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Changing early intervention provider practices to a coaching model through self-study and distance mentoring model: family-guided routines-based interventions and the key indicators

Cindy Lefeber
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Abstract
The purpose of this study was to determine whether the use of the Distance Mentoring Model-Family Guided Routines Based Intervention strategies, adult learning strategies and self-study research would assist me in assimilating the Key Indicators into my early intervention provider practices. The Key Indicators are Setting the Stage, Observation and Opportunity to practice, Problem Solving and Planning and Reflection and Review (SS-OO-PP-RR). To determine the extent to which my teaching practices reflect the current practices in early intervention I engaged in Iowa Distance Mentoring Training through the state of Iowa while collecting and analyzing data through qualitative self-study, a constant comparative method, and descriptive quantitative research.

Over the course of twelve home visits I increased my use of early intervention provider practices as seen by performance points on the Key Indicators, an item analysis of the Key Indicators, and an analysis of the four main sections of the Key Indicators. I identified some situations that need further improvement. The use of self-study proved to be effective in providing me with insight to make changes which increased my use of intervention strategies.
Changing Early Intervention Provider Practices to a Coaching Model

Through Self-study and Distance Mentoring Model—

Family Guided Routines Based Interventions

and the Key Indicators

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Cindy Lefeber

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has been approved as meeting the research requirement for the Degree of Master of Arts.

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ABSTRACT

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Introduction

Historical perspective

Congress passed Public Law 94–142 the Education for All Handicapped Children Act (1975) which provided free and appropriate education for all children who were school aged. Early intervention was not initially a part of this law. Services for young children became a part of the law with Public Law 99–457, The Education of All Handicapped Children Amendments (1984). The field of early intervention formally began at this time even though it had informally been in operation in some states prior to 1986. Early intervention (EI) providers historically have provided services and supports for families who have infants and toddlers with developmental delays or who were at risk for developing delays.

The field of early intervention has seen many changes from 1970 through the present. In the 1970s, caregiver education and participation in education and making decisions about their child was promoted (Field, Widmayer, Stringer, & Ignatoff, 1980; Forgatch & Toobert, 1979). Research completed by Tudor (1977) indicated that by teaching caregivers intervention strategies, caregivers could use these strategies to teach their children new skills. This approach did not do what it was intended to do, as educators decided what caregivers should be trained on and when, rather than these being the caregivers’ decisions (McWilliam, McMillen, Sloper & McMillen, 1997). Early intervention providers also had a difficult time imparting knowledge to caregivers so that learning could occur between home visits even though current research supported the use of caregiver education and participation had been promoted (Field, Widmayer, Stringer & Ignatoff, 1980; Forgatch & Toobert, 1979; McWilliam, McMillen, Sloper, & McMillen, 1997).
Further changes occurred with Public Law 108–446, the Individuals with Disabilities Education Improvement Act (2004). This piece of legislation provided families with a few more choices in the planning process in regard to the education of their children (McWilliam, 2010). In 2011 new implementation regulations for Part C were published by the Office of Special Education Programs, U.S. Department of Education, which brought significant changes to how early intervention (EI) was implemented in the states.

In 1988 I began my career as an Itinerant Home Intervention Teacher or Early Intervention Provider (now titled Early Childhood Specialist in Southwest Iowa) in the state of Iowa and continued teaching in Iowa's early intervention system, Early ACCESS. During this time I have had the privilege to experience the above changes that this field has seen. I have also observed a shift in the framework for caregivers from being seen as clients, not partners, in the educational process of their child (Mahoney et al., 1999) to viewing and empowering caregivers as partners (Dunst, 1985). Traditionally providers primarily used direct instruction, informed the caregivers about what their child should be educated on and provided materials and toys to help educate the child during home visits. Outcomes or goal development has changed from formerly obtaining very little input from the caregivers to currently being driven by caregiver input.

**Purpose and importance of research**

In contrast to what EI providers historically used as teaching methods, providers are now expected to use coaching with families to enable caregivers to carry out and embed strategies into their already existing daily activities and routines (McWilliams, 2016; Rush & Sheldon, 2011; Woods, Kashinath, & Goldstein, 2004). Though recommended, these coaching skills were typically not taught to teachers or other providers like me in professional preparation programs.
One way to assist EI providers to incorporate these new skills and use new educational tools is the use of family-centered practices through Family Guided Routines Based Intervention (FGRBI). Research currently indicates that the evidence-based practice of using caregiver coaching strategies and embedding activities within natural environments assists families in helping their child and themselves achieve the skills they want to accomplish (Woods, Kashinath & Goldstein, 2004).

In order to train and support early interventionists to make this change in how they provide early intervention services with families and caregivers, the state of Iowa has been involved in extensive professional development in Family Guided Routines Based Intervention with Florida State University for the past four years. The state of Iowa has invited all Area Education Agencies (AEA) to participate in this cohort experience by allowing four EI professionals from each AEA to attend the yearly training. The trainings have been attended by early interventionists, speech and language pathologists, physical therapists, service coordinators and other professionals the state may have approved to attend the training. This cohort is in year four and will run for approximately one more year. I have been a participant within this learning community during the 2015–2016 school year. The framework for Iowa’s professional development plan is the Iowa–Distance Mentoring Model (IA-DMM) under the direction of Juliann Woods of Florida State University. Information on this model for Iowa can be found at http://dmm.cci.fsu.edu/IADMM. IA-DMM provides professional development for those who work with infants and toddlers with disabilities and who have a high probability of developmental delay through a framework that encourages the use of family-centered services within natural environments. IA-DMM utilizes research on adult learning to teach providers how to incorporate family-centered, Family Guided Routines Based Intervention. Central to the
method are the Key Indicators: Setting the Stage, Observation and Opportunity to Practice, Problem Solving and Planning, and Reflection and Review. They are abbreviated SS–OO–PP–RR; the term Key Indicators will be used from here throughout the rest of the paper to refer to this model.

Research question

Along with utilizing adult learning strategies employed by the IA-DMM training, I conducted self-study research (Samaras, 2010) to provide an in depth study of my actions and thoughts as well as feedback from others. I engaged in a collaborative discussion and review of practices with three colleagues who participated in the IA-DMM training from Green Hills Area Education Agency. I conducted this research in order to answer my research question of: Would Distance Mentoring Model strategies, adult learning activities and self-study research assist me to assimilate the Family Guided Routines Based Intervention—Key Indicators and coaching strategies into my provider practices?

