**Behavior Assessment and Intervention for**

**VR Clients: A Closer Look**

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Edited transcript of YouTube video: <https://youtu.be/L2986vguyx0>

Ann Outlaw: Hi, everyone. I am Ann Williams Outlaw from S-E-D-L or SEDL in Austin, Texas, an affiliate of the American Institutes for Research or AIR. I will be moderating today’s webcast entitled “Behavior Assessment and Intervention for VR Clients: A Closer Look.” This is the second webcast in a series about behavior assessments and supports. The first webcast, “[Comprehensive Behavior Supports for VR Clients](http://ktdrr.org/training/webcasts/webcast29-30/29/index.html),” can be found on our website at [ktdrr.org](http://ktdrr.org/training/webcasts/webcast29-30/index.html).

Today’s webcast is offered through the Center on Knowledge Translation for Disability and Rehabilitation Research, KTDRR, which is funded by the National Institute on Disability, Independent Living and Rehabilitation Research or NIDILRR. I also want thank my colleague Joann Starks for her support for today’s webcast.

The Center on KTDRR has a sub-grant with the American Institutes for Research to develop a series of webcasts and to establish a community of practice to help promote the understanding and use of evidence-based practices in the field of vocational rehabilitation or VR. Cindy Cai is the project director of the sub-grant. Her colleague, Emma Hinkens, has been instrumental in the development of this webcast and related community of practice.

Slide 2- Here is our agenda for today. After an overview of the webcast topics, I will introduce our presenters and we will have a facilitated discussion. We will then wrap up by letting you know how to become part of this discussion.

Slide 3- Today’s presentation will expand on the [previous webcast](http://ktdrr.org/training/webcasts/webcast29-30/29/index.html) by providing more in-depth information about the behavior assessment and intervention process in the VR context. We will discuss four central questions: First, How can functional behavior assessment address the barriers to employment for individuals with disabilities? Second, How is functional behavior assessment and intervention used in the VR context? Third, What are some of the strategies to implement functional behavior assessment and intervention to support VR clients? Finally, How can VR agencies support functional behavior assessment and intervention to increase the employment of individuals with disabilities?

We are happy to have four panelists with us today. The first is Christine Hoffner Barthold, PhD, Board Certified Behavior Analyst, and she is an Assistant Professor of Special Education at the Graduate School of Education at George Mason University. Jessica Stehle,MA, CRC, is Virginia’s Department for Aging and Rehabilitative Services, ID/DD Employment Resource Consultant. Justin Creech,Positive Behavior Support Facilitator, is here and he is an endorsement board member, teacher, and mentor to prospective students at Positive Behavior Consulting, LLC. And Richard Kriner is also joining us; he is anMS, CRC, LPC, PBSF, and he is the Autism Research Coordinator at the VA Department for Aging and Rehabilitative Services.

Now, I’ll turn it over to Chris, and she will discuss how functional behavior assessment can address the barriers to employment for individuals with disabilities from a researcher’s perspective? Chris, are you ready to begin?

Christine Barthold: Slide 5- Yes, I am. Thank you, Ann. I want to start a little bit about the barriers to employment for individuals with disabilities. Now, most of the research that I’m going to present has to do with individuals with autism spectrum disorder, but for the most part in my practice and also in other work I found that a lot of this work also translates to other individuals with significant disabilities.

As we know individuals work in a range of places. For example, community-supported employment, where individuals work in the community with coaches, community day programs, which do not necessarily involve vocational tasks and vocational rehabilitation, programs such as sheltered workshops. As we know, sheltered workshops and the more restrictive placements tend to be a little bit more controversial than community supported employment for minimum wage.

A couple of things that we do know is that individuals with disabilities tend to be employed far below the national average. People are often underemployed or not employed in the fields that they want to be employed in, and that’s often due to things that have to do with problem behavior. Problem behavior is often cited as an indicator of low employment outcomes. We did a study a couple of years ago looking at VR clients and reasons why cases get closed, and what we found is that problem behavior is often cited as a reason why those cases get closed and why individuals have a problem securing and maintaining competitive employment.

Slide 6- Now, we know that positive behavior supports can help people maintain employment in the community. We talked about that last time. A lot of providers are used to providing those supports maybe with younger children or in the school setting, and as we know supported employment in VR is a very different place. One of the biggest differences between a K12 setting and an employment setting is the philosophy of person-centered planning and self-determination.

As a behavior analyst, who enters the world of residential and community services, it’s important to understand how these underpinnings and these philosophies can affect how you’re going to intervene. If we think about historically, people or individuals with disabilities had very little choice in what they could do, where to eat, work, play, or worship. If you think about the choices that you made just today, we know that choice is a key part of preventing and also intervening with problem behavior. Therefore, client choice is an integral part of most programs.

Also related to this is self-determination, the ability to decide for yourself what you will do with your day and your life so our clients are the individuals with disabilities and that’s different than a K12 setting. In a K12 setting, a lot of times our clients are the parents, the teachers, and we are obtaining consent from them not directly from the individuals. So it’s very important that the individual is a part of this process, that they are an active part of this process, and that they’re also a willing part of this process.

It’s also important to note that choice making is a skill. It’s not something that we’re born knowing how to do. It assumes some things. It assumes that someone can discriminate the social contingencies that make a choice reinforcing. For example, getting up and going to work when you don’t want to. It assumes that someone knows their preferences. It also sometimes, especially at work, it assumes that someone can defer a smaller reinforcer, for example, eating candy now for a larger reinforcer, for example, a wardrobe with better clothes and better health. If I didn’t feel like coming to work today I was able to put that off because I know that the long-term reinforcers are way bigger than that short-term reinforcer of sleeping in. We have to start at that point, teaching people how to be self-determined and how to make choices. We can do that for our clients.

Slide 7- As we know, individuals with disabilities can learn with the right supports, and we know that they can learn how to make good choices. We know that they can learn how to behave appropriately on the job. We know that functional behavior assessment works with children and those in more restrictive environments. However, that doesn’t help people necessarily get jobs in the community. We’ve got to take what we’re doing and put this out in the community so that people can get jobs, they can continue to stay in jobs that they enjoy, and get promoted and have a good quality of life.

Slide 8- We’ve talked a little bit about functional assessment. We really haven’t talked specifically about the process or the underpinnings of that process. The biggest underpinning of it is that we assume that the environment controls how we respond, that things that happen either immediately before the behavior or maybe more distally are controlling a response. Those are antecedents, and you’ll see that in this graphic.

Antecedents really trigger our behavior. For example, if I’m sick this morning, I may be less likely to get up when the alarm goes off. Our response is something that we do, so behavior is anything that we do whether it’s good, bad or indifferent. Sometimes you’ll hear people say that someone’s engaging in behaviors. That’s really a misnomer that I’m hoping to get rid of because we all engage in behaviors. Some of them are appropriate to the settings, some of them are inappropriate. We want to stack the deck with appropriate behaviors in order to make those inappropriate behaviors just kind of fall away.

