an interview protocol with seven sets of questions focusing respectively on (1) basic processes for AT service provision, (2) AT teams, (3) AT assessment, (4) AT funding, (5) AT training, (6) administrative support and outside agencies, and (7) AT implementation. The verbatim wording of all questions is presented below in the findings section of the report.

Data collection

Two OCALI evaluators conducted focus-group interviews on-site at the offices of the five County Boards selected to participate in this part of the study. At each site, from two to 18 participants engaged in interviews. The evaluators posed each question, allowed



participants to respond, and recorded their responses using Google Docs. Interviews lasted from 60 to 120 minutes. Participants responded enthusiastically to the questions and a great deal of information was gathered at each site. Only one of the groups had a fairly large number of participants which made it a bit more challenging for all members to fully participate. If members of that specific group did not respond to a question they were prompted to respond.

Data analysis

Two members of the OCALI evaluation team analyzed the data by carefully reviewing responses to each question. Simple content analysis was used to categorize information by topic from the responses gathered from all five County Boards. The team also calculated the frequency of responses within each category as noted in the “Frequency All” columns in the tables below (i.e., Tables 1-28). Additionally, the evaluators used the responses in the various categories to perform subgroup frequency counts within those categories for both the self-reported high- and the self-reported low-scoring counties. These data are presented in the “Frequency High Group” and “Frequency Low Group” columns within the tables.

Limitations

Focus-group interviews provide an efficient way to collect information from several people at one time. They also have notable limitations. Typically, the people interviewed in focus groups comprise a sample, but they are not necessarily representative of the larger group from which they are selected. Focus group interviews may also intimidate some members, especially shy or introverted ones, while giving other members, especially assertive or extroverted ones, an opportunity to dominate the discussion. Sometimes people who are interviewed in focus groups try to figure out what the interviewers are hoping to hear and respond accordingly—a circumstance leading to social desirability bias.

Possible biases observed by OCALI interviewers are as follows. Some teams spoke more frequently, enthusiastically, and spontaneously about their successes, and spoke with greater reluctance about barriers and challenges to service delivery. This circumstance may have occurred as the result of the respondents’ interest in supplying socially desirable responses—that is, responses showcasing their strengths while minimizing their shortcomings. When interviewers suspected this was occurring they encouraged more complete responses, by using questions and deeper probes as well as allowing adequate time for participants to share their thoughts about the barriers that impacted their AT service delivery.

During the interviews, the same questions from the same set of interviewers were provided at each of the sites, however, this may have created some unintended challenges. It became apparent that responses from at least one CBDD were impacted by their somewhat limited understanding of AT, thus allowing them to self-report



positive results which may not be perceived as such positive responses when viewed through a larger lens and a more all-encompassing definition of AT.

Findings – Part 1 – AT Survey

GENERAL INFORMATION

- 1. For which County Board do you work?**
- 2. Which term best describes your role?**

The first two survey questions were demographic questions asking which county the individual worked for and their background or role within the agency. All 88 counties responded although some did not complete the entire survey. The survey was sent to superintendents of the 88 CBDDs, but over half passed it on to a representative from their county for survey completion. The role of the individuals who completed the survey are shown in Table 1 below.

Table 1
CBDD Staff Role

Superintendent	49%
County Board Staff Member	27%
Other	18%
Speech Language Pathologist	2%
Occupational Therapist	2%
AT Specialist	2%

AWARENESS, ELIGIBILITY, AND ASSESSMENT

Survey questions 3-6 addressed AT awareness, eligibility, and assessment.

- 3. On a 1 to 10 scale, how well do you think your County Board handles dissemination of information about assistive technology (AT)? (N=91)**

Using a 10-point scale, this question asked about how well the County Board disseminates information about AT. The instructions indicated a range from “very badly” which was the lowest rating (1) to “very well” which was the highest rating (10). A little over half of the respondents (52%) indicated they do not do well at distributing information about AT to those they serve.

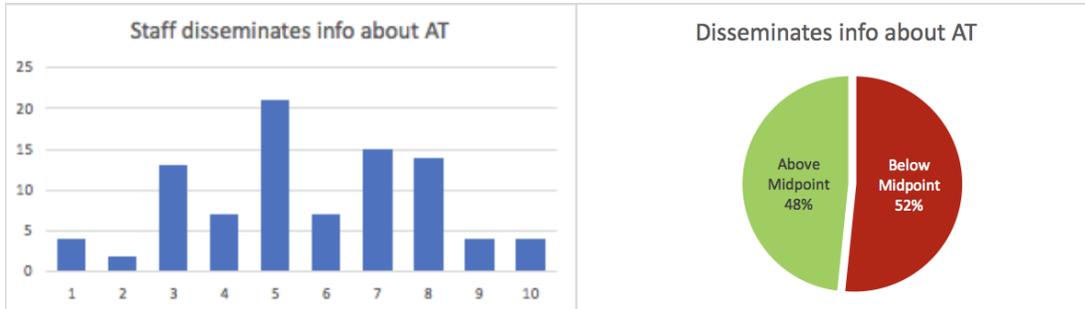


Figure 1. Staff Disseminates Info About AT.

4. On a 1 to 10 scale, how knowledgeable are your County Board’s staff members about AT? (N = 91)

Of the respondents surveyed 55% of the counties reported their staff members were fairly knowledgeable about AT, thus scoring within the 6-10 range. Forty-five percent (45%) of the respondents scored in the lower group (1-5-range). None of the respondents indicated their staff had no knowledge of AT.

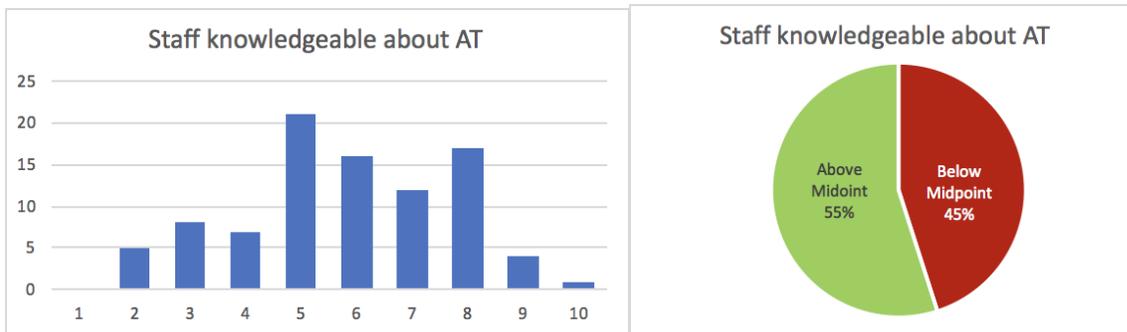


Figure 2. Staff Knowledgeable About AT.

5. Please indicate your level of agreement with the following statements:

The County Board disseminates promotional materials about AT.

As shown in Figure 3, half of the respondents felt that the County Board does disseminate information about AT. However, approximately 30% felt that the County Board does not disseminate information about AT and 18% did not know if materials were distributed, likely indicating they did not distribute information about AT.

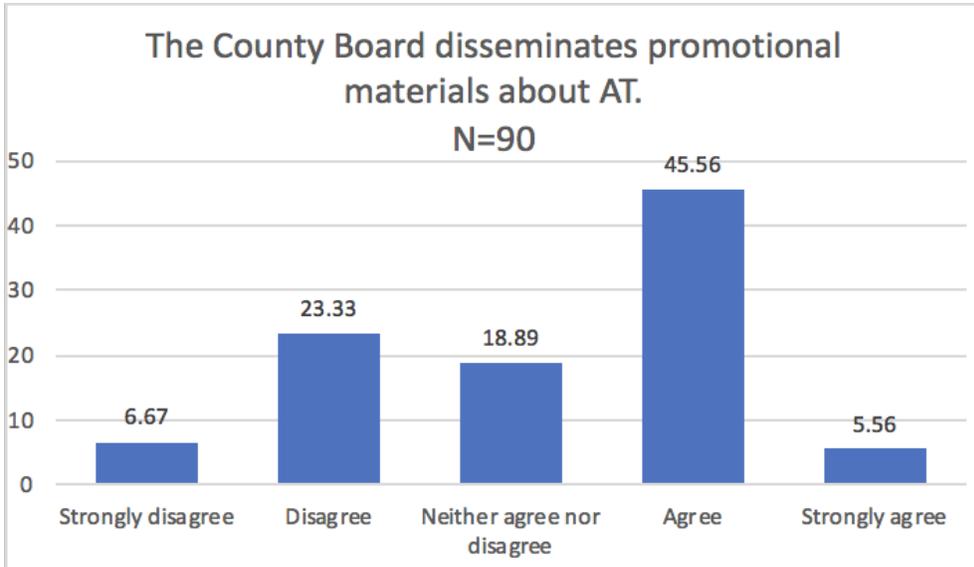


Figure 3. County Board Disseminates Promotional Materials About AT.

Staff members are aware of a wide variety of AT options.

Comparing responses in Figure 4, the data shows that the majority of the respondents (57%) felt that their staff members were aware of a wide variety of AT options. However, 23% either disagreed or strongly disagreed indicating their confidence in their staff's awareness of the wide variety of AT may be limited. Another 20% responded with neither agree nor disagree which may indicate they too are unaware of the wide range of AT options available.

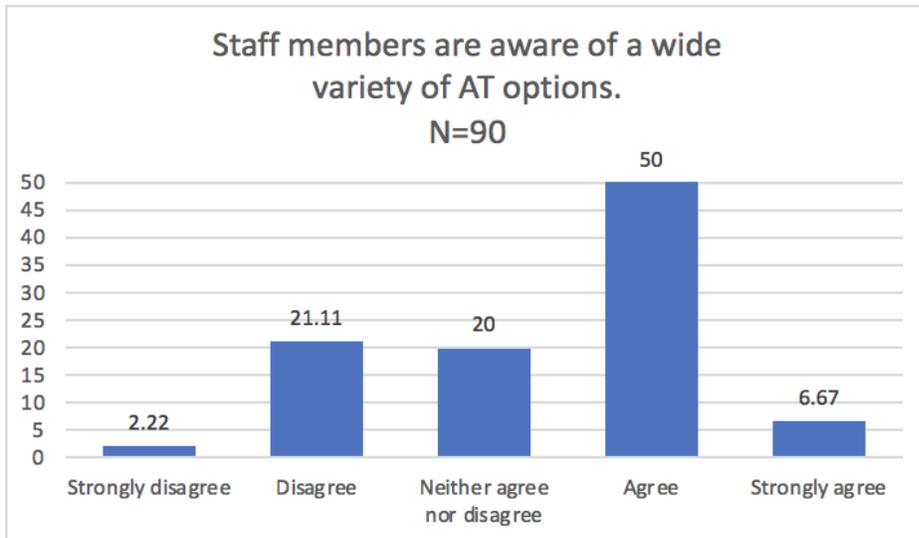


Figure 4. Staff Members Aware of AT Options.

Staff members know when an individual is a good candidate for AT.

As seen in Figure 5, because 46% of the respondents either disagreed or said they neither agree nor disagree in response to this question, it becomes apparent that slightly less than half of the CBDDs indicated their staff was unsure about identifying good candidates for AT use.

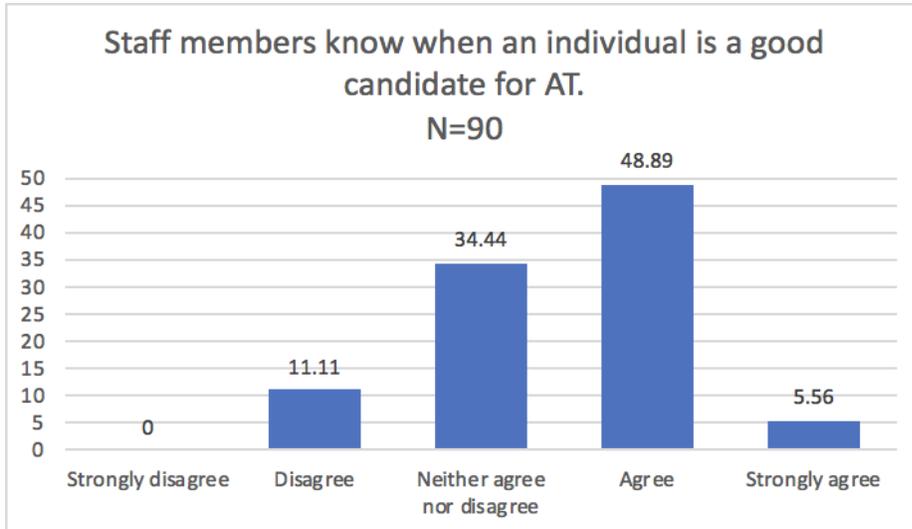


Figure 5. Staff Members Know Good Candidates for AT.

Assessment of all individuals served by the County Board of DD includes consideration of AT options.

This question asks if AT is being considered for all consumers who receive some sort of assessment through the CBDD system. Slightly less than half (49%) feel as if AT is being considered for all consumers (agree/strongly agree) whereas 24% indicated that AT is not being considered for all consumers (disagree/strongly disagree). Twenty-seven percent (27%) were unable to respond in agreement or disagreement to the statement.