Literature Review

A paradigm shift in how to provide services to families and their children requires major changes in philosophy and acceptance of new practices. The primary question in my study was: Would Distance Mentoring Model strategies, adult learning activities and self-study research assist me to assimilate the Family Guided Routines Based Intervention—Key Indicators and coaching strategies into my provider practices?

Self-study research design

Self-study is a personal and collaborative investigation of the individual’s personal teaching framework that requires collaboration and reflection with peers within the field so that knowledge can be obtained by examining the individual and peers’ mindsets before, during and
after the self-study so that learning not only impacts the individual but also the field of education. Self-study methods allow teachers and other professionals to develop questions stemming from personal practice or problems of practice. Self-study happens within a framework of a supportive community of collaborative learners. It is within this supportive community that self-study researchers are able to open their minds to new views, practices, questions and critique from others in order to learn and expand this learning into their present teaching practices. Self-study allows researchers to use a variety of methods to study their practices (Bullough & Pinnegar, 2001; Loughran, 2004; Pellegrino, Bransford, & Donovan, 1999; Samaras, 2010; Samaras & Roberts, 2011; Tidwell, Heston, & Fitzgerald, 2009).

**Adult learning strategies**

Teacher behaviors do not automatically change even with research and recommendations from leaders in the field indicating that change is due. Dinnebeil, McInerney, and Hale (2006) found that teacher behaviors generally did not change from teacher directed to a consultative or coaching model even if teachers had believed that they had adopted a coaching model. In order to assist early intervention providers to gain new skills in using educational coaching practices with their families, adult learning strategies were evaluated and utilized (Keengwe & Onchwari, 2008, 2011; Pellegrino, Bransford & Donovan, 1999; Snyder & Wolfe, 2008;).

Videotaping home visitation sessions to share with peers and trained professionals was found to be an effective method of sharing information with colleagues with the same professional development needs (Campbell & Coletti, 2013; Colyvas, Dunst, Hamby, O’Herin & Trivette, 2009; Dunst & Trivette, 2009; Sawyer, & Campbell, 2010). Strategies such as naming the behaviors that are observed in professionals who excelled in the coaching practices were needed in order to assist those who are just beginning to learn the coaching strategies (Friedman,
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Woods, & Salisbury, 2012). By naming and describing the desired behaviors, providers are then able to place behaviors into categories and identify and name their actions and the actions of colleagues, making it easier to distinguish and learn new skills. Wilcox and Woods (2011) found that triadic interactions are better able to facilitate the use of coaching strategies than caregiver-to-child or provider-to-child only interactions.

**Family Guided Routines Based Intervention Key Indicators**

Research on family-centered practice began to emerge in 1992. The Americans with Disabilities Education Act (2004) first warranted coaching as a strategy to use with caregivers in 2004. The use of coaching strategies, which includes the use of Key Indicators such as problem solving strategies and embedding interventions into daily family routines and activities, generally promotes the caregivers’ abilities to support their child’s learning within their home and daily activities. These practices began to be accepted and research emerged between the years of 2000 and 2010 and continues today (Kashinath, 2006; Koche, Kuhn, & Eum, 2013; Woods, Kashinath, & Goldstein, 2004). The Family Guided Routines Based Intervention (FGRBI) is based on research that supports the use of addressing goals that are identified by the family and by embedding interventions in everyday routines (Bailey, Raspa, & Fox, 2012; Bricker & Cripe, 1992; Brown & Woods, 2015; Bruder, 2010; Dunst et al., 2001; Dunst, Hamby, O’Herin, & Trivette, 2009; Friedman, Woods & Salisbury, 2012; Hanft and Pilkington, 2000; Hwang, Chou, & Liu, 2013; Kashinath & Goldstein, 2004; 2006; Marturana & Woods, 2012; Mahoney et al., 1999; Woods, Wilcox & Woods, 2011).

**Distance mentoring model**

Current practice recommendations are to use Family Guided Routines Based Interventions that center on a triadic relationship of the provider, child and caregiver with the
focus being one of enabling the caregiver to teach and interact with the child to help the child learn through daily interactions, activities and routines that that family participates in. Research has shown however, that early intervention providers typically utilize a provider and child-focused approach (Peterson, Luze, Esbbaugh, Jeon & Kantz, 2007).

The Distance Mentoring Model (DMM) from Florida State University and the Iowa Department of Education have entered into a training endeavor (IA-DMM) using what has been researched and found to be effective to assist adult learners and teachers and providers in the field of early intervention to incorporate new methods and practices into their repertoire of helping practices. A wide variety of adult learning methods are used in the IA-DMM training such as videotaping of home visits for critique from IA-DMM critical friends and colleagues and researchers using Key Indicators, self-assessment using the Key Indicators, four days of training with trainers and monthly webinars (Basu, Salibury, & Thorkildson, 2010; Brown & Woods, 2015; Campbell & Coletti, 2013; Dinnebeil, McInerney, & Hale, 2006; Dunst, Hamby, O’Herin & Trivette, 2009; Dunst & Trivette, 2009; Hwang, Chau, & Liu, 2013; Friedman, Woods, & Salisbury, 2012; Kashinath, 2006; Kashinath, Woods, & Goldstein, 2006; Knoche, Kuhn, & Eum, 2013; Romski et al., 2011; Wilcox & Woods, 2011; Woods, Kashinath, & Goldstein, 2004;).

Key Indicators and adult learning characteristics

There are six characteristics that Bransford and Pellegrino (1999) identified in *How People Learn* that can be used when planning adult learning activities. These characteristics include introduce, illustrate, practice, evaluate, reflection, and mastery. I found that these characteristics fit well with the IA-DMM Key Indicators as they were also developed around what is known about adult learning. The four main categories of the Key Indicators are 1) Setting
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the Stage; 2) Observation and Opportunity to practice; 3) Problem Solving and Planning; 4) Reflection and Review. The following table depicts how I aligned the six characteristics of adult learning and the Key Indicators.