The third part about this is the consequence or what happens after. Again, you know we think about consequence is a bad thing, but the consequence can be a good thing too. Favorable consequences tend to maintain behavior and unfavorable consequences tend not to. Those things that are favorable we call reinforcing. Those things that are not favorable we call punishing. If you have an antecedent that triggers a behavior and an individual engages in a response and that consequence is favorable, they’re probably going to continue doing that in the future.

What’s strange about consequences and antecedents is that you can’t necessarily tell by what the behavior looks like or the consequence looks like whether or not that consequence is favorable or unfavorable. For example, some people may find reprimands reinforcing because they tend to not have a lot of social interaction in their lives. You’ve heard the term, “There’s no such thing as bad publicity.” You can’t necessarily say that because somebody feels good or feels bad or it looks like it’s an unfavorable consequence that it is. It’s very important to do a comprehensive assessment of what’s going on.

This graphic here also tells you a little bit about how that assessment works. The first thing we do is that we review records. We look at prior history. We look at what’s been done in the past. We look at what works; what doesn’t. We work with the individual, ask them what’s working, what’s not, talk to people in the community. Then we really drill down and identify the problem.

One of the things that I think my colleagues will talk about a little bit later is that we try to be very specific about what we’re trying to accomplish. Typically, people in VR will come to us with a whole litany of problem behaviors that we’re trying to address, and we try to set goals and set priorities because if you try to do too much at once, it actually muddies the waters. I personally ask individuals to drill down to three really specific things that they want to work on. I’ll talk about that process a little bit later.

I’ll then go in and do some surveys of individuals in the environment. I may also do some surveys of the individual, the employer, that type of thing, to find out what individuals in the community and what the stakeholders are thinking about the problem behavior. Are they willing to help out with the interventions? Are they burnt out? Are they looking for strategies? I then go to an indirect assessment. That’s not enough. Sometimes you’ll see people stop there, but that really isn’t enough.

The next thing I need to do is that I need to go into the community and really observe the individual in the natural environment and find out what types of things are really going on. Is there a pattern of antecedents or triggers that I can find? Is there a pattern of consequences that people might not be aware of? Often, what I find is that, the results of direct observations surprise people because they don’t realize the patterns of the behaviors that they’re in at the moment.

I’m not just looking at problem behavior. I’m also looking at appropriate behavior. What types of ways does the individual communicate? What ways do they make choices? Can I build upon those things to help them get to where they want to be? Once I’m done with that, I then go back to the drawing table. I put all of my data together. This is not a short process as you can imagine. This isn’t a one-day process or anything like that. This often takes several weeks to complete. Then I come back, and we have a meeting where I put together a preliminary plan based upon my data.

Let’s say that the antecedent to a problem behavior is that a person’s working by themselves. When they work by themselves, they tend to get a little off-task and as they’re off-task, the coach comes over and gives them a reminder to get back on task. That reminder actually serves as a reinforcer for being off-task because they’re receiving attention for the problem behavior. I might suggest a different way to do things.

Now, are we stuck with that plan? Is my job done? No, it’s not. We have to test it out, see if it’s working, see if my hypothesis is really correct. I’m going to be coaching the staff on how to do implementation. I’m going to be taking data to see if things are working well. If they’re not, we’ll go back to the drawing board and we’ll do it again. It’s not unusual to have a couple of iterations of a behavior plan before you really hit pay dirt. If there are other things that are left over, things that were priority that we didn’t get to, I’ll start this process over again.

Slide 9- Now, before I talk about the difference between working with adults and working with children, and one of the biggest things about working with adults is that the individual is their own client, and they have the right to set their own goals. In fact, it really is best practice for individuals to set their own goals and for us not to tell them what they’re going to be working on. In my practice, I found that the typical goal-setting process was a little unsatisfying. It needed a little bit more structure.

What we started doing was a structured interview process. We’re doing some research on this right now. Keep your eyes tuned because you’ll probably see more of this throughout the years and you might see some publications coming out in the coming months. What we’re doing is that we’re using a structured interview where, right now, we have five domains: family, friends, social, employment, and education.

You might wonder why we’re using all five domains. It’s because all of these things do tend to impact our performance at work. I’m sure that you’ve had family situations that have impacted your performance at work. Certainly, education affects employment. There are lots of data to support that. We really want to make sure that we’re hitting on anything that could affect behavior at work. We ask individuals to think of words that come up when they think of these domains. We use visual supports for these as well.

Let’s use employment. Let’s say what are some words that come to you when you think of employment? They might say, Getting a job, making money, learning new things. Okay. People who get jobs make money, learn new things. What did they do? What do you see them doing? Well, they do what they’re told. Okay. Then I’ll ask, Do you do that most of the time or do you think that’s something that you want to improve upon? Let’s say the individual says they want to improve upon. Well, what are you doing right now? I don’t really listen and I don’t really ask for help. Great. Do you want to work on that, yes or no? If it’s a yes, we’ll work on it. If it’s a no then we table it. Again, I ask people to set three priorities for intervention. Then if we don’t get to everything, we can always do the process again.

Interestingly enough, we have had a lot of really good success with this process, especially, with individuals who in the past have been told, or other people have assumed that they can’t set their own goals. So far, we’ve done this with about 25 different people, and only one person has not been able to set their own goals using this process.

Slide 10- The process that I’m talking about here certainly needs refinement. There are lots of things that we can do and lots of things that we can support not only in K12, but also in the employment setting to help people set their own goals and really talk about problem behavior. I like to talk to parents and caregivers, and I tell them to think about things that will help their children get and keep jobs. As we talked about in the last presentation, we talked that it’s not necessarily just the job skills that people need, but also the social skills. It’s really those social skills and the soft problem behaviors that really keep people from getting and keeping a job. It’s not necessarily that they can’t file. I tell people to start early. If you’re seeing a problem behavior don’t wait, refer, get a behavior plan in place, and keep expectations high, advocate for professionals to make sure that they are keeping these things on the radar as well.

For professionals, we have to remember that we need to keep a lifespan perspective when we’re working with individuals. Early childhood professionals should be thinking about employment. Employment professionals should be interacting with early childhood professionals. We need to keep the eyes on the prize. The eyes on the prize is a good quality of life, and part of that is being able to work and live where you want to live and behavior supports can do that.

As researchers, we’ve got a boatload of work to do because a lot of this work is still in its infancy as far as supported employment in adults. Like I said, the literature’s very rich in K12, but for the most part the work in adult services and with supported employment is rather sparse especially community-based. We have a lot of stuff with individuals with very significant disabilities, but we really need to start working with individuals who may be deemed, and I almost want to put this in air quotes, high-functioning. Those are also the people who are falling through the cracks.

We also need to find ways to make sure that our work as researchers are getting to the practitioners. That’s why I was so excited to be working on this webinar today because I really want the work that we’re doing and the things that we’re finding to be able to influence practice. It’s not enough to do research in the ivory tower. Your research really needs to influence and impact the people who are working every single day. You need the input from those people to influence your research, and it really needs to be a circular process.