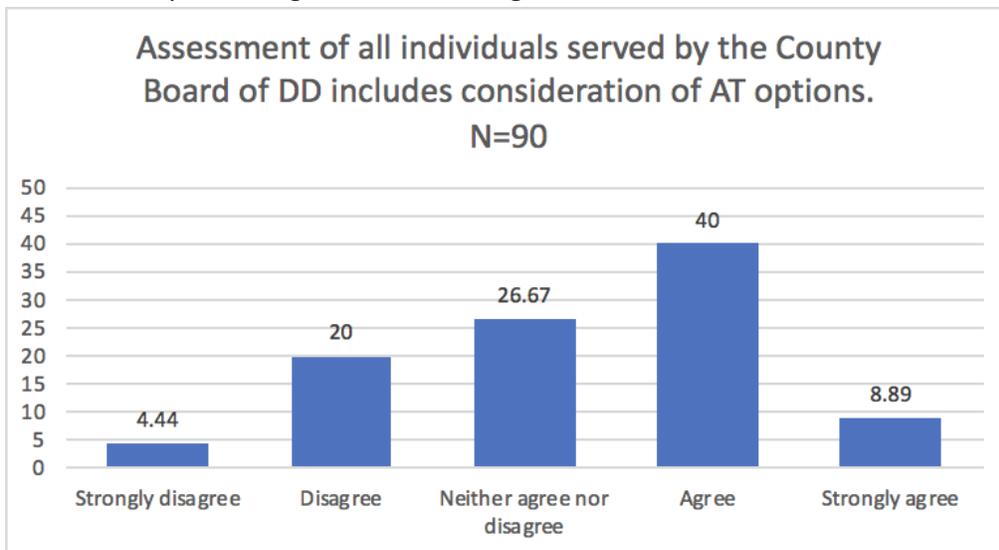


Figure 6. Assessment Includes Consideration of AT Options.

The County Board has a formal process for AT assessment.

Figure 7 shows that disagree/strongly disagree responses are greater (37%) than the agree/strongly agree responses (29%). This data indicates that less than 1/3 of the CBDDs responding to the survey utilize a formal process for AT assessment.

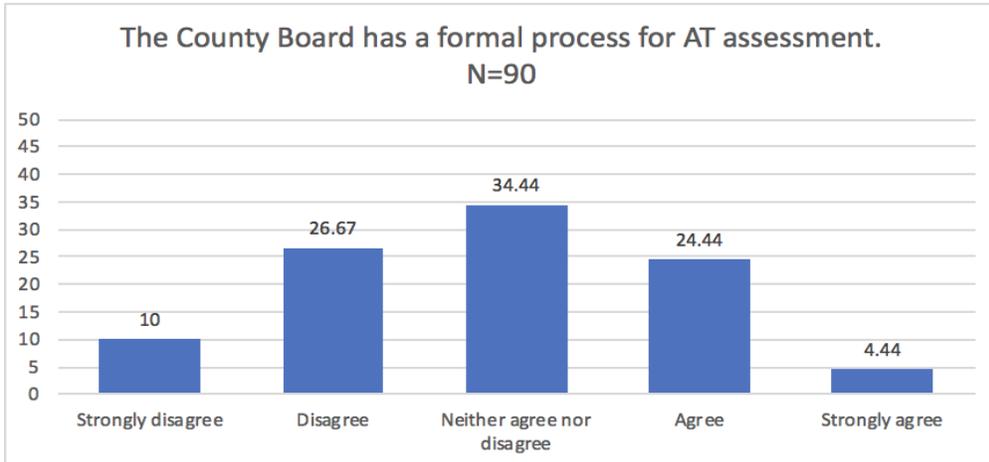


Figure 7. Formal Process for AT Assessment.

A team approach is used when making decisions about AT.

Figure 8 shows that the agree/strongly agree responses are much greater (74%) than the disagree/strongly disagree responses (7%). This strongly indicates that a team approach is being used to make decisions about AT at the majority of CBDDs surveyed.

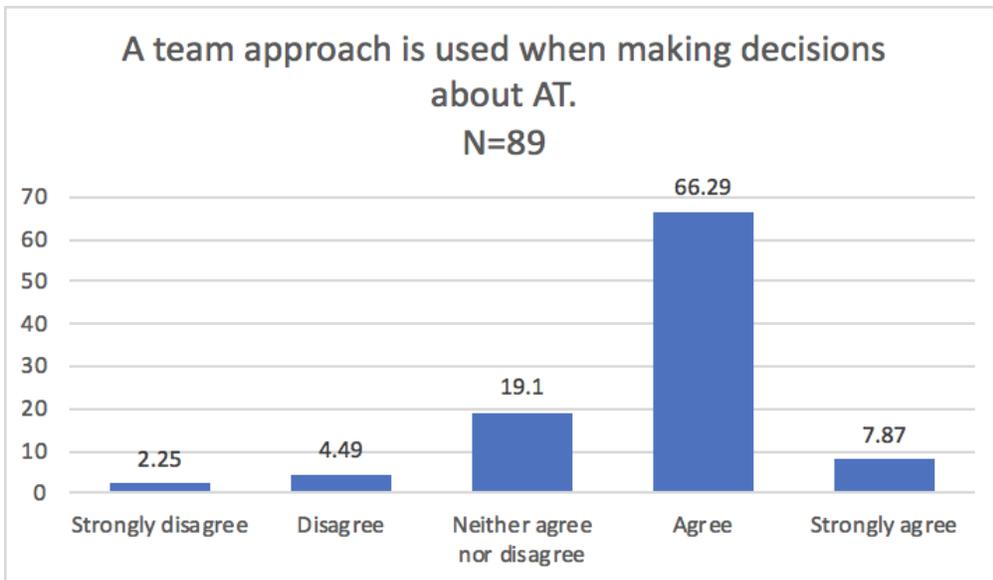


Figure 8. Team Approach Used for AT Decision.

AT trials are provided prior to purchase.

In response to this question, 34% felt that AT trials are being provided prior to purchase and 26% felt that AT trials were not happening prior to purchase. Only approximately 1/3 of the CBDDs surveyed are employing this aspect of the AT assessment process.

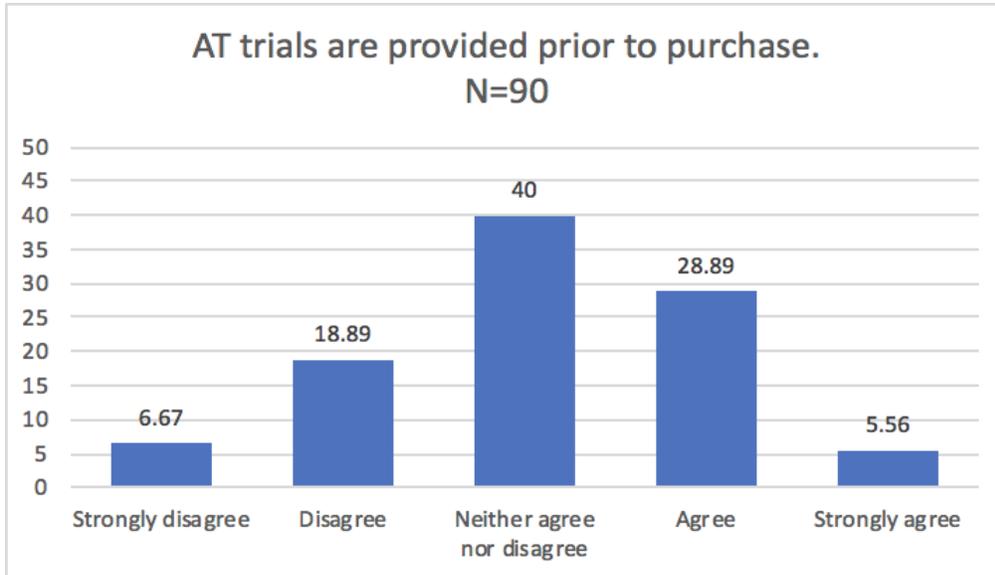


Figure 9. AT Trials Provided Prior to Purchase.

AT recommendations include a range of AT features.

Twenty-one percent (21%) feel that the AT recommendations being generated do not include a wide range of AT features and 38% feel that AT recommendations generated do include a range of AT features. It is noteworthy that 41% of the respondents responded neither agree nor disagree.

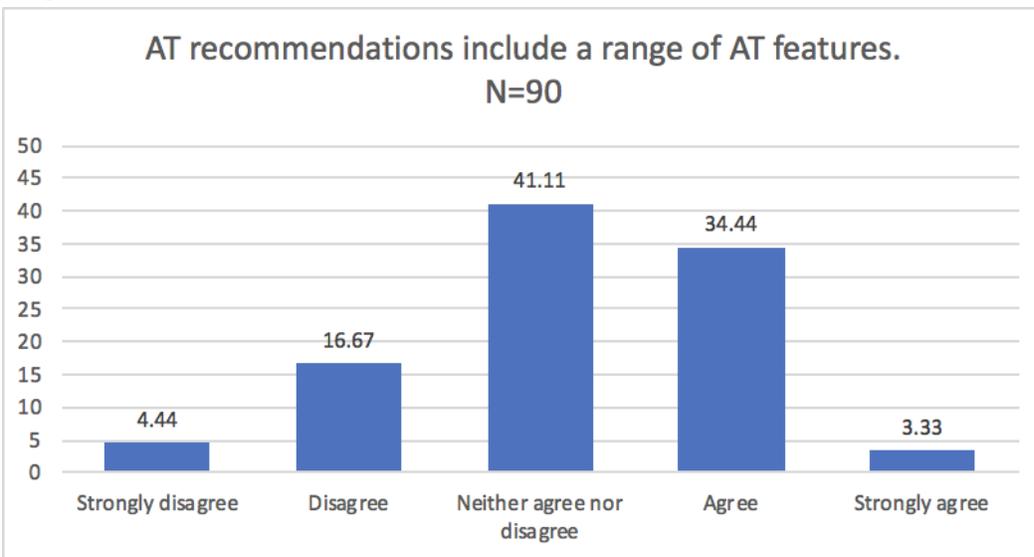


Figure 10. AT Recommendations Include a Range of AT Features.

6. Which of the following factors do AT assessment teams typically consider?

- **The individual's strengths and needs**
- **The environments in which the individual lives, attends school and/or works**
- **The individual's previous use of AT**
- **The tasks the individual wishes to accomplish with the use of AT**
- **The individual's personal preferences**



- **Family member’s perspectives**
- **The individual’s culture and customs**

For this question, the respondents were asked to select “yes” or “no” for each statement. This question considered the CBDD perceptions of the factors assessment teams should consider during the AT assessment process. Overall, it is apparent that the vast majority of CBDDs believe that AT assessment teams should consider all of the following factors. However, previous use of AT and culture and customs are the areas that are most often not considered. The responses to each statement are shown in the Figure 11 below.

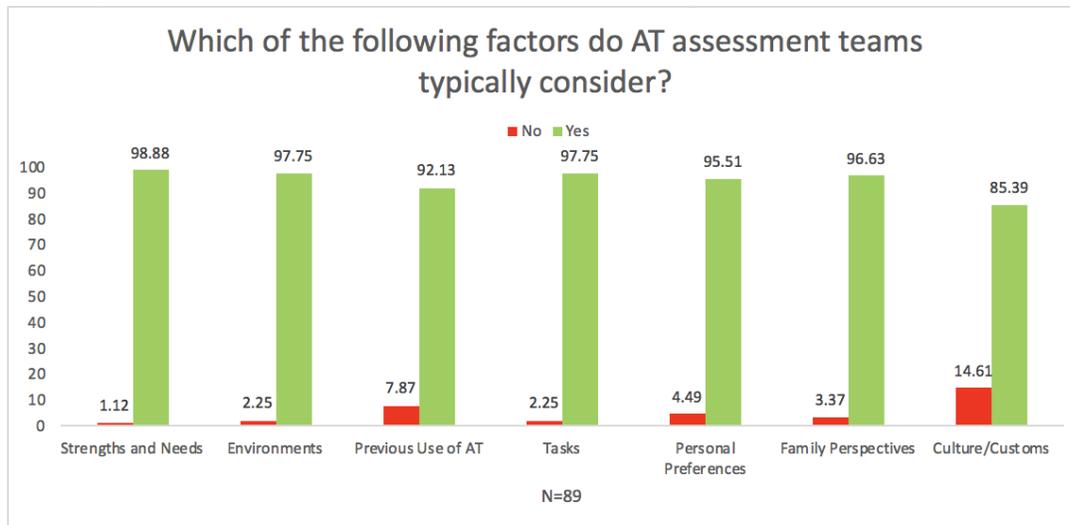


Figure 11. Factors Considered by AT Assessment Teams.

IMPLEMENTATION

Questions 7-10 addressed AT implementation planning and AT implementation.