Table 1

Comparison of the Key Indicators and Bransford & Pellegrino’s (1999) Six Characteristics of Adult Learning

<table>
<thead>
<tr>
<th>SSOOPPRR KEY INDICATORS</th>
<th>SIX CHARACTERISTICS OF ADULT LEARNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Distance Mentoring Model (DMM), Florida State University</td>
<td>Introduction, Illustrate, Practice, Reflection, Evaluate, Mastery (Bransford &amp; Pellegrino 1990)</td>
</tr>
<tr>
<td>Setting the Stage – Review progress, family priorities, outcomes, development, jointly plan the targets, facilitate caregiver participation and caregiver decision making</td>
<td>Introduction</td>
</tr>
<tr>
<td>Observation and Opportunity to Practice – Observe caregiver child interaction, provide feedback, match intervention to caregiver and child needs, scaffold, provide specific feedback</td>
<td>Illustrate, and Practice</td>
</tr>
<tr>
<td>Problem Solving and Planning–Problem solves what works or doesn’t work for embedding into daily routines, helps caregiver to plan where, when, how to embed</td>
<td>Practice, Reflection, and Evaluate</td>
</tr>
<tr>
<td>Reflection and Review –Promotes caregiver reflection, review of target, asks caregiver “what worked,” “what it</td>
<td>Reflection, Evaluate and Mastery</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>SSOOPPRR KEY INDICATORS</th>
<th>SIX CHARACTERISTICS OF ADULT LEARNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>will look like when it is working,” leads development of plan for family for embedding intervention</td>
<td></td>
</tr>
</tbody>
</table>

**Methods**

Prior to and during this research I engaged in adult learning through professional development with the state of Iowa through Florida State University and the IA-DMM. This adult learning model utilizes research-based strategies to assist adults to learn new skills and strategies. This model provides training in Family Guided Routines Based Interventions (FGRBI) and FGRBI Key Indicators. The IA-DMM and FGRBI training provided the beginning framework for this self-study.

The Iowa–Distance Mentoring Model required that trainees attend two two–day trainings in FGRBI and the use of the Setting the Stage, Observation and Opportunities to Practice, Problem Solving and Planning and Reflection and Review Key Indicators tool. The trainings gave early intervention providers an understanding of the conceptual underpinnings, framework and philosophy of the FGRBI and the Key Indicators. Providers were given in–depth training on how to implement FGRBI through the use of the Key Indicators and coaching practices. In addition to the trainings, providers participated in eight monthly interactive webinars to receive new information and strategies.

The following methods were used to answer the question: Would Distance Mentoring Model strategies, adult learning activities and self-study research assist me to assimilate the
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Family Guided Routines Based Intervention–Key Indicators and coaching strategies into my provider practices?

**Participants and setting**

I completed my research within the homes of 12 families in rural Southwest Iowa who were receiving early intervention services through Green Hills Area Education Agency during the months of January and February 2016. The majority of the families were Caucasian with the exception of one family that had one Caucasian parent and the other Hispanic. Of the families, 56% were middle class and 44% were low income. Fifty-six percent of the children seen were from families with two parents, 22% of the children were from homes with single mothers and 22% were from divorced families. One child recorded in the two parent home category was in a foster-to-adopt home. The children in the study ranged from one year (22%) to two years of age (78%).

**Procedures**

**Recruitment.** I sent out recruitment letters to the families that I was currently working with to ask if they would like to participate in the study. I also included information about IA-DMM and what I intended to study. I included a letter of intent to participate as well as a permission form to videotape and a self-addressed stamped envelope (addressed to my critical colleague at GHAEA who also serves these families). This was done so that families would feel comfortable in saying no to participating in the research. The first family to sign and return the proper forms was chosen to be the family to participate in the videotaped sessions.

The Iowa–Distance Mentoring Model required that trainees attend two two-day trainings in FGRBI and the use of the Setting the Stage, Observation and Opportunities to Practice, Problem Solving and Planning and Reflection and Review Key Indicators tool. The trainings
were designed to give early intervention providers an understanding of the conceptual underpinnings, framework and philosophy of the FGRBI and the Key Indicators. Providers were given in—depth training on how to implement FGRBI through the use of the Key Indicators and coaching practices. In addition to the trainings, providers participated in eight monthly interactive webinars to receive new information and strategies.

**Measure 1: Baseline.** A baseline video of a home visit was conducted prior to beginning IA-DMM training. The baseline was conducted during one home visit. The Key Indicators Self-assessment was used by both myself and the Florida State University researchers. This baseline provided a starting point in which to compare changes in the amount and type of indicators after the research was completed.

**Measure 2: Videotaped sessions.** Two sixty–minute video recordings were completed during the project. These videos were reviewed and rated with the use of the Key Indicators by me, three Green Hill Area Education Agency (GHAEA) critical friends and colleagues (who were also involved in this training) and a DMM researcher. For each video submitted, I completed a Self-assessment rating on the Key Indicators.

**Measure 3: Key Indicator self-assessment.** Prior to rating myself on the Key Indicators, I obtained inter–rater reliability with a critical colleague also involved in the IA-DMM training. I obtained 85% reliability with this colleague on the Key Indicators. I then completed the Key Indicator Self-Assessments following 12 home visits and two video–taped sessions. Through the use of the completed Key Indicator self-assessments, the rating scales that were completed by the IA-DMM researcher and my GHAEA-IA-DMM colleagues, I was able to accurately compare ratings and reflect on changes over time utilizing the Key Indicator framework.
Measure 4: Self-study journal entries. Following each of the twelve home visit sessions, I completed a one-page journal entry as part of the self-study methods to reflect on what occurred in the home visit, my actions during the interaction and the reactions of the family and child to my use of the problem solving strategies. I wrote one-page journal entries following my home visits beginning January, 2016 through February, 2016.

Measure 5: Collaborative investigation with critical colleagues. Throughout the study, my critical friends, GHAFA colleagues who also attended the IA-DMM training, engaged with me in a collaborative investigation of our practices. While this study ran, we met in six monthly, 60-minute Skype sessions. Each month one of the colleagues would provide a video-taped home visit session for the group to review and rate with the Key Indicators. We then had our peers state what they perceived to be the strengths and areas they wanted to work on. The critical friends would provide information about why they agreed or why they felt there were additional strengths. We would expand on ideas to help the colleague in the area of need. Typically the person sharing the video would identify the same items to work on as the group had identified.

To assist in the understanding of the many components of the training, a visual in the form of Table 2 is presented.