While this is all in its infancy, I think we’re going into a really good place. I think that Justin, Jessica, and Richard are going to give you some really good case studies on how this really can work in the community. I’m going to turn this back to Ann. Thank you very much for your time.

Ann Outlaw: Slide 11- Well, thank you very much, Chris. Now, I’ll just turn it over to Jess, who will discuss behavior assessment and intervention in the context of vocational rehabilitation.

Jessica Stehle: Slide 12- Thanks, Ann. Yes. In looking at who might benefit from behavior assessment and intervention, really there are various reasons why someone would benefit.

In general, we’re looking at people with complex needs. They had a history of difficulty with getting and keeping a job, and people who’ve demonstrated behaviors that were concerned or at the challenge of attaining employment or maintaining the jobs that they get. I mean as Chris had mentioned, people who are more in a restrictive placement, they could be at risk and in need of behavior support, and also people who maybe they’re not in a setting like a day program, but maybe they are in a job setting, where what’s being expected of them doesn’t match their intellectual ability and strength. They can also benefit from behavior assessment and interventions so that we can them at a job to commensurate with their ability.

When you have someone who we think that where they’re at in their lives is not matching their potential, it’s really important to bring in a professional and start, at least, with that functional behavior assessment. I definitely want to remind people that behavior support services are not limited to a specific disability population. Behavior assessment and intervention can be beneficial to people with all different types of challenges and strength.

Slide 13- At Virginia DARS, when we’re exploring behavior assessment and intervention, we first want to make sure that the individual is medically stable. In particular, we want to make sure that they’re not at risk to harm themselves or someone else. Behavior intervention should not take the place of psychiatric or medical treatment. It can definitely work well in conjunction with these types of care, but before getting started we first want to make sure a person’s medical needs are assessed and addressed by the appropriate professional.

The successes of behavior interventions are largely dependent on individuals having strong support teams to help them make the changes that they need to so that they can achieve their desired goals. A unified team that’s going to collaborate and problem solve is crucial. Team members have to be willing to communicate successes and challenges throughout the entire process that I include throughout the behavior assessment and then also the intervention. We really want to make sure that there is strong communication, as Chris had mentioned, that when you need to go back and make modification, adjustments to the plan, we can do that.

We also need to make sure that the people receiving behavior assessments and intervention services have team members who are willing to support them across that aim. As a VR counselor, that really needs to looked at up front. Without structured support, it’s hard for someone to change their current patterns of behavior. Ideally, we’d like people to have others to be able to support them at home, at work, and in the community, but it’s not realistic that everyone is going to have family members and friends who can help them with implementing their plan across the setting. There are times when the workspace is really the only place we can have a structure and have a job coach on-site to help with implementing the interventions on the plan. When that’s the case, that’s fine; we’re trying to work with people where they’re at.

In the instances where they may not be at the level of support needed to implement interventions at home and/or in the community and a person doesn’t have a job yet, we don’t just wait. We have behavior support specialist to start to get to know the person, understand the history of behavior challenges. They’ve been able to get a good understanding of what the plan is going to need to incorporate and also start to work with the individuals on identifying coping strategies that could be helpful.

Then once the person is hired and has a job, the full plan is written and starts to get implemented based on the specific work environment they’re in and the responsibilities that they have. While there are factors that promote positive outcomes for behavior intervention as best as possible, as I said before, we’ll try to meet people where they’re at given the level of support that they have and definitely if other specialists or professionals need to be included in this team, we want to make sure that we incorporate them.

Slide 14: In our last webcast, I talked about the role of the Vocational Rehabilitation counselor in regards to behavior support services. Right now, I’m just going to quickly recap the VR counselor’s responsibilities. The counselor is often the person to identify the needs for a behavior assessment. The need is typically determined by the counselor’s interaction with the individual and then also by reports from family members, teachers and clinic specialists or other professionals who are involved in the person’s life. The counselor doesn’t have to be the first person to identify the needs for behavior support services. That could be another team member who’s educated in behavior assessment and intervention that initially recognizes an individual could benefit from these services. Oftentimes, it is the counselor who sees the need. What if the other team members aren’t as aware of behavior support services? For this reason, it’s really important that VR counselors are knowledgeable about behavior assessment and intervention so that they’re able to appropriately identify individuals who could benefit from this type of support.

For teams who have members that aren’t familiar with the behavior support services, it’s the role of the counselor to provide that initial general education to help people understand why the counselor thinks this service could be appropriate and to help the team and the individual understand how this service could help the individual with reaching their goals. The counselor is also responsible for coordinating the behavior support services. This involves helping the individual and family get the information and the education they need to make an informed decision about provider selection. Having a good provider match is key to the process.

I’ll talk about how a unified team is also important to the success of the process and so it’s the role of the counselor to work with the behavior support provider to unify the team and really to promote collaboration. The VR counselor is responsible for making sure communication is consistent, and it’s clear among team members and that everyone is following through with the agreed upon responsibility. By keeping in close communication with the individual with his or her team members, the VR counselor is able to monitor the progress throughout the services and if progress isn’t being seen, then the counselor needs to be sure to discuss it with the behavior specialist so that the team can support it according to the plan.

In Virginia, DARS sponsors cost services for individuals who meet established financial needs criteria or who meet criteria to be exempt from financial participation. When DARS is sponsoring behavior support services, it’s the role of the VR counselor to authorize payment to the provider, to make sure that the provider is submitting monthly reports and bills, and it’s also the role of the counselor to be sure to review these reports and bills before they actually go ahead and approve payment. If the counselor has any questions or concerns about the services provided, it’s their responsibility to immediately contact the provider because again, we want to make sure that the individual is getting what they need.

Slide 15: To coordinate behavior support services, the counselor starts by consulting with the selected provider to gauge the piece about provider match. At DARS, we basically authorize up to 30 hours for the functional behavior assessment and the behavior support plan. The provider conducts an intake assessment to figure out the service needs of the person and then also to see if using therapeutic behavior services would be beneficial to this individual. If through that initial meeting, everyone’s in agreement about moving forward, then the provider conducts the functional behavior assessment. The provider submits the results of the FBA along with the written behavior support plan to the VR counselor, and the team meets to review the plan and to talk about how to implement it, and who’s responsible for what.

The provider completes the assessment and the plan by interviewing the individual and the support team members observing the individual in a variety of different environments like at their home, at their workplace if they already have a job, and also in the community. The provider assesses the need for modifications and adjustments across the different environments that they’ve observed the individual in. The provider also develops tools to collect baseline information and ongoing data in order for the team to be able to measure the progress being made with the individuals towards reaching his or her goal.

It’s also the role of the provider to train the support team members about general behavior intervention services, the specific goals, and objectives in the person’s plan. The provider is responsible for reviewing and evaluating and revising the behavior support plan as needed. The VR counselor needs to make sure that all of this is going on because this is what we’re expecting of the provider. Again, if there’s a concern then we need to talk to the providers to figure out how to make the necessary adjustments.