- 7. On a 1 to 10 scale, how well do you think your County Board handles planning for AT implementation? Give the lowest rating if your County Board does not plan for AT implementation. (N=89)**

Questions 7 and 8 are similar, but question 7 asks if the County Board plans for AT implementation and then question 8 asks about the actual AT implementation process. Grouping the responses in to a lower half range (scores between 1-5) and an upper half range (scores between 6-10) we can see that the groupings are fairly similar: 44% in the upper half range and 56% in the lower half range. More than ½ of the responses fell within the lower half range, thus indicating that many CBDDs need further assistance in planning for AT implementation.

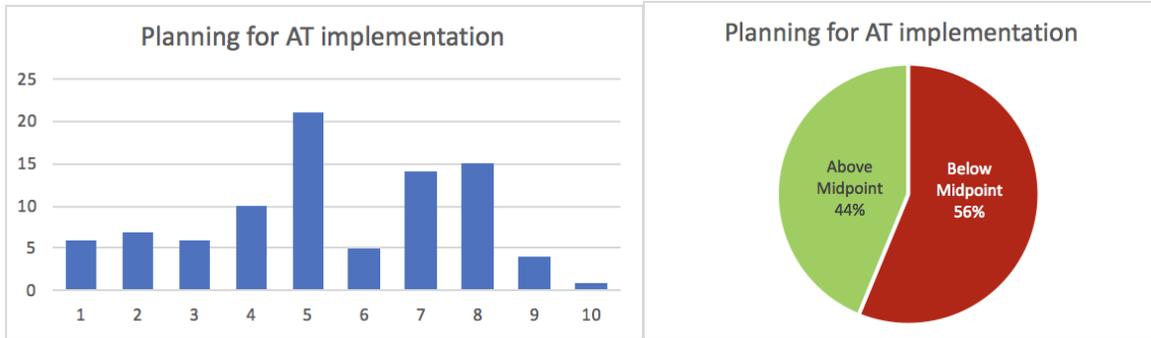


Figure 12. Planning for AT Implementation.

8. On a 1 to 10 scale, how well do you think your County Board handles AT implementation? Give the lowest rating if your County Board does not implement AT. (N=89)

Comparing these graphs to those in Figure 12, a slight increase in the upper half responses (scores between 6-10) is seen. This implies that the CBDDs are doing a slightly better job at actual AT implementation than planning for AT implementation, however, there are still 49% of the CBDDs who did not indicate confidence in their AT implementation skills.

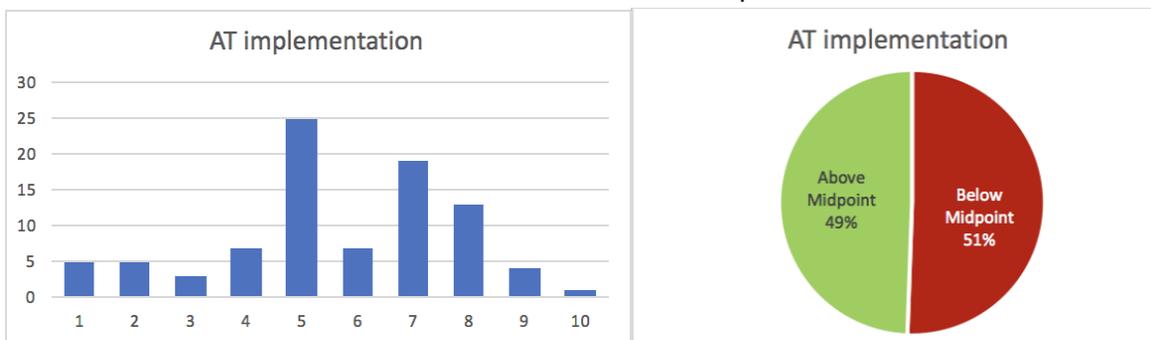


Figure 13. AT Implementation.

9. Which of the following issues are addressed in the AT implementation plan?

- **Outcomes to use as benchmarks of the effectiveness of the individual's AT use**
- **Considerations about how the device will be financed**
- **Determinations about who will train the individual using the AT**
- **Determinations about who will follow-up to ensure the individual is using the AT effectively**
- **How personally owned AT will be integrated into the overall set of supports provided to the individual**

For this question, the respondents were asked to select “yes” or “no” for each statement. The responses to each statement are shown in Figure 14. On the whole, those who are using AT seem to be incorporating many aspects of AT implementation. The weakest area is the use of outcomes as benchmarks of the effectiveness of the individual's use of AT. Identifying specific individuals for follow-up is another area that is commonly overlooked. The other aspects of AT



implementation were heavily weighted toward “yes” responses and are summarized below.

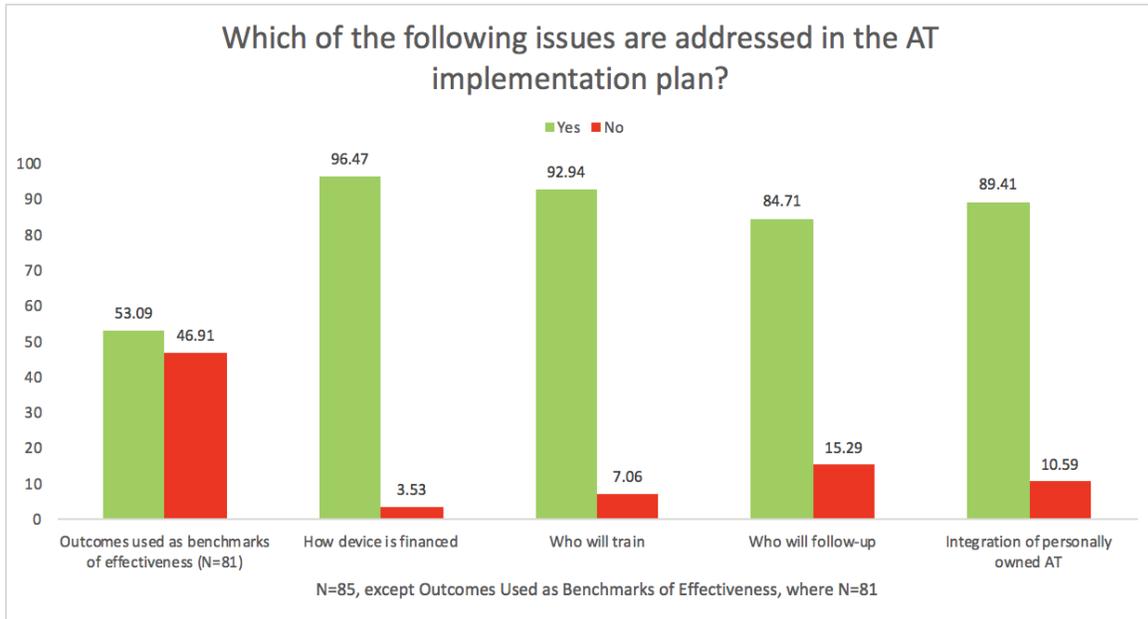


Figure 14. Issues Addressed in the AT Implementation Plan.

10. Please indicate your level of agreement with the following statements.

County Board staff assist individuals in the use of AT to achieve identified outcomes.

Sixty-three percent (63%) of the respondents feel their staff does assist individuals in the use of their AT to achieve identified outcomes. However, earlier it was noted that some CBDDs are not identifying the task that needs to be accomplished and some are not using outcomes as benchmarks for AT effectiveness upon implementation. Therefore, some of the disagree/strongly disagree responses here may be a result of the lack of tasks or outcomes being identified.

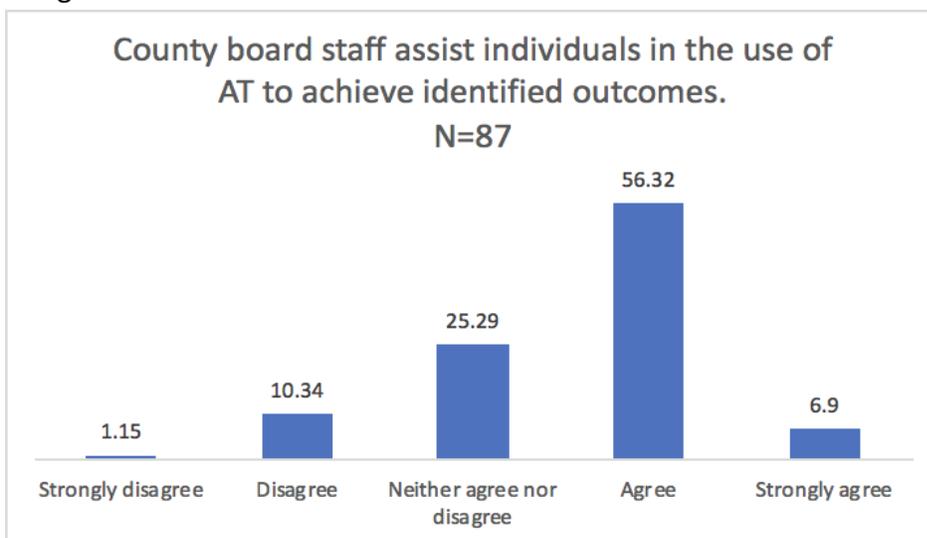


Figure 15. Individuals Assisted in Use of AT to Achieve Identified Outcomes.



County Board staff collaborates with other agencies and professionals to address challenges that limit an individual's use of AT.

The vast majority of CBDDs responding felt that they do collaborate (71%) with other agencies and professionals to address challenges of their consumer's AT use. Only 11% felt their staff did not collaborate with others as indicated in Figure 16.

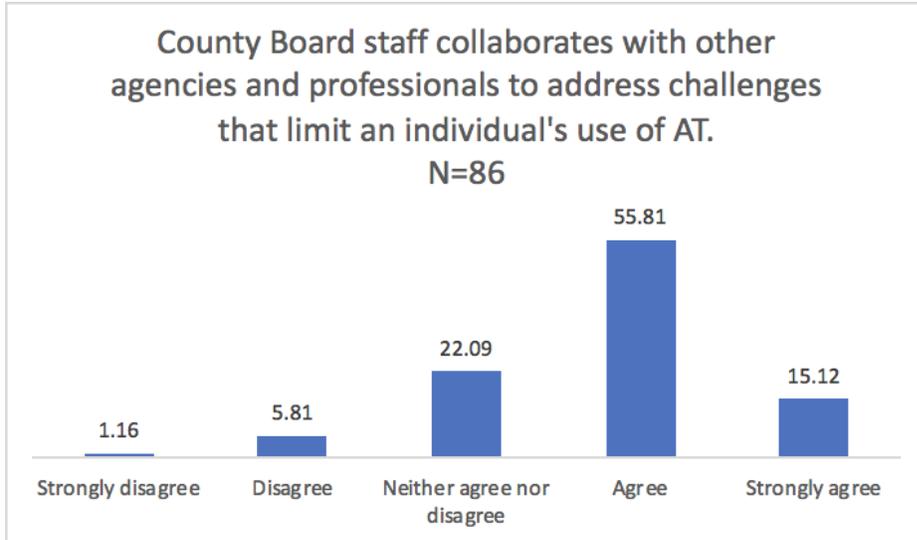


Figure 16. Collaborate with Other Agencies and Professionals to Address Challenges.

The County Board provides information about device maintenance and repairs (e.g. to individuals, families and caregivers).

There were a greater number of favorable responses (52%) than unfavorable responses (21%). But this data also indicates that at least 21% and perhaps up to 48% (combining the responses from disagree/strongly disagree and neither agree nor disagree) feel that the CBDD does not provide information about maintenance and repairs for AT equipment.

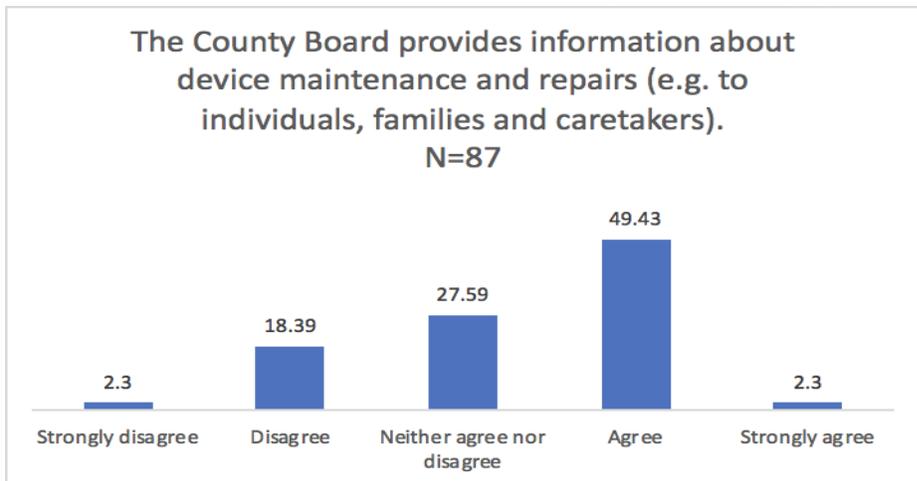


Figure 17. Provides Information About Device Maintenance and Repairs.



The County Board makes a backup system available when an AT device goes in for repair.

The responses were slightly weighted toward those who feel backup systems are not provided (36%) vs. those who feel that backup AT devices are provided (24%) when devices go in for repair. Also to note, the majority of those responding did not have an opinion about whether the Board provides a backup system (neither agree nor disagree: 40%) perhaps indicating that they do not know if that is happening.

