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MEANINGFUL COMMUNITY ACCESS AND SUPPORTS FOR PEOPLE RECEIVING HCBS

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This manual provides guidance to family members, direct support professionals (DSPs), and self-administered services recipients on how to facilitate meaningful community access and supports for people with disabilities receiving Home and Community-Based Waiver Services. The manual and corresponding training will review legislation and background supporting community access, community-based instruction, systematic instruction, and data collection.



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Module 1: Legislation and Background Information Supporting Community Access and Engagement



Module 1 provides information about the legislation and background information that supports the need for DSPs and family members to facilitate community engagement of people with disabilities. Community access and engagement for people with disabilities is an important component of high-quality Home and Community-Based Services (HCBS) waivers for residential and day supports.

After completing Module 1, you will be able to:

- Describe how legislation evolved over time to support meaningful access to community settings for people with disabilities
- Describe the continuum of supports/flow-through framework for disability service and limits to this framework
- Describe Medicaid Home and Community-Based Services (HCBS) waivers and the HCBS Final Settings Rule and how this rule impacts services



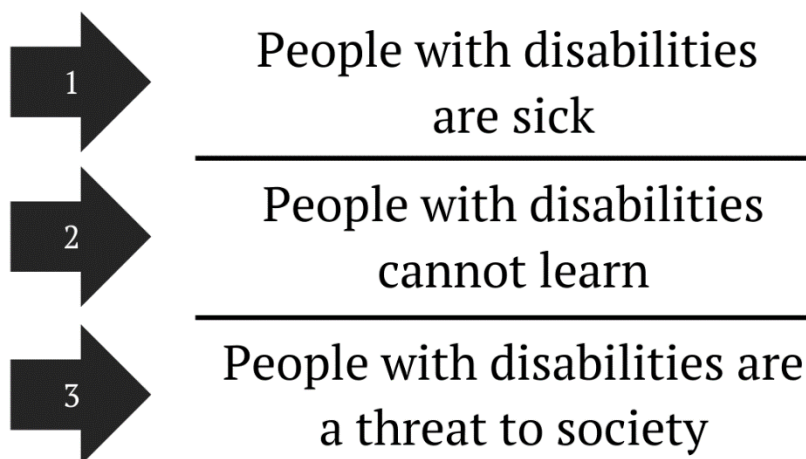
Continuum of Support/Flow Through Model

Specific factors such as legislation and consumer advocacy created an increased emphasis on community access and engagement for people with disabilities (PWDs). Despite what we know about supporting people with disabilities in a variety of home, educational, work, and community settings, people with disabilities have not always had the same opportunities to participate in these settings as their same-aged peers. When discussing community access for PWDs, it is important to describe the traditional continuum of supports and the limits this model places on people with disabilities receiving disability supports.

People with disabilities were often placed in large state-run, congregate institutions on the basis that they could neither be “fixed” nor “cured”. According to McDonnell, et al., 2003, the institutional paradigm was primarily based on three common misconceptions listed in Figure 1.1:

Figure 1.1.

Misconceptions about People with Disabilities



Institutions typically did not provide people with disabilities access to the community, instruction, or support on fundamental skills for independent living. Many advocates and policymakers viewed the conditions in these institutions as deplorable and believed that the placement of people with disabilities in institutions was dehumanizing. A major paradigm shift began to occur in the late 1960s and early 1970s. At that time, advocates for people with disabilities began to look for alternatives to segregated, institutional placements. The catalyst for this change was the principle of normalization (Nirje, 1969). Nirje defined normalization as:

“Normalization means a normal rhythm of day for the retarded. It means getting out of bed and getting dressed even when you are profoundly retarded and physically disabled. It means eating under normal circumstances: sometimes during the span of the day, you may eat in large groups, but mostly eating is a family situation which implies rest, harmony, and

satisfaction. A normal daily rhythm also means not having to go to bed earlier than your peers because you are mentally retarded, not earlier than your sisters and brothers,



or not to early because of lack of personnel... It is wrong when a retarded person, for example has his training classes, his structured therapies, and his recreation activities in the same building that serves also as his home.”

To achieve the principle of normalization, Nirje contended that people with disabilities need to be supported in a way that mirrors people without disabilities. Therefore, people with disabilities should not receive educational



services, structured therapies, and recreation opportunities in the same building that served as their home. In essence, the normalization principle reflects three major themes that have influenced disability policy: equality, quality of life, and human rights. Each of these themes are described in Figure 1.2.

Figure 1.2.

Principle of Normalization Themes



Wolfensberger (2000) expanded on the definition of normalization by discussing the idea of “social role valorization” (SRV). SRV examines the social impact that the roles we play in society have on our position, standing, and opportunities in the community. Simply put, SRV posits that people who fill roles in society that are valued by society typically have access to and



support from their communities. People who fill roles that are devalued by others will typically not be supported by their communities. This theory is important because community access and engagement are valued components of our society; when people with disabilities don't meaningfully engage in their communities, they may be devalued.

Disability services typically use developmental milestones of the person with a disability. These milestones use a medical framework that assumes that disability needs to be fixed or "cured" before people, especially those with more significant disabilities, can engage in the community. As a result, disability services developed and primarily used a hierarchy of services known as a "flow-through" or "continuum of supports." This approach was designed to teach people with significant disabilities prevocational skills that lead to employment and residential skills (Riesen, 2010). To achieve this goal, individuals receive service in a variety of facility or community settings as illustrated in Figure 1.3.

Continuums are commonly used in education, residential, and employment settings. The continuum of employment supports was conceptualized to teach people with disabilities skills that would eventually lead to employment. For example, in the employment continuum, people are placed in a variety of settings based on the achievement of certain developmental milestones. The continuum of placements includes day programs, work activity centers, sheltered workshops, and transitional employment. Movement in the continuum is based on the ability of the person with a disability to perform prevocational skills. Once a person demonstrates that he or she possesses certain prevocational skills, they can transition to a less restrictive setting. Unfortunately, the skills that are often taught in these settings are simulated and do not resemble actual community-based jobs. Consequently, the person may learn a prevocational

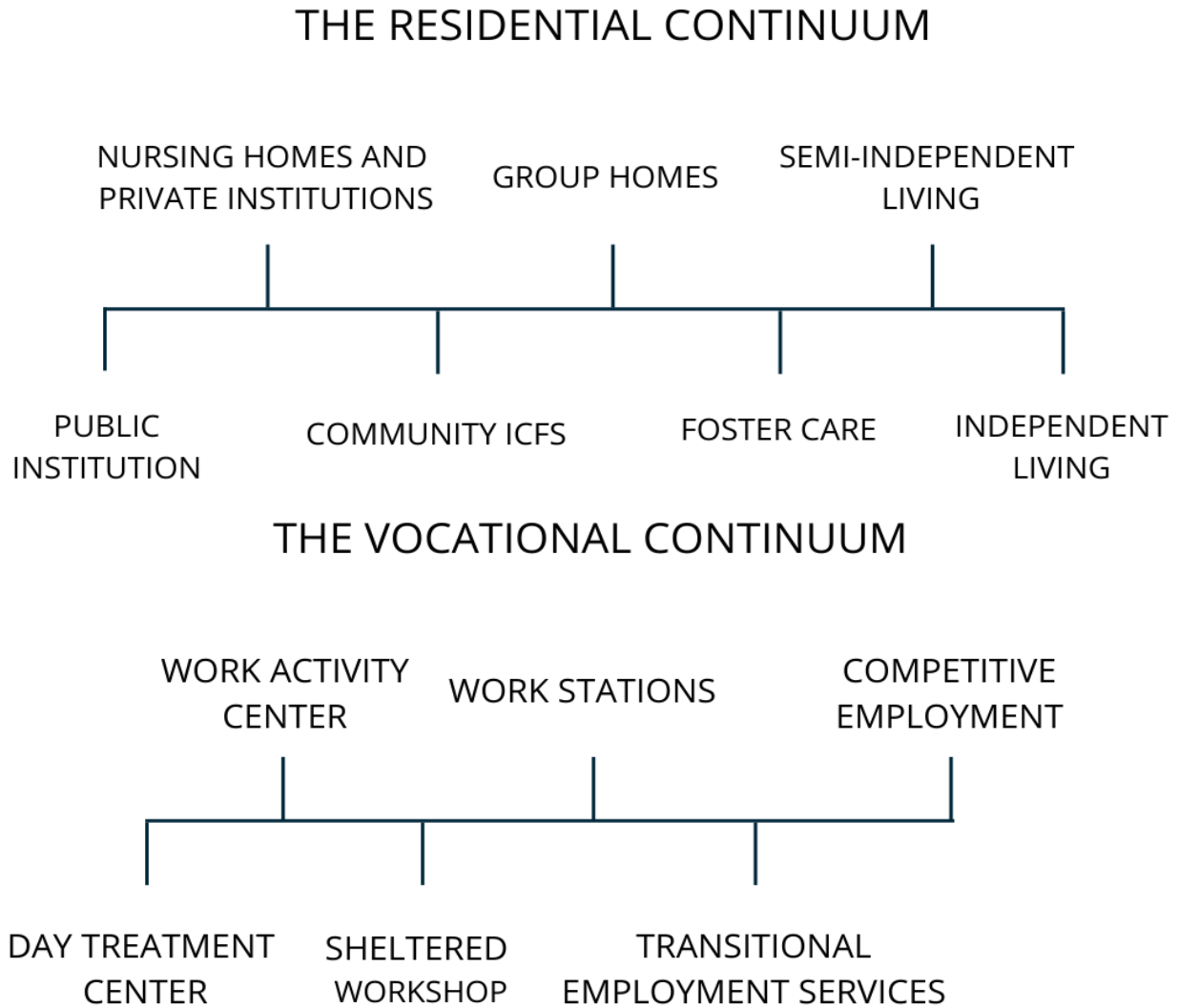


skill that they will not be able to generalize to an actual employment setting. This training approach does not necessarily prepare people with disabilities for the demands of community-based employment because research has shown that people with severe disabilities need to be provided instruction and support in the actual performance environments (Horner, McDonnell, & Bellamy, 1986; Westling & Fox, 2000). In addition, the development of social skills is also impeded when people with disabilities are placed in sheltered programs because they have less exposure to real-life social interactions. Finally, one of the greatest shortcomings of facility-based programs is that few people move from these settings to inclusive employment. Research has shown that once a person with a disability is placed in a sheltered setting, their chances of transitioning to inclusive employment are near zero (Zivolich, 1991).



Figure 1.3.

Illustration of the Continuum of Supports adapted from Taylor (1988)



Legislation Supporting Community Access for HCBS Recipients

There are approximately 3 million people in the United States who receive Medicaid Home and Community-Based Services (HCBS) with a combined Fiscal Year (FY) 2020 state and federal funding of \$116 billion (O'Malley Watts, Musumeci, & Ammula, 2020). The Utah Department of Health & Human Services reported that there were 6,348 Utah individuals on a Medicaid 1915 (c) HCBS waiver; people with intellectual disabilities represented 77% of these waiver recipients. HCBS waivers were conceptualized to provide a pathway to community integration for people with disabilities who traditionally received services in restrictive, institutional settings. While HCBS waivers have existed since 1981, the intent of these waivers has not been fully achieved. That is, some HCBS waiver recipients continue to have little choice in the supports and services they receive and do not have meaningful access to integration in community settings and activities.

Advocacy groups, researchers, and policymakers recognized this disparity and worked to improve meaningful integrated outcomes for people with disabilities for years. The 2014 HCBS Final Settings Rule represents a culmination of advocacy, legislation, and policy-making efforts. It is important to note that the Final Settings Rule is a progression and continuation of the values and ideas distilled in early legislation. Therefore, HCBS providers, parents, and others who are involved in supporting people with disabilities should have a basic understanding of key pieces of legislation. This legislation not only influenced the Final Settings Rule but is used to fund services and supports for meaningful community integration.