Table 2

<table>
<thead>
<tr>
<th>Timing</th>
<th>Activity</th>
<th>With Whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two days, Fall 2015</td>
<td>IA-DMM training</td>
<td>Provided by Florida State University DMM trainers.</td>
</tr>
<tr>
<td>Eight monthly</td>
<td>Interactive webinars</td>
<td>Put on by Florida State University DMM trainers</td>
</tr>
</tbody>
</table>
Changing Early Intervention Provider Practices to a Coaching Model

<table>
<thead>
<tr>
<th>Timing</th>
<th>Activity</th>
<th>With Whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>Video–based feedback session following the viewing and rating of each videotaped home visit session</td>
<td>Colleagues</td>
</tr>
<tr>
<td>Monthly</td>
<td>Feedback sessions to review Key Indicator ratings and findings from viewing colleague’s home visit videotape</td>
<td>IA-DMM researcher and colleague</td>
</tr>
<tr>
<td>Two days, March 2016</td>
<td>Training</td>
<td>Provided by Florida State University DMM trainers</td>
</tr>
</tbody>
</table>

**Data analysis**

The percentages obtained through my self-assessment ratings and the ratings I received from my colleagues and from our trained researcher were analyzed utilizing the rating scale from the Distance Mentoring Model. By converting the ratings into graph form I was able to visually inspect changes in the use of the Key Indicators over time.

Table 3

**Forms of Data Collection**

<table>
<thead>
<tr>
<th>Journal Entry Topics</th>
<th>DMM SSOOPPRR Key Indicators Self-assessments</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflections on 12 home visits</td>
<td>Assessments following 12 home visits</td>
<td>Data was collected on the four main areas of the SS–OO–PP–RR Key Indicators</td>
</tr>
<tr>
<td>Reflections on videotaped sessions of my colleagues and I following our collaborative discussions</td>
<td>Assessments completed following my videotaped home visits</td>
<td>Data was collected on the percentage of times each indicator was used during 12 home visits</td>
</tr>
<tr>
<td>Reflection on review session with</td>
<td></td>
<td>Data collection was</td>
</tr>
<tr>
<td><strong>Journal Entry Topics</strong></td>
<td><strong>DMM SSOOPPRR Key Indicators Self-assessments</strong></td>
<td><strong>Data Collection</strong></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>collaborative colleagues and DMM research rater</td>
<td>completed through three videotaped sessions with one of the 12 families</td>
<td></td>
</tr>
<tr>
<td>Reflections following DMM webinars</td>
<td>The self-study data was categorized according to themes that emerged throughout the study</td>
<td></td>
</tr>
</tbody>
</table>

**Self-study qualitative analysis.** Self-study research is not designed to provide answers, but instead to provide educational researchers with an avenue to explore and challenge their thoughts, assumptions and beliefs so that they might improve their overall understanding and teaching practices (Bullough & Pinnegar, 2001). I utilized four of the thirteen guidelines developed and recommended by Bullough and Pinnegar (2001) “for establishing quality” that “point toward virtuosity in scholarship” (p. 16) to assist me in my self-study research. Of the thirteen guidelines, I focused on the following:

Guideline 2: Self-study should promote insight and interpretation… Guideline 6: The autobiographical self-study researcher has an ineluctable obligation to seek to improve the learning situation not only for the self but for others… Guideline 8: Quality autobiographical self studies attend carefully to person in context or setting… and Guideline 13: Interpretations made of self-study data should not only reveal but also interrogate the relationships, contradictions and limits of the views presented. (Bullough & Pinnegar, 2001, pp. 16–20)
**Constant comparative qualitative method.** A content analysis of the journal entries following each home visit and review of videos was also conducted by using the constant comparative qualitative method. This is an inductive method of analysis that allows a researcher to critically examine data, drawing meaning from it during the ongoing research (Glaser, 1965). I used open coding to categorize my research and was able to change my categories as the research emerged. This method fit well with my self-study research, as self-study allowed me to challenge my assumptions, study my problem of practice and analyze my actions both as an individual and as a member of a collaborative investigative group as the research is occurring. This allowed me to make changes to my thought process so that I could improve my overall understanding and teaching practices (Bullough & Pinnegar, 2001).

**Results**

My research question was: Would Distance Mentoring Model strategies, adult learning activities and self-study research assist me to assimilate the Family Guided Routines Based Intervention- Key Indicators and coaching strategies into my provider practices? To find the answer to my question I conducted both quantitative and qualitative self-study research. I present the quantitative results first.

**Quantitative results**

Comparisons of Key Indicators are displayed in Figures 1, 2, 3 and 4. The Key Indicator self-assessment was completed after each of the 12 home visits. Performances in each of the four main areas of the Key Indicators were rated for the 12 home visits. The four areas were 1) Setting the Stage, 2) Observation and Opportunity to Practice, 3) Problem Solving and Planning and 4) Reflection and Review. An increase in the use of all of the Key Indicators was identified compared to the first home visit where the lowest ratings occurred. Each of the four areas shows
that scores fluctuated over time yet ratings reached 100% for a minimum of six times in the 12 home visits in the first three areas of the Key Indicator self-assessment.

Baseline data was collected from one home visit. The results showed that in the Key Indicator area of Setting the Stage, I obtained 50% of the performance points available. In the area of Observation and Opportunity I obtained 33.3% of the performance points available. I obtained 100% in the Problem Solving and Practice area of the baseline. In the final area of Reflect and Review I received 33.3% of the performance points. All baseline percentages achieved were lower than the first data points with the exception of the area of Reflection and Review which was 25%.

Figure 1—Indicates the baseline in red for the Key Indicator category of Setting the Stage and performance points in blue for each of the twelve home visits.
Figure 2—Indicates the baseline in red for the Key Indicator category of Observation and Opportunity and performance points in blue for each of the twelve home visits.

Figure 3—Indicates the baseline in red for the Key Indicator category of Problem Solving and Practice and performance points in blue for each of the twelve home visits.
Figure 4—Indicates the baseline in red for the Key Indicator category of Reflection and Review and performance points in blue for each of the twelve home visits.

Figure 5 shows the total percentage of performance points awarded for all of the Key Indicators. The baseline percentage obtained was 50% which was below the first data point of 58%. Figure 5 also indicated that the percentage of performance points awarded rose steadily up to 100% then dropped to 98%, then fluctuated between 98% and 88% until it rose steadily back up to 100% for visit 12.
Figure 5–Indicates the baseline in red for the Key Indicator and the overall total performance points in blue for each of the twelve home visits.