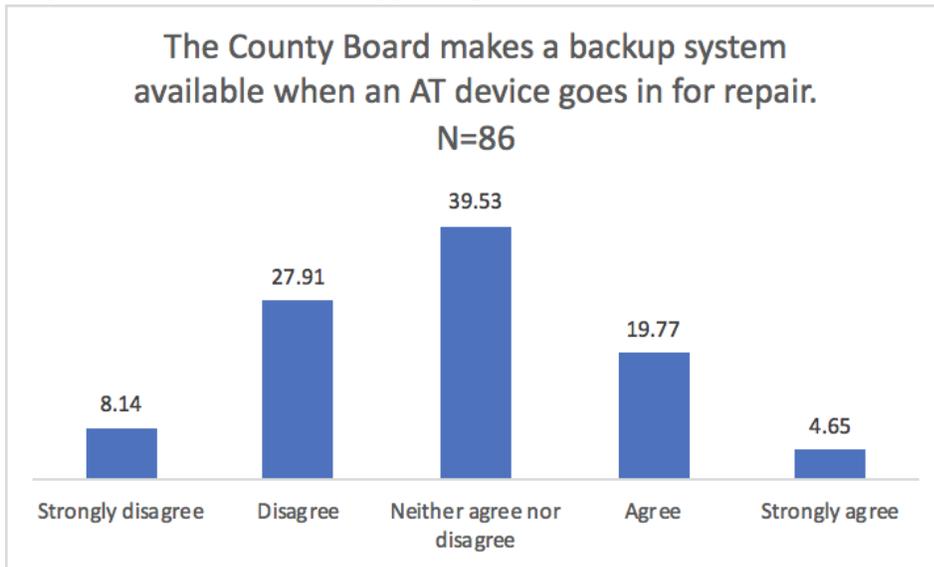


Figure 18. A Backup System is Available During AT Repair.

The County Board quickly addresses barriers to AT use.

Figure 19 shows that the majority of the respondents feel the County Board is quickly addressing barriers to AT use (41% vs. 21%). Again, there was a large response for neither agree nor disagree (38%) which may indicate that the responder was unsure of whether barriers are being addressed or it could also mean that the barriers are being addressed, just not quickly.

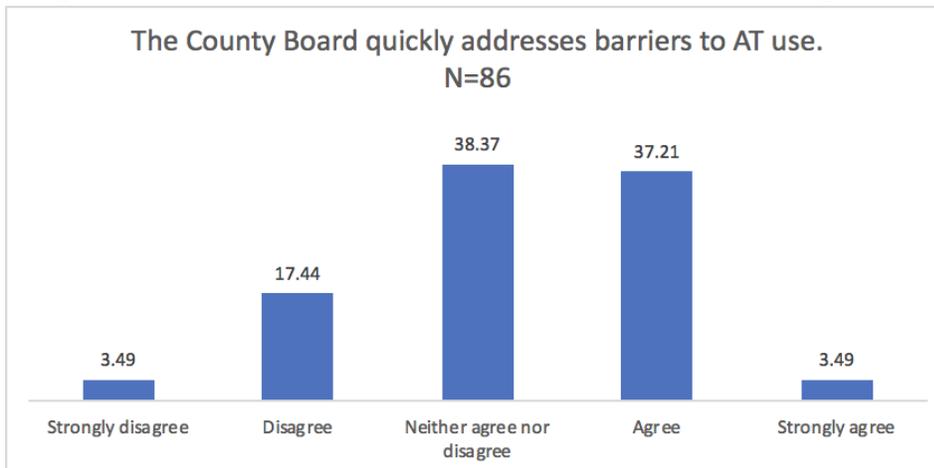


Figure 19. Barriers to AT Use Are Addressed.



**11. On a 1 to 10 scale, how effective is your County Board's system for evaluating AT use?
Give the lowest rating if your County Board does not evaluate AT at all. (N=86)**

This question speaks to the follow-up and follow-along aspect of the AT assessment process where the individual's use of AT is checked periodically to see if it is still meeting the needs of the individual or if changes have occurred and modifications or a reevaluation are needed. Fifty-eight percent (58%) of the responses fell within the lower half range (scores between 1-5) suggesting that the CBDD is not very effective in their efforts to evaluate AT use.

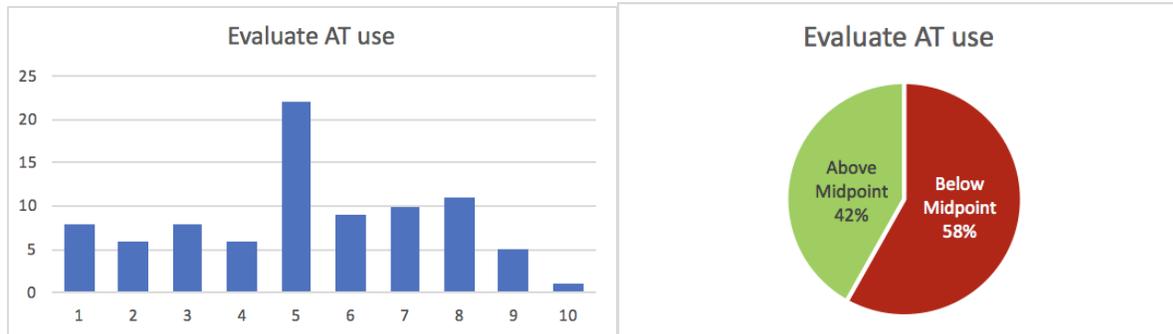


Figure 20. Evaluate AT Use.

12. Which AT evaluation strategies does your County Board routinely use?

- **Checking periodically to determine if the AT is meeting the individual's needs**
- **Providing a re-evaluation if there are changes to an individual's needs or circumstances**
- **Keeping track of data about the effectiveness of AT use**
- **Modifying implementation in response to data about the effectiveness of AT use**
- **Sharing information about the effectiveness of AT use with the individuals who are using the AT**
- **Sharing information about the effectiveness of AT use with other stakeholders (e.g. County Board staff, families, staff from other agencies)**

For this question, the respondents were asked to select "yes" or "no" for each statement. Although many best practice evaluation strategies are being used in the CBDD system, Figure 21 shows weakness in the area of tracking data to show effectiveness of AT provided and also modifying the implementation plan based on data about the effectiveness of use. The individual responses to each statement are shown below.

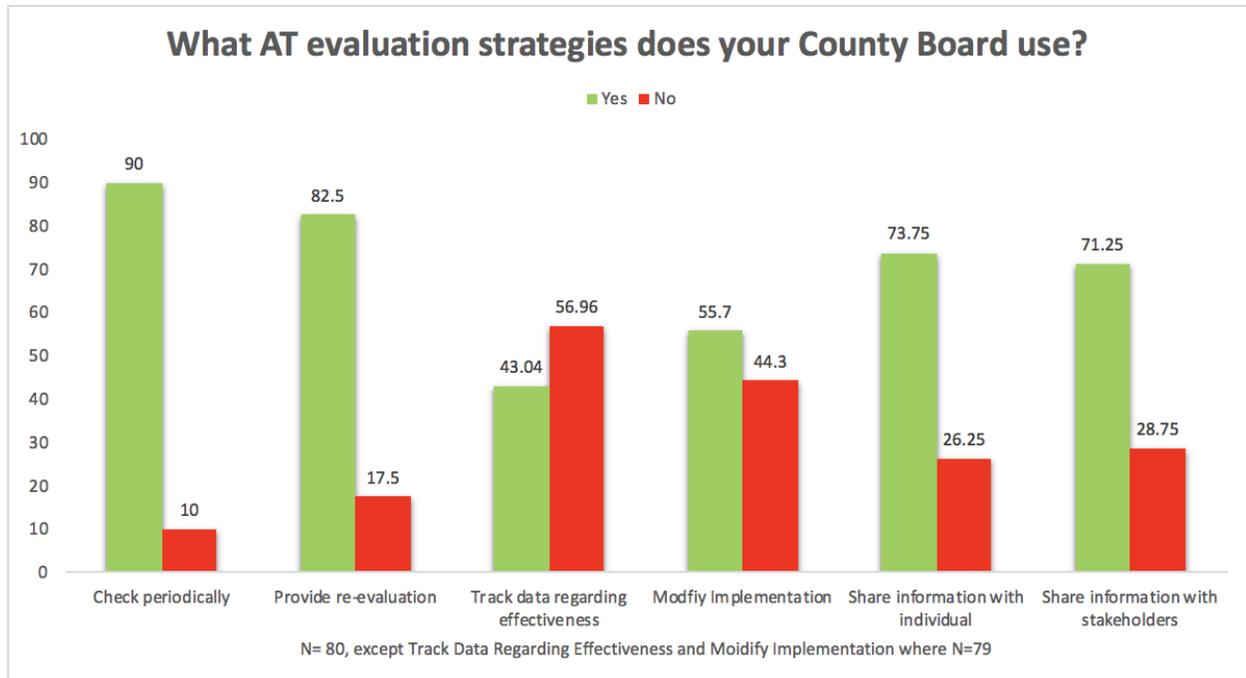


Figure 21. Evaluation Strategies.

13. High quality training provides a sufficient amount of relevant instruction to all involved stakeholders. Using a 1 to 10 scale, please rate the effectiveness of the AT training your County Board provides. Give the lowest rating if your County Board does not provide AT training. (N=84)

This question seeks to determine the effectiveness of AT training being provided by the CBDD. The scale ranged from 1 = “low quality” to 10 = “high quality”. The highest frequency response was a “1” which indicates the effectiveness of the AT training is “low quality” or the CBDD is not providing AT training. Further analysis indicated that 67% of the responses fell within the lower half range (scores between 1-5) and only 33% fell within the upper half range (scores between 6-10).

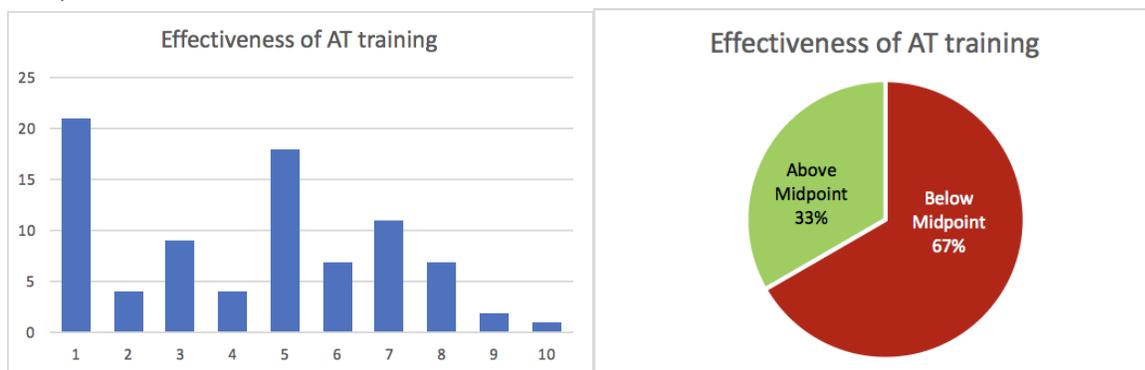


Figure 22. Effectiveness of AT Training.



14. An efficient AT funding system draws on all available sources of support (e.g. public funds, private funds, donations) to provide the highest quality AT to clients. It is staffed by personnel who know how to access funds from the full range of sources. Using a 1 to 10 scale, please rate the efficiency of your County Board's AT funding system. (N=84)

Forty-six percent (46%) of the responses fell within the upper half range (scores between 6-10) and 54% fell within the lower half range (scores between 1-5) with the greatest frequency occurring at number 5. This data shows the responses are fairly equally distributed with a slightly higher weight given to the lower half responses indicating that the County Board does not always offer an efficient funding system to provide high quality AT for individuals served by the CBDD.

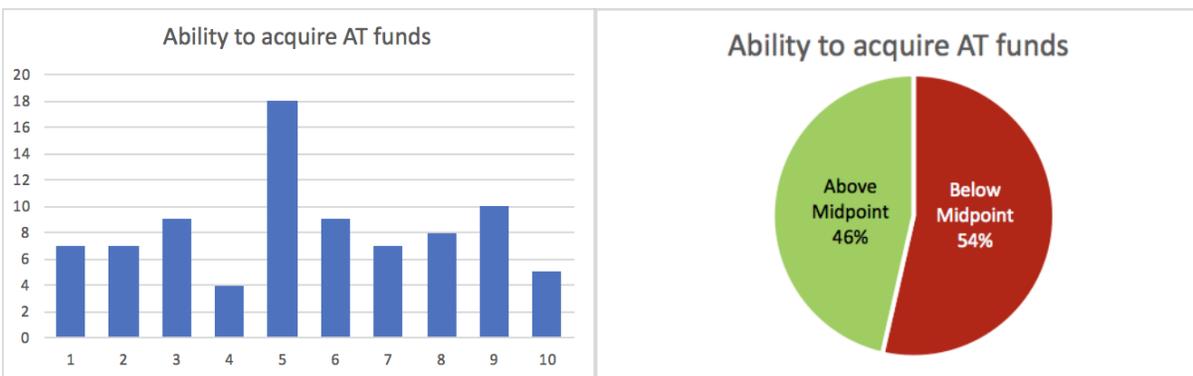


Figure 23. Ability to Acquire AT Funds.