The behavior and support plans should include the goals and objectives that want to be addressed, the outcome measurement, the number of hours that potentially will be needed for the services and then also the schedule of the service delivery. The plan needs the statement of the proposed function of the person’s challenging behavior and also a statement that lists the environmental influences on the challenging behavior. The plan also needs to identify the most effective support techniques and reactive strategies to use when a challenging behavior is displayed. Replacement skills and behaviors have to be identified and strategies to teach these skills to the individual have to be included in the plan.

Then finally, the applicability of the plan across all these environments needs to be reviewed. Depending on the recommendations of the provider, other professionals might need to be added to the team. For example, if soft skills instruction is recommended, then the VR counselor would have to coordinate a provider for what we call in Virginia community support services. They work with the individuals; teach him or her their social skill training, personal hygiene needs, maybe travel training. We will have to coordinate that service and support.

Similarly, if after the FBA determined that the individual would benefit from consulting with the therapist, then the VR counselor needs to make sure that they’re working with the individual and the family to try and identify a provider that would be a good match, given whatever the mental health challenges are. As the plan evolves, the VR counselor has to be ready to support the person in accessing whatever services, specialists, resources, anything that’s needed to help facilitate a successful implementation of the plan and to help the person to achieve his or her goals.

**DARS expects that the nurse of therapeutic behavior services provides** services that are person-centered and person-directed and that the services and support are delivered in community-based settings where the person receiving the support works within sense of time. We also expect that services and support, they’re natural – they’re not intrusive and they’re not stigmatizing. The services of the provider are ended if the goals of the plans are met. If the VR counselor or the provider determined that the individual isn’t able to meet the goals of the plan for one reason or another, or if there are health and safety issues that make it clear that continuing with the plan isn’t actually in the person’s best interest.

Slide 16: Next, Justin Creech**,** he’s an endorsed Positive Behavior Support Facilitator, is going to walk us through a case example. Justin is going to talk about how he worked with Jamie, an individual who is receiving services from DARS, and how behavior assessment and intervention helped Jamie achieved employment and reached other goals that he had for himself.

Jamie has a diagnosis of autism spectrum disorder, and when Justin started working with Jamie, he was 24 years old and living at home with both of his parents. Jamie was referred to Justin because he had lost previous jobs due to aggression, socially inappropriate behavior, and threatening behavior. The team already knew Justin would be a good fit with Jamie because Justin had actually successfully worked with Jamie prior to him seeking employment.

The VR counselor involved with this case said that implementing positive behavior support services with Jamie made a huge difference. In working with Jamie, Justin was able to observe Jamie in more than one environment. He was triggering the challenging behaviors. He had to develop a plan to help Jamie alleviate his anger and learn how to better cope with challenging emotions. The counselor also said it was very helpful that once Jamie became employed, Justin assessed Jamie at his jobsite and made the necessary changes to Jamie’s plan to reflect how it should be used on the job and also to make sure that Jamie had the appropriate support in place while he was at work.

Slide 17: Here are the members of Jamie’s team. There was the DARS VR counselor, Jamie’s mom, and his job coach. At the time of services, Jamie was attending a day program so his day program supervisor was included in the team as was Jamie’s DD case manager. Then of course there was Justin, Jamie’s positive behavior support facilitator.

With that I’m going to turn it over to Justin to talk about how he worked with Jamie and Jamie’s team to provide behavior assessment and intervention.

Justin Creech: Thank you so much, Jess. We started out with the functional behavior assessment. Typically, what the assessment looks like is a combination of record reviews, observation across all settings.

Slide 18- We take baseline data and certainly we do interviews. The interviews are with the people who know Jamie the best. We did the combination of interviews, one at his day program, at least one, and then another one at his home where Jamie was more comfortable, and it was him and his mom. Sometimes these interviews took place with the entire team and other times it took more of an individual approach.

As far as the functional behavior assessment is concerned, my personal process takes approximately one to two months. Now, this can certainly be sped up if the VR counselor is looking for a more imminent plan due to risks on the job.

Slide 19- As far as looking at the behaviors, looking at the functional behavior assessment, we identified two behaviors that we wanted to reduce. These two behaviors were physical aggression and corrective comments. Based on the assessment, these were socially significant to Jamie because they were certainly negatively impacting his relationships with others and also affected his ability to gain employment.

One of the reasons that I was called was that he was working only with the job coach, and he was aggressive while he was with the job coach at an employment setting, and they were seeking a job. He was aggressive towards a peer that he knew from another place and so this evoked the choice of getting me involved and coming up with a plan.

Slide 20- With the two behaviors we’re looking at are the physical aggression and corrective comments, and these were operationally defined in his plan. We were able to come up with hypothesis statements. Hypothesis statements tell us why we think someone may be engaging in those behaviors based on the assessment that we did. What we found out was in the past, if the peer engages in a behavior that is aversive to Jamie, then Jamie may become physically aggressive towards the peer to escape the aversive behavior. Like I said, this was a physical aggression with a historical behavior that had occurred in a previous internship. He lost that internship due to this behavior. There was another incident with this job coach, which led the job coach to contact me regarding services.

As far as the next hypothesis statement goes, we’re looking at corrective comments. In the past, if someone engages in a behavior that Jamie perceived as breaking the rules or harmful to that person or others, then Jamie may give corrective comments to tell that person what they’re doing wrong. Basically, this happened towards peers and staff. Remember that Jamie was with his job coach. It happened while he was at home with his mom, and it also happened at day program.

Slide 21- We began collecting data at his day program and actually the baseline data reports were three to four times a week. According to the supervisor of that program, they said that it was under reported and it actually happened more often. We later looked at corrective comments a little bit differently within this plan that I think really helped us. We started looking more at his social skills to help him build relationships with others that may help him on the job. I’m going to talk about that a little bit more in detail once we get to the intervention part of the slides.

Slide 22- When we looked at a behavior support plan, we’re really looking at three main subjects. We’re looking at prevention strategies. We’re looking at teaching strategies, and we’re looking at reactive strategies. We’ll start with the prevention strategies. Again, these strategies were more well defined and more specific within his plan and discussed thoroughly within his team. I will say this is a collaborative approach. This approach that we have is not one where I come and say, “This is what we’re going to do.” This approach is one where I’ll come back with the team and we would share the ideas based on what we had previously come up with of why we think the behavior is occurring in the first place. With that type of collaborative approach, it can really increase buy-in.

With the prevention strategies here, we identified what triggers – or what doesn’t work for Jamie. We identified that a well-structured environment was very important to him. Another one was one person telling him what to do. This is very important to Jamie. In my interviews with him, he really got frustrated and upset when more than one person told him what to do, showing him what to do one time and then letting him actually do it.

He talked about his previous history at an internship where more people would tell him what to do, and they were showing him how to do it over and over again. He didn’t like this type of over-prompting. That was very important for the job coach to know. Allowing him time to finish the task he started. It really upset him when he began to do a task and then the person in charge, a supervisor of the internship or whatnot, would ask him to do something else while he has not finished that task, and so that was also a trigger for him.