Figure 6 is an item analysis of the Key Indicators self-assessment that shows that items 1, 2 and 7 were obtained 100% of the time. These items involved gathering information and encouraging caregiver reflection, asking the caregiver to update the progress on implementing the intervention between visits and providing specific and general feedback on both the child and caregiver actions/behaviors in order to teach and encourage the caregiver. Items that had the lowest percentage of attainment were items 3, 9 and 11. Item number 3 required that the child’s development and caregiver interest be tied into the child’s goal and build consensus. Item number 9 requires that there is a discussion about opportunities for practice in additional contexts/routines–planning when, where and how to do it. Item number 11 encouraged the caregiver to state what it would look like when “it is working” and encourages caregivers to name specific or measurable targets.
Figure 6—Indicates the total percentage of performance points I obtained on each of the twelve Key Indicators from all of the home visits completed during this research.

Qualitative results

The qualitative data was obtained from examining the use of adult learning strategies, self-study one page journal entries that were written following home visits where the Key Indicator self-assessment tool was used, and following dialogue with critical friends and colleagues.

**Independent variable—Adult learning strategies.** Through IA-DMM training the providers who attended the trainings were reminded that we were also adult learners, therefore it would be beneficial to work on one difficult part of implementing the Key Indicators at a time rather than to try to achieve all of the indicators at once. This strategy was true for the families I worked with. Discussing one or two strategies to use with caregivers rather than to provide them with a plethora of strategies to pick from allowed them the opportunity to really hone in on that strategy and become successful in implementing it. This also made it easy for review at the end
of the session and easy to review at the start of the next home visit when reviewing the progress on what the family had chosen to work on between home visits.

I also found that I was able to learn much from observing the caregiver and child interactions. The use of coaching strategies such as demonstration with narration, guided practice with feedback, and caregiver practice with feedback were effective in helping adults to learn how to assist their child to learn.

Scaffolding new learning for the providers was a strategy used by IA-DMM as providers were at different stages of learning the coaching strategies and the Key Indicators. Scaffolding learning for caregivers was an adult learning concept that we used with parents as well. I have done this for many inexperienced caregivers but I had not thought about every adult learner needing this. As adult learners we learn when our teachers and providers make conscious decisions about when to teach us particular skills based on our individual differences and skill level.

I found that for me to learn about the caregiver child interaction I needed to listen, observe and ask "why" questions following the observation. To help some caregivers to narrow their focus I found it helpful to list their priorities, show them the list and ask what they would like their top priority to be. I then would have then state what they wanted to work on and during what part of their daily routine. By using the Key Indicators I was able to use many strategies to help families learn through meta-cognition. I have observed that caregivers learn and become encouraged by seeing their child succeed as a result of their efforts. When caregivers learn how to teach their child through positive interactions with them they build confidence and competence.
Independent variable—Critical friends and colleagues dialogue. I found that having discussions with my critical friends and colleagues who were also being trained through IA-DMM was paramount to my success in using the Key Indicators. The critical friends and colleague discussions helped me to clarify and deepen my understanding and provided a platform for me to examine, question and reshape my pedagogy. I was also able to use my critical friends and colleagues to assist me in analyzing situations outside of the videotaped sessions to help me problem solve additional strategies to use in very specific situations.

Independent variable—Videotaped home visit sessions. Videotaping home visits and watching myself as well as critical friends and colleagues was another very effective adult learning strategy. It provided me with a way to see the strategies or lack of strategies in action. This strategy gave me the context and content for our critical friends and colleague discussions. By observing my critical friends and colleagues implementing the Key Indicators at home visits, I was able to identify and analyze the Key Indicator and strategies that were used and pinpoint items that needed more work as well as to gain new strategies and ideas for my own strategy implementation.

Independent variable—IA-DMM video review with researcher and critical friends and colleagues. I found that by having both the critical friends and colleagues meeting and the meeting with the IA-DMM researcher my understanding of the Key Indicators and how my actions fit into them were further developed. As these meetings continued with each of the critical friends and colleagues and the researcher, more information was shared by the researcher specific to our needs and the questions we had about the Key Indicators. This helped to deepen my understanding not only of the Key Indicators but of how to implement them as well. When too much time had gone between our critical friends and colleagues discussion of a video and the
discussion with our critical friends and colleagues and DMM researcher I found that it became difficult to remember all the details of the video even with self-study notes in hand. At the second IA-DMM training additional or new information about how our performance on the Key Indicators was rated. This was an intentional strategy by the DMM researchers to build our skills first and add additional learning as we were ready for it (scaffolding).

Table 4 provides a visual of the Key Indicators (on the left) and my thoughts and results in completing them with caregivers (on the right).

Table 4

<table>
<thead>
<tr>
<th>Independent Variables—DMM Key Indicators</th>
<th>Results</th>
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</thead>
<tbody>
<tr>
<td>Setting the Stage</td>
<td></td>
</tr>
<tr>
<td>1. Gather updates on the child/family—listens, encourages reflection.</td>
<td>1. I found that gathering information and asking for updates about the child and family was a good starting point for the visit and one that I did naturally.</td>
</tr>
<tr>
<td>2. Updates intervention from plan made at the last home visit—listens, encourages caregiver reflection and problem—solves as needed.</td>
<td>2. By updating the intervention plan that family worked on between home visits I found that I gained a starting point for discussion and caregiver reflection that allowed me to dig deeper into problem solving with the caregiver.</td>
</tr>
<tr>
<td>3. Shares information about development, current status, intervention, family interests, connects to IFSP, priorities and builds consensus.</td>
<td>3. Giving caregivers feedback on what they were able to do with their child and how it helped the child learn, coupled with additional information about their child’s development, assists caregivers to learn why specific activities and actions are important to development.</td>
</tr>
<tr>
<td>3. Caregivers begin to see a connection to their</td>
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</table>
### Independent Variables–DMM Key Indicators

<table>
<thead>
<tr>
<th>Results</th>
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<tbody>
<tr>
<td>4. Reviews session priorities and jointly plan targets, teaching strategies, routines–facilitates caregiver participation and decision–making.</td>
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<tr>
<td>interactions with their child and how it has helped them to learn.</td>
</tr>
<tr>
<td>4. Ask caregivers clarifying questions rather than to say what you think they want. This action puts the decision making back into their hands ensuring that what is planned is what they want to target for the visit.</td>
</tr>
<tr>
<td>4. I found that goal or jointly planning targets for the session is important for both the caregiver and me as it helps to provide a focus for the session and allows me to have a starting point to go back to if we begin to lose focus on the topic.</td>
</tr>
</tbody>
</table>