15. AT is central to the mission of a County Board if the Board (1) has written guidelines for accessing and providing AT services that are broadly disseminated and that are followed by all staff members, (2) employs personnel with competencies needed to support quality AT service, and (3) includes AT supports and services in the technology planning and budgeting process. Using a 1 to 10 scale, please rate the extent to which AT is critical to the mission of your County Board. (N=84)

Unfortunately, the results from this question indicate low responses with 70% falling within the lower half range (scores between 1-5) and only 30% within the upper half range (scores between 6-10). Question 15 is overarching question that focuses on the culture and mission of the agency and how embedded AT services and supports are within the entire system framework. It is also a multifaceted question with many parts so perhaps a lower score may be indicated if not all of the variables were true.

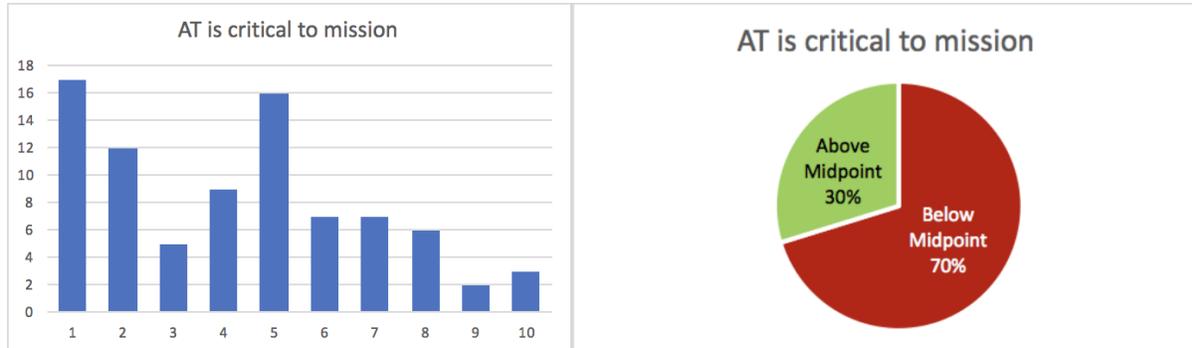


Figure 24. AT is Critical to Mission.

16. Do you know of AT lending libraries in your area? If so, please provide names and contact information. (N=61)

This final question was an open-ended question used to collect data for the “Identification of Assistive Technology Lending Programs in Ohio” a DD Council grant being implemented concurrently with this grant. The purpose of the question was to locate AT lending libraries across the state that could be surveyed for the other grant. Responses included 19 unique entries of AT lending libraries in Ohio. This information was transferred to the list of lending programs developed for the Lending Programs grant if the agency’s ability to provide AT loans could be verified.

Summary of AT Survey Findings

Summary – Part 1 – AT Survey

Part 1 of this project set forth to answer the following questions:

- (Part 1: AT Survey) What is the self-reported prevalence of relevant practices for providing AT services and supports?
- (Part 1: AT Survey) What are the self-reported supports available within the CBDD system to allow for AT provision?

What is the self-reported prevalence of relevant practices for providing AT services and supports?

To determine the extent to which certain AT practices are being employed, specific questions about the AT assessment process including AT consideration, decision-making, equipment trials, implementation, and follow-up were asked.

On a positive note, the majority of County Boards reported using a team approach to make AT related decisions and most have a good understanding of the best practice components of the AT assessment process.

Only 1/3 of the CBDDs indicated they are using a formal process for AT assessment. Within the AT



assessment process, less than ½ of the County Boards responded that they are considering a range of AT options when making AT decisions. Less than ⅓ of the County Boards mentioned that AT trials are being provided prior to purchase. Only ½ of the County Boards reported effective implementation strategies and even more (58%) feel they are not evaluating the individual’s use of AT once it is in place.

What are the self-reported supports available within the CBDD system to allow for AT provision?

The CBDDs provided a variety of supports to allow for AT provision, which included disseminating information and promotional materials about AT, providing training time to help staff become more knowledgeable about AT and learn about AT options, and securing a variety of funding sources to acquire AT. In most cases, over half of the CBDDs were able to provide these supports for the provision of AT.

To a lesser degree, only about 30% of the CBDDs were able to provide effective training opportunities for their staff and place AT critical to the mission of their agency by providing written guidelines or policies related to AT, hiring personnel with AT competencies, and including AT in the planning and budgeting of the CBDD.

Findings – Part 2 – Focus Group Interviews

This section reviews the responses from the face-to-face interviews with the five selected CBDDs.

BASIC PROCESSES

The first set of questions to which focus-group participants responded were related to basic processes. The overarching prompt asked participants to describe the AT process at their County Board. The interviewers used six questions to learn more about these basic processes. Categorized responses to each of these questions are discussed below.

1. How do you define AT? Provide some examples of AT used in your agency/region.

This question asked for two kinds of information—general definitions of AT and specific examples of AT used in the region served by each County Board. Definitions of AT differed somewhat across the five responding County Boards. In two of the definitions, a staff member talked about AT in terms of its role in giving individuals with disabilities greater access to what is going on in their environments and communities. One definition elaborated on how AT gives individuals with disabilities greater access within their homes. Two of the Boards offered the formal definition of AT as defined by Individuals with Disabilities Education Improvement Act (IDEA). Another idea shared related to the way AT can be used to expand communication possibilities and access to the curriculum and included specific applications in the school



environment. Staff members from two high self-rated counties appeared knowledgeable about the breadth and scope of AT and had a good understanding of the legal definition of AT according to both the Tech Act and IDEA. Staff members from one county identified with a high self-rating seemed to focus their definition of AT on home modifications and supports for independent living. Staff members from the low self-rated counties had a more limited understanding of the definition of AT, often with a fairly narrow focus related to functional performance in just a few domains (e.g. communication, curriculum, etc.) and did not mention the legal definition.

The second part of the question asked about illustrative types of AT. Respondents offered many ideas in response to this part of the question. A categorized list of their ideas is presented in Table 2 below, along with Frequency Counts showing how many times a device category was mentioned. One column lists frequencies for all respondents, another lists frequencies for the County Boards with high self-ratings, and a third column lists frequencies for the County Boards with low self-ratings. The high self-rated group suggested a wider range of AT tools (33 unique devices) than the low self-rated group (14 unique devices); a little more than a 2:1 ratio. Additionally, the devices most frequently identified by teams with low self-ratings were subsumed in the category of communication devices and supports.

These responses support that staff from the high self-rated County Boards tended to be able to generate more (and a wider variety of) examples of AT than those in the low self-rated County Boards. Furthermore, the types of AT identified among the low self-rated group are primarily in the areas of communication devices, mobility and positioning aids, curriculum supports, and sensory supports whereas the types of AT identified by the high self-rated group included some of those items but also the type of AT seen in independent living environments such as home adaptations (automated doorbells and garage door openers, home assistants such as Google Home and Amazon Echo) which are often geared toward the adult population.

Table 2
Illustrative AT Devices

Device	Frequency All	Frequency High Group	Frequency Low Group
Home Adaptations	11	11	0
Communication Devices and Supports	10	3	7
Technology Access (i.e. computers, mobile devices, AAC)	7	6	1
Mobile Devices/Apps	6	5	1
ADLs	5	5	0
Time/Organization Aids	3	3	0



Home Assistants (Google Home, Echo)	2	2	0
Positioning Aids	2	0	2
School/Curriculum-Based	2	0	2
Sensory Aids	2	0	2
Mobility Aids	1	0	1
Vision Aids	1	1	0

2. How do you determine who needs AT supports?

This question asked how each County Board identifies those individuals who require AT supports. The most frequently mentioned method was the use of Service and Support Administrator (SSA) assessments, which four of the County Boards noted. A categorized list of their ideas is presented in Table 3 below along with Frequency Counts showing how many times a method was mentioned. Responses from the group of County Boards with high self-ratings indicated the overall use of more unique kinds of identification methods (12 versus five for a little over a 2:1 ratio). The County Boards with high self-ratings were more likely than those with low self-ratings to embed identification efforts in their routine procedures for delivering services (e.g., SSA processes). Again, because low-self rated County Boards tended to have a narrower definition of what AT is, it is likely that this narrower understanding impacts who they determine as needing AT supports and services.

Table 3
AT Individual Identification Methods

Method	Frequency All	Frequency High Group	Frequency Low Group
Staff Determination	12	8	4
Individual/Family Request	4	3	1
Formal Evaluation (Outside Agency)	1	1	0

3. What is working well for AT service provision (supports)?

This question asked the participants to identify the supports for AT service provision that were successful in their County Boards. Respondents offered many ideas in response to this question. A categorized list of their ideas is presented in Table 4 below along with Frequency Counts showing how many times a support was mentioned. The groups offered numerous ideas of what they found successful for providing AT service. Responses identified by both high and the low self-rated teams included having knowledgeable and supportive staff who have specialized AT knowledge, adequate staffing to support AT implementation, staff consistency, good



communication skills, and availability of AT loan equipment for trials. The adequate staffing category includes specific mention of related services staff including Occupational Therapists (OT), Physical Therapists (PT) and Speech Language Pathologists (SLP). Also appearing more than once was strong relationships with AT Vendors.

Table 4
Supports for AT Service Provision

Provision	Frequency All	Frequency High Group	Frequency Low Group
Knowledgeable/Supportive Staff	8	2	6
Adequate Staffing for AT Implementation	5	4	1
Access to AT Internally/Externally	3	1	2
Effective Communication Internally and Externally	3	2	1
Vendor Relationships	3	3	0
AT Procedures and Implementation	2	2	0
Teacher/Related Services Staff Consistency	2	1	1
Access to AT Team	1	1	0
Administrative Support	1	0	1
AT is Becoming Mainstream & Familiar to Providers/Users	1	0	1
AT Training	1	1	0
Autonomy to Perform Job	1	1	0
Community/Family Supports Beyond Work/School Day	1	1	0
Consultation with Outside Agencies	1	0	1

4. *What three things do you believe made it possible to provide AT services in your region – or what three things do you think would help you build AT services in your region?*

This question asked for two kinds of information – things that made it possible to provide AT services and things needed to build AT services. A categorized list of the ideas that participants offered in response to the first part of the question is presented in Table 5 below along with



Frequency Counts showing how many times a provision was mentioned. A categorized list of the respondents’ ideas in response to the second part of the question is presented in Table 6 below along with Frequency Counts showing how many times a provision was mentioned.

The high self-rated group offered numerous examples of provisions available which allow them to provide AT services. In fact, staff members in those County Boards shared eight unique provisions whereas those from low self-rated counties shared just one example.

Ideas for provisions that are needed to build AT services were offered from both the high self-rated and the low self-rated groups. The highest frequency response which was offered from both groups was the need for staff education and awareness.

Table 5
Provisions That Made AT Services Possible

Provision	Frequency All	Frequency High Group	Frequency Low Group
Funding	6	6	0
Administrative Support	5	3	2
Family Support	2	2	0
Processes for Documentation and/or Implementation	2	2	0
AT is Mainstream, Affordable	1	1	0
Communication	1	1	0
Technology Increasing Independence	1	1	0
Vendor Support	1	1	0

Table 6
Provisions Needed to Build AT Services

Provision	Frequency All	Frequency High Group	Frequency Low Group
Staff Education/Awareness	6	3	3
AT Loan Programs	2	0	2
Staff Buy-In on Why AT is Important	2	2	0
Central Repository to Obtain AT Resources	1	0	1



Collaborative Resources to Share AT Ideas (i.e. Pinterest)	1	1	0
Communication	1	1	0
Funding	1	1	0
Support for Adult Services	1	0	1
Time for Learning/Training	1	0	1

5. What is challenging for AT service provision (barriers)?

This question asked the respondents to identify the barriers that challenged AT service provision. A categorized list of the respondents' identification of barriers is presented in Table 7 below along with Frequency Counts showing how many times a barrier was mentioned. Both groups reported the same number of barriers. However, the types of barriers differed somewhat by group. The lower self-rated group noted barriers related to the lack of regional AT resources and difficulty communicating with staff in different agencies and the high self-rated group identifying barriers related to lack of technology and ongoing education and training. Both groups noted barriers related to funding, staffing limitations, lack of AT knowledge/expertise, and a lack of time. The low self-rated groups also mentioned unrealistic expectations related to the selection and potential outcomes of specific devices. For example, sometimes users/families already had a device in mind before the assessment process occurred that was not a viable solution for the user or the user had changing needs but the family did not see the need for a change in AT to meet these new needs. Staff indicated these conversations were difficult and sometimes made it challenging to match appropriate features and devices to the needs of the person with a disability.

