Engaging Practitioners in Program Evaluation: A Preliminary Report of Perceptions and Observations of Practitioner-Caregiver Partnerships in Early Intervention

A Program Evaluation Report

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Evaluation Need

Five years ago, the Nebraska Department of Education offered a new training and support plan for early intervention practitioners across the state. The *Personal Development Facilitator Institute* (PDFI) included a number of training components that focused on assessment, IFSP/IEP's, Primary Service Provider (PSP) service delivery, and coaching. The impetus for the training institute was to assist school districts and early intervention (EI) practitioners to meet the federal law requiring that children with special needs be supported in their natural and least restrictive environments, participating in the same learning opportunities as that of their peers. Further, the training focused on advancing the ability of the practitioners to build family and caregiver competence and confidence to care for and educate their child on their own.

Historically in early intervention programs, much emphasis had been placed on the child with special needs acquiring certain "skills" those practitioners determined were needed before the child could access the opportunities that all other children had. This often resulted in the child being able to demonstrate isolated skills with the practitioner out of (meaningful) contexts, while many, many learning and practice opportunities in the child's everyday home and community activities remained seemingly unavailable to them. More importantly, with the focus being on what the practitioner could teach the child during a visit to the home or the community setting, the potential learning that could have occurred every day was significantly limited. Enabling and supporting the caregiver to guide the child in using new skills would increase the number of learning/practice opportunities for the child as well as increasing their own ability to manage the child's needs.

In addition to the federal requirements regarding service delivery in natural and least restrictive environments, current EI literature clearly points to the importance of:

1) *engaging families and caregivers in partnerships (Dunst, 2000),*
2) *building caregiver competence and confidence (Guralnick, 1989), and*
3) *supporting learning opportunities for the child which occur outside of home and community visits by professionals (McWilliams, 1996).*

Furthermore, the literature to-date that describes what actually happens during home visits suggests that the purpose and outcome of each visit may be perceived differently by caregivers than by the practitioners (Hebbeler, 2002). Clearly, a different approach to early intervention must therefore be considered.

Grand Island Public Schools
Early Intervention/Early Childhood Special Education Programs
(EI/ECSE)

As was the case throughout Nebraska, a small contingent of the early intervention team members from the Grand Island Public Schools had participated in all levels of the state-sponsored *PDFI* training, and was responsible for bringing information back to the entire Grand Island team to promote application of the PSP approach. In addition to changes in skills, team members have had to consider changes in attitudes about their view of ALL families' ability (no matter what their situation) to make decisions and advocate for their child. Given that the traditional training of many professionals working in early intervention programs has focused on direct service to the child, (vs. engaging caregivers in supporting their child during daily and routine activities) this represents a major shift in philosophy. It is important to recognize the continuum of professional profiles on the Grand Island team related to implementation of the new approach. Similar to other teams across the state of Nebraska, some Grand Island practitioners had been working in the field a long time, and had skills which lent themselves to using direct intervention practices with the child who has special needs; these experienced practitioners had difficulty in partnering with and enabling caregivers to provide the child with supports and strategies. Other team members, newer to the field, were more easily shifting to a new view of intervention which focused on the family, but may not yet have acquired the experiences and skills which lend themselves to being a resource about the child's disability and development. In between were those experienced and new practitioners who found the new philosophy attractive, exciting and a good match to their existing skills and knowledge.

Over the past three years, the Grand Island team had been exploring their service delivery processes and activities, including assessment practices, IFSP/IEP qualities, and the PSP model. In January of 2005, they agreed to advance their professional development by engaging in a program evaluation study with evaluators Ms. Sue Bainter, OTR/L and Dr. Chris Marvin, from the University of Nebraska-Lincoln. The team felt strongly that their use of coaching strategies to support the development of confidence and competence in caregivers was making a difference. However, they had found it difficult to demonstrate the resulting outcomes in an objective and meaningful way.

Evaluation Study Purpose

The Grand Island team's initial desire for any information resulting from the study was to use what they discovered to grow and learn as professionals, both individually and as a team serving children birth to age 5 and their families and other caregivers. In addition, with the growing recognition of the need for accountability in documenting program effectiveness, the team also wanted to enhance their capacity for self-assessment with a data collection system they might use routinely. In particular, the study set out to answer these questions:

1. What is the evidence of a ***partnership*** between the practitioner and the caregiver?
2. How do the practitioner and caregiver perceive their contributions to the ***partnership***?
3. What evidence is there of practitioners building caregivers' ***competence and confidence***?