#### Observation and Opportunities

<table>
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<th>Results</th>
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</thead>
<tbody>
<tr>
<td>5. Observes caregiver–child interaction in family–identified routines–provides feedback and builds on dyad strengths.</td>
</tr>
<tr>
<td>5. The coaching strategies and the act of observing the caregiver and child interact along with DMM training, critical colleague discussions following the watching of videotaped home visits have all helped me to change my teaching philosophy.</td>
</tr>
<tr>
<td>6. Uses coaching strategies, matched to caregiver and child behaviors as caregiver embeds intervention in routine–scaffolds and repeats to builds competence and confidence.</td>
</tr>
<tr>
<td>6. There is value in observation as I am able to see the child and family strengths and am able to scaffold learning for both the child and caregivers.</td>
</tr>
<tr>
<td>6. Families have shared that they feel “empowered” when they have the knowledge of how to help their child.</td>
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</tbody>
</table>
### Independent Variables—DMM Key Indicators

<table>
<thead>
<tr>
<th>Indicates</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Provides general and specific feedback on caregiver and child behaviors and interactions—teaches and encourages caregiver. Feedback can be given using coaching strategies such as observation, conversation, joint interaction, direct teaching, demonstration with narration, guided practice with feedback, caregiver practice with feedback and problem solving.</td>
<td>7. Strategies such as demonstration with narration, guided practice with feedback and caregiver practice with feedback give the provider the tools to work with the caregivers, allowing providers to successfully teach the caregiver.</td>
</tr>
</tbody>
</table>

#### Problem Solving and Planning

8. Problem-solves with the caregiver about what does and doesn’t work to embed intervention—brainstorms, discusses different strategies, routines, new targets or more child participation.

9. Supports caregiver to identify additional opportunities for practice in additional contexts/routines—plans when, where, how to do it.

8. Brainstorming and problem solving different routines to use to help generalize skills from one part of the day to all parts of the day is still a challenge for me that I will continue to work on.

8. Caregivers are much more verbal about what they want to do and can do when they are active in problem solving and planning.

8. I see a benefit to not bringing the toy bag into the home. I am able to focus on building the skills of the caregiver through observation and problem solving strategies in order to help their child learn.

9. Identifying additional opportunities for practice in additional routines takes practice and planning on the provider’s part as it is easy to go back to old habits and stay in one routine.

9. When caregivers state how they work on a skill, to have better understanding of that skill the provider can ask the caregiver to show them how they do that (ask for a demonstration). This provides more opportunities to problem solve with the
<table>
<thead>
<tr>
<th>Independent Variables–DMM Key Indicators</th>
<th>Results</th>
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<tbody>
<tr>
<td>Reflect and Review–</td>
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<tr>
<td>10. Asks questions, comments to promote caregiver reflection and review of targets, strategies, routines and “what worked” in specific routines or sessions.</td>
<td>10. Meta-cognition occurs when asking caregivers to verbally reflect what occurred during the home visit, what worked, what didn’t and what they would like to work on next.</td>
</tr>
<tr>
<td>11. Encourages caregiver to describe what it will look like when “it is working”—encourages naming specific or measureable targets, strategies and routines.</td>
<td>11. Asking caregivers to describe what it will look like for their child to have success in a routine proved to be more difficult for me as the question seemed redundant. I found though that caregivers were able to answer the question quite confidently. I will continue to work on this item of the Key Indicators.</td>
</tr>
<tr>
<td>12. Encourages caregiver to lead development of a “best plan of action” for embedding intervention throughout the day—facilitates caregiver leadership and decision making.</td>
<td>12. I found that it helped to write out prompts and sample questions to remind me to ask the caregivers how they would embed the strategies into additional routines and to describe what success would look like for them and their child.</td>
</tr>
<tr>
<td></td>
<td>12. Asking caregivers what they would like to work on between home visits is an effective strategy. This strategy also helps caregivers and provider to have a starting point for the next visit.</td>
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**Discussion**

To determine if I could change my teaching practices and pedagogy to reflect the current practices in Early Intervention, I engaged in Iowa Distance Mentoring Training through the state of Iowa while collecting data through self-study qualitative and descriptive quantitative study
(Florida State University, 2016). I used the following question to guide my research: Would Distance Mentoring Model strategies, adult learning activities and self-study research assist me to assimilate the Family Guided Routines Based Intervention—Key Indicators and coaching strategies into my provider practices?

**Attributions in fluctuations of Key Indicators**

I found that there were fluctuations seen in the Key Indicator areas of opportunity and practice (Figure 2) and problem solving and planning (Figure 3). The home visits that corresponded with these fluctuations were 3, 7, 9 and 10. By examining my Key Indicator self-assessment and the self-study journal I found that the difficulty I experienced in completing the Key Indicators at these visits was related to where the home visit occurred, the time of day it occurred or the type of service model the caregiver preferred.

**Bedtime routine.** When examining the fluctuations, I found that home visit numbers 3 and 7 were completed with the same child and family. The family priority was to have the child sleep through the night. Through examination of my self-study journal entries I found that it was difficult to be able to obtain full credit in some of the areas of the Key Indicators when the routine was one that is difficult to observe. Routines such as bedtime are typically difficult to observe. This family did not have the same problem at naptime that it had at bedtime due to the family dynamics being different at the different times of the day. Through critical colleague discussion I found that others have this same problem (Trivette, Dunst, Hamby, & O’Herin, 2009). At the IA-DMM training March 1, 2016 it was discussed that caregivers could use their cell phones or iPads (if they have them) to take short video clips to either send to or to show the provider (Woods, Friedman, & Edelman, 2016). This method could give another avenue for
providers to see situations at home that are hard to emulate through other routines and times of the day.