Social Security Act

Section 1915(c) of the Social Security Act of 1935, as amended authorizes the Medicaid HCBS waiver program. Section 1915(c) was created as part of the 1981 amendments to the Social Security Act. Before this amendment, the Medicaid program, which was created in 1965, provided little in the way of coverage for long-term services and supports in the community but offered full coverage for institutional care. This discrepancy was often referred to as the Medicaid “*institutional bias.*”

HCBS waivers were specifically created to address this institutional bias so that Medicaid programs could provide coverage for services in homes and communities. Medicaid waivers are intended to complement the regular services that are available through the Medicaid state plan. A Medicaid waiver waives certain statutory requirements, like requiring services to be provided in an institutional setting, so a state offers Medicaid beneficiaries the option of receiving services in their home and community. The Center for Medicare and Medicaid Services (CMS, 2015) gave states tremendous flexibility in designing the waiver. CMS specified various options for flexibility, some of which included (1) determining the target group(s) of Medicaid beneficiaries who are served through the waiver, (2) specifying the services that are furnished to support waiver participants in the community, (3) incorporating opportunities for participants to direct and manage their services, and (4) determining the qualifications of waiver providers.



The Americans with Disabilities Act

The Americans with Disabilities Act (ADA) was signed into law in 1990 and amended in 2008. This landmark legislation guarantees important civil rights for people with disabilities and ensures that people with disabilities have equal opportunities for access and employment. The ADA extends the civil rights, non-discrimination mandate of section 504 of the Rehabilitation Act to private employers and organizations that do not receive financial assistance. In the ADA's

“Historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem” (42 U.S.C § 12102 (a)(2)).

findings, Congress stated that people with disabilities continue to face forms of discrimination and isolation based on their disability.

The broader protections outlined in the five titles of the ADA prohibit discrimination against people with disabilities in employment, public services, public accommodations, transportation, and telecommunications. Professionals, parents, and people with disabilities should also understand the Title II integration mandate. The mandate states: “a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities” (28 C.F.R. § 35.103(d)). The integration mandate influenced the way programs and services are provided to people with disabilities and it enables people with disabilities to interact with persons without disabilities to the fullest extent possible. Figure 1.4 provides information about how the U.S.



Department of Justice (2011) defines integrated and segregated settings under the ADA.

Figure 1.4.

U.S. Department of Justice Definition of Integrated and Segregated Services.

Integrated vs. Segregated Setting	
Integrated	Segregated
<ul style="list-style-type: none"> • Integrated settings provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. • Integrated settings are located in mainstream society. • Integrated settings offer access to community activities and opportunities at times, frequencies, and with people of a person's choosing. • Integrating settings afford individuals choice in their daily living activities. • Integrated settings provide individuals with disabilities the opportunity to interact with nondisabled peers to the fullest extent possible. 	<ul style="list-style-type: none"> • Congregate settings populated exclusively or primarily with people with disabilities. • Congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on a person's abilities to engage freely in community activities and to manage their own activities of daily living. • Settings that provide daytime activities primarily with other people with disabilities.



HCBS Settings Rule

The Center for Medicare and Medicaid Services (CMS) issued the Home and Community-Based Waiver Services (HCBS) Final Settings Rule (CMS2249-F/2296-F) in 2014. The Final Settings Rule was designed to enhance the quality of HCBS programs and increase opportunities for people with disabilities to have meaningful access to integrated community settings. According to the CMS, the Final Settings Rule requirements establish an outcome-oriented definition that focuses on both the nature and quality of a person's experience. As such, the settings requirements are designed to maximize opportunities for people with disabilities to have access to the benefits of community living and the opportunity to receive services in the most integrated setting.

The Final Settings Rule allows states to develop a transformation process to meet these new requirements and states have until March 2023 to be in compliance with the final rule. One of the challenges of meeting these requirements, however, is ensuring that provisions set forth by the Final Settings Rule promote meaningful access to the integrated community (Friedman & Spassiani, 2017). That is, services and supports need to be designed to ensure that people with disabilities are not simply physically relocated to the community but rather access to community settings is individualized and supports a full range of meaningful options. Unfortunately, many PWDs and their families do not fully understand the complete impact of the Final Settings Rule and provider organizations are struggling to understand and implement the required changes (Friedman, 2018). Given these challenges, it is increasingly important for people with disabilities, family members, and provider organizations to understand how to develop supports and services that meet the regulatory intent of the Final Settings



Rule. This manual is designed to be used by providers who receive HCBS funding as a guide on how to meet the requirements of the Final Settings Rule. Part II of this manual provides specific information about HCBS terminology and provides a series of exploratory questions developed by the Center for Medicaid Services (CMS, n.d.) to assist with the assessment of Final Settings Rule compliance for residential and non-residential settings. These questions should assist provider agencies with determining whether the residential and non-residential settings meet the Final Settings Rule requirements.

Quality Indicators

The Final Settings Rule promulgated specific regulatory changes designed to ensure that people receiving Medicaid-funded HCBS are provided with opportunities to have meaningful community integration and choice. Specifically, as outlined in Section 441.301 (c)(4) any residential or non-residential setting where people live or receive HCBS must have the five qualities outlined by the U.S. Department of Justice as referenced in Figure 1.4.

In addition to the quality indicators, the CMS outlines 12 settings characteristics that meet the Final Settings Rule criteria for both residential and non-residential HCBS settings. Some of the 12 characteristics apply to only residential settings while some apply to both residential and non-residential settings. Table 1.1 provides statutory language for each setting's characteristics and its application to residential or non-residential settings. This manual will highlight how each of these characteristics aligns with specific provisions of the Final Settings Rule.



Table 1.1.

HCBS Residential and Non-Residential Settings Characteristics

HCBS Settings Characteristics	Residential	Non-Residential
<p>1. Setting is integrated in and supports full access of people receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.</p>	<p>X</p>	<p>X</p>
<p>2. The setting is selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person’s needs, preferences, and for residential settings, resources available for room and board.</p>	<p>X</p>	<p>X</p>



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<p>3. The setting ensures a person’s rights of privacy, dignity, respect, and freedom from coercion and restraint.</p>	X	X
<p>4. The setting optimizes, but does not regiment a person’s initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.</p>	X	X
<p>5. The setting facilitates individual choice regarding services and supports, and who provides them.</p>	X	X
<p>6. The person has a lease or other legally enforceable agreement.</p>	X	
<p>7. The setting ensures the person has privacy in their sleeping or living unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit.</p>	X	
<p>8. The setting ensures the person has the freedom and support to control their schedule and activities and have access to food at any time.</p>	X	



COMMUNITY-BASED INSTRUCTION AND SUPPORTS

9. The person can have visitors of their choosing at any time.	X	
10. The setting is physically accessible to the person.	X	
11. The setting ensures that any modification of the HCBS Settings qualities and conditions is supported by a specific assessed need and justified in the person-centered service plan.	X	X
12. The setting enforces the Home and Community-Based Settings Regulation requirements.	X	X

HCBS Final Settings Rule for Community Integration

Historically, people with disabilities had limited opportunities to engage meaningfully in community activities and settings. Before HCBS, many people with disabilities were placed in large congregate institutions with limited or no community access.

When HCBS waivers were adopted by states in the early 1980s, people receiving waiver services were afforded more opportunities to engage in meaningful residential and non-



residential settings that were less restrictive. However, many HCBS waiver recipients still do not have access to the full range of community options available to people without disabilities. The ADA Title II integration mandate and the Department of Justice reinforced the notion that services, programs, and activities should be provided in the most integrated setting possible. Cullen et al. (1995) suggest that while people with disabilities are being physically located in the community, they are not meaningfully integrated and engaging in the full range of community options. Figures 1.5 and 1.6 outline considerations for service providers for integration and engagement in the community. The Final Settings Rule is designed to ensure that the HCBS recipients are provided with opportunities to have meaningful community integration and choice.



Figure 1.5.*Considerations When Developing Services & Supports for Residential Providers*

- 1** Do individuals come and go at will? Is there a curfew or other requirements for a scheduled return to the setting?
- 2** Do individuals in the setting have access to public transportation? Are there bus stops nearby or are taxis available in the area? Is an accessible van available to transport individuals to appointments, shopping, etc.? Are bus and other public transportation schedules and telephone numbers posted in a convenient location?
- 3** Does the individual work in an integrated community setting? If the individual would like to work, is there activity which ensures the option is pursued?
- 4** Does the individual participate regularly in meaningful nonwork activities in integrated community settings for the period of time desired by the individual?
- 5** Is the setting based in a location that facilitates integration within the greater community including access to restaurants, businesses, and other residential areas? The setting should NOT be located in a facility that provides inpatient treatment or is adjacent to a public institution.



Figure 1.6.*Considerations When Developing Services & Supports for Non-Residential Providers***1**

Does the setting provide opportunities for regular meaningful non-work activities in integrated community settings for the period of time desired by the individual?

2

Does the setting afford opportunities for individuals to have knowledge of or access to information regarding age-appropriate activities including competitive work, shopping, attending religious services, medical appointments, dining out, etc. outside of the setting, and who in the setting will facilitate and support access to these activities?

3

Does the setting allow individuals the freedom to move about inside and outside of the setting as opposed to one restricted room or area within the setting?

4

Is the setting in the community or building located among other residential buildings, private businesses, retail businesses, restaurants, doctors' offices, etc. which facilitates integration with the greater community?

5

Does the setting encourage visitors or other people from the greater community (aside from paid staff) to be present, and is there evidence that visitors have been present at regular frequencies?



Person-Centered Planning

The HCBS Final Settings Rule reinforces the idea that person-centered planning is directly linked to positive community outcomes for HCBS recipients. Person-centered planning (PCP) should be a primary strategy that assists HCBS recipients with accessing meaningful, integrated settings and achieving valued outcomes such as competitive integrated employment. PCP emerged in the 1980s as a strategy to understand and discover how a person with a disability would like to live his or her life and to determine what supports are needed to help the person achieve their goals (O'Brien, O'Brien, & Mount, 1997). Several requirements for the PCP process and the person-centered service plan are outlined in the CMS Home and Community-Based Services Waiver Requirements (42 CFR 441.301(c)(1), et seq.). Each of these requirements are shown in Figure 1.5. The HCBS requirements also stipulate that each person-centered service plan should be reviewed and revised upon reassessment of functional needs at least every 12 months or when the person's circumstances or needs change significantly, or at the request of the person.

When facilitating the person-centered planning process, steps must be taken to ensure the person with a disability leads



the person-centered planning process, unless state law confers decision-making authority to a legal representative (42 CFR 441.201(c)(1)). Regardless of who has decision-making authority, the person-centered planning process

should be driven by the person receiving HCBS services to the maximum extent possible so that the HCBS recipient achieves person-center outcomes in the most integrated setting. The



waiver requirements state that those who provide HCBS, or those who have an interest in or are employed by a provider of HCBS for the person, **must not provide case management or develop the person-centered service plan**, except when the State demonstrates the only willing and qualified entity to provide case management and/or develop person-centered plans in a geographic area also provides HCBS. The HCBS waiver requirements also stipulate that the person-centered process should include several important elements which are discussed in Table 1.2.



Figure 1.5.

HCBS Waiver Requirements for Person-Centered Planning



- The individual may invite anyone they feel is necessary to their meeting. this could include family, friends, teachers, significant other, coworkers, etc.
- The individual should be educated on how the planning process works, including how to schedule their own meeting, and how the development of their plan works. This includes knowing how they can update their own plan.
- The individual should be informed about the choices they will be making about services and supports during their meeting.
 - For example, options of living circumstances should be discussed and visited before the meeting is scheduled so the individual can clearly understand their choices.
- The individual is provided with a method to request updates to the plan as needed.



- The meeting should occur at a time and place that is convenient for the individual.
- The person-centered planning process reflects cultural considerations of the individual.
- A strategy should be in place for solving conflicts or disagreements during the process, including clear conflict-of-interest guidelines for all planning participants.



Table 1.2.

HCBS Waiver Requirements

Item	Requirement
1	The written plan must reflect that the setting in which the person resides is chosen by the person. The State must ensure that the setting chosen by the person is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as people not receiving Medicaid HCBS.
2	The written plan must reflect the person's strengths and preferences.
3	The written plan must reflect clinical and support needs as identified through an assessment of functional needs.
4	The written plan must include individually identified goals and desired outcomes.
5	The written plan must reflect the services and supports (paid and unpaid) that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.