Evaluation Design

Population

During the 2005-06 school year the Grand Island School District's Early Intervention team served approximately 97 infant/toddlers and 146 preschool-age children with disabilities. The team consisted of nine ECSE teachers, four Speech-language pathologists (SLPs), one Occupational Therapist (OT), one Physical Therapist (PT), one Psychologist, three Services Coordinators, and two bilingual (Spanish) interpreter/family liaisons. The program included: weekly home visits to families or community-based preschool teachers and/or childcare providers; speech-only services; and an ECSE center-based preschool. In addition, weekly team meetings were held to provide opportunities for colleague-to-colleague coaching; this was considered to be an important component of the overall implementation of the PSP approach.

Demographics

Five female practitioners participated in this project. This included three teachers with master's degrees in early childhood special education (ECSE) and two speech-language pathologists certified by the American Speech Language Association (ASHA). These practitioners had 3-20 years of professional experience and 2-4 years experience on the team in Grand Island. The data collection focused on the interactions between these practitioners and the caregiver for one of the five children who were a part of this study and enrolled in the Grand Island EI/ECSE program, for children birth to age 5. The children ranged in age from 2 months to 4 years 9 months of age and were receiving special services from the school district because of documented developmental delays or conditions associated with probable delays in the preschool years. All of the children had been enrolled in these services for less than 1 year; one child had just begun services and the recorded coaching session was only the first visit between the practitioner and the family. The other sessions were between practitioners and caregivers who had an established working relationship of at least 6 months. The caregivers of these children included four mothers and two teachers. The coaching sessions used for this study took place in the family home (4), the child's preschool classroom but outside of the actual preschool session (1), and a school conference room (1). One ECSE teacher participated in two sessions; one home visit and one IFSP meeting.

Project Procedures

Data Collection: Five consenting practitioners helped to secure the necessary consents from six caregivers in order to videotape six sessions, each one an interaction between one practitioner and one caregiver during a regularly scheduled visit or meeting. One practitioner was videotaped twice; however each session was with a different caregiver. Two of the sessions were in the child/caregiver's home. Two of the sessions were in a preschool center; both of them after the children had gone home, with the interactions being between the practitioner and the teacher to discuss observations made by both the practitioner and the teacher about the child's participation during preschool. The other two sessions were meetings, one an IFSP and the other an IEP. Two meetings were used in order to make comparisons about coaching strategies used between home/community visits and more formal meetings. The videotaped observations were carried out over a period of approximately three and a half weeks, with visits of 30-60 minutes in length. All audible interactions between the practitioner and caregiver were recorded along with any interactions either of them might have had with the child that was present.

On the day following each observed visit, the evaluator made phone contact with each practitioner and caregiver independently. Similar survey questions were asked of each participant regarding their satisfaction with the visit and their perception of their role in the observed visit. Regarding the particular home or community session visit, participants were asked if they had been part of a partnership, if there were opportunities for reflection and new learning, and whether they made plans for what would happen next. All participants were asked to provide an example for each corresponding question. See survey questions included in Appendix A.

Engagement of Practitioners. It was important to begin with the perceptions of the Grand Island team of practitioners so as to set the stage for personal reflection and comparison to any data resulting from the study. A team meeting was held in January 2005 during which the practitioners engaged in a discussion about what they perceive to be their role in home and community visits and the perceive benefits of their actions. The following questions were used to generate discussion and consensus amongst team members:

- *What do you see as your role during home and community visits?*
- *What behaviors and practices do you use to carry out your role during home and community visits?*
- *What evidence is there that you utilize this role, in terms of behaviors of the caregiver?*

In general, the answers to the questions posed demonstrated a desire on the part of the practitioners to focus their efforts on the caregiver as a means of supporting the child to participate in natural learning opportunities, while building the caregiver's competence and confidence. The practitioners referenced a number of caregiver behaviors/practices as evidence of their successful efforts including: relationships with caregivers, engaging the caregiver during visits, supporting the child's routines, and both developmental growth of the child and empowerment of the caregiver, as well as use of the coaching strategies themselves. A summary of their responses can be found in Appendix B.