**Medical model.** I found that home visit numbers 3 and 9 were with the same family. This family preferred to combine a medical model and a home visitation model. In my self-study journal I noted that I had a conversation with this caregiver about looking at daily routines as a way to embed skills so that focusing daily on these skills could occur naturally. In my journal I noted:

I discussed using this new way of providing services with the family; however the conversation seemed to confuse the caregiver and put stress on her when I mentioned that we would incorporate the strategies into her already existing daily routine. It seemed that as soon as I said that ‘she’ would be doing the strategies, she shut down. (Journal entry, 1.19.16)

Eventually after a few more visits, after more practice with the Key Indicators, and the FGRBI, I was able to re-introduce some of the Key Indicators into my practice with this family and had better success. The difference was that this time I simply said, “You just identified that you would like to work on increasing the number of times you say the word ‘up’ to her. When you think of mealtime, when do you think you could use the word ‘up’?” (Journal entry, 2.16.2016). This method of approach seemed to cause less stress to the caregiver. In the future when discussing the benefits of embedding interventions into the daily routine I could point out the number of opportunities that a child would have to work on a skill if it is embedded into a variety of daily routines as opposed to only focusing on that skill for a maximum of 60 minutes of therapy a week (Kashinath, Woods, & Goldstein, 2006; Woods, Freidman & Edelman, 2016).
Daycare. There were some fluctuations in the percentages during home visit #10 which was conducted at the daycare at the request of the caregiver. This family wanted weekly home visits to occur as a combination of visits conducted at home and at the daycare center. The daycare center was a place that I had visited before and found that it was a little more difficult to come into a place that had preconceived expectations for what should occur at the visit. It was also difficult due to the nature of being in an environment where the caregiver is in charge of many other children. In my journal notes I reflected that “it is difficult to be able to hit all of the Key Indicators when there are so many (children) to vie for the caregiver’s attention” (Journal entry, 2.5.16). IA-DMM trainers and researchers also brought these concerns to discussion with the trainees noting that coaching can occur in these environments as well and working with the teacher rather than to work separately and to “join into the curriculum and culture of the classroom” (Woods, Friedman, & Edelman, 2016). Even though I did not obtain the highest percentages within this scenario I did feel that the visit was very productive and as a result of the visit the caregiver began to implement different strategies and activities and began to see that the child could do more than she was expecting the child to do.

I attribute the increase in the percentage of performance points achieved to a number of factors. As noted in Tables 4 and 5, which reflect the self-study journal notes, I found that to be able to put the Key Indicators in place with families, I needed to see them in action (videotapes of colleagues and myself), study the results by comparing my ratings to those of others on the Key Indicators self-assessment (accomplished through critical discussions with the IA-DMM Researcher and my critical colleagues), see myself in action through videotaped sessions so that I could critically examine my actions, journal my thoughts after each critical action and obtain additional information as I continued through the Family Guided Routines Based Intervention
practices with the Key Indicators (Marturana & Woods, 2012; Wilcox & Woods, 2011). By examining my actions at home visits through my journal entries, I was able to keep my thoughts fresh in my mind and gain data to refer back to throughout my research journey. I also feel that the self-study method of using critical dialogue with colleagues, who were involved in IA-DMM training, was crucial to my success. Dialogue with critical colleagues who share a common investment in learning is invaluable, as the conversation, critique and support come from living and experiencing very similar realities (Samaras & Roberts, 2011).

**Key Indicator: Strengths and weaknesses**

*Items with 100 percent performance points.* The data indicates that I was able to obtain all of the points awarded for the Key Indicator items 1, 2, and 7. Items 1 and 2 are in the Key Indicator, Setting the Stage. Item 1 focuses on gathering updates on the child and family and encouraging caregiver reflection. Item 2 asks the caregiver to update the intervention implementation since the last visit by listening and encouraging caregiver reflection and setting up problem-solving as needed (Florida State University, 2016). I found that I was naturally able to do item one as it was something I typically did in my practice prior to training in Family Guided Routines with Based and Interventions. I found that with item two I typically asked for an update on the progress of the intervention implementation of the skill that was worked on between home visits. To refine my practice I needed to concentrate on the type of questions that I asked in order to elicit caregiver reflection. In my journal I noted that after asking about how the intervention implementation went I would then respond with a reflective statement such as, “Sounds like things really improved” then would ask a reflective question such as, “How were you able to make that happen?” (Journal entry, 2.5.16). These open-ended questions provided opportunity for further reflective conversations and problem solving.
Item 7 is located in the Key Indicator area of Observation and Opportunity to Practice. This area is one on which I really had to focus to achieve success. Prior to our shift in service delivery model, I provided caregivers with a plethora of strategies at each home visit, which they would seem very happy to receive. To step back and observe rather than fire suggestions to the caregivers was a large change in practice. I believe that I benefited the most from watching my colleagues demonstrate their ability to observe their families in action in their videotaped feedback sessions. Prior to this shift in service delivery model, families were happy with our services but I now believe that they will not only still be satisfied with services but will also have the ability to problem solve for themselves, which is teaching them a lifelong skill.

**Items with 79-95 percent performance points.** I obtained between 79–95% performance points on items 4, 5, 6, 8, 9, 10 and 12. These items all required me to focus on what I was doing by preplanning how I was going to achieve these items. I found that it was best to have a plan of which item I was specifically going to make sure I accomplished. I took the Key Indicators to the home visit and tried to hit each one of them but specifically would hone in on the item that I wanted to get experience with and be successful with, utilizing adult learning strategies. (Trivette, Dunst, Hamby, & O’Herin, 2009). This often meant writing out reflective questions that I might use as well as specific behaviors that I needed to remember to do, such as to position myself in a triangular position with the child and caregiver (Wilcox & Woods, 2011). This seating arrangement assisted me in being able to offer assistance through verbal feedback, narration for the caregiver’s actions, observation and modeling. If the provider is too far away from the caregiver and child interaction, the session can become impersonal.

On Key Indicator item 3 –Shares information related to development, current status, intervention and, family interests –connects to IFSP or larger goals, priorities and builds
consensus. I received 75 percent of the performance points. Item 3 provided me with difficulty as I did not fully understand all the information that was needed to obtain full credit for this item. At the spring IA-DMM training, further clarification was given on this item. The item needed to reflect back to the outcome or goal by having the provider discuss the child’s IFSP progress or development. I had some of the parts to this indicator but not all and not all the time (Florida State University, 2016).