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6	The written plan must reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
7	The written plan must be understandable to the person receiving services and supports, and the people important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited to English proficient.
8	The written plan must identify the person and/or entity responsible for monitoring the plan.
9	The written plan must be finalized and agreed to, with the informed consent of the person in writing, and signed by all people and providers responsible for its implementation.
10	The written plan must be distributed to the person and other people involved in the plan.
11	The written plan must include those services, the purpose or control of which the person elects to self-direct.
12	The written plan must prevent the provision of unnecessary or inappropriate services and supports.
13	The written plan must document that any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan.



Module 1 Summary and Key Takeaways

Module 1 outlined the legislation that supports meaningful community access for people with disabilities. HCBS waivers play an important role in community engagement. HCBS waiver providers must take steps to ensure that waiver recipients are provided with services and supports that meet the Final Settings Rule. All waiver services must meet these requirements by March 2023.

Key takeaways:

- The continuum of supports or flow-through framework limits the support people with disabilities can receive
- Legislation has evolved over time to support meaningful access to the community for people with disabilities
- Medicaid HCBS and HCBS Final Settings Rule provide people with disabilities the opportunity to fully participate in the community



Key Terms and Phrases	
Term/Phrase	Definition
Center for Medicare and Medicaid Services (CMS)	CMS is the federal agency that works with states to administer Medicare and Medicaid. CMS provides interpretive oversight and guidance regarding the Final Settings Rule
Integrated Setting	The Department of Justice defined integrated settings as those that provide people with disabilities opportunities to live, work, and receive services in the greater community, like people without disabilities. Integrated settings offer people access to community activities and opportunities at times, frequencies, and with persons of a person’s choosing
Institutional Bias	Favoring an institutional setting over services delivered in the home or community
Person-Centered Plan	Outlines individualized goals that are relevant to the person receiving services
Settings that are NOT Home and Community-Based	Private and public institutions. A public institution is an inpatient facility financed and operated by a county, state, municipality, or another government unit



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Module 2: Describing Community-Based Instruction and Supports



The previous module provided information about how services have evolved to support the idea that people with disabilities should be provided with opportunities to meaningfully engage in community settings. Policy and legislation require to ensure that HCBS waiver recipients are provided with supports to fully access community settings. To ensure quality access, people with disabilities need to be provided with the instruction and supports necessary to meaningfully engage in their communities. Quality programs use validated community-based instruction and support to increase access to the community. Module 2 provides an overview of community-based instruction and support.

After completing module 2, you should be able to:

- Describe quality of life and quality of life measures
- Describe community participation
- Describe natural supports and how they support CBI and community participation
- Describe community-based instruction and support
- Describe functional skills and how they relate to CBI and supports
- Describe the difference between CBI and activities/outings
- Describe the benefits of CBI



Quality of Life

Quality of life (QOL) refers to how well a person's life is going and if they are satisfied with their life. Figure 2.1 outlines the quality-of-life framework described by Schalock, et al. (2002). DSPs should use this framework when providing instruction to teach functional skills and developing supports to maximize community access. Continually using the QOL framework is important because people with disabilities are traditionally marginalized and experience higher levels of segregation and isolation from peers without disabilities (Wilson et al., 2017).



Figure 2.1.

Schalock et al. (2002) Quality-of-Life Framework

- QOL is composed of the same factors and relationships for people with intellectual disabilities that are important to those without disabilities.
- QOL is experienced when a person's needs and wants are met and when one has the opportunity to pursue life enrichment in major life settings.
- QOL is primarily the perception of the individual that reflects the quality of life they experience.
- QOL is based on individual needs, choices, and control.
- QOL is a multidimensional construct influenced by personal and environmental factors, such as intimate relationships, family life, friendships, work, neighborhood, city or town of housing, education, health, standard of living, and the state of one's county.

Storey (2022) outlines specific QOL measures that DSPs can use when planning to support people with disabilities to meaningfully engage in their homes and communities. Storey's measures of quality of life are summarized below:

Physical well-being. Physical well-being includes, but is not limited to, nutrition, fitness, and personal safety. DSPs should take these factors into consideration when referencing the physical well-being quality of life measure. For example, a person



with a disability, with the support of their DSP, may decide to meal plan nutritious lunches they can take to work.

Material well-being. Material well-being includes wealth-ownership and housing quality. DSPs should take these factors into consideration when referencing the material well-being quality of life measure. For example, a DSP may decide with the person with a disability to label food the person with a disability owns so their roommate doesn't eat it.

Social well-being. Social well-being includes interpersonal relationships, social support networks, and community involvement. DSPs should take these factors into consideration when referencing the social well-being quality of life measure. For example, a DSP may talk with the person with a disability and decide together that the person with a disability will attend a pottery class with their friend.

Productive well-being. Productive well-being includes, but is not limited to, personal development, choice and control, and employment. DSPs should take these factors into consideration when referencing the productive well-being quality of life measure. For example, a person with a disability, with the support of their DSP, will choose their own schedule for the day.

Emotional well-being. Emotional well-being includes, but is not limited to, life satisfaction, religious belief, and self-esteem. DSPs should take these factors into consideration when referencing the emotional well-being quality of life measure. For example, a person with a disability, with the support of their DSP, may decide that they will attend the church service of their choice.

Civic well-being. Civic well-being includes, but is not limited to, privacy, protection under the law, and voting rights. DSPs should take these factors into consideration when referencing the civic well-being quality of life measure. For example, a DSP may talk with the person with a disability and recognize that the person needs help registering to vote.



Improvement of Quality of Life

Because of societal changes, the lifespan of people with disabilities has increased. Older adults with disabilities have reported a higher quality of life when they have meaningful relationships, social roles, and control over their lives (Friedman, 2019). In addition, people with disabilities report more frequent participation in the community when employed. Employment leads to more choice and control, provides a livelihood, and opportunities for social networking. Social support has proven to have a positive psychological impact on those with disabilities. Relationships provide resources, information and advice, emotional comfort, and distraction from stress (Blick et al., 2016; Silverman et al., 2017; Soresi et al., 2011).

Sheth et al. (2019) found that community living leads to a higher quality of life for people who previously lived in institutions and transitioned to living in the community. Sheth and colleagues outline four specific areas of life to determine if community living improved quality of life, including:

1. **Living situation:** People with disabilities who transitioned to community settings were over 14 times more likely to enjoy where they lived in the community than in an institution. They were almost twice as likely to feel safer living in the community. People responded that they had more involvement in choosing their community living situation and getting more undisturbed sleep.
2. **Choice and control:** People with disabilities who transitioned to community settings had significantly more choice and control in daily activities and routines in the community. These people were 20 times more likely to be able to choose who provided the help if they needed assistance in daily living skills. In addition, people living in the community had greater opportunities to express



- choice when it came to when to eat, what to eat, when to be alone, when to go to bed, when to watch tv, and what to watch on tv.
3. Dignity, respect, and access to personal care: People with disabilities who transitioned to community settings and needed help with daily living skills explained that they had better experiences with caregivers treating them with respect and listening to their needs in the community. People living in the community also had increased access to hygiene and medication.
 4. Community integration and inclusion: People with disabilities who transitioned to community settings reported higher rates of community integration and inclusion. People were over twice as likely to be able to leave their homes without having to pre-plan a community activity. There were higher rates of seeing family and friends, accessing errands or work activities, and attending leisure events.

Participation in the Community

As mentioned above, community participation is a critical component of QOL measures. The American Association on Intellectual and Developmental Disabilities (AAIDD, 2010) identifies participation as one of the five domains of life that influence human functioning. AAIDD refers to participation as the performance of people in actual activities in social life domains, including, home living, work, education, leisure, spiritual, and cultural activities. In addition to participation, AAIDD recognizes intellectual abilities (i.e., general mental ability, such as planning, problem-solving, and comprehending ideas), adaptive behavior (i.e., conceptual, social, and practical skills people do in their everyday lives), health (i.e., the overall state of one's physical, mental, and social well-being), and context (i.e., the interrelated conditions within which people live their everyday lives, such as



their families, communities, and cultures) as the remaining domain that influences human functioning. Research suggests that community participation has been linked to positive health and well-being (Dean et al., 2016). Participation places emphasis on community inclusion and personal self-determination. People with disabilities who experience inclusion and support are more likely to participate successfully in the community (Soresi et al., 2011). Research suggests people with disabilities experienced a significant increase in participation in community integrated activities when they were simply present in the community; an additional increase was found when people with disabilities actively participated in the community (Thorn et al., 2009). Additionally, teaching skills to people with disabilities in community settings promotes learning, generalization, and maintenance of skills (Gilson et al., 2017).

Natural Supports

The use of natural supports allows for continued access to the community for people with disabilities. Figure 2.2 outlines considerations for creating natural supports. Direct support professionals (DSPs) can help people with disabilities gain natural supports through CBI.



Figure 2.2.*Considerations for Creating Natural Supports*

- Discuss the idea of developing natural supports with the client.
- Is the person comfortable using natural supports?
- Explain to the natural support his or her role which emphasizes guiding and supporting; not completing any tasks or skills for the person.
- Look for both formal and informal opportunities. For example, a formal support may be a cashier helping the person at a grocery store whereas an informal support may be a friend helping the person at a coffee shop.

Types of natural supports outlined by Trach and Mayal (1997) are provided below:

Community supports. Regardless of whether you live in a rural or urban area, the community has a support system available to all people. For people living in urban areas, the community may offer services such as public transportation systems, YMCA programs, and formal disability-specific advocacy groups. For people living in more rural locations, community support systems may include fewer formal programs like Rotary clubs, church groups, and 'tight-knit' community relationships. Regardless of the types and availability of support in different communities each will have a unique way of supporting the citizens within it. A DSP needs to carefully consider what the



particular community has to offer and ensure the people with whom they work have access to these types of supports.

Organizational supports.

Many routines within a person's life may fall outside of a trained skill but are nonetheless essential for community participation.

Organizational supports allow for a person to receive assistance in preparing for and organizing

activities in the community. These may include an alarm clock, a bus schedule, an electronic device, or knowing the layout of a grocery store.

Physical supports. Consideration of the design and function of physical objects and equipment in a setting is an important step to ensuring the success of the person in their community. Are aisles wide enough for a wheelchair to pass through? If an item is out of reach for the person, is it possible to use a reaching tool or ask for assistance? Will the lighting, or lack thereof, be an issue for the person? Consideration of a person's individual needs, paired with the physical environment, can begin during instruction and continue as issues arise.

Social supports. Ongoing interaction with others in a person's community is vital to meaningful community participation. When considering social supports in a community setting it's essential to allow a person to decide whom they are interacting with and where they are interacting. When a person likes what they are doing and whom they are doing it with, they are more likely to successfully engage in their communities. Unfortunately, this can also be one of the most difficult support systems for PWDs to establish. DSPs must consider the ongoing

Natural supports allow for the ordinary cues that exist in the environment to help people know what to do. For example, a person can use natural supports to understand that when someone smiles and says "hello," they should respond with a greeting (Causton-Theoharris, 2009).



routines of others (i.e. when people frequent bars or cafes) to ensure that a person is included in these activities.

Service supports. Accessing professional and non-professional disability-related services is a crucial part of achieving quality community participation for people with disabilities. However, these services can be hard to access and people with disabilities may not even know they exist or understand what services they provide. Because of these issues, the DSP must be knowledgeable about various programs (e.g., flex transit, independent living centers, etc.) to help a person make decisions about potential supports and how to access them. DSPs must keep up to date on this information by continuing to receive additional training provided by local and state agencies and independently seeking out information from reputable sources (i.e. professional organizations, institutions of higher education, and disability advocacy groups).

What is Community-Based Instruction?

Community-based instruction (CBI) is an instructional strategy that is commonly used to support youth and young adults receiving special education and related services to engage in the community. CBI provides people with disabilities the opportunity to learn specific skills needed to meaningfully engage in the community. These skills are taught at regularly occurring intervals and ongoing data collection and assessment are used to determine the person's progress toward learning the skill and becoming independent (Hopkins & Dymond, 2020). Providing instruction in applied community settings is important because people, especially those with more extensive support needs, often have difficulty generalizing tasks. People with disabilities who require any amount of support can gain independence and



generalization of skills across many settings with the use of CBI and corresponding support. The process of CBI should be continuous, sequential, interactive, and instructive. Each step of CBI should teach functional skills that align with a person’s goals (Beakley et al., 2003). Direct support professionals can use CBI and corresponding supports to ensure that HCBS recipients have meaningful access to their communities.