Behavioral Indicators. In order to begin the process of developing behavioral indicators to be used for coding the data collected, the evaluators looked for similarities and patterns within the team's responses to the stimulus questions posed at the January 2005 team meeting. Using the information about specific behaviors within coaching practices from the PDFI training (Rush & Shelden, 2004) as a cross reference, the evaluators identified seven themes based on how the information from the team clustered. These included:

- *relationship building and advancing a partnership between practitioner and caregiver;*
- *focusing caregiver's attention on child's abilities and learning opportunities;*
- *supporting caregiver's interactions with child and use of new strategies;*
- *caregivers showing ability to solve problems and support/guide child's learning;*
- *caregivers collaborating and participating in the visits;*
- *caregivers generating questions/solutions/ideas independent of practitioner/visit;*
- *children showing developmental growth/new accomplishments.*

The resulting themes were then reframed by the evaluators using a filter of evidence-based practice literature. The aim was to confirm the specific evaluation questions around a focus on a) partnerships between practitioners and caregivers, and b) the development of caregiver

competence and confidence as a result of these partnerships. Three categories evolved to cluster specific behavioral indicators. These categories were applied to both the practitioner and the caregiver; specific behavioral indicators were considered "partners" to one another, i.e. each practitioner behavior had a corresponding caregiver behavior that related to what the practitioner was aiming to do in the visits. This relationship between behavioral indicators was a key detail in establishing the potential for data reflective of the interrelationship and influences between the behaviors of the coaching partners. The three categories included: 1) *Collaboration/Partnership 2) Reflection/New Learning,* and 3) *Action/Participation*. . Each category included a subset of three behaviors each for both the practitioner and the caregiver. A complete listing of specific behaviors for each category can be found in Appendix C. These same three categories guided the development of the Post-Visit Survey questions (Appendix A).

Data Analyses. Video-tapes were watched independently by two observers. In two-minute intervals, the observers noted (+/-) all behavioral indicators evidenced at least once for both the practitioner and the caregiver for each of the three categories of behavior. Tapes were watched in their entirety; the number of intervals observed varied by the length of time each tape/session played. Observers discussed differences and reviewed the tape a second time to assure agreement. The number of intervals with at least one evidenced behavior were totaled for each behavioral category and divided by the total number of minutes (intervals X 2) to compute a rate per minute per category. Reliability of coding was not stable enough to compute rate per minute for individual behaviors under each category. Mean rate per minute calculations were used to compare practitioners to caregiver's behavioral categories and to compare home visits to IFSP/IEP meetings.

The responses to the Post Visit Survey questions were noted as +/- and verbatim statements recorded. The examples provided were used to help validate the rating of +/- per question and note representativeness of the content of the visit. Total number of positive responses was divided by the total number of questions asked to compute a percentage of agreement per partner. An independent mean percentage was computed for practitioners and caregivers.

Results

The results obtained from the evaluation study represent a single point in time to document the Team's efforts and were presented at a team meeting in January of 2006. The evaluators represented the data in a number of ways, in hopes of broadening the potential conclusions and new directions the team might draw from the information.

Evidence of Partnership, and Caregiver Competence and Confidence (Reflection and Active Participation).

Comparisons can be made between the practitioner and the caregiver behavioral categories during home/community visits and during meetings.

Practitioners spent comparable amounts of time establishing the caregiver as a partner as well as encouraging them to reflect upon daily routines and learning opportunities for the children. The least amount of time was spent engaging caregivers in active participation with the

child during the visit, or actively participating in development of plans for what would happen after the visit.

Caregivers demonstrated an active interest in partnering with practitioners during the visits. Their rates of active reflection on developmental changes, or on their own behaviors and generation of new ideas for children's learning opportunities were low, as were their rates of actively participating with children in the visit or contributing information about possible new learning opportunities, and practicing use of new strategies after the visits. Caregivers' participation in problem-solving, planning, and use of new strategies/learning opportunities was similar in home visits to that observed in IFSP/IEP meetings.

Table 1.
Minimum mean rate per minute for success indicators noted for practitioners and caregivers in home visits (2), classroom visits (2), and IFSP/IEP meetings (2).