Table 7
Barriers to AT Service Provision

Barrier	Frequency All	Frequency High Group	Frequency Low Group
Funding	7	5	2
Lack of AT Knowledge/Expertise	5	1	4
Lack of Technology Resources	3	3	0
Time	3	2	1
Unreal Expectations	3	0	3
Staffing Limitations	2	1	1
Communication	1	0	1



Lack of Ongoing Education/Training Opportunities	1	1	0
Lack of Regional Resources	1	0	1

6. Explain what AT service delivery looks like at your agency.

This question asked each County Board to explain their AT service delivery process. Each process was unique to a County Board. Some Boards shared specific steps within their AT service delivery processes. A categorized list of the shared steps related to AT service delivery is presented in Table 8 below along with Frequency Counts showing how many times a step was mentioned. Although elements of the AT assessment and implementation process were evident in both the high self-rated group and the low self-rated group, there was a greater number of specific service delivery steps evident among County Boards in the high self-rated group.

Table 8
Steps for AT Service Delivery

Step	Frequency All	Frequency High Group	Frequency Low Group
Referrals	3	2	1
Trials with AT equipment	3	2	1
External Therapists/Service Providers	2	1	1
Needs Assessment	2	2	0
SLP	2	1	1
Waivers	2	1	1

AT TEAMS

The second set of questions to which focus-group participants responded were related to AT teams. The overarching prompt asked participants to describe the staff who are involved in AT services in their County Board. The interviewers used four questions to learn more about the AT teams. Categorized responses are discussed below in consideration of each of the four questions.

1. Describe the AT expertise of staff member(s). How did they get that expertise?

This question asked for two kinds of information – the AT expertise of staff member(s) and how they obtained such expertise. One participant reported no AT expertise in their County Board. Another participant reported that their Board had no AT expertise for adult services.



Respondents offered multiple ideas in response to the second part of the question, which asked about how their Board’s staff member(s) obtained AT expertise. A categorized list of their ideas is presented in Table 9 below along with Frequency Counts showing how many times a method was mentioned. The data showed that the high self-rated counties use a greater number of avenues to obtain AT information and expertise than the low self-rated counties. Responses from the high self-rated counties (but not the low self-rated counties) included online learning opportunities, webinars, and access to lending libraries to explore AT. Further, staff in the high self-rated group also indicated learning about AT from staff mentors.

Table 9
Methods for Obtaining AT Expertise

Method	Frequency All	Frequency High Group	Frequency Low Group
Conferences/Vendor Fairs	3	2	1
Self-Taught	3	2	1
Staff Mentors	2	2	0
Vendor Training	2	1	1
Graduate School	1	0	1
Lending Library - Explore AT	1	1	0
Online Resources (Etsy, Pinterest)	1	1	0
Webinars	1	1	0

2. Do you have an AT team? If you have an AT team, who is on the team?

This question asked whether or not each County Board has an AT team, and, if it does, about the members of such a team. The two counties in the group with low self-ratings stated that their Board does not have an AT team. The three groups with high self-ratings reported their Boards do have an AT team. These three County Boards answered the second part of the question. A categorized list of their ideas is presented in Table 10 below along with Frequency Counts showing how many times a member’s position was mentioned. It is evident from this information that AT teams often consist of AT specialists and related service providers. Although the low self-rated group did not have a formal AT team, there seemed to be a mechanism through the Service and Support Administration (SSA) services to address AT needs and funding.



Table 10
Members of AT Team

Member	Frequency All	Frequency High Group	Frequency Low Group
AT Specialist(s)	2	2	0
OT	2	2	0
PT	2	2	0
SLP	2	2	0
SSA	2	1	1
AT Assistant	1	1	0

3. Which team members have AT as part of their job description?

This question asked participants to identify the team members whose job descriptions include AT. A categorized list of team members is presented in Table 11 below along with Frequency Counts showing how many times a job position was mentioned. The data show that including AT in different job descriptions is more common in counties that have high self-ratings than in those with low self-ratings. In fact, AT was mentioned in the job descriptions for seven types of employees in the counties with high self-ratings, whereas it was mentioned in the job descriptions for just one type of employee (i.e., speech-language pathologists--SLPs) in the counties with low-self ratings.

Table 11
Team Members with AT in Job Description

Team Member	Frequency All	Frequency High Group	Frequency Low Group
Therapists (OT, PT, SLP, PTA)	4	2	2
AT Specialist(s)	2	2	0
AT Assistant	1	1	0
Medicaid Services Manager	1	1	0
SSA(s)	1	1	0
SSA Director	1	1	0



4. Who else supports the AT process in your agency?

This question asked participants to report those in their County Board who support the AT process. A categorized list of supportive personnel is presented in Table 12 below along with Frequency Counts showing how many times a group of personnel was mentioned. Comparisons between those giving high self-ratings and the those giving low self-ratings showed that a wider range of groups support the AT process in counties with high self-ratings. For the high self-rated group there were six different types of personnel that provide support to the AT process whereas in the low self-rated group, only three different types of personnel who provide support to the AT process.

Table 12
Members who Support AT Process

Member	Frequency All	Frequency High Group	Frequency Low Group
Related Service Providers (OT, PT, SLP)	6	3	3
Administrators	3	2	1
DD Staff (SSAs, care providers, etc.)	3	3	0
Physicians	1	1	0
Teachers	1	0	1
Vendors/Providers	1	1	0

AT ASSESSMENT

The third set of questions to which focus-group participants responded were related to AT assessment. The overarching prompt asked participants to describe the AT assessment process at their County Board. The interviewers used four questions to learn more about the AT assessment process. Categorized responses are discussed below in consideration of each of the four questions.

1. How are you handling requests and needs for AT?

This question asked the participants to report on how their County Boards handle requests and needs for AT. A categorized list of their ideas is presented in Table 13 below along with Frequency Counts showing how many times a method was mentioned. The Boards in the high self-rated counties tended to respond to requests with a team approach and more formalized assessment processes whereas those in the low self-rated counties tended to use SLP-led assessments (often embedded in the Individualized Education Program [IEP] process), Medicaid Waiver processing to address AT needs, or more informal approaches such as trial and error.



This difference may point to the use of more formal processes in counties with wider experience of providing AT services and a broader view of AT.

Table 13
Ways to Handle AT Requests/Needs

Method	Frequency All	Frequency High Group	Frequency Low Group
Team Assessment	6	4	2
Waiver/Insurance/School Funding	4	0	4
SLP-Led Assessment	2	0	2
Hands-On Trials	1	0	1

2. What does your AT assessment process look like?

The question above asked participants to explain the AT assessment process at their County Board. Their responses are divided into two sets – responses concerning who is involved in assessments (Table 14) and responses concerning how the process works (Table 15). The information in Table 14 suggests that counties with high self-ratings use a team approach to AT assessment, while those with low self-ratings rely on individual SLPs, external therapists or SSAs. Differences identified from these data include a higher propensity to use a formal evaluation process for assessment, planning, implementation and ongoing assessment in high self-rated counties and a higher propensity to refer to outside agencies and/or use the Waiver process for AT assessment in the low self-rated counties.

Table 14
Members Involved in AT Assessments

Process	Frequency All	Frequency High Group	Frequency Low Group
AT Team	2	2	0
External Therapists	2	0	2
SLP	2	0	2
SSA	1	0	1



Table 15
AT Assessment Processes

Process	Frequency All	Frequency High Group	Frequency Low Group
Assessment, Planning, Implementation	3	3	0
Hands-On Equipment Trials	3	2	1
Ongoing Assessment	2	2	0
Refer to Outside Agencies	2	0	2
Waiver Process (Funding)	2	0	2
IEP First	1	0	1
N/A (No AT Assessment Process)	0	0	0

3. When AT is needed, do you charge for assessment services?

This question asks whether or not each agency charges for AT assessment services. One participant reported that his or her County Board does not provide AT services other than what is provided through the Waiver process. The other four counties reported no charge for AT assessment services. The two low self-rated Boards indicated that they do not charge for AT services, but often draw on the resources of other Boards such as using medical insurance to pay for an AT assessment through an external provider if such service is available. Table 16 shows Frequency Counts of how many times an answer was mentioned.

Table 16
Charge AT Assessment Services

Charge	Frequency All	Frequency High Group	Frequency Low Group
No	4	3	1
No AT Services	1	0	1

4. What systems are in place to support the AT assessment process?

This question asked about the systems in place in each County Board that support the AT assessment process. No systems were reported by teams in the low self-rated counties, while systems were reported by all teams in the high self-rated counties. A categorized list of support systems is presented in Table 17 below along with Frequency Counts showing how many times a system was mentioned.



Table 17
Systems Supporting AT Assessment Process

System	Frequency All	Frequency High Group	Frequency Low Group
Loan Equipment	2	2	0
None	2	0	2
Referral Policies/Procedures	2	2	0
Administrative Support	1	1	0
Assessment Flowchart	1	1	0
AT Meetings	1	1	0
Evaluation of Effectiveness	1	1	0
ISP Meetings	1	1	0
Shared Policies/Documents	1	1	0
Timeline	1	1	0

AT FUNDING

The overarching prompt for this section asked participants to describe how AT is funded for those who are served by the County Boards. The interviewers used two questions to learn more about AT funding. Categorized responses are discussed below in consideration of each of the two questions.

1. What funding sources do you use to obtain AT?

This question asked members of each team to list the funding sources their County Board uses to obtain AT. The average number of different sources listed by each county was approximately six. Two Boards used three sources; one Board used four sources; one Board used eight sources; and one Board used 10 sources. A categorized list of funding sources is presented in Table 18 below along with Frequency Counts showing how many times a source was mentioned.



Table 18
Funding Sources for AT

Source	Frequency All	Frequency High Group	Frequency Low Group
Waiver / Alternative Options	6	3	3
County Board Funding Through Family Support Services/Family Resources	4	2	2
Medicaid	3	2	1
Nonprofit Organizations	3	1	2
School Districts	3	1	2
Grants	2	1	1
Insurance	2	1	1
Self-Pay (Teachers, Parents)	2	1	1
Family Children First	1	1	0
Private Donations	1	1	0

2. Is there a specific budget for AT funding at your agency? If yes, can you share any details?

This question asked about the specific budgets for AT funding at each County Board. The members of the two teams in the counties with low self-ratings reported no specific AT budget at their Boards, while the members of the three teams in the counties with high self-ratings reported that their Boards did have sources in their budgets to support AT. Details about the budgets for AT funding at the Boards were provided by the latter group of participants. A categorized list of information about budgets is presented in Table 19 below along with Frequency Counts showing how many times an idea was mentioned.

Table 19
Specific Budget Details for AT Funding

Detail	Frequency All	Frequency High Group	Frequency Low Group
Lending Library	1	1	0
Individual Options Waiver	1	1	0
Agency Commitment	1	1	0



One-Time Funding from Private Donor	1	1	0
On-going Waiver Programs	1	1	0
Emergency Dollars	1	1	0
Supportive Living Fund (COG)	1	1	0

AT TRAINING

The fifth set of questions to which focus-group participants responded related to AT training. The overarching prompt asked participants to describe the AT professional development interests of staff members and approaches for providing support. The interviewers used two questions to learn more about the AT professional development. Categorized responses are discussed below in consideration of each of the two questions.

1. Are there staff members who have expressed an interest in learning more about AT? What could the county board do to support those individuals?

This question asked for two kinds of information – whether or not staff members have indicated their interest in further AT knowledge and specific examples for how the County Board could provide such information. Four of the participating teams reported that staff members at their agencies had expressed interest in learning more about AT. All five of the participating teams provided examples for how the County Board could support those individuals who have expressed an interest in learning more about AT. The mean number of supports listed by each agency is about four supports. One Board listed two supports; one Board listed three supports; two Boards listed four supports; and one Board listed eight supports. A categorized list of support possibilities for AT training is presented in Table 20 below along with Frequency Counts showing how many times a support method was mentioned.

Table 20
County Board Support Possibilities for AT Training

Support	Frequency All	Frequency High Group	Frequency Low Group
AT Training	4	2	2
Conferences	4	3	1
Continuing Ed	2	1	1
Vendor Training	2	1	1
College Courses	1	1	0



Embed AT Awareness Training in Staff Orientation Meetings	1	0	1
Money	1	0	1
Department of Developmental Disabilities (DODD) - Pipeline Weekly	1	1	0
Opportunities	1	0	1
Staff to Support Group Meetings	1	1	0
Time	1	0	1
Webinars	1	1	0

2. What AT training opportunities have been provided to families? Have you participated in AT training through the county board? If you haven't, why not?

The first part of this question asked participants to describe the AT training provided to families. The following questions asked the participants to indicate whether or not they had attended AT training that had been provided through the County Board; however, participating team members offered responses to the first part of the question only. A categorized list of their responses is presented in Table 21 below along with Frequency Counts showing how many times a training opportunity was mentioned. More training opportunities were offered in the counties with high self-ratings than in those with low self-ratings (10 types of opportunities versus one type of opportunity). Family members reported participating in learning opportunities about AT for independent living. Of particular note was a unique training model offered by one county. This county offers two different types of community meetings for the individuals they serve and individuals from the broader community. One group is a talking group where individuals who use augmentative communication devices meet at local restaurants and talk with each other. The group is facilitated by SLP grad students from a nearby college and the conversation is typically centered around a theme. The other unique type of AT training opportunity offered by this county is their “technology and seniors” group where individuals who use AAC devices get together with seniors in the community to teach them about technology. Both of these community groups offer unique ways for their individuals with developmental disabilities to implement their AT in a way that is beneficial to all, both functionally and socially.