Generalization occurs when a person engages in a community skill or task in trained and untrained environments. For example, if a person learns to use an ATM at the bank, he can also use an ATM at a hotel.

Functional Skills

Functional skills are skills needed to independently engage in a variety of school, employment, residential, community living, and recreational/leisure settings. Functional skills should have immediate utility for the person and should be identified based on information obtained during the person-centered planning process. For example, if a person with a disability living in a residential setting expresses interest in grocery shopping and cooking, functional skills to support these interests include, (a) learning to ride the bus to the grocery store, (b) shopping for groceries, (d) meal preparation. Direct support professionals should consider four major types of skills taught in the community for CBI (Storey, 2022). Refer to Table 2.1 for examples of the skill types as adapted from Storey (2022).



Table 2.1.

Four Major Skill Types and Community Examples

Skill	Community Settings	Relating Skills to the Person
Travel & Mobility	Public transportation, crossing the street, driving a car, walking/bike trails	Crossing the street at the crosswalk near the person’s house
Community Skills	Shopping centers, restaurants and cafes, medical facilities	Shopping at the grocery store of the person’s choice
Recreation/leisure	Gym, movie theater, museum, library	Attending a yoga class over a boxing class because they prefer yoga
Financial Skills	Bank, using an ATM, payment methods	Withdrawing money from the ATM at the person’s bank

The direct support professional should ensure the skills they teach people with disabilities are specific to the situation and person. People with disabilities who participate in CBI are more likely to



complete more steps of a functional skill independently and maintain those skills. Additionally, teaching functional skills that relate to a person's goals increases the chance of a higher quality of life for the person (Storey, 2022; Hoover, 2016). Figure 2.3 provides context for making sure the skills are related to the person.

Figure 2.3.

Relating Functional Skills to the Person

- The skill produces something useful for the person or is part of a broader skill that does so.
- The skill has a desirable outcome for the person.
- The skill is acquired through interactions with more than a single (caregiving) person.
- The skill is acquired in the natural setting.
- The skill is likely to be needed and practiced frequently.
- The skills are appropriate for the person's age.
- The skill can be used in different situations with appropriate adaptations.

What Community-Based Instruction is Not

Community-based instruction is not a field trip or outing, an event that occurs one or two times per year, universal to all people, or "just for fun". CBI should provide exposure to experiences that support learning, facilitate independence, and align with the interests and preferences of the person with a



disability. Examples of places or activities that CBI would likely **not** occur at include:

- Park
- Amusement Park
- Fair
- Rodeo & Livestock Show
- Festival
- Zoo
- Movie Theatre

Difference Between CBI and General Activities or Outings

General activities and outings are valuable and should continue, but community-based instruction allows for more learning opportunities and requires greater planning and intent. CBI provides people with disabilities more meaningful life experiences, valued social roles, inclusion, and increased self-advocacy. Examples of the differences between activities or outings and CBI are provided below:

- Where CBI is individualized, activities and outings tend to be experienced with a group
- Where CBI promotes social and functional skills, activities and outings tend to be isolating experiences
- Where CBI is part of ongoing instruction that leads to generalization, activities and outings tend to not lead to opportunities that will lead to more independence

Benefits of CBI

There are several benefits for people with disabilities participating in CBI. Storey (2022) outlines several of these benefits. They are adapted below:

1. Increased likelihood of generalization

- Liza's support staff works with her to plan the bus route she will take to work. This raises the chance



that Liza will be able to plan her bus route to another frequented setting independently.

2. Natural cues and corrections

- Josh is learning to ride the bus. He doesn't hear the announcement for his stop and therefore misses it. This situation provides a natural consequence that Josh can use to learn to listen more closely for natural cues and may reduce the chance he will make the same mistake in the future.

3. More community presence for people with disabilities

- Tristen's staff works with him to understand his community map. Using a community map increases Tristen's chance to engage in more community activities.

4. More efficient acquisition of skills leading to greater independence

- Ricky is learning to deposit checks and withdraw money at his bank and ATMs. Learning how to use an ATM increases the chance that Ricky will gain financial independence.

5. Opportunities for increased social competence and the development of social networks

- Maria's staff helped her gain independence at the gym. Now, when Maria goes to the gym, she is greeted by the front desk staff. These interactions increase the chance that Maria will gain an understanding of appropriate social behaviors and gain a social network.

6. Inhibition of undesirable behaviors

- Ashley engages in arm flapping self-stimulatory behavior. Her staff works with her to spin a fidget ring when at a restaurant instead of flapping her arms, as flapping her arms at a restaurant brings up



safety concerns (i.e., hitting glassware or a food tray). Using the fidget ring increases the chance that Ashley will use her fidget ring instead of flapping her arms in community settings where arm flapping may be a safety concern.



Module 2 Summary and Key Takeaways

Module 2 described quality of life and how it correlates to community participation. Quality community participation can be achieved through CBI and supports. DSPs should be familiar with a person's PCP to know what functional skills need to be taught in the community. Natural supports should be used to facilitate community participation.

Key takeaways:

- Quality of life is defined as how well a person's life is going and if they are satisfied with their life
- Research shows that quality of life is improved when people participate in the community
- Community participation is one of the five domains of life that influence human functioning; community participation is described as emphasizing community inclusion and personal self-determination
- Natural supports allow for continued access to the community; Trach and Mayal (1997) outline community, organizational, physical, social, and physical supports as types of natural supports
- CBI provides people with disabilities the opportunity to learn specific skills needed to meaningfully engage in the community
- Functional skills are skills needed to independently engage in a variety of settings; functional skills should have immediate utility for the person
- Activities and outings do not support the movement towards independence that CBI does
- Storey (2022) outlines six benefits of CBI



Key Terms and Phrases	
Term/Phrase	Definition
Community-Based Instruction	Provides PWD the opportunity to learn specific skills needed to meaningfully engage in the community
Community Integration	Full integration into the community
Community Participation	Interaction in the community and participation in regular community-integrated activities
Functional Skills	Skills that a person needs to increase independence and enhance their quality of life
Generalization	A person engages in a community skill or task in trained and untrained environments
Informed Choice	Being able to make independent decisions based on information given, experiences, and examples
Natural Environments	Any place where people live, learn, work, or play
Natural Supports	Allow for ordinary cues that exist in environments to help people know what to do
Participation	Involvement in a life situation



Quality of Life	How well a person's life is going and if they are satisfied with their life
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Module 3: Community-Based Instruction: Where to Begin



The previous module provided information on community participation and community-based instruction. Participation in community settings increases the quality of life for people with disabilities. DSPs should understand how to provide meaningful community-based instruction to those they support. Module 3 will present information on how to provide community-based instruction.

At the end of this module, you will be able to:

- Describe how to identify CBI goals
- Describe age-appropriateness and chronological age
- Describe how to tie goals to a PCP
- Recognize tools to help you identify goals for the person
- Describe community mapping
- Recognize transportation barriers for people with disabilities and describe how to use CBI to teach transportation skills



Identifying CBI Goals

Identifying meaningful CBI goals is an important component of DSP's job. DSPs should consider several factors when supporting people in the community. First, DSPs should ensure that each goal reflects the strengths, interests, and needs of the person with a disability. Individualized goals should be tailored to information obtained during the person-centered planning process and should align with the person's overall life vision. Second, DSPs must take specific steps to ensure that goals are not developed out of convenience or because a DSP perceives the goal as important. Each CBI goal that is developed should enhance a person's quality of life and access to meaningful community settings. Finally, CBI goals should be age appropriate and appropriate for the person's chronologic age.

Ensure that each goal reflects the strengths, interests, and needs of the person. Ensuring that each community-based goal reflects the strengths, interests, and needs of a person identified in a person-centered plan. Reviewing this plan with the person receiving HCBS allows for the DSP to receive the most accurate information. For example, a DSP reviews the PCP and reads that the person listed animals as an area of interest, that the person is a hard worker, and that the person desires social interaction. The DSP talks to the person, and together they decide that the person will volunteer at the local animal shelter. This corresponds with the person's interest in animals, allows them to apply their strength of hard work to the volunteer work, and fulfills the person's need for social interaction by being around other volunteers and workers.

Ensure that goals are not developed out of convenience. A DSP should not create a community-based goal because it is easy for the DSP to teach, or the DSP thinks it's important. Goals should be developed with the person with a



disability in mind. To ensure that goals are based on the strengths and interests of the person with a disability, the DSP should review the PCP and communicate with the person to understand what they want and need. For example, a DSP concludes that a person's goal should be checking out and reading a book at the library so the DSP can study during this time. The person doesn't have an interest in reading and would prefer a goal of purchasing ten items at the grocery store instead. The DSP should adjust the goal to what the person wants, as the person oversees their own life and therefore gets the final say in what is best for them.

Develop age-appropriate goals based on the person's chronological age. Chronological age is the actual age of a person. Mental age represents the average performance of another person without disabilities chronological age. For example, a 16-year-old young adult who has a mental age of 5.5 years is perceived to perform similarly to a child who is 5.5 years. Unfortunately, relying only on a person's mental age often results in low expectations and services and supports that are not always age appropriate. People with disabilities must be treated the same way as other people their age.

Age-appropriateness means chronological age, not mental age. Age-appropriateness uses a person's chronological age to determine activities and/or tasks that match their age. People with disabilities should engage in age-appropriate activities and tasks. For example, a 40-year-old man with a disability playing at a children's playground is not age-appropriate; it is not a typical activity for a single, 40-year-old man. Age-inappropriateness decreases the social image and increases the stigma of people with disabilities (Storey, 2022). An age-appropriate activity might be playing basketball with same-aged peers at the park.



Tying CBI Goals to the Person-Centered Plan

People who receive Medicaid Home and Community-Based Services (HCBS) are required to have a person-centered plan. The person with a disability creates the PCP with their support coordinator (i.e., case manager) and their support team. The PCP outlines individualized goals that are relevant to the person receiving services as well as services that will support the person in reaching these goals (Legal Information Institute, 2014). DSPs and families will have copies of a person's PCP and should use the goals outlined in the plan to identify goals to work toward in the community.

If you do not have access to a person's PCP, speak with your manager or the person's support coordinator to help you identify individual, relevant goals. If you are unable to access the PCP or need a jumpstart on goal planning, there are several tools you can use to help you and the person with the PCP identify meaningful goals. Charting the LifeCourse (lifecoursetools.com) is a common framework used for person-centered planning, and many of its ideas and tools are used across services.


Tools to Help You Identify a Goal

DSPs can use the Life Domain Vision Tool, shown in Figure 3.1 to identify goals in various domains of a person's life. Start by talking to the person and their support team (if necessary) to get a better idea of what vision the person has for their future and how you and the person with a disability can break down that vision into attainable goals in each domain.



Figure 3.1.









Charting the LifeCourse Life Domain Vision Tool




LIFE DOMAIN VISION TOOL | PERSON CENTERED

Name of Person Completing: _____ Date: _____

On Behalf of: _____

LIFE DOMAIN	DESCRIPTION	MY VISION FOR MY FUTURE	PRIORITY
	Daily Life & Employment: What do I think I will do or want to do during the day in my adult life? What kind of job or career would I like?		
	Community Living: Where would I like to live in my adult life? Will I live alone or with someone else?		
	Social & Spirituality: How will I connect with spiritual and leisure activities, and have friendships and relationships in my adult life?		
	Healthy Living: How will I live a healthy lifestyle and manage health care supports in my adult life?		
	Safety & Security: How will I stay safe from financial, emotional, physical or sexual harm in my adult life?		
	Advocacy & Engagement: What kind of valued roles and responsibilities do I or will I have, and how can I have control of how my own life is lived?		
	Supports for Family: How do I want my family to still be involved and engaged in my adult life?		
	Supports & Services: What support will I need to live as independently as possible in my adult life, and where will my supports come from?		