	Practitioner Promoted		**Caregiver Demonstrated**	
Success Indicators	**Rate/min. Four Visits**	**Rate/min. Two Meetings**	**Rate/min. Four Visits**	**Rate/min. Two Meetings**
Collaboration/Partnership	.53	.45	.77	.59
Reflection/New Learning	.66	.32	.28	.23
Action/Participation	.21	.07	.23	.15
Totals	1.40/min	.84/min.	1.28/min	.97/min.
Overall Means for Six Visits	at least 1.21/min		at least 1.17/min	

Overall means for all six visits resulted in very similar rate/minute of overall behaviors for the partners, with about one behavior per minute. However, the practitioners' rate of efforts for establishing the collaborative partnership and even for promoting reflection and brainstorming of new ideas exceeded the rate of behaviors used to promote active participation between caregiver and child or from the caregiver for future planning. These practitioner behaviors also surpassed the rate of behaviors in the caregiver that evidence caregiver reflection or active participation. This data would suggest that both partners are similarly engaged in the visits in that both are demonstrating some behaviors that were able to be coded as reflective of shared interest and topics. But the relatively small amount of time spent in promoting or demonstrating active participation does not seem sufficient to prepare the caregiver for what will happen once the practitioner has left the visit.

Mean ratios of practitioner to caregiver behaviors were calculated for two home and two community classroom visits. See Table 2. Again, there appears to be a balance overall in frequency of behaviors, but closer examination shows a possible imbalance in favor of eager caregiver partnerships and heavy practitioner effort for little caregiver response once the partnership was established.

Table 2.
Mean ratio of partnership behaviors in home and classroom visits between practitioners and caregivers.

Partnership Success Indicators	Ratio of Practitioner-Caregiver Behaviors	
	Home Visits	Classroom Visits
Collaboration/Partnership	1 : 1.5	1 : 1.4
Reflection/New Learning Opportunities	2 : 1	2.5 : 1
Action/Participation	1 : 1.8	1.6 : 1
Overall	1 : 1.1	1 : 1.2

Perceived Contributions to the Partnership

Finally, the practitioner and caregiver perceptions, collected via the telephone surveys, were calculated as percentage of questions reported in the positive. All of the practitioners perceived their efforts during the visits as having promoted a partnership with caregivers, caregiver reflection and new learning, and active participation during or following the visit. All were able to give examples to support their positive responses. All the caregivers reported a perceived partnership between themselves and the practitioners; 83% perceived learning something new and/or figuring out something that was a priority as a result of the visit; 67% perceived making a plan as to what would happen next in the practitioner's absence.

Conclusions

There are no guidelines to provide comparisons for how practitioner time should be spent when engaging caregivers in home and community visits. Nor do we know how frequently key behaviors need to occur (per minute or per visit) in order to influence caregiver behaviors. We also do not know how frequently (per minute or per visit) caregiver behaviors must occur to result in targeted child growth and development. We *do* know that caregiver capacity and confidence are positively affected when they are actively engaged, feel a partnership, and can drive which priorities are addressed in our service delivery. We also know that some amount of action and participatory activities during our visits is much more likely to result in the caregiver being able to carry out their intentions in our absence. We cannot expect that on their own, our discussions with caregivers, and even active reflection by the caregiver, will result in changes for the family/child. Best practice tells us that caregivers need information, feedback, and support while participating in interactions that allow them to individualize their efforts on behalf of their child everyday in their home and community. Practitioners must be planful and intentional about the support they provide *during* their visits in order for this support to extend *outside* of the visits. The efforts of the practitioner must be dynamic and responsive to the caregiver and child.

Because the Grand Island team was engaged in the process of developing what eventually became the behavioral indicators used for coding observations of select practitioner-caregiver interactions, the results of the study provide them with initial information to reflect upon. The

results indicate that the practitioners who were observed for this study are demonstrating efforts to engage caregivers as partners and encouraging them to reflect, problem-solve and identify their children's learning opportunities. Parents and teachers with whom the practitioners meet show eager willingness to partner in planning the focus for discussion or observation and attend to one another during the visit. All study participants reported perceptions of contributions to a partnership.

The evidence of caregiver competence and confidence is the question which remains for the team. Caregivers who were actively involved with their child or the practitioner were demonstrating rates of active participation fairly equal to that of the practitioners' rate for promoting such participation. *But is this enough to effect change in their behaviors or that of their child?* The evidence of caregiver *reflection/new learning is at a rate of about half that of the practitioners' efforts to promote it.* How will the current and future efforts of the practitioners contribute to the subsequent level of caregiver reflection and active participation during visits? How will the practitioners adjust their efforts so as to increase the frequency of these practitioner AND caregiver behaviors during the visits and subsequently affect child change/development as a result of the partnerships? This study does not provide information to suggest the frequency (rate per minute) of specific behaviors that might result in such outcomes.