Slide 23- Continuing with our prevention strategies, limiting the distractions was really important. Clear expectations - he had to have things very clear for him, very much in black and white, avoiding gray for him to understand it. A positive rapport between the supervisor and Jamie was really important. In the past, he’s had different supervisors or different mentors and coaches where he had gained positive rapport and those interactions worked out really well, but he’s also had ones in the past that did not work out. He’s also utilizing his strength of sorting and/or cleaning. These were his strengths based on his previous internship in the past.

Slide 24- Continuing with the preventive strategies for Jamie, a couple of other strategies were in plan which is preparation for changes and schedule, and having a five-minute warning in explaining the reason for the changes. It’s very important for people to explain why the schedule is going to change. Also task analysis and breaking down the task into simple steps is important for Jamie. He had an iPod and he had an app. I believe the app – if I remember it correctly was Visual This app was used in his day program and was used at home and on the job, which would break down the task and his schedule of duties. He could be independent by marking off each task as it was completed.

Slide 25- Possibly, the most successful strategy that I believe we had within this plan falls under the realm of teaching strategies. We used a five-point scale, and I’m going to show you that in a lot more detail on the next slide. We also used a stop-and-think card, which was used to support Jamie with corrective comments or move on to task without commenting. What this meant was, in fact if you get to see this, it’s basically a laminated card that has a stop sign on it. On the back of it said, “Is it affecting me in a harmful way?” It came out and it had arrows pointing to one side said, “No. We move on to the task.” Another side said, “Yes. Contact mom, day support supervisor, or job coach depending on working with that.” So the very concrete way to look at when he felt like he was going to give a corrected comment towards someone else. He had a lanyard and he kept the lanyard on him and it was in his pocket. This was something that he used for that.

**Slide 26- On our next slide, keeping view, this is our five-point scale.** This is what I mean. Looking at the scale, it’s very individualized. I work probably an hour to two hours with the team and Jamie on this particular slide, and I wanted to understand with Jamie’s anger, what it looked like at a one, two, three, four, and five. What it felt like at each number and then, what he can try to do? Basically, the appropriate coping skills we’re looking for are the replacement skills we’re looking for. How can we spot this early and help him? I’m going to pick out a number here and one of them was making random statements, so number three. Making random statements, repeating lines from movies, loud laughter may not be appropriate. He said he felt like at a three, “I’m not calm. It’s hard for me to focus. Frustrated.” Then he can try to listen to music if he said, at Day support, use a lanyard. He likes to actually put that in his hands and that helped him calm down. Also asking for a break and calling his job coach if it’s the daytime hours during days that he was at day support. This is what he can do to actually calm down from a three to a two, down to a one. Our goal was to lower that anger scale down to a one.

The team really bought into this. This is something we implemented across settings. We did this at day program and we did this at home. Jamie really bought into it to where we took each of these numbers, one to five, and then we had them all in a laminated card and then what to do on the back of a card. That was also a part of the lanyard that he kept all day. This was something that he initially had to be prompted to use, which is great because the staff could see, based on his comments here, what he looked like at a three or a four so on. Then eventually it was stated to a point where Jamie could do this himself independently which is our goal and then he would never even have to take out of the pocket to know what to do. He did it just from memory.

Slide 27- So moving forward, we’re going to move in to the reactive strategies for Jamie. These are basically reactive strategies and then what do we do when we see things we like, we see the things that we want to see more of, and what do we do when we see the behaviors we don’t want to see. That encompasses in this specific section. With the reactive strategies for Jamie, we want to give him specific praise for the behaviors that we want to see. We provided examples to this, in this plan. We wanted to utilize the five-point scale and provide praise for using those coping skills within the scale so he’s more likely to do it again in the future.

Slide 28- Other reactive strategies included a monitoring report. Now, when we had a monitoring report, this came in later in the intervention where we though this could be really helpful for the team as far as his impact at day program and while he transitions to a job. At this point, he didn’t have a job. He was looking for a job, but we want him to practice this at his day program now, so we’re already doing this and feel like he can be expert at it.

What this report was, what we focused in on a couple of areas that might impact relationships with others and on the job. Those were on task, respecting others, accepting feedback, attitude is positive in workplace. We focused on this at day program initially. All of these were clearly defined in the plan. Meaning, respecting others, a three and an excellent meant something very specific within this plan and two and one and zero and so on. What this report looked like was the day program supervisor and the job coach, when they were out doing job development sessions, would rate him on this at the end of the day with him and then he would rate himself and they would compare numbers. This was something that was also used later when he did get a job. We also used the stop and think card for corrective comments and of the reactive strategies section itself.

Slide 29- As far as outcomes, I’m happy to say, he was employed. He had competitive employment. I actually did see his mom at a conference I was speaking at not too long ago and he was still employed there. It has been well over a year where he’s been employed. He also actually moved out of his mom’s home into his own apartment with support. He’s using his five-point scale but it’s more independently, it’s more natural now at this point. I want to report on the margin report outcomes in a second, show you what that looks like in a graph, but we are no longer having to do that. There were no aggressive incidents. If you remember correctly, his historical behaviors, it was rare but certainly significant behavior when it comes to relationships with others and employment.

Slide 30- Just showing you the report, this is a report from the job coach. Remember we had this on a zero to three scale? I’m just going to show you from September and October of 2014 when we were doing the intervention and also when it started. It will show you how to better get on task, respect others, accept feedback, positive attitude and work pace. This was the average score that the job coach scored him on for a month. This is what it looked like. You can see he had really high ratings. Like I said, I wish we had before the baseline data to compare to this. But again, we were looking at corrective comments more at that point and by the time we got to the intervention, we just wanted to go ahead and put this in place.

Slide 31- Finally, this was the same look at - this was at day support. This was August 19th to October 6th and this shows his ratings during that time which is close to excellent on average. We really saw some improvements with him. I’m glad to hear he had positive outcomes and we really had a great collaborative team to work with. Thank you so much. I appreciate it.

Ann Outlaw: Slide 32- Thank you very much, Justin. It was great to hear his successful outcomes. Now we’ll turn over to Rich who will talk about how VR agencies can support functional behavior assessment and intervention to increase employment of individuals with disability.

Richard Kriner: Thank you. Thank you Justin and Christine and Jessica for the information you shared. As we move into my section of the slides, I’m going to be talking to you guys a little bit more broadly in terms of one of the most major considerations you want to look at if you’re in a state and you don’t have this type of service available yet and are interested in development. I think when we talk about development, you can really look at things and if we look at it really from the lens of what we’ve done here in Virginia, starting at the projects specific level of developing these services. For example, I’ll be talking from what lessons we learned as we started this behavior service program off with then an autism specific project. I think also you can look at the level of agency wide. Since we initially developed this and offered them specific programs, we have expanded it across our VR program for all disability populations. Then I think that end goal is looking at systems of alignment. So how do you prepare yourself as you develop these programs to set yourself up for success as you look to integrate and ensure that alignment with other programs and services that are already supporting this type of intervention.