Table 21
Family AT Training Opportunities

Training Opportunity	Frequency All	Frequency High Group	Frequency Low Group
In-home Training	3	1	2
Community Social Groups Centered Around AT	2	2	0
Group Meetings for Family Members	2	2	0
AT Video (OACB)	1	1	0
Newsletter (CBDD)	1	1	0
One-on-one Training	1	1	0
Sibling Organizations	1	1	0
Smart Home Demos	1	1	0
Training Manuals	1	1	0
Vendor Training Materials (DVD and Phone Support)	1	1	0

ADMINISTRATIVE SUPPORT

The sixth set of questions to which focus-group participants responded were related to administrative support and outside agencies. The overarching prompt asked participants to describe the administrative or other supports that are provided to assist staff with AT services. The interviewers used three questions to learn more about the administrative support within the CBDD and how staff members interface with outside agencies. Categorized responses are discussed below in consideration of each of the three questions.

1. How does your administration support AT service delivery? In what ways?

This question asked participants to report on administrative support for AT service delivery in their County Board. A categorized list of supports is presented in Table 22 below along with Frequency Counts showing how many times a support was mentioned. Both the teams from high self-rated counties and those from low self-rated counties indicated that their administrators support them by allowing vendors to come in and provide training to the staff and by convening team meetings to discuss the AT needs of the individuals they serve. Respondents from the low self-rated counties also mentioned that administrators trusted their therapists' expertise and supported their training requests, but they did not share specific



requests that had been made. By contrast, staff from the high self-rated counties mentioned more concrete supports such as attendance at AT conferences, hiring staff with specialized training, and providing planning and training time.

Table 22
Administration Support for AT Service Delivery

Support	Frequency All	Frequency High Group	Frequency Low Group
Training	5	3	2
Team Meetings (SSA)	2	1	1
Allow Staffing of Specialized Employees	1	1	0
Attend Conferences	1	1	0
Provide Planning Time	1	1	0
Support Training Requests	1	0	1
Trust Therapist's Area of Expertise	1	0	1

2. What other agencies support your AT work?

This question asked participants to identify other agencies that support their AT work. A categorized list of such agencies is presented in Table 23 below along with Frequency Counts showing how many times an agency was mentioned. The number of agencies listed was similar across the high and low self-rated counties: five for the high self-rated group and four for low self-rated counties. This finding indicates that both groups are making use of some community resources to support their AT efforts. The teams from high self-rated counties indicated more types of supports including community donations and fundraisers as well as partnerships with nearby college programs.

Table 23
Agencies Supporting AT Work

Agency	Frequency All	Frequency High Group	Frequency Low Group
Non-Profit Organizations	6	2	4
Community Fundraisers/Donations	3	3	0
College-Based Programs/Facilities	2	2	0
School Districts	2	1	1



AT Consortium	1	0	1
Hospitals	1	0	1
Restaurants	1	1	0

3. Which agencies do you support with your AT work?

This question asked the participants to identify those agencies that are supported by their County Board’s AT work. A categorized list of the agencies to whom the County Boards provide support is presented in Table 24 below along with Frequency Counts showing how many times an agency was mentioned. A comparison of counties with high and low self-ratings showed that those with high self-ratings provided AT support to a number of different agencies, but that those with low self-ratings offered limited support to specific agencies or did not offer support outside of their own agency at all.

Table 24
Agencies Supported by AT Work

Agency	Frequency All	Frequency High Group	Frequency Low Group
Non-Profit Agencies	4	4	0
Private Agencies	4	4	0
Local Education Agencies (LEAs)	3	3	0
Surrounding County Boards Of DD	3	2	1
Universities	3	3	0
CBDD Administrators	1	0	1
Don’t Support Other Agencies	1	0	1
Families	1	1	0
Judicial Agencies	1	1	0
State Education Agencies	1	1	0

IMPLEMENTATION

The seventh set of questions to which focus-group participants responded related to implementation. The overarching prompt asked participants to describe how AT is implemented at their County Boards. The interviewers used two questions to learn more about



implementation. Categorized responses are discussed below in consideration of each of the two questions.

1. What social groups or events exist in which AT can be infused?

The above question asked participants to report on existing social groups and events in which AT could be infused. A categorized list of the groups they mentioned is presented in Table 25 below along with Frequency Counts showing how many times a group or event was mentioned. The community activities category included fundraising events such as a golf outing to raise money for AT services as well as events such as sensory nights at the movies, theater, or zoos. Community clubs/groups and organizations offering Special Olympics activities, playgroups, parent groups, therapeutic horseback riding programs, tech fairs, and community meetings are other examples of social activities in which AT could be infused. There was no significant difference between responses from the high self-rated counties and those from low self-rated counties in terms of their ideas for ways in which AT could be infused in social groups.

Table 25
Social Groups and Events for Potential AT Infusion

Social Group/Event	Frequency All	Frequency High Group	Frequency Low Group
Community Clubs/Groups/Organizations	9	6	3
Community Activities	6	5	1
Residential & Day Programs/Camps	6	1	5
Libraries	1	1	0
Museums	1	1	0

2. What things are you doing related to AT service provision that other county boards might also adopt?

This question asked participants to note activities related to AT service provision they believe other County Boards could adopt. A categorized list of their ideas is presented in Table 26 below along with Frequency Counts showing how many times an idea was mentioned. Frequency Counts show that slightly more ideas were generated from the teams in high self-rated counties. Of particular note is the fact that responses from the high self-rated counties overlap with those from the low self-rated counties to a very limited extent.



Table 26

Ideas Related to AT Service Provision for County Board Adoption

Idea	Frequency All	Frequency High Group	Frequency Low Group
Supportive Administration/Environment	2	1	1
Allow Families to See AT	1	1	0
AT Team for Family Support	1	1	0
Close Contact with Individuals Served By CBDD	1	1	0
Collaboration Between Counties	1	1	0
Collective Community	1	0	1
Email Blasts (AT Corner)	1	1	0
Enthusiasm	1	0	1
Facebook Group	1	1	0
Good Communication	1	1	0
Good Work Culture	1	0	1
Parent is Active Member of Team	1	0	1
Partnerships Between Providers and Agencies	1	1	0
Productive/Supportive SSA's	1	1	0
Providers Care	1	1	0
Segregated Classrooms	1	0	1
Social Groups (Talking Group, Seniors and Technology)	1	1	0
Turn Existing Staff into AT Specialists	1	1	0
Vendor Presentations	1	0	1
Vendors Openly Expressing Alternatives	1	1	0



ADDITIONAL COMMENTS

Focus-group participants were asked to provide any additional comments they might want to share. A categorized list of their ideas is presented in Table 27 below along with Frequency Counts showing how many times a comment was mentioned. Similar to Table 26, the additional comments generated minimal overlap except multiple Boards mentioned newsletters. Several of the County Boards interviewed already had a newsletter of some sort and they felt it would be a good avenue to share AT success stories or product solutions. Many other ideas on this list led to some of the final suggestions in the summary to follow.

Table 27
Additional Comments

Comment	Frequency All	Frequency High Group	Frequency Low Group
Newsletters	2	2	0
Advice for New AT Department: AT is About Problem Solving	1	1	0
AT in Workplace	1	1	0
AT Library Meetings (lessons on software and hardware – Tap It, Boardmaker Online)	1	1	0
AT Lower on List of Needs Within Agency	1	0	1
AT Training Opportunities for SSA’s	1	1	0
CCBDD – Tools, Confidence, Respect, Flexibility, Communication	1	1	0
Cost Savings with Remote Monitoring and AT Products	1	1	0
Create Video to Show “Smart Home”	1	1	0
Family Access to Remote Monitoring Systems	1	1	0
Have AT Services Accessed Through COG	1	0	1
Increase Education About Statewide or Community Resources (OCALI, OSSB)	1	0	1
Large Amounts of Problem Solving Within County	1	0	1



May We Help	1	0	1
Need Services/Knowledge Beyond AAC	1	0	1
Provide Loan Equipment	1	0	1
Recycle Used Equipment	1	1	0
SLP Countywide Support Group	1	0	1
Smart Home Supports (Nest, Echo) More Readily Available	1	1	0
Suggestion: Paper Newsletters for Older Parents	1	1	0
Empower Individuals Served by CBDD to Provide Technical Assistance	1	1	0
Training Suggestion: Expose Families to AT	1	1	0
Training Suggestion: Teach About Apps (Appy Hour)	1	1	0
Public Library Adapted Programs	1	1	0

Summary – Part 2 – Focus Group Interviews

Two questions were considered by the OCALI evaluation team when conducting the second part of the study.

- (Part 2: Interviews) What are the commonalities in AT service provision of high-self-rated and low-self-rated county boards?
- (Part 2: Interviews) What are the differences in AT service provision of high-self-rated and low-self-rated county boards?

Although County Boards with high self-ratings of AT capacity shared some practices and contextual challenges with those with low self-ratings, data analysis pointed to some important differences. Table 28 presents some of the most striking commonalities and differences. In terms of differences, high-capacity counties seemed to place AT services in a more prominent position than did low-capacity counties. They mentioned AT in job descriptions, trained staff, used a team approach both to assessment and service delivery, provided systemic supports for AT services, allocated funding for AT functions, tended to use more systematic and formal AT assessment procedures, and provided AT support to other agencies. All of the counties, however, seemed to recognize that AT was one important way to address the needs of some of individuals they serve but acknowledged that funding issues posed a significant challenge. Staff



in all counties also seemed to be able to identify various approaches for expanding AT capacity in their agencies.

Table 28
Commonalities and Differences

Commonalities Across Counties	Differences Between High- and Low- Self-Rated Counties
Both groups mentioned hands-on trials as one aspect of the AT assessment process which leads to the need to share information about AT lending programs throughout Ohio.	High self-rated counties had systems in place to support the AT assessment process; low self-rated counties did not have similar systems in place.
Responsiveness to family requests for AT seems to occur across high self-rated and low self-rated counties.	Formal assessments of AT needs were more often used in high self-rated counties than in low self-rated counties
Opportunities for expanding AT capacity seem to be available in both high self-rated and low self-rated counties.	High self-rated counties used AT teams for both assessment and service delivery; low-capacity counties did not use AT teams for either assessment or service delivery.
Having consistent, knowledgeable staff and supportive administration was identified by both groups as provisions that could lead to successful AT implementation.	AT functions are mentioned in job descriptions in high self-rated counties but not in low self-rated counties.
Both groups felt that if AT services become more effective, staff needs an increased awareness and education about AT.	A greater number and variety of employee groups support AT functions in high self-rated counties than in low self-rated counties.
Additional funding appears to be a need across the high self-rated counties and low self-rated counties.	High self-rated counties allocated funds to support AT functions; low self-rated counties did not.
Additional training related to AT is needed and was identified among both high self-rated counties and low self-rated counties.	More AT training opportunities were available to staff in high self-rated counties in contrast to low self-rated counties.
	High self-rated counties provided AT support to other agencies; low-capacity counties did not.



Recommendations

The results of the survey and focus group interviews were presented to a team with both policy expertise as well as experience with the DODD systems. Those participating on the team included Melissa Bacon, Program Director, Office for Policy, Strategic Initiatives & Stakeholder Engagement, OCALI; Jody Fisher former Project Manager, Office of Policy and Strategic Direction, DODD; and Teresa Kobelt former Assistant Deputy Director of Policy and Strategic Direction, DODD. The team provided recommendations and offered suggestions on ways to impact the DODD system related to the findings of the study. Those suggestions and recommendations were used in the development of the final recommendations presented below.

AT AWARENESS

CBDDs define AT devices and services with a great deal of variability. High self-rated County Boards seem to have a broader definition of AT, were more knowledgeable about the variety of AT devices available, and the populations who could benefit from AT. This response points to a fundamental need to help CBDDs across the state gain a consistent and common understanding of the breadth and depth of AT and the value it may provide to a person with a disability. Many AT resources are available free of charge including AT related YouTube channels, webinars, and listservs. These resources can be embedded in face-to-face trainings and within the proposed central repository for AT resources.

AT Awareness Recommendations

1. Increase AT awareness training to include the range of AT options available, from no- and low-tech options through high-tech options and include all age ranges. This training could be implemented with minimal cost through webinars, orientation meetings, videos, and listservs. Increase awareness in basic AT foundational knowledge by incorporating AT overview content in orientation and/or yearly staff meetings. The Eight-Hour Direct Service Provider Training modules (<http://dodd.ohio.gov/Training/Pages/default.aspx>) may be a place to embed AT since these are required trainings.
2. Develop a tiered approach to training geared toward various personnel (i.e. administrators, SSAs, direct support professionals, related services, etc.).
3. Embed AT success stories and product highlights in existing agency newsletters.
4. Create short videos of local success stories showcasing use of AT.
5. Increase administrator awareness of AT through the Administrative Development Program (CBDD Executive Development and Superintendent Programs).
6. Develop a central digital repository of AT information/supports.
7. Offer AT mini grants for CBDD to develop AT knowledge, train teams and build capacity (training grants); trainer suggestions include: Mike Marotta, Kirk Benke, Kelly Fonner, Joan Breslen Larson, and Tony Gentry.