Reflections of the Evaluators

Strengths:

- Overall, the practitioners we observed demonstrated their use of acknowledgement and affirmation of caregiver strengths throughout the visits. All caregivers appeared to feel comfortable in sharing their observations, thoughts, questions and comments about their children. Even if we had not coded for active participation and partnership, it would have been very evident. This characteristic is of particular note because the caregivers who participated in the study were from a variety of backgrounds and experiences.
- All of the caregivers expressed strongly that they felt they were actively involved in the visits. Examples they gave during the telephone interviews provide strong evidence of this.
- All practitioners readily provided examples of each of the three components of the visits (i.e. partnership, reflection/new learning, action/participation), which seems to demonstrate that they were focused on their use of the coaching strategies.
- All practitioners actively used reflective questions during the visits for a variety of purposes related to engaging the caregiver to think about some aspect of the child and/or their learning.
- All practitioners attempted to engage the caregivers in planning for after the visit, some more intentionally than others. All of the caregivers gave examples of their plan following the visit (during the telephone interviews); however two of the examples were not related to the topics/focus of the visits.
- Each practitioner seemed to have their own style for how they used the coaching strategies. Even though we cannot comment on the individual effectiveness given our unfamiliarity with the specific situations and relationships, all caregivers appeared comfortable and active in the flow of the visit with respect to the sequence of questions, comments, feedback, etc. used.

Recommendations:

- While all the data supports collaboration/partnership, we would encourage the team to consider their efforts of intentionally establishing the beginning of a joint plan at the outset of the visit when setting the agenda, as a means of encouraging the action/participation part of the visit.
- Become more intentional when engaging in the action/observation part of the coaching relationship, which may include establishing roles, giving feedback about particular actions and strategies that resulted in greater participation on the part of the child in actual learning opportunities, and discussing how it benefited the caregiver.
- Consider that the amount of reflection/new learning used by the caregiver as compared to the practitioner may very well be appropriate to the situation; however, it is likely that this ratio will probably be dynamic over time.

Future Considerations:

- Reflect on the action/participation component (as currently defined by the coding system) of the overall visit in relation to changes noted in the caregiver and the child. The behavioral indicators in the action/participation section include what is termed "action/observation" in coaching. If change is not occurring at a satisfactory rate, the practitioner may need to consider how much action/observation is occurring across a number of visits, is it enough, and is it intentional?
- The data collected from the community visits were a result of coaching which occurred when the child was not available. Practitioners should also consider the indicators which include active caregiver-child interactions; does the practitioner promote active participation on the part of the caregiver when the child is there? How are these two components of the coaching relationship (when the child is present, when the child is absent) connected in terms of the overall coaching progression and success in these settings?

Recent reports about coaching in early childhood from Rush and Shelden (2005) suggest the following trends pertinent to the current discussion. While this information has not yet been demonstrated empirically, it does bear further consideration in the context of the data collected from the Grand Island team:

- Joint planning and reflection should always be present in a coaching conversation;
- If no joint planning occurs between the caregiver and the practitioner, it is much less likely that action will occur on the part of the caregiver in-between visits;
- The priority for promoting reflection is to help the caregiver be able to reflect upon their own actions while they are acting independent of the practitioner;
- Frequency/duration of visits must match the learner's priorities for support;
- The manner in which observation/modeling is used during coaching visits matters in terms of what caregivers are able to carry out on their own, and therefore observation/action must be intentionally planned by the practitioner and the caregiver.

Respectfully submitted, May 12, 2006

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Appendix A
Practitioner Follow-Up Survey
(pg 1 of 2)

Follow up survey questions (after the visit):

To be asked of the practitioner:

I established collaboration/partnership with caregiver – yes/no; How?

I created reflection and new learning in caregiver – yes/no; Give examples.

I promoted the caregiver's planning for what would happen next in my absence – yes, no; Give examples.

Appendix A
Caregiver Follow-Up Survey
(pg 2 of 2)

Follow up survey questions (after the visit):

To be asked of the caregiver:

I felt a partnership with the practitioner during the visit – yes/no; How?

I was actively involved in the visit – yes/no; Give examples.