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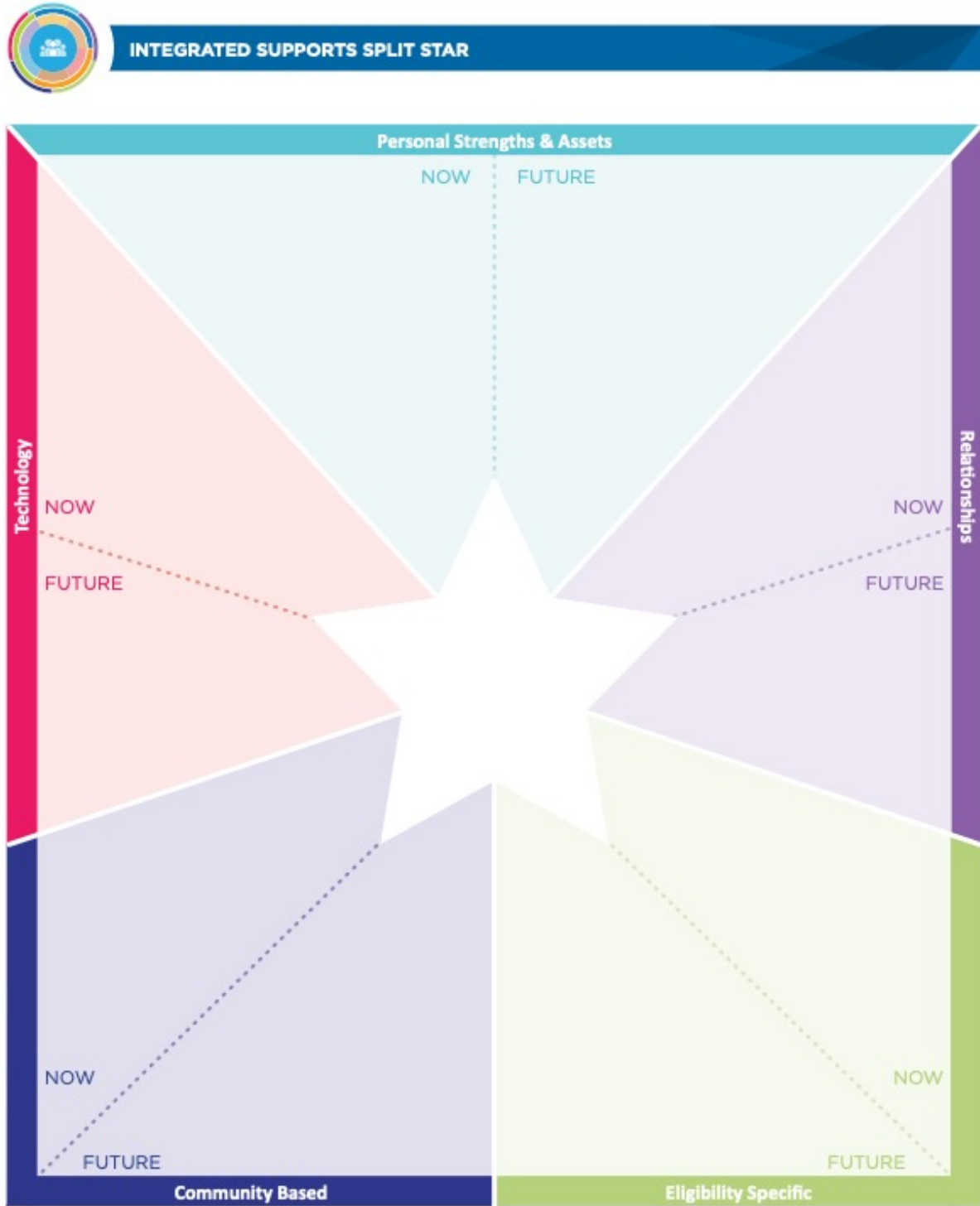
Identifying Supports

People use a variety of supports to achieve their vision to engage in a variety of community settings. People use supports to meet their day-to-day needs, achieve long-term or short-term goals, solve problems, and enhance their quality of life. DSPs can use the Integrated Supports Star, as shown in Figure 3.2, from Charting the LifeCourse to help people recognize the supports they have and want to have in their lives.



Figure 3.2.

Charting the LifeCourse Integrated Supports Split Star



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Follow these steps to use the Integrated Supports Star:

Decide the purpose. DSPs and the person with a disability should decide why they are using the Integrated Supports Star. Is the Integrated Supports Star being used to map supports or to work on a specific goal or situation? Write the purpose of the Integrated Supports Star, or the person's name, in the middle of the star.

Explore each part of the star. This step allows the DSP to learn more about the person and their situation. It helps the DSP and person to brainstorm what supports the person is currently using that can help them achieve their desired outcome. Use the following list, in any order, to assist in discovering a person's supports in each category.

- **Personal Strengths and Assets:**
 - Skills – personal abilities, knowledge, or life experiences
 - Strengths – things a person is good at or others like and admire
 - Assets – personal belongings and resources
- **Relationships**
 - Family/Friends
 - Coworkers
 - Acquaintances
- **Eligibility Specific**
 - Needs-based – services based on age, geography, income level, or employment status
 - Government-paid – services based on disability or diagnosis, such as special education or Medicaid
- **Community-Based**
 - Places – businesses, parks, schools, faith-based communities, health care facilities
 - Groups or membership organizations



- Local or public resources – resources that everyone can use
- **Technology**
 - Personal – technology that anyone can use
 - Assistive or adaptive – technology that helps with day-to-day tasks
 - Environmental – technology designed to help with or adapt to surroundings

Identify specific resources. After exploring each part of the star, the DSP and person can identify resources or ideas for each part of the star to address the issue or support need. The DSP and person should explore options that provide relief now and in the future. The supports that are identified can be written on the Integrated Supports Star Worksheet, Figure 3.2 below, or another place that works better for the person, such as a specific notebook or document on the computer.

On-going use of the star. The Integrated Supports Star is designed to be used multiple times. It can be repeated for any situation or problem that needs to be addressed. Completed stars can be reviewed at meetings to add or delete things that have been accomplished. The Integrated Supports Star is designed to be used continually, not to be completed and put away.

Resources:

Life Domain Vision tool: <https://ceiutah.com/webinars/tool-for-developing-a-vision/>

Integrated Supports Star tool: <https://www.lifecoursetools.com/lifecourse-library/integrated-supports-star/>

Additional Charting the LifeCourse tools:
https://ceiutah.com/webinars/?tx_project-type=persona-centered-planning



Community Mapping

Community mapping is a strategy used to identify resources and valuable settings in a person's community. Community mapping will help you and the person with a disability identify natural and relevant community-based settings to learn and practice community-based skills. For example, grocery stores, parks, banks, restaurants, coffee shops, hobby stores, movie theaters, and public transit locations are all settings you may want to consider when determining where to teach a skill. Knowing what settings are available to you and the person with a disability is important to consider before instruction.

Community mapping can be implemented in various ways, but key aspects to consider may include: (1) the setting is in proximity to the person's home; (2) the setting needs to be physically accessible to the person; (3) the setting allows for skill(s) to be practiced naturally; (4) the setting is conducive for teaching in (busyness, space limitations, etc.); (5) the setting is relevant to the person's goals. When using community mapping, planning a visit to each setting targeted for CBI with the person with a disability is crucial. These visits will help you and the person document and highlight relevant features and strategies to support the person in each setting.

How to Create a Community Map

Mapping Assets for Postschool Success (MAPS) (Flanagan & Bumble, 2022) is one way to engage in community mapping. MAPS uses Google My Maps and a five-step process to get the person and their team started on creating a basic map. Once the team has developed a basic map, users can layer additional maps with different categories of resources on top of already existing ones to create a more comprehensive community map. Features



allow users to pinpoint locations and items on the map, create routes, directions, and distances, and outline areas to highlight (Elliot, 2009; Flanagan & Bumble, 2022). Figure 3.3 shows an example of Google My Maps. Table 3.1 outlines the five steps to creating a community map as described by Flanagan and Bumble (2022).

Figure 3.3.

Example of Google My Maps

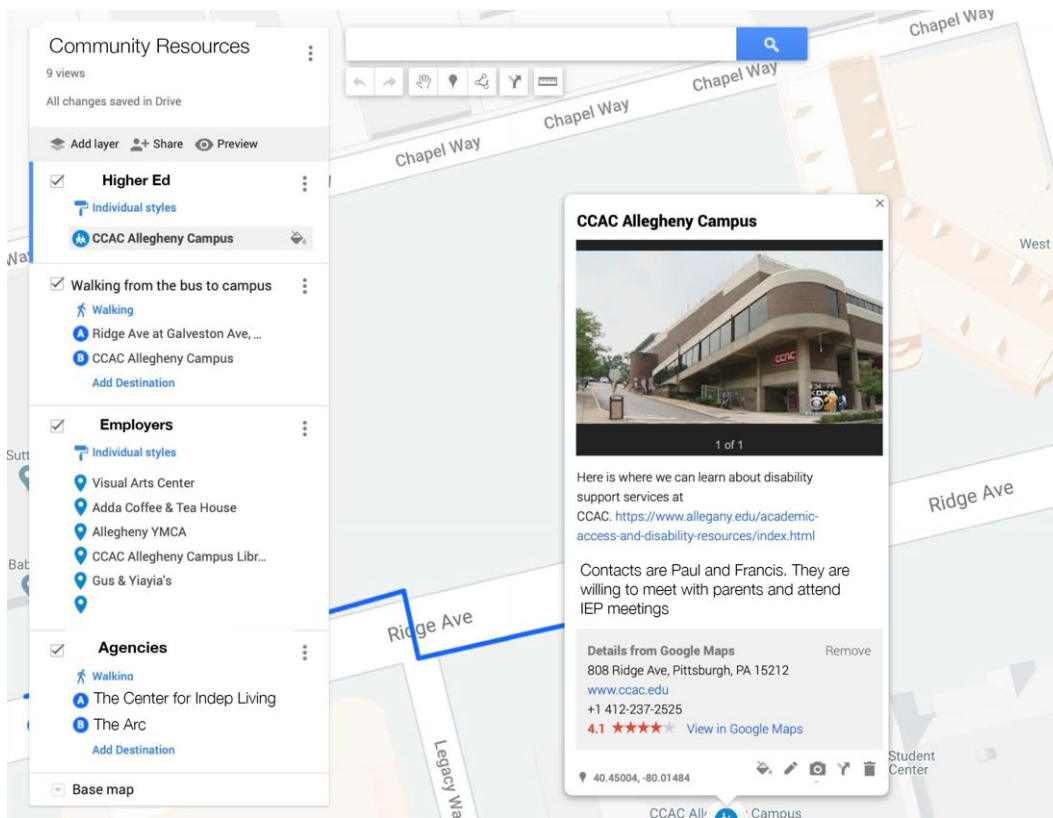


Table 3.1.

Five Steps to Creating a Community Map

Step	Description
Step 1: Enlist Your Team	The first step requires that DSPs assemble a core group of people to support map development and a secondary group of advisors who can provide support and guidance. The person with a disability and the people the person is frequently around, such as a direct support professional, family, close friends, or roommates, comprises the core group. The core group will then identify the group of advisors from larger agencies or organizations to receive guidance, such as Vocational Rehabilitation, a local Independent Living Center, the local chamber of commerce, local employers, religious or cultural groups, educators, etc.
Step 2: Establish Your Mapping Goals	The second step requires the team to establish the map’s overall purpose and mission. The purpose and mission will support the group during the creation of the map to think about what resources they need to identify and how they will support the person in reaching their goals.
Step 3: Identify and Categorize Local Assets	The third step requires the team to identify resources using the four “Ps”: people, programs, providers, and places, to categorize. Team members will then work in pairs or small groups to create a master list of resources on a shared document, such as a Google Doc or a poster paper. Teams will



	<p>then research through the web or personal contacts any other resources that may be beneficial to include on the map.</p>
<p>Step 4: Create and Customize Base Map</p>	<p>The fourth step requires the team to create the interactive map using the platform http://mymaps.google.com. Teams will work together or independently with assigned roles to make a list of all resources, add resources to the map, and add materials that support the map as needed (videos, images, contact information, etc.). Teams can use the “navigation center” in Google My Maps to add resources, set up layers, and customize resources. Teams may use the “layer” option to categorize resources based on skill that the person can practice within the setting or in any other way the team sees fit. Teams can also organize by colors and icons, add photos and videos, create routes, and add text descriptions.</p>
<p>Step 5: Disseminate the Base Map</p>	<p>The final step requires the team to distribute the map to anyone who may benefit from the map (family, educators, service providers, etc.) or who may have additional ideas of resources to add to the map.</p>

If technology is a barrier or the team desires a more informal process, you can easily develop a community map on Microsoft Word or another word processing program. Refer to the Appendix for an example of a community mapping template for your use.