Policy/Procedure Recommendations

1. Develop a systematic professional development plan.

AT ASSESSMENT

AT consideration and assessment is based on the individual responder's knowledge of the breadth of AT (i.e. only those with communication needs, only for school-age, only for independent living, etc.) which may result in a narrow understanding of the AT services and supports that are needed. In some cases, SSA personnel are making decisions about AT service provision despite the fact that their knowledge of AT may be limited. Some County Boards mentioned that AT is only considered when funding is available which does not support best practice for consideration of AT needs.

Only 1/3 of the County Boards indicated they are using a formal process for AT assessment. The data also supports the fact that within the AT assessment process, many best-practice aspects of the process are lacking including a proper consideration process, hands-on AT trials, and identification of tasks and benchmarks to indicate effectiveness of selected AT. According to the data, the individual's culture and customs were also an area of weakness within the Board's understanding of factors that should be considered during the AT assessment process. The level of family support, as well as the individual's culture and customs may impact the success of recommended AT and therefore the family's input regarding this matter should be included. Disregard to these important steps of AT assessment often leads to a mismatch of the AT selected and possible AT device abandonment.

AT Assessment Recommendations

1. Provide training about the AT consideration and assessment process to DSPs, SSAs, related service (OT, PT, SLP), and administrators.
2. Offer AT mini grants for CBDDs to develop AT knowledge, train teams to employ best practices for the AT assessment process and build capacity (training grants).
3. Consider use of consortium models to leverage resources across a wider region with either financial or people resource contributions (Councils of Governance [COG], other stakeholder agencies, etc.); however, be careful that development of these models doesn't inhibit the capacity development of local teams.
4. Embed Person Centered Planning in the AT assessment process to ensure that the individual's preferences are considered.
5. Include family members in the AT decision-making process so that the individual's family support system, culture, and religion are taken in to account when selecting AT.

Policy/Procedure Recommendations

1. Embed AT consideration in the Individual Service Plan (ISP) process.
2. AT consideration and assessment could be embedded in the SSA functions and duties during ISPs and reflected in rule (5123:2-1-11).



3. Consider modifying the Ohio Developmental Disability Profile (ODDP) to include an AT consideration question which might help to identify those who may benefit from AT.
4. Consider modifying the suggested content of the ISP and/or the Imagine Information System (ImagineIS) to include reminders about AT consideration.

AT IMPLEMENTATION

Only half of the County Boards reported effective implementation strategies and even more (58%) feel they are not evaluating the individual's use of AT once it is in place. During AT implementation, data must be collected, once the AT is in place, to determine whether the AT being used is meeting the needs of the individual and/or if perhaps the AT needs modification. Again, if ongoing assessment of the effectiveness of the device in place does not occur this can contribute to device abandonment or effective outcomes may not be obtained.

Often, families are willing to allow the individual to use their personally owned AT (i.e. smartphones, tablets, wheelchairs) in the work or community environment, but if those devices are being used to support the individual while obtaining services in the CBDD system, there should be a plan in place to address what happens should the device break, become lost, or have a need for updates. According to the data, more than 10% of the time, implementation plans are not addressing use of personally owned AT.

Knowledge of available resources such as lending libraries, AT-related online resources (Pinterest lists, YouTube channels, listservs, etc.) are limited. If CBDD staff members are made aware of these resources, they would be better able to implement and support recommended AT.

AT Implementation Recommendations

1. Increase awareness of regional and state lending libraries by posting a list of all lending libraries in Ohio on a central repository.
2. Utilize user experts for training and support either regionally or virtually through online and face-to-face opportunities to collaborate through open office hours or formal training events.
3. Use social or special interest groups (peer assistance models, AAC groups, etc.) to allow authentic practice with AT.
4. Develop and market AT implementation resources (such as Quick Start Guides or a framework to outline implementation process) for CBDD staff.
5. Develop a repository of used equipment (AT Ohio already has something but it isn't well marketed). Questions - Where is the equipment that is turned into the Bureau of Services for the Visually Impaired (BSVI) and Opportunities for Ohioans with Disabilities (OOD) when it doesn't work out for an individual?



Policy/Procedure Recommendation

1. Include guidance within written implementation exemplars on how to fund updates, repairs, or replacement of personally owned AT should it become damaged or broken during CBDD activities or should the equipment require updates to support CBDD activities.

AT FUNDING

Many different funding resources are being used throughout the CBDD system. But misconceptions exist about the parameters surrounding the use of Medicaid Waiver funding for AT. Another concern voiced was that the provision of AT can impact the level of care and subsequent funding for the individual. This is counter to the objective of providing AT in order to allow a person to increase their independence. During the interview process, one County Board mentioned a concern about culture in the agency in that some staff members were hesitant to recommend certain AT solutions due to perceived cost of AT and a lack of available resources to fund the purchase of the recommended equipment. It should also be noted that AT is generally not included as a specific line item in the CBDD budget.

AT Funding Recommendations

1. Increase awareness of the wide range of funding sources including reuse/recycle libraries (i.e. AT Ohio Trading Post) both statewide and regionally by including funding options on a central repository and integrating available options in staff training.
2. Develop a set of funding guidance materials (i.e. webinars, online modules, written guidance documents) regarding Medicaid Waivers and other funding sources such as insurance, grants, crowdsourcing, and donations to include eligibility, rules, and funding options.
3. Increase awareness of the AT continuum no-, low-, mid-, and high-tech AT as well as commonly available technologies vs specialized products in order to optimize free AT resources.

Policy/Procedure Recommendations

1. Consider adjusting the policy for funding based on an individual's level of care - such that when issuing new AT devices, which may change an individual's level of care, the funding level should be held harmless until an adequate trial period is completed.
2. Consider maintenance of funding based on the highest level of care needed for any given task when new AT is provided. Often AT may improve a specific area of function for particular tasks but may not provide the user with consistent performance across all tasks.



ADMINISTRATIVE SUPPORT

Administrative support was seen as vital to the provision of AT; however, few policies seem to exist that relate to AT service provision. Additionally, 70% of the CBDDs felt that AT was not considered critical to the mission of their agency and therefore were not embedded in the framework and mission of their work. Training was identified as the greatest need among both high and low self-rated counties. The support included both time away from other duties to participate in training activities and in some cases funding to support training. Training is needed by CBDDs in order to develop competency to deliver effective AT services particularly since there are so few professionals available who receive this type of training in preservice programs. Additional supports identified included providing planning and team meeting time.

Administrative Support Recommendations

1. Develop and provide a self-assessment matrix of AT supports and services to help CBDDs understand what benchmarks they should be meeting for system implementation of AT supports and service delivery.
2. Provide time and opportunities for training of all supporting staff (administrative, SSAs DSPs) and embed in current training requirements if possible:
 - o Administrative development program (CBDD Superintendent development programs, CBDD Executive Development Programs)
 - o Eight Hour Direct Service Provider Training Series
 - o Online training modules
 - o County Board Members January training
 - o Ohio Providers Resource Association (OPRA) training - include AT in training
 - o Ohio Association of County Boards (OACB) Conference - develop an AT tract

Policy/Procedure Recommendations

1. Because each CBDD has their own unique set of policies and procedures, it may be useful to develop a template of exemplar AT policies and procedures that could be considered and used by the CBDD to develop their own policies and procedures inclusive of AT.
2. Consider modeling the development of future AT rules from already established AT rules within the Ohio Department of Developmental Disabilities (DODD) system if effective (i.e. Employment 1st AT rule - 5123: 2-9-13 - effective April 2017).
3. The DODD is in the process of creating an AT rule/guidance document; currently in draft format. When that document is completed it will need to be marketed to CBDD staff for understanding and implementation.



ADDITIONAL COMMENTS

OCALI's AT&AEM Center conducted a study of the 88 Ohio County Boards of Developmental Disabilities (CBDD) in order to gauge the system's capacity for providing assistive technology (AT) services and supports. This mixed method study consisted of two parts, 1) a survey of the 88 CBDD's current AT service delivery practices, and 2) interviews with five select CBDDs for the purpose of differentiating AT barriers and supports for high self-rated and low self-rated CBDDs. This data was gathered to ultimately make recommendations to inform current practices and potential policy changes that might improve the AT service delivery of CBDDs.

This study demonstrated a clear need to develop and/or expand the AT capacity at many of the CBDDs particularly in the area of adult services. When CBDDs were engaged in AT service delivery fewer services appeared available as those individuals with disabilities moved out of K-12 services and into adult services. Additionally, those current delivery systems could meet the AT needs of some, primarily in the areas of augmentative and alternative communication (AAC) and seating and mobility, but there was not a consistent and routine method used in other areas of AT to (a) consider AT, (b) to assess AT needs, and (c) to specifically match the technology to all individuals who may benefit from the use of AT.

Building comprehensive AT service delivery capacity across the state is essential. It will likely require a multi-faceted approach inclusive of a multi-year plan, developing key partnerships and collaborations with agencies and experts in the field of AT, locating AT "bright spots" within the CBDD system for replication, extending pre- and post- service AT training opportunities to increase staff competencies, and developing a central repository of AT resources and supports designed to provide a one-stop AT shop for CBDDs.

Because there are limited AT resources currently available within the DODD and CBDD systems, consideration should be given to the funding and development of a Coordinating Center of Excellence (CCOE) on AT that would leverage collaborating partners such as the Ohio Developmental Disabilities Council, OCALI's AT&AEM Center, Ohio Department of Education's Office for Exceptional Children (ODE/OEC), Ohio State University Medical Center, Ohio State University Nisonger Center, AT Ohio, University programs with AT preservice programs (BGSU), Children's Hospital Network facilities with strong AT programs (Nationwide, Columbus and Pearlman, Cincinnati), and current "bright spots" within the CBDD system as sources of expertise, support, and possible pooling of existing resources and/or collaboration on the development of new resources. The CCOE would facilitate the design and implementation of a multi-year plan to help build the capacity of those who provide services to adults with developmental disabilities to be better able to assess and implement AT services. A timeline of what it would take to implement a baseline of care with AT should be developed recognizing that AT is not an option but a basic right. The plan should also include marketing strategies to get the information out to the appropriate persons (Providers, Consumers, Families, etc.).



It may be useful to begin with a regional shared services approach for developing AT capacity rather than initially attempting to develop services within each separate CBDD. Regions could be defined by Councils of Governance (COGs), or other already existing regional distinctions within the DODD system. Beginning with a regional approach could help in leveraging already limited resources of people and money, as well as, facilitate increased speed in developing AT services across the state.

An AT point of contact (POC) should be identified within each CBDD, or if a regional approach is used, for each region. The POCs could be used to provide a link to the CBDDs for state-wide dissemination of AT information from the Coordinating Center or DODD. Opportunities for the POCs to engage in periodic networking and face-to-face meetings should also occur. Networking opportunities by the POCs could allow for identification of resource needs and the subsequent shared development of those services and resources. This could lead to quicker implementation of services, improved sustainability over time, and the reduction of time and consequently, funding needs. As AT resources are developed for the CBDD a digital central repository should be established to allow for a one-stop-shop for CBDD staff. Resources may include training opportunities, success stories, exemplar policy and procedure documents, vendor contact, etc.

Building AT competencies within the CBDD is not as simple as just hiring qualified AT professionals. There is a known shortage of individuals who possess the competencies to assess, recommend, and implement AT currently within the CBDDs and available for hire outside of the system. Few AT pre-service training programs exist and often there is little information provided about AT in professional programs that might train those who become, or are currently, key service providers at CBDDs.

Because of the rapidly changing nature of AT, the CBDD must be willing to commit to investments of time and money for ongoing training to develop and sustain the AT competencies of their staff. A “one and done” training approach will not lead to a sustainable service delivery model over time. Training will be needed at all levels of the system including CBDD staff members and administrators. Training should be provided in various ways including face-to-face, supportive coaching, and online training modules for example. Additional AT training could be embedded in already existing professional development events, such provided in an AT tract within CBDD staff attended conferences (OACB conferences, OPRA events, DODD brown bag lunch, etc.) or adding AT information to required trainings (CBDD Superintendent Development Programs, CBDD Executive Development Programs, eight-hour direct service provider training, etc.). Careful consideration should be given to the use of online training and its effectiveness for all. Often Direct Service Providers (DSP) reportedly don’t have access to computers at work which would make online training inaccessible to that particular target audience. Broadband connectivity may also be an issue in some rural areas and prohibit online trainings.

This study has provided information that will be necessary as planning and deployment of a state-wide AT services plan is developed in collaboration with the CBDDs. In the first part of the



study, aggregate CBDD responses to key questions relevant to the performance of AT supports and services can help guide the development of this comprehensive plan. Additionally, the interviews of low self-reported CBDDs helped to provide more insight into the barriers that may limit the development of AT services. The interviews of high self-reported CBDDs helped to identify supports that were useful to develop those CCBD's AT services. Again, this information can be extremely useful as a state-wide plan is developed.