Slide 33: This next slide here is just a visual. The main areas I’m going to be talking to you guys about are three core components. It’s going to be considerations around provider development, recruitment and retention, and then policy and practice. When all those things come together are really the areas you want to look at as you address the capacity development need. The other thing I’ll say on this is, these are all processes that are probably things - projects that you would get a deep parallel and not think that necessarily you would do sequentially. As I go through the slides, I’ve got some examples here.

Slide 34- Other than provider development considerations, this really gets to those knowledge and skills competencies and as we look at this from the perspective of a VR agency, what others think that are essential for our providers that are going to be implementing these services to come to the table with. As we drill down a little bit, we’re talking about things like education and credentials. For Virginia, one of the things that had a bearing on our decision on the direction we went is we already had a base of behavior service providers. Now they weren’t practicing vendors for our VR agency but they were working with other programs within our state. For example, since the ‘90s, we had positive behavior support facilitators working with adult and adolescent populations primarily through the Medicaid waiver. We also have behavior analysts who were involved in our system although historically, their emphasis had been on earlier intervention in school-age individuals and however that’s changed and there’s been an increased interest amongst our ADA providers to expand to the adult community. Going down, some of the other things is, for many as we looked at it and what we’re developing from the project specific perspective, some of those specializations that were important were that we were developing providers and promoting access to educational opportunities so that they understood autism and they understood evidence-based practices for supporting individuals with autism in the community, in the workplace. You can also get much more broad with this and as we’ve moved into an agency-sponsored program, you’re going to be looking at other types of specializations - folks that have training and background and understanding of brain injuries and substance abuse depending on where you’re going to go with it.

The other thing, we have a level, I would say, under the development considerations will be coaching and mentoring. As an agency, if you’re developing new vendor relationships, new health providers that are entry-level providers, what kind of strategies are put in place to ensure these entry-level providers that they have support as they’re really going about and learning their job for the first time. Are a few things like other systems, level strategies in place to provide coaching and mentoring? Are there specific agency strategies where there might be leaders embedded that have more experience in providing these types of interventions and have this credential? I’ll give an example. One of the strategies we did to address this in Virginia as it pertains specifically to our autism project. I think I’ll say looking at continuing education and how as a VR agency we can make sure that we’re offering viable opportunities or providers who might have credentials and are already required to do CEUs to gain additional knowledge, awareness, and possible skills in supporting our group of adults who are looking to find and maintain employment.

Slide 35- Another important consideration when we talk about training is not just around how do we look at our providers that we’re developing and our new vendor relationships, but what about the effects that are going to be a part of implementing and carrying out this kind of intervention? Again, I will give you a specific example here a little bit later but in Virginia, we wanted to make sure that we have counselors that work in the agency that we’re going to be responsible for the case management aspect of the source delivery, as well as our other providers. Our set of other providers, for example, like our job coaches and our vendors who are providing life skills training - again, I have information on behavior support intervention for our specific model and we’re looking at things like increasing the awareness and buy-in as well as promoting effective practice and consistent application of these interventions across the state and all local areas.

The other thing is, I didn’t include it on this and I think this is something that we’ve learned as we’ve gone along. I think if you’re in our state and you’re looking at the developing this stuff, you definitely would want to keep the family on the radar as well. So much of what we do, the family members are a critical part of the support team; they’re not only going to be involved in the process of developing the plan but they’re going to play a major role in having the community environment in terms of implementing interventions. So having them at the table will be very important as you look at training strategies.

Slide 36- Moving to the next slide, recruitment and retention. I think this really speaks to - there’s an existing pool of providers out there in your community and it really just depends on how your state is organized in terms of how they identify and maybe that providers that can do this type of intervention, but here in Virginia, when we we’re looking at it, we knew again that we had the PBSF folks from a historic perspective. I think we had about 80 or so those that were credentialed and providing services here in Virginia. We also had the behavior analyst community; I think it’s around 450 of those here in Virginia. We wanted to look at ways as we started the development service, made sure that we have capacity and promote access to this intervention. That’s why we have counselors and individuals that were supporting around Virginia that we were engaging folks that were out there and they were just maybe practicing via a different service stream.

So looking at strategies to engage in and educate our existing providers, making sure that they are aware of VR services and our reinforcement process and the type of environment that we are going to be working in. Some examples that you might look at things that we’ve done that worked well would be engaging providers and recruiting them to present for local offices or workshops that we might be doing or if there’s a - we have an association here in Virginia for our VR folks who are members of the National Rehab Association and we do conferences for that once a year. In fact, I’ve actually worked with Justin and some other providers to come in and do presentations at those conferences. That was a way to start that dialogue and to create that relationship. At one point, we had a community, a very vibrant community of practice going up in Northern Virginia to be like our Fairfax community where we had counselors, our behavior providers, our job coaches, our life skills providers. Just a range of providers at the table but we were really looking at the big picture and the types of gaps that existed and ways that we could go about implementing new partnerships to support access to a much needed evidence-based services and supports, and behavior interventions was part of that.

Looking at collaborating while finding opportunities, one of the things that really I think sparked a lot of what we were able to do around capacity development was a Autism Speaks community grant that we worked on and it included folks from our provider community included experts in some of our research institutions here. We were involved in some evidence-based research with the VCU RRTC. We certainly engaged them in the process as well as our providers and we use this as an opportunity to go about looking at a model and practice strategies but then also to develop and implement some training processes.

Slide 37- Moving to the next slide. I think this dovetails well into what I was saying. Probably about collaboration is really the key to success. If you’re out of state and you’re looking at developing the staff, it’s really going to be critical that you start off by taking a look at what’s really going on in your state already. What are the current guidelines and rules around behavior service providers? Which agencies they’re using and how is that funding stream work? Is there any research going on in your local community where this kind of work is being done? Then engage those experts, engage those partners, and bring them together as you go about developing your new programs for your VR agency. Looking at everything from the vendor requirements and again, that would get to the credentialing already a positive behavior support facilitators, is that something you already have going on in your state? On behavior analysts, are they managed through your board of health professions? Are they licensed and are they being used? So just making sure you’re parallel to what’s going and I think that sets you up for success in the long run when you look at broader systems alignment. Looking at definitions and practices, guidance tools, all those kind of things if you bring that - you engage other partners that are doing this stuff, and other experts and other stakeholders, you’re really setting yourself up for success. One of the things that we learned early on and it took us a little while to get this right, we’re setting the right rates for our providers. I’ll give you the example of one of the things - in fact I’ll talk about this in more detail when I give you my case example here shortly. Initially, when we put our rates out, we found that it really wasn’t something that was feasible for our providers for a number of reasons and we worked with them to address that, to make sure that we could recruit providers with those expertise that we really needed to implement these services and ensure it was done with fidelity and we had positive outcomes.