Transportation

Transportation is one of the most significant barriers to accessing communities for people with disabilities (Bezyak et al., 2017). People with disabilities travel less frequently and rely on public transportation more than those without disabilities. Barriers to transportation affect a person's ability to participate in the community. As a result, DSPs should identify the transportation needed to access these settings independently, especially once support is faded. Options for transportation may include private automobiles, scheduled rides from staff, public transportation, flex transit, biking, walking, etc. Transportation skills may also be an ongoing identified goal for many people with disabilities; DSPs may want to consider embedding transportation goals within other goal areas. The importance of embedding transportation goals in other goals is underscored by the fact that adults with disabilities often use strategies to compensate for transportation limitations. For example, Brumbaugh (2018) found that about 44% of adults with travel-limiting disabilities ask others for rides, almost 23% limit their travels to daytime, and about 12% use special transportation services. Some people with disabilities even limit how often they travel. Brumbaugh also found that around 70% of adults with disabilities reduce day-to-day travel, about 21% give up driving, and about 14% use public transit less often than those without disabilities. Community-based instruction is the most effective way to teach travel skills to people with disabilities. CBI allows people more practical experience to plan



for unseen events that can only occur in the natural environment. It is also a helpful way to identify what tools and strategies one might need for a trip (McDonnell et al., 2021).

Emergency Situations

While unlikely, emergency situations may arise during community-based instruction. Proper training and guidance is important to ensure DSPs know what to do and have the necessary resources; this also helps to mitigate fears for individuals with disabilities and their families. When an emergency of any type occurs, the priority must be to secure the supervision and safety of the person receiving support. DSPs should notify the proper authorities and outline the process. An example process for someone getting lost is described below:

1. The direct support professional knows who to call and relay pertinent details of the situation.
2. Notify provider management.
3. If two instructors are supporting individuals together, one should search for the person who is lost, and one should remain with the other members of the group.
4. If only one instructor is present, he/she should search with the entire group, if possible. In addition, they should request assistance from available security systems.
5. If the person is not found within 10 minutes, the manager is to be contacted for additional instructions. The manager will make further contact as necessary to the parent/guardian and to law enforcement agencies.
6. If lost on public transportation, give full information to the transit system, including the person's information, what route the person was last on, and the destination of the trip.



7. Write a summary of the incident and give a copy to the manager.
8. Notify all appropriate persons when the person is located.



Module 3 Summary and Key Takeaways

Module 3 described how to prepare for implement CBI. DSPs must remember that the person with a disability has control of their own life, and therefore has the final decision on what goals will be implemented during CBI. DSPs can use Charting the LifeCourse and community mapping as tools for CBI.

Key takeaways:

- DSPs should ensure that each goal reflects the strengths, interests, and needs of the person, ensure that goals are not developed out of convenience, and develop age-appropriate goals
- Chronological age is the actual age of a person; age-appropriateness means chronological age, not mental age
- Use a person's PCP to identify goals to work on in the community
- Community mapping is used to identify resources and valuable settings in the community
- Use Charting the LifeCourse and Google My Maps as tools for implementing CBI
- Transportation is one of the most significant barriers for people with disabilities, therefore, DSPs must identify transportation that allows for independence in the community



Key Terms and Phrases	
Term/Phrase	Definition
Age-appropriateness	Refers to chronological age, not mental age
Chronological age	The actual age of a person
Community mapping	Is used to help identify natural and relevant community-based settings to learn and practice community-based skills
Mental age	The age perceived by others of a person
Person-centered planning	A process led by a person with a disability and their team to identify individual strengths, preferences, and goals that will lead them to their desired life



Module 3 References:

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Module 4: Systematic Instruction, Response Prompting, and Fading



The previous module outlined the importance of CBI and CBI goals. A DSP needs to use a person's PCP to identify CBI goals and create goals that are meaningful to the person. Once a goal is identified, DSPs must provide systematic instruction to teach the skills outlined by a person's goals. DSPs must record data to track the person's progress. Once a person with a disability has shown mastery of skills, DSPs should begin to fade their assistance. Module 4 provides information on teaching strategies, prompt strategies, data collection, and fading assistance.

At the end of this module, you will be able to:

- Describe the importance of teaching individual skills to PWD
- Identify the different systematic instruction techniques and how to deliver them
- Identify the different prompting techniques and how to deliver them
- Describe instructional scripts
- Recognize the importance of data collection and how to collect data
- Describe how to fade supports



Teaching Skills

Determining what skills to teach is a critical component of instructional planning. Each skill should enhance a person with a disability's quality of life regarding Schallock's (2002) quality of life framework. The skills may also be identified as a priority during the person-centered planning process. DSPs should

address a person's needs, the types of supports available, the modifications and adaptations, and the skills that need to be taught in several domains including, domestic, personal care, health and



safety, money management, home maintenance, food management, time management, morning, day, and evening routines, and leisure (Storey & Miner, 2011). Figure 4.1 outlines considerations for teaching independent and community skills.



Figure 4.1.*Considerations for Teaching Independent and Community Skills*

- The skill that is taught has immediate utility for the person.
- The skill is desirable for the person.
- The skill is acquired in a social context - acquisition is the product of interactions with more than one caregiver.
- The skills are acquired in the actual, physical environment where the skill is naturally performed.
- The skill is age appropriate.
- The skill is adaptable.

Ecological Inventory

Ecological inventories are used to analyze the demands of specific environments and determine what types of instruction and support a person with a disability needs to meaningfully engage in these environments. An ecological approach includes identifying current and future environments, activities that a person will participate in, and the skills required to participate. Table 4.1 outlines the steps to completing an ecological inventory adapted from Storey (2022).



Table 4.1.

Steps to Completing an Ecological Inventory

Step	Description
Step 1: Identify Curriculum Domains	Where will the task or skill take place? Showering takes place in a residential environment. Going to the bank takes place in a community environment.
Step 2: Identify and Survey Current and Future Natural Environments	Where does the activity naturally take place? If working on shopping skills, the person with a disability should be taught these skills in a grocery store. The store is the natural environment.
Step 3: Breakdown Major Environments into Sub-Environments	What are the other environments within the main environment? Going to the doctor’s office (major environment) has many different sub-environments. They include the waiting room, the examination room, the pharmacy, etc.
Step 4: Identify Relevant Activities	What activities will happen in the environment and sub-environments? Activities at a restaurant would include greeting the host/hostess, asking for a Table, ordering food, and paying for food.
Step 5: Identify Skills Required	What skills are required to complete the activities? To complete the activity of going to a movie, a person would need communication skills to order the ticket and financial skills to pay for the ticket.



When completing an ecological inventory, observing other people performing each activity is important to determine the requisite skills. After observing others complete the activity, observe the person with the disability complete the skill and document whether the person completed the skill correctly or incorrectly. Figures 4.2 and 4.3 provide examples two types of inventories: Grocery Shopping and Using and ATM. In the first example, the DSP documents the performance level of the person with a disability identifying items of a shopping list and paying for items. In the second example, DSP observes an individual making a deposit and withdrawing cash at an ATM. In each example, The DSP documents the performance of the individual by recording if they correctly or incorrectly perform the task. The DSP then indicates what type of instructional support is needed, and the types of adaptations or modifications are needed.

Figure 4.2.

Grocery Shopping Ecological Inventory

Grocery Shopping			
Name: Max			
Environmental Setting: Smith's Marketplace			
Sub-Environment: Cash register			
Skill	Performance Level		Notes
	Independent	Needs Support	
Identifying items on a shopping list		X	He can read and understand items on the list, but needs help to find them in the store.
Paying for items at a cash register		X	He can retrieve the method of payment but needs help completing the transaction.



Figure 4.3.

Banking Ecological Inventory

Banking			
Name: Michelle			
Environmental Setting: Chase Bank			
Sub-Environment: Outdoor ATM			
Skill	Performance Level		Notes
	Independent	Needs Support	
Using an ATM for a deposit		X	She can locate the ATM and recognize if she is using the ATM for a deposit or a withdrawal. She needs help remembering her pin and knowing what buttons to push.
Using an ATM for a withdrawal.		X	

Task Analysis

After conducting an ecological inventory to determine what type of instructional support is needed to learn the targeted skill, the DSP should develop a plan and corresponding instructional programs to teach identified skills. A task analysis is a useful way to do this. A task

analysis (TA) is the process of breaking down a skill into smaller, teachable steps. TAs are used to identify every behavior needed to complete a task so, ideally, an instructor



would personally complete the task analysis before instruction begins. Figure 4.4 provides considerations for developing a task analysis.

Figure 4.4.

Considerations for Developing a Task Analysis

- **The objective should be identified and clearly stated**
- **The instructor should perform the task several times while planning the task analysis**
- **The task should be broken down into steps that are applicable for the person**
- **The steps should be in the exact order that they are to be completed**
- **Mandatory steps, steps that absolutely need to be done for the task to be completed correctly, should be identified**
- **The action for each step should be identified**

Tables 4.2 and 4.3 are two examples of task analyses. The first task analysis was designed to teach Max to shop for grocery items. For the task analysis, the DSP clearly stated the goal, “given a shopping list of ten items, Max will independently find and purchase all items on the list at 100% accuracy for three consecutive trials according to the steps outlined in the task analysis”. The DSP then completed the task of shopping on their own. The DSP wrote down the steps that needed to be done to complete the task, in order.



Table 4.2.

Grocery Shopping Task Analysis

<p>Observable and Measurable objective: Given a shopping list of ten items, Max will independently find and purchase all items on the list at 100% accuracy for three consecutive trials according to the steps outlined in the task analysis.</p> <p>Setting: Smith’s Marketplace</p> <p>Materials: Shopping list and cash, credit, or debit card</p>		
Step	Quality and Speed	Comments
Get a cart or basket		
Find items on your shopping list		
Put items in the cart or basket		
When all items are in the cart or basket, wait in the check-out line		
Place items on the conveyor belt		
Get out your wallet and take out the method of payment (cash or card)		
Pay for groceries		
Walk bagged groceries to the vehicle		
Put groceries in the vehicle		
Return cart or basket		



Table 4.3.

Banking Task Analysis

<p>Observable and Measurable objective: Given a debit card and an ATM, Michelle will independently withdraw \$20.00 from an ATM with 100% accuracy for three consecutive trials according to the steps outlined in the task analysis. Setting: ATM at Chase Materials: Debit card</p>		
Step	Quality and Speed	Comments
Insert the debit card into ATM		
Enter four-digit PIN 2788		
Press enter		
Select withdraw		
Select checking account		
Push button for \$20.00		
Press the button to confirm the withdrawal		
Select exit/print receipt		
Remove card		
Remove cash		
Remove receipt		

Response Prompts

A DSP may need to use prompts to teach a person with a disability a desired skill. Response prompts are used in instruction to elicit the correct responses from people and make the



procedure nearly errorless (Collins, 2022). Prompts are generally categorized from least to most intrusive. Prompts may include indirect verbal, direct, gestures, model, and physical prompts. Table 4.4 describes in detail each prompt. DSPs should be cautious about using prompts incorrectly, as doing so may lead to prompt dependency. Prompt dependency occurs when a person waits for a cue before performing the task. For a person to perform a target behavior independently, instructors must systematically fade the prompts. Researchers call this transfer of stimulus control. That is, you do not want the person’s behavior to be contingent upon an instructor’s prompts, rather you want natural cues/stimuli to prompt the person to perform the target task/behavior.

Table 4.4.