I learned new ways of helping my child or figured something out that has been a priority for me/us – yes/no; Give examples.

I made a plan for what would happen next in the practitioner's absence – yes/no; Give examples.

Appendix B

Raw data resulting from team meeting January 2005:

What is your role in home/community visits/what do you hope to accomplish?

- build communication/rapport with the caregiver
- support kids "where they are at", "being and doing"
- support caregivers in carrying out strategies
- facilitate successful transitions
- assess/evaluate environments, kids, programs, ourselves – ongoing
- collaborate with caregivers
- support caregivers to address their concerns
- build on strengths, reinforce what they are already doing
- empower caregivers versus solving their problems for them
- build competence and confidence
- look for/identify learning opportunities

What behaviors and practices do you use to carry out your role during home and community visits?

- welcome visits upon referral, primary coach stays the same throughout the process
- support to community preschools
- ongoing assessment – AEPS, ABC, IGDI
- use of culturally sensitive language
- teaming
- building relationships with caregivers
- parent participation in process, ownership/empowerment
- conferences with parent on a regular basis
- informal progress notes collected during pre-K day
- family-centered IFSP/IEP
- develop goals/outcomes together
- educating others on our new role, hearing others (caregivers) describe our role meaningfully
- going into a variety of settings, places where the child is at
- building supports into routines
- reflective questions

What evidence is there that you utilize this role, in terms of behaviors of the caregiver?

- conflicting goals and philosophies from parents/caregivers/teachers unresolved
- children look more like their peers, doing things that their peers are doing

- parental requests/seeking treatment in lieu of or in compliment to community agencies such as medical clinic
- requests for 1:1 rather than with peers
- parent/caregiver stays or leaves when you come
- parental requests for help to integrate therapy suggestions from clinic at home
- combined efforts with Head Start
- parent able to come up with ideas versus still looking to provider
- service delivery/frequency is dynamic in response to varying needs of caregivers
- witness parent advocating for their child's needs
- fewer missed home visits, less "closed doors"
- developmental growth of child
- staff/provider recognizing and trying to address more complex needs than just child via viewing family with child as a whole unit
- see caregiver managing child's needs on their own
- requests from preschools for in-services/supports, they want to know more
- apparent comfort with our presence, a partnership
- request for enrollment of peers to center based preschool
- less transfer requests from staff
- happier work climate

Appendix C

Practitioner Behavioral Indicators (to be observed in the practitioner)

Establishes collaboration/partnership with caregiver by:
a. Clarifying/agreeing on purpose of session or giving opportunities for caregiver to bring up priorities/concerns early in the visit
b. Using language/terms that appear appropriate to caregiver's understanding and comments/<u>questions</u> to determine current understanding/beliefs or explore what has been tried or what has changed since last visit
c. Affirming caregiver's knowledge/strengths about the child and/or development
Creates reflection and new learning in the caregiver by:
a. Asking questions that promote comparison/analysis to what caregiver already knows or is doing
b. Describing strategies, routines and/or learning opportunities (including IFSP/IEP outcomes) in which the child and/or caregiver is involved
c. Providing comments/feedback that affirms or guides the caregiver's ideas/actions
Promotes action/participation in the caregiver by:
a. Describing/suggesting planned or spontaneous learning opportunities or new strategies to use in the visit
b. Engaging caregiver in interactions with child during visit
c. Developing plans with caregiver for what will happen next as a result of the visit focus

Caregiver Behavioral Indicators (to be observed in the caregiver):

Collaboration/partnership demonstrated by:
a. Bringing up issues/concerns for discussion (not just announcements)
b. Sharing information about what has happened or is happening with child (own efforts or child behaviors)
c. Using questions, comments throughout the visit to show interest in child growth/development
Reflection and new learning demonstrated by:
a. Reporting changes in child's daily participation/growth and/or the use of new <u>activities or learning opportunities w</u>ith child
b. Describing or coming up with new <u>strategies</u> to meet IFSP/IEP outcomes and/or solve new issues
c. Linking comparisons, conclusions, new questions to practitioner's feedback or comments
Action/participation demonstrated by:
a.. Demonstrating or practicing <u>strategies</u> with practitioner and/or child <u>during</u> the visit
b. Describing (changes in) child's behavior as they observe child <u>during</u> visit
c. Contributing ideas to a plan for child's <u>learning opportunities</u> in next few days/weeks.