Slide 38- So moving to that next slide and this is where you’re going to hear some of those examples. This is a case example of how in Virginia, we look at provider development, develop some strategies and implement those strategies to address what we believe were gaps and development of important characteristics in the providers we’re going to be working with. This was specific to some of the work we were doing around autism, but we were able to release some of the funding we received from Autism Speaks to sponsor our small cohort of providers that worked with our job coaches who worked for our CRP agencies. Here in Virginia we call them POS or point-of-service organization. We targeted this group of folks because one of the things we wanted to make sure and this is going back to that first slide I shared with you guys is in terms of work experience and understanding that the providers we’re going to be working with, understood how VR worked, understood service delivery in community environment and in the workplace. So we found some job coaches that were willing and very interested in getting this credential and we had a small cohort getting through training and ultimately do some field work so that they could become credentialed as a positive behavior support facilitator and meet our vendor requirements, which at that time we were just developing.

The other thing that we did is, we felt like the training and development, you can sit in a classroom and you can learn the theory and you can learn the practice, you can learn the strategies, but developing the skills was going to be a really big, critical component of what we did. So we coordinated different fieldwork activities so that if these individuals were doing a portfolio development requirement, on this training and credentialing process we have here in Virginia that they were doing it and working with VR consumers. This not only benefited the individual trainees but the rehab counselors and the other providers that were sitting around the tables, as well as the individuals that they support also benefited from this. There’s an array of different benefits folks got from it, anywhere from just becoming more aware of the very effective strategy to clients who have positive outcomes as a result of the services that we’re providing.

The other thing that we wanted to look at when we put together our provider development process was ongoing training, that mentoring, that coaching and ways to support that entry-level provider that’s just going out there, doing something different, blazing the trail and that whole thing of Do your best and forget the rest. You got to start somewhere. We wanted to make sure that we had an opportunity to engage these folks and provide some continuous learning education and use a web-based model where we would bring the providers together once a month and we use some of our national experts to present content to these folks. We also included opportunities for folks of staff cases and then share resources and ideas with one another. We did this over the course of a year, continually engaging folks to support them. Then lastly, we piloted and tested these services and we use this as an opportunity to learn about what is and what isn’t going to work. The case you heard earlier from Justin was one of the first cases that we piloted. We took those lessons that we learned in terms of the process and the strategy and fine lines and teaming. We continued to take what we learn and build that in to our policy development and our training, our strategies moving forward.

Slide 39- For the next slide, I’m going to give you another case example and this gets to training your agency staff and the other providers who aren’t necessarily going to be the behavior providers but are most likely going to be at the table and be a part of that process. Our goal was really to create an awareness and understanding of back to behavior intervention and behavior interventions within the context of a VR setting. We wanted folks to understand our policy and guidelines and the kind of things that we would expect in terms of the different roles. What would be expected of rehab counselors? What might be expected of a job coach as a member of our support team or life skills trainer as a member of our support team? When we designed our training, we were looking at those different things. Again, we looked at creating opportunities for networking and teambuilding for counselors and field staff. A lot of our training strategies were integrating an emphasis on developing local level partnerships. There would be follow-up from one webinar to another that we might do or there might be opportunities where there was some face-to-face workshops done where we facilitated small groups and what we did.

Slide 40- Some examples of the kind of training that we provided the folks, we’ve done webinars, we’ve done on-site training, we’ve developed some web-based trainings that we want to make a available on demand to folks so that folks can access them whenever they need them or even if they’re going through them live, then it would be available if they wanted to go back and review. We’ve also embedded some experts within our agency. Again, this is program specific but I see it expanding and we’ve built it in a way to allow for this kind of scalability. When we’re talking about the autism project, one of the things we created was our autism subject matter experts. Then in addition to me we formed a statewide team to where we could work with these local level providers and our rehab counselors and we could coordinate team meetings. We could reach out to folks and communicate with them regarding training, even support needs and coordinate additional training or technical assistance or even provide some hands-on coaching and support as we were going about implementing these new services. That is it for my section of the presentation. I think we’re going to be moving on to practice guidelines next.

Ann Outlaw: Slide 41- Definitely. Well, thank you very much. Our previous webcast focused on the potential application of practice guidelines in VR service delivery.

Slide 42- So let’s pick up that discussion here. The first question we have is, how can practice guidelines help VR practitioners provide behavior support to clients? Who would like to answer this question on our panel?

Jessica Stehle: Hi. This is Jessica. I’ll answer that question. We feel that practice guidelines can clarify expectations for services. They can also highlight the need for a flexible and individualized approach to services. There are so many different reasons why people may be referred service behavior assessment and intervention, but each case really needs to be approached in an individualized manner. Practice guidelines can also help VR practitioners identify quality providers. Having credentials, qualified professionals is imperative to promoting positive outcomes and something that we really can’t stress enough. We feel like these guidelines could help with linking people in need of services with qualified providers.

Ann Outlaw: Slide 43- Now let’s discuss the second question. What type of information should the practice guidelines include? Again, we’re going to turn to our panel.

Jessica Stehle: There’s a lot of information that should be included in the practice guidelines. First, the guidelines should include how to identify a qualified professional. They could comment on educational training, credentials, and experience that makes a provider built to deliver quality behavior assessment and intervention services. We have some requirements in Virginia that we feel are helpful in promoting qualified professionals. For example, behavior analysts have to be licensed by the Virginia Department of Health Profession and they’re regulated by the Board of Medicine. These bodies enforce the standards of practice and also ensure patient competent care. Positive behavior support facilitators in Virginia have to be trained by the partnership for people with disabilities at VCU. This group provides oversight and distributes information related to PBSF practice standards. When developing practice guidelines around identifying a qualified professional, we would want to be sure that we’re tapping into information already out there. This could include the National Standards of Competency that was developed by the Association for Positive Behavior Support and that is a multi-distance disciplinary membership organization. Now, Richard’s going to give some other examples of information that we feel would be useful to be included in the practice guidelines.

Richard Kriner: Thank you, Jess. I think Jess covered the providers pretty well. Again, like I presented in that last section, I think as you look at providers and look at standards of practice, just realize that there’s going to be information benefit the national level and at a state specific level and information that relates specifically to the providers that you’re going to be working with in terms of their credentialing and whether the regulations and the rules that are part of that specific credential that they have. Some are being aware of those kinds of things, you just build it in based on that specific model that you’re going to use and recognizing those different levels of guidelines and regulations at the state and national level.