Response Prompts

Prompt Type	Description
Indirect Verbal Prompt	An indirect verbal prompt is an indirect verbal statement that cues a person about an expected response. For example: “What do you need to do now?” or “What is next?”
Direct Verbal Prompts	A direct verbal prompt explicitly cues the person about the expected response. For example, “Put the toothpaste on your toothbrush.”
Gesture Prompts	Nonverbal instructor prompts or gestures that draw attention to the stimulus material, such as pointing at the correct button on the ATM. Screen.
Model	The DSP models and demonstrates how to perform the expected response.



Physical Assistance

A DSP may use a full physical prompt such as hand-over-hand prompting to guide the person to a correct response. A DSP may use a partial physical prompt, such as touching a hand or an elbow. For example, the DSP might tap the person on the elbow to cue them pick-up the toothpaste.

Wolery et al. (1991) outlined six guidelines for using response prompts. Following these guidelines will maximize the effectiveness of instructional programs and increase the effectiveness of response prompts:

1. Select the least intrusive but effective prompt: Instruction using the least intrusive prompt allows the person to perform the target behavior as independently as possible.
2. Combine all prompts if necessary: Prompts can be combined to increase instructional effectiveness. For example, the instructor can blend a model prompt with a direct verbal prompt.
3. Select natural prompts and those related to the behavior: Prompts should resemble behaviors naturally used in the environment(s).
4. Prompt only when the person is attending: Ensure the person is focused on the task at hand. If they are not focused, they will not learn the target behavior.
5. Provide prompts in a supportive, instructive manner: DSPs should not use prompting to punish or adversely affect individual behavior. Prompts should never be used in a corrective manner but instead to facilitate learning.
6. Fade prompts as soon as possible: Instructors must fade prompts for people to perform skills independently.



System-of-Least Prompts

System-of-least prompts (SLP) requires the DSP to use a hierarchy of prompts from the least to the most level of assistance. For a DSP to correctly instruct use response prompts, they need to understand what controlling and non-controlling prompts are. A non-controlling prompt increases the likelihood of a current person's response but may not always elicit a correct response. For example, when teaching Max to shop at the grocery store, the DSP would use the least intrusive prompt first and allow Max the opportunity to respond. If he does not respond, then the DSP delivers the next level or prompt, up to the controlling prompt. A controlling prompt is the prompt that reliably and consistently elicits a correct response from the person with a disability. Consider Max who is learning to grocery shop. The DSP determines that the controlling prompt is a verbal prompt – after the DSP delivers a verbal prompt, Max always performs the step correctly.

DSPs should determine at least three prompts from the prompt hierarchy that they will use during instruction. The first level allows the person to correctly perform the task without a prompt. The next levels of prompts will be arranged from least to most intrusive and will end with the controlling prompt. It's also important to determine the response interval, that is, how long the DSP will wait before implementing a prompt. The response interval will depend on the person with a disability and how long they need to execute a correct response. Collins (2022) outlines seven steps required for implementing SLP, as shown in Table 4.6.



Table 4.6.

Steps to Implement System-of-Least Prompts

Step	Description
1.	Secure the person’s attention
2.	Deliver the task direction
3.	Wait for a set number of seconds (the response interval) for the person to respond independently
4.	If the person responds correctly, give praise; if there is no response or an error, give the least intrusive prompt (e.g., indirect verbal prompt) in the hierarchy and again wait a set number of seconds for a response
5.	If the person responds correctly, give praise; if there is no response or an error, give the least intrusive prompt (e.g., indirect verbal prompt) in the hierarchy and again wait a set number of seconds for a response
6.	If the person responds correctly, give praise; if there is no response or an error, continue to give the next least intrusive prompt (e.g., direct verbal prompt) in the hierarchy until the person responds correctly
7.	Praise the correct response before going to the next trial for a discrete behavior or to the next step of the task analysis for a chained task

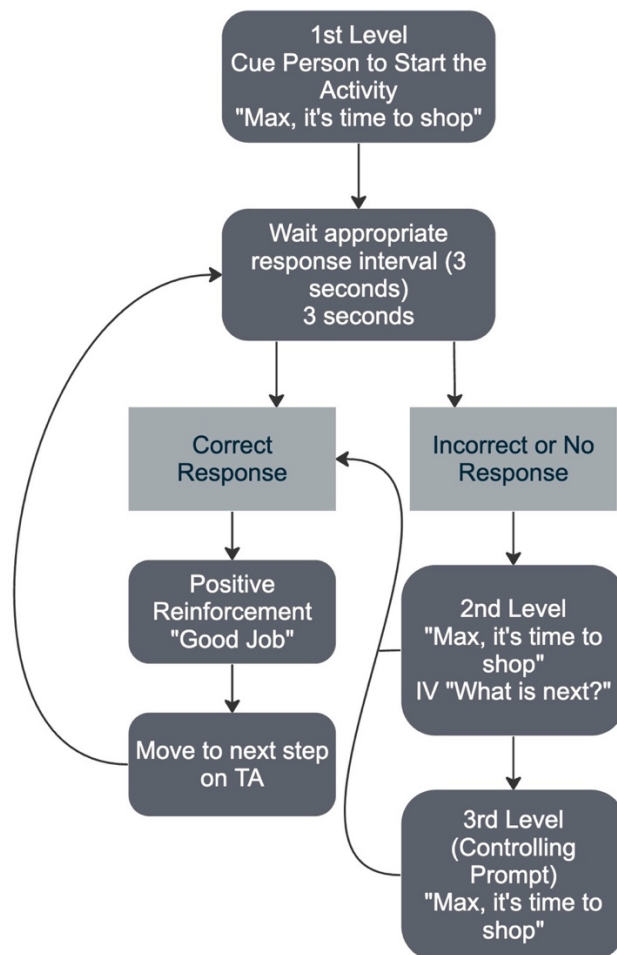
Consider the example of a person who is learning to shop (Figure 4.5). To begin instruction, the DSP would provide an



instructional cue and allow the person the opportunity to respond "Max, it is time to shop." If Max does not respond within the appropriate response interval, the DSP systematically increases the amount of assistance using the non-controlling prompts, "Max, what is next?" and so on up to the controlling prompt "Max, I need you to walk into the store." During the initial phase of instruction, the DSP should verbally reinforce the person after he completes each of the steps in the task for shopping. As the person acquires the skill, the reinforcement should fade to natural levels.

Figure 4.5.

System-of-Least Prompts Flowchart



Constant Time Delay

Constant time delay (CTD) uses intentional fading of a controlling prompt- a prompt that has a high probability of the person correctly responding (i.e., pointing to the next step in a task analysis or a verbal prompt)- paired with instruction. As a result, the person should have a little-to-no error in responses. The controlling prompt should not change as instruction continues, but the time when a prompt is delivered changes as the person begins to show success after each practice session or lesson and gradually increases over time, allowing the person to independently complete the desired behavior until the prompt is completely faded from use. Table 4.7 outlines the steps for performing CTD according to Collins (2022).

Table 4.7.

Steps to Perform Constant Time Delay

Step	Description
1.	Secure the person's attention
2.	Deliver the task direction
3.	Wait a predetermined set of seconds for the person to respond (e.g., 0s delay during the first session, 4s delay during all subsequent sessions)
4.	Deliver controlling prompt
5.	Praise correct responses or repeat the prompt for incorrect responses or failure to respond



6.	Record data
7.	Repeat as needed

Instruction must always begin with a 0-second delay phase; the DSP provides the instructional cue (e.g., “What time does the bus come?”) followed immediately by the controlling prompt (e.g., “7:30”). Using the 0-second delay with the controlling prompt ensures that the person can consistently and correctly respond to the instruction. Consider this the teaching phase of instruction. After the person correctly responds to the 0-second delay over multiple trials, the DSP will switch to the time delay phase of instruction (e.g., 4 seconds for the person to respond with “7:30”). In this phase of instruction, the DSP will deliver the instructional cue and then wait for the pre-specified time delay



phase to give the person time to answer correctly. If the person does not respond within the time delay, the DSP will provide the controlling cue and again wait for the person to respond. If the person correctly responds, the DSP will provide praise and move on. If the person responds incorrectly, the DSP will correct the error (Riesen et al., 2023). For example, a DSP may start by prompting a person directly after instructing them (0s) and fade the prompt (4s) after practicing the instruction multiple times with successful outcomes until the person no longer needs the prompt for errorless outcomes. Once the person has correctly responded to the instruction, the behavior is to be reinforced by the DSP, and the

person proceeds to the next step of the task analysis (Horn et al., 2020).

Compensatory and Other Support Strategies

Compensatory strategies are supports that may include modifications or additional equipment so a person with a disability can complete the task. Examples from Riesen and colleagues (2021) include:

- Picture schedules
- Video modeling
- Notebooks and calendars
- Alarms or timers
- PredicTable routines and structures
- Minimize background distractions
- Assistive technology

Instructional Scripts

Instructional scripts detail the measurable objective, materials needed for skill acquisition, the setting of learning, and the teaching strategy and error corrections used (Riesen, et al., 2022). Instructional scripts support the DSP and any other supporters in knowing what the goal is and what methods the DSP is using to obtain the goal. Figures 4.6 and 4.7 show examples of instructional scripts for different instructional strategies adapted from Riesen et al. (2022).



Figure 4.6.

System of Least Prompts Script

Learner: Max	Measurable Objective: Given a shopping list of ten items, Max will independently find and purchase all items on the list at 100% accuracy for three consecutive trials.
Setting: Smith's Marketplace list and cash, credit, or debit card	Materials: Shopping
Teaching Strategy: System of Least Prompts	
Response Interval: 3 seconds	Controlling Prompt: Model (M)
Non-Controlling Prompts: Independent (I), Indirect Verbal (IV), Verbal (V)	
Error Correction	
Correct Response: Provide verbal reinforcement "Nice work" for each prompted and unprompted correct response.	
Incorrect Response: Verbally identify the error "Max, you did not complete the step correctly" and provide a model. Ask Max to repeat the step.	

Figure 4.7.

Constant Time Delay Script

Learner: Michelle	Measurable Objective: Given a debit card and an ATM machine, with 3-5 opportunities to complete each step, Michelle will independently withdraw \$20 from an ATM with 100% accuracy for two consecutive trials.
Setting: Chase Bank	Materials: Debit card
Teaching Strategy: Constant Time Delay	
Instructional Cue: "What is the next step?"	Controlling Prompt: Model (perform the task)
Time Delay: 5 seconds	
Error Correction	
Correct Response: Provide verbal reinforcement "That's right" for each prompted and unprompted correct response.	
Prompted Error: Verbally identify the error "Michelle, that step is completed like this" and provide a model. Move on to the next step.	
Unprompted Error: Verbally identify the error and remind the learner to wait, "No, that step is completed like this (model). Remember to wait if you aren't sure" and move on to the next step.	
No Response: Remind the learner to complete the step after your prompt "Remember to do the step after me" and move on to the next step.	



Data Collection

Collecting data during instruction is a key aspect to knowing if a person with a disability is acquiring the skill or if the DSP needs to reassess the methods used for teaching. Data collection will tell the DSP what is and is not working and when interventions need to fade to continue the independence of the person with a disability. Tables 4.9 and 4.10 show examples of data collection sheets, adapted from Riesen and colleagues (2021), that can be replicated and individualized.

Table 4.9.

Task Analysis Data Sheet

Learner: Max										
Measurable Objective: Given a shopping list of ten items, Max will independently find and purchase all items on the list at 100% accuracy for three consecutive trials.										
Setting: Smith’s Marketplace										
Materials: Shopping list, and cash, credit, or debit card										
Steps	Session									
	Baseline				Instruction					
	1	2	3	4	5	6	7	8	9	10
1. Get a cart or basket	M	M	M	M	V	IV	IV	I	I	I
2. Find items on your shopping list	V	IV	IV	V	IV	IV	I	I	I	I
3. Put items in the cart or basket	M	M	M	M	M	V	IV	IV	I	I
4. When all items are in the cart or basket, wait in the check-out line	V	V	IV	IV	IV	IV	I	I	I	I
5. Place items on the conveyor belt	M	M	V	V	IV	IV	IV	I	I	I
6. Get out your wallet and take out the method of payment (cash or card)	V	V	V	IV	IV	IV	I	I	I	I



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7. Pay for groceries	V	V	IV	IV	IV	IV	I	I	I	I
8. Walk bagged groceries to the vehicle	V	IV	IV	I	I	I	I	I	I	I
9. Put groceries in the vehicle	M	V	V	IV	I	I	I	I	I	I
10. Return cart or basket	M	M	V	V	IV	IV	IV	I	I	I
Percent of Unprompted Correct Responses	0	0	0	10	20	20	60	90	100	100
	Summary Data									
	%	%	%	%	%	%	%	%	%	%
	100	100	100	100	100	100	100	100	100	100
	90	90	90	90	90	90	90	90	90	90
	80	80	80	80	80	80	80	80	80	80
	70	70	70	70	70	70	70	70	70	70
	60	60	60	60	60	60	60	60	60	60
	50	50	50	50	50	50	50	50	50	50
	40	40	40	40	40	40	40	40	40	40
	30	30	30	30	30	30	30	30	30	30
	20	20	20	20	20	20	20	20	20	20
	10	10	10	10	10	10	10	10	10	10
	0	0	0	0	0	0	0	0	0	0



Table 4.10.

Time Delay Data Sheets

Learner: Michelle										
Measurable Objective: Given a debit card and an ATM, with 3-5 opportunities to complete each step, Michelle will independently withdraw \$20.00 from an ATM with 100% accuracy for two consecutive trials.										
Setting: Chase bank										
Materials: Debit card										
I – unprompted correct, P – prompted correct, E – prompted/unprompted error, NR – no response										
Steps	0s delay			5s delay						
	1	2	3	4	5	6	7	8	9	10
1. Insert the debit card into the ATM	P	NR	P	E	P	P	P	I	I	I
2. Enter four-digit pin 2788	NR	P	P	P	P	E	P	P	I	I
3. Press enter	P	P	P	E	P	I	I	P	I	I
4. Select withdraw	P	P	P	P	E	P	P	I	I	I
5. Select checking account	P	P	NR	P	P	P	P	P	I	I
6. Push button for \$20.00	P	P	P	P	P	P	E	P	P	I
7. Press the button to confirm the withdrawal	P	P	P	P	P	I	P	I	I	I
8. Select exit/print receipt	P	P	P	I	I	I	I	I	I	I
9. Remove card	NR	P	P	P	I	P	I	I	I	I
10. Remove cash	P	P	P	P	P	I	I	I	I	I
11. Remove receipt	P	P	P	P	E	P	P	I	I	I



Percent of Unprompted Correct Responses	0	0	0	10	18	36	36	64	91	100
	%	%	%	%	%	%	%	%	%	%
	100	100	100	100	100	100	100	100	100	100
	90	90	90	90	90	90	90	90	90	90
	80	80	80	80	80	80	80	80	80	80
	70	70	70	70	70	70	70	70	70	70
	60	60	60	60	60	60	60	60	60	60
	50	50	50	50	50	50	50	50	50	50
	40	40	40	40	40	40	40	40	40	40
	30	30	30	30	30	30	30	30	30	30
	20	20	20	20	20	20	20	20	20	20
	10	10	10	10	10	10	10	10	10	10
	0	0	0	0	0	0	0	0	0	0

Fading

Fading support means reducing the type and level of assistance a DSP provides to a person with a disability. Prompts increase the chance that a person with a disability will learn a targeted behavior, but prompts can lead to dependency (refer to prompt dependency in module 4). Fading assistance decreases the chance of prompt dependence; fading shifts the behavior from prompts to environmental stimuli (Causton-Theoharis, 2009; Schoen, 1986).



Whether a DSP is using direct instruction or establishing natural supports, the goal of any instructional plan is to promote a person's independence in the community. An important component of any instructional plan is to develop a timeline for fading supports. When a person demonstrates that they have learned to perform all tasks correctly, the DSP should begin the process of fading. Fading should be incremental and should be based on a schedule. At first, the DSP may start to fade support from the immediate area as soon as the person demonstrates



mastery of a specific task or routine. For example, if the person met the criteria for successfully withdrawing money at an ATM, the DSP could fade support by leaving the person's side but remain at the bank. Gradually, as the person masters

all the essential functions of withdrawing money from an ATM, the DSP would fade and leave the bank. The DSP should ensure that unpaid, natural supports are in place during the fading process. In addition, the DSP can engage in "what if" and role-play scenarios with a person to ensure they will be able to respond to certain situations once the DSP has successfully faded their support. For example, the DSP could ask the person a question such as (a) what will you do if you miss your bus? (b) what will you do if you are going to be late for meeting up with a friend? (c) what will you do if there is an emergency at home? (medical emergency, fire alarm, power outage, weather-related problem) (d) what will you do if a stranger is bothering you? (e) what will you do if you are not feeling well while out? (f) what will you do if you are unsure of how to complete a task?



Examples of Various Studies in Different Community Settings

The efficacy of response prompts such as SLP and CTD to teach community skills to PWD is well documented. For example, Bassette et al. (2020) used the system of least prompts and video modeling to teach independent physical activity to students with moderate to severe disabilities. The physical activity of each participant increased, and skills generalized to community settings for each participant.

Athorp et al. (2022) used the system of least prompts and video modeling to improve the daily living skills of a student with a disability. The student was taught kitchen skills and identified cooking pasta, making smoothies, using measuring cups, and reading recipes as areas of focus. The researchers created a task analysis and corresponding videos for instruction. Researchers provided Leslie with verbal instruction to open the video corresponding to the focus activity. She had 15 seconds to begin the video or start the activity on her own. If she didn't start either in 15 seconds, researchers used a system of least prompts. Leslie improved in each skill and researchers found that video modeling was an effective strategy when used with other intervention strategies.

Mechling and Cronin (2006) used constant time delay to teach three students aged 17-21 to order food at a fast-food restaurant with the help of assistive technology. Students watched a simulation of ordering at a restaurant in the classroom and researchers implemented a 3-second CTD. Once students showed mastery by 100% unprompted correct responses across three trials, they moved to the community to practice their skills. All students used augmentative and alternative communication devices which they used to order at restaurants. Researchers



continued to use a 3-second CTD in the community setting. All students showed generalization skills in the community setting and the research found that using assistive technology and CBI allowed for independence in all three students.

Bassette et al. (2018) used the system of least prompts to teach three students aged 13-15 to take and send pictures of their surroundings via a phone. Students practiced their skills in five different settings, three of which were at their school, one being a familiar setting in the community, and one being an unfamiliar setting in the community. Before students demonstrated their knowledge of what to do if lost, they watched two videos. One modeled someone explaining they were lost and looking for a key identification point to help identify their location. The second video modeled how to take and send a picture. After watching the videos, researchers told students to show staff what to do when lost. If students couldn't complete a step independently, staff would assist them by using SLP. Results demonstrated that students increased their ability to perform the task independently and that students could generalize their skills by completing the steps in an unfamiliar community setting.

McDonnell et al. (2021) used most to least prompting to teach adults with disabilities transportation skills. The students practiced these skills on public transportation with the use of various assistive technologies. People traveled to meaningful places identified from their goals, including homes, workplaces, relatives' houses, leisure settings, day programs, and other community facilities. Students also practiced their individualized skills; participants might have practiced crossing the street, following directions, stranger danger, using a bus pass, locating bus stops, solving travel problems, and using personalized Google Maps depending on the person's needs. Additionally, students used their assistive devices to support skills on public transportation. For example, students used google Maps (printed



or application), social stories, task lists, public transportation apps, digital schedule boards, and/or printed route schedules. Ten participants completed the travel training along with a pre and post-test after eight travel sessions. Scores increased for each participant from the pre to post-test.

Burckley et al (2015) used a task analysis paired with video prompts and video cueing (via iPad software) to teach an 18-year-old student shopping skills. The person completed shopping trips at three different locations of the same chain grocery store. Researchers implemented a task analysis for the person to complete the task independently. The task analysis was as follows:

1. Walk into the store
2. Obtain a shopping basket
3. Tap the picture of the first item
4. Navigate to the location of the first item
5. Select the first item and put it in the basket
6. Tap the picture of the second item
7. Navigate to the location of the second item
8. Select the second item and put it in the basket
9. Walk to a checkout lane and get in line

The person completed 66% of the steps independently at the first location, and 88% of the steps independently at the second and third locations. A parent, educational staff, and residential staff all reported some improvement in the participant's community shopping skills.



Module 4 Summary and Key Takeaways

Module 4 discussed instruction strategies for direct support professionals to use when implementing CBI. DSPs should perform an ecological inventory before instruction. DSPs should then develop a task analysis to determine which instructional program should be used to teach the desired skill. Instructional programs outlined in module 4 included system-of-least prompts and constant time delay. Module 4 also detailed response prompts needed to conduct the teaching strategies and described the importance of fading and how to fade. DSPs should follow the information in module 4 when the person with a disability has shown mastery of skills. CBI should lead to independence.

Key takeaways:

- DSPs can use a person's PCP to determine which skills need to be taught
- DSPs should use an ecological inventory to determine what types of instruction and support a person needs; follow the steps outlined by Storey (2022) to complete an ecological inventory
- After DSPs complete an ecological inventory, they should develop a task analysis; a task analysis breaks skills down into smaller, teachable steps
- Response prompts may be needed to teach a desired skill; prompts include indirect verbal prompts, direct verbal prompts, gesture prompts, model, and physical assistance
- Prompt dependency occurs when a person waits for a cue before performing the desired skill
- System-of-least prompts uses the hierarchy of prompts to teach the desired skill; follow the steps outlined by Storey (2022) to conduct the system-of-least prompts teaching strategy



- Constant time delay uses intentional fading of a controlling prompt; follow the steps outlined by Storey (2022) to conduct a constant time delay teaching strategy
- Riesen and colleagues outline compensatory strategies that can be used in support with teaching strategies
- Instructional scripts are used to outline the goal and what methods should be used to obtain the goal
- Data collection allows the DSP to recognize if the person is grasping the skill or if the team needs to reassess the methods of teaching
- Many researchers have performed CBI with great success
- Fading is reducing the type and level of support given by a DSP; DSPs should develop a timeline for fading support



Key Terms and Phrases	
Term/Phrase	Definition
Non-controlling Prompt	Increases the likelihood of a response, but may not always elicit the correct response
Controlling Prompt	Reliably and consistently elicits a correct response
Response Interval	The time before a prompt is delivered (Riesen et al., 2021)



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Appendix

Figure 1. Ecological Inventory

Skill:			
Name:			
Environmental Setting:			
Sub-Environment:			
Skill	<u>Performance Level</u>		Notes
	Independent	Needs Support	

Figure 2. System-of-Least Prompts Script

Learner:	Measurable Objective:
Setting:	Materials:
Teaching Strategy:	
Response Interval:	Controlling Prompt:
Non-Controlling Prompts:	
Error Correction	
Correct Response:	
Incorrect Response:	



Figure 3. Constant Time Delay Script

Learner:	Measurable Objective:
Setting:	Materials:
Teaching Strategy:	
Instructional Cue:	Controlling Prompt:
Time Delay:	Error Correction
Correct Response:	
Prompted Error:	
Unprompted Error:	
No Response:	



Table 1. Task Analysis

Observable and Measurable objective:		
Setting:		
Materials:		
Step	Quality and Speed	Comments



Table 2. System-of-Least Prompts Data Sheet

Learner:										
Measurable Objective:										
Setting:										
Materials:										
Steps	Session									
	Baseline				Instruction					
	1	2	3	4	5	6	7	8	9	10
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
Percent of Unprompted Correct Responses										
	Summary Data									
	%	%	%	%	%	%	%	%	%	%



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Table 3. Time Delay Data Sheet

Learner:										
Measurable Objective:										
Setting:										
Materials:										
I – unprompted correct, P – prompted correct, E – prompted/unprompted error, NR – no response										
Steps	0s delay			5s delay						
	1	2	3	4	5	6	7	8	9	10
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
Percent of Unprompted Correct Responses										
	%	%	%	%	%	%	%	%	%	%



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Table 4. Community Mapping Form

Community Mapping Form		Additional Comments					
		Contact Info (if needed)					
		Environments Comments					
		Transportation Needed					
		Accessible (Y/N)					
		Activity/Skill					
		Hours					
		Description					
		Business Name					