Slide 44- Moving to the next slide. These other things, again I think, as we developed our program here in Virginia and we developed our specific programmatic guidelines, we wanted to make sure that our rehab counselors and our office managers and other members of our staff that we’re going to be responsible for implementing these services locally, in support of consumers, have the very concrete information that they would need to know on how to make this work. A big piece of that is when do we refer somebody for services. That was something that we included in our training to something that we’ve included in our guidance document. I think one of the messages that we’ve really tried to push out to folks is that we want to be proactive in making referrals and that we don’t want to wait for that crisis. That’s that culture change I think for folks because it’s a new service. I think that folks are sometimes hesitant to try something new or anxious in that they might feel like they’re jumping the gun. Both in our guidelines and our training, we’ve really tried to alleviate that anxiety and support folks in terms of how to make those referrals and taking a very proactive step. One of the things that we’ve included in terms of how we tier our services that are provided to the vendors of our therapeutic behavior services, is there is an upfront consult. All I would say to folks if I’m doing technical assistance with them that it’s not going to hurt to reach out, speak to the vendor, once you selected a vendor that you feel is a good fit for that individual client and your needs and to flesh out whether or not this individual case warrants a full functional behavior assessment and client development.

I’m going to the next bullet here. In terms of quality indicators of a plan, we wanted to make sure that our providers understood what are the things that we’re looking at that are going to be core components of the service delivery. We really broke it down so that each individual step in the process is outlined for folks and we talk about the different services that will be provided. For example, if we look at the behavior plan, we broke down the behavior plan. We talked about the elements that we want to see in the behavior plan. Everything from the statement of the proposed function of the individual’s challenge of behavior to identifying - and not going in any order, the active strategies you use when challenging behaviors displayed. So the things, the terminology, and the guidelines that we put on in here weren’t necessarily things that we developed independently on our own but it was things that we developed based on that review of National Standards and Practices and based on the work that we did with our partner agencies and experts to look at what they were already doing, what we have learned, what’s working in other environments so that we could really be sure that we were taking and using those practice guidelines and standards and strategies that had been demonstrated to be effective.

Another thing that we put on here in terms of our quality - and we go to the quality characteristic. For us in the VR world, so much of what we do focuses on the end person’s center and we felt that was going to be a very important part of the characteristics of the service delivery for this behavior intervention and so we talked about the importance of person-centered thinking and person-directed types of strategies and process as well as services that are delivered out in the community and team based. Those were some of the things that were also included. We also defined and jump into that next bullet, what we talked about what the support team is and who would be part of support team. In addition to our guidelines document, I talked earlier about some of the on-demand trainings that we’ve done and we’ve created a PowerPoint session that specifically talks about the team and not only gets into the composition of the team but team facilitation and working with the team and being effective with the team. I think the other thing we’ve talked about is the continuing education.

Again in Virginia, we’ve stepped back a few bullet points and we’ve talked about the providers specifically in this state that we’re working with, the behavior analysts and the positive behavior support facilitators. Both of those providers have agencies that are overseeing their work and establish guidelines around this area of continuing education. I think it’s critical that you just crosswalk through those things that are going on and each state’s going to be a little bit different. In Virginia, our behavior analysts have oversight by our State Board of Health Professions and our Board of Medicine. So there are some very specific criteria there but I think part of that partnership and that reaching out is where we’re able to identify ways that we can create training opportunities that align well with those continuing education requirements that most providers would have as part of that credential and management bodies that oversee them.

I think we need to be looking at statewide considerations. Again this goes back to, if you look at it at multiple tiers, when we developed that program we started project specific. We went agency wide. Right now, I think it’s in its formative stages but we’re very much active at developing communication, collaboration, and coordination with our other partner agencies that provide this service. A specific example of something that we did recently is we had a work that is facilitated by our folks in our DD/ID community where VR was at the table, the Department of Education was at the table, we had stakeholders from our behavior analyst community as well as from our positive behavior support facilitator community. We sat down together and we developed a guidance document that talks about the knowledge and skills competencies for behavior services providers. It hit not only on those folks that are going to be the authors of the plans, those credentialed folks, but it also talked about direct support staff that are going to be responsible for implementing the plan. It’s a very comprehensive document and it was something that we all contributed to that we feel like is going to be really the cornerstone of some of what we do as we move into the future in terms of systems alignment and consistency with definitions, consistency with practice and process.

Then there are agency specific considerations. I think that’s something that we really already covered but it’s just part of what we need to make sure that we’re addressing as we work with folks. Not only training on the content of the interventions and the process, but training folks and guiding folks based on those processes and strategies that are going to be valuable and fit within the context of your VR agency. Recognizing a lot of what we do is short-term services. So within that guidance document, that’s something that we need to recognize, that these things sometimes need to be implemented on a timeline that fits within the context of how we do business and it’s not always a matter of you need to shorten the intervention but recognizing that interventions might also there might be several points of contact. We might work with a consumer that’s involved in VR services. For example, we might have somebody that comes in a VR agency and they’re in a training program or a community college and they might need some behavior service interventions initially and we stabilize them in that environment but as they transition to a new environment, we might reengage our providers and we’ll get modifying their strategies so that they generalize too, that new employment environment. So those are the things that I think would be important and the things that we’ve learned. There are lessons learned from what we’ve done here in Virginia.

Ann Outlaw: Slide 48- Thank you very much Richard. Finally, who should be involved in developing these practice guidelines?

Richard Kriner: At the risk of being too repetitive but I think one of the things that I really want to emphasize to folks who are in the process of development is the need to be a collaborative process. It’s going to be valuable in the long run if you have systems of alignment in terms of what other state programs are already doing around us. So you need to engage folks out there in your partner agency community. You should have stakeholders. I think it’s valuable if you can have individuals with disabilities and/or family members represented in any type of group process that you have to ensure that they have a voice in what you’re doing as well as the provider community at the table.

Ann Outlaw: Slide 47- Thanks, Rich. Well, I think that concludes today’s webcast. There’s more information for you to view here if you’re interested in any of these resources, they’re on this slide. Just email us at [ktdrr@air.org](mailto:ktdrr@sedl.org) if you need help finding any of these.

Slide 49- Finally, I’d like to thank everyone for joining us today, to our presenters especially. We hope that you found this webcast to be informative. I want to remind you that today’s event is one of the series of webcasts on knowledge translation from VR research to service delivery. Also, we intend that these webcasts will foster the creation of the community of practice where this dialogue among researchers, educators, practitioners, policy makers, and other stakeholders can continue to inform and serve those dedicated to vocational rehabilitation and its goals. To stimulate more discussion, we invite listeners to contact us to provide your input on today’s webcast, to share your thoughts on future webcast topics and to of course participate in our community of practice to continue this dialogue.

We’d like to hear from you because your views can inform and shape our work. You can contact us at the email address shown on this screen, which is [ktdrr@air.org](mailto:ktdrr@sedl.org). We would appreciate your input about the webcast by completing a brief online evaluation form. The [link is here](http://www.surveygizmo.com/s3/2346720/EvaluationComprehensiveBehavior) on the last page of the PowerPoint file and everyone who registered for this webcast will also get it in an email with a [link to the evaluation form](http://www.surveygizmo.com/s3/2346720/EvaluationComprehensiveBehavior). Once again, I want to thank Cindy Cai, Emma Hinkens, and Joann Starks and our colleagues at AIR and SEDL for their support. We also appreciate the support from NIDILRR to carry out this webcast and other activities. On this final note, I would like to conclude the webcast and we look forward to your participation in the next event. Thank you.