Key Indicator item 11—Encourages caregiver to describe what it will look like when it is working — encouraging naming specific or measurable targets, strategies and routines, received 62% of the performance points. I found that I had the most difficulty in implementing item number 11, and in my self-study journal I stated, “This item feels the most unnatural for me. It is as though we have been discussing this item throughout the whole session and feels redundant to me” (Journal entry, 2.17.2016). At visit number 12, however, I was able to incorporate this item into the home visit naturally and the response I got as a result of my asking this question surprised me. In my journal entry for this home visit I wrote the following:

I remembered to ask what success will look like for the caregiver and the child this time and I was amazed at what the mom said. She had so many ideas of what it would look like. I think it was good for me to have that experience. I was half expecting a response of ‘isn’t that what we have been talking about all along’ but that was not the case…… I am still working on pulling in all the pieces of the SS–OO–PP–RR Key Indicators together but I am light years from where I started. I need to continue to work on asking families what success will look like for them and how they might embed the activities into other parts of their routines. (Journal entry, 1.26.2016)
I think that this service delivery model really helps caregivers to be a part of the problem solving and planning. By doing this I am finding that they are much more verbal about what they want to do and what they can do. I also like asking them about where they can embed these skills into their daily routines. This item has been difficult for me to master but I am beginning to remember to do it. It has had to be a conscious effort on my part—one that has required me to review the items before going into a home visit and even circling the ones that I typically forget.

**Benefits of self-study methods and video recordings**

I found it helpful to observe videotaped sessions of myself and my colleagues while looking at the Key Indicators. From self-study journal notes I commented, "I was able to pause the video, take notes, and then resume the video again. This also provided me with the option to rewind and watch as needed" (Journal entry, 2.16.2016). I then was able to rate my peers as well as my own Key Indicator Self-assessment. I found that there was camaraderie among my early intervention colleagues and me, as we viewed our own and each other’s videotapes. We had come from utilizing the same previous teaching methods, had been trained on the new strategies together and were providing each other with critical feedback on our use of the new coaching strategies (Samaras, 2010).

Each month my critical friends and colleagues and I would meet in a Google Hangout one week prior to our meeting with the DMM trainer-researcher. We would discuss each of the Key Indicators and talk about how we perceived the colleague’s videotaped home visit. We offered support and feedback as we went through the checklist. All of the critical colleagues were able to freely ask clarifying questions in order to reach a better understanding of the visit, coaching strategies used and suggestions for future coaching strategies (Samaras, 2010).
The act of preparing and being videotaped assisted me to learn new skills. When I was videotaped I wanted to do my very best, therefore I studied all of the Key Indicators so that I felt more competent in remembering what each one entailed. I wrote down sample reflection questions, reviewed what had happened at the home visit previously and took along my self-made cheat sheet so that I could glance at it from time to time. I believe that these steps were critical for me to learn new skills. Following the videotaping of my session I downloaded the video and watched it, again taking notes, pausing when I needed to and rating myself on my Key Indicators self-assessment. I then would write one page in my self-study journal.

In the following week, my critical friends and colleagues and I would then meet with our IA-DMM trainer–researcher to formally go over our video feedback. The researcher would begin by having us review our own video, then asking our critical colleagues for their feedback and would offer her additional input into the findings. I typically observed that my peers did not give themselves as much credit as they obtained per my rating and the DMM researcher’s rating.

We would wrap up each session by stating what Key Indicator we would like to focus on between visits. This was helpful as it gave us a starting point for the next video session. I did find, however, that because we would have watched the video for that month several weeks prior to our video feedback session with our DMM researcher, the information would not be as fresh in our minds for our feedback session even if we had taken detailed notes.

The conversations that we had with our DMM researcher assisted us to deepen our understanding of each of the Key Indicators. At times I was able to use my critical friends and colleagues to assist me in analyzing situations outside of the videotaped sessions. As these meetings continued with each of the critical colleagues and the researcher, more information was given as our understanding deepened (Basu, Salisbury, & Thorkildsen, 2010). Information was
given on how to frame our questions, how to engage the caregiver in further discussion, what information was needed that may not have been discerned from reading the description given in the Key Indicators, how to give routines not identified by the caregiver to help the caregiver with issues such as behavior problems when the problems are not readily visible or occurring during that home visit.

There was much overlap between six characteristics that Bransford and Pellegrino (1999) identified in *How People Learn* (introduce, illustrate, practice, evaluate, reflection) and the Key Indicators from the Family Guided Routines Based Intervention and Distance Mentoring Model (Florida State University, 2016). This is illustrated in Table 1. Throughout my self-study research, it was critical for me to keep adult learning strategies in mind for my learning as well as for the families that I work with. Utilizing adult learning strategies is an important tool that providers can use to be successful in providing guidance to caregivers so that they may understand why and how to use new strategies with their child (Trivette, Dunst, Hamby, & O’Herin, 2009).

**Effective methods in promoting change**

A self-study method of one page journal entries was used to record my collaborative inquiry discussions. By doing this I also was able to provide myself with a way to analyze my thoughts and changes, not only while I was gathering data but also as I was writing this research paper (Bullough & Pinnegar, 2001). Simply put, I would not have remembered the various strategies I used, the thoughts I had, the changes in those thoughts and many anecdotal notes I took that pertained to very specific and also general situations. I analyzed this part of my data using the qualitative analysis method of constant comparative.
When I began to write in my journal, I wrote whatever came to mind on what I had experienced and how I might change or add to my teaching strategies (Bullough & Pinnegar, 2001). I wrote freely without constraint. I found this to be liberating and just what I needed. Then about a third of the way into the study I determined that I needed a little more structure to my writing in order to make sure that I covered all of the areas of the Key Indicators. It was then that I developed a form to type into based on the Key Indicators. This structured approach proved to be helpful in reflecting on the Key Indicators.

At the same time, I developed shorter versions of the Key Indicators. My journal excerpt stated, "This afternoon prior to my last home visit, I developed a cheat sheet to use at home visits. I highlighted the things I wanted to remember. I then used this at my home visit" (Journal entry, 1.27.16). It provided me with a way to take a few quick notes in the moment so that I could just look down and be reminded of what I was supposed to do. I found that not only was this helpful in focusing my thoughts at the home visits, but just the act of taking the time to write up the cheat sheet helped me to understand the process better. I used this cheat sheet for about half of my home visits thereafter. I was then able to do a quick review before the home visit and then pick from my trouble spots for areas I wanted to focus on more. This definitely enhanced my effectiveness during home visits.

Journaling provided me with a way to keep track of a variety of thoughts and assisted me to code my experiences. I feel that journaling and examining what we are saying and making changes in our thought processes is another way to achieve meta-cognition. The following is an excerpt taken from my journal that shows my reflection after a home visit and how I was able to reflect on changes that I could make:
At the end of the last session we made a plan for this session and the caregivers wanted to focus on building play skills, attention span, continuing to provide language stimulation and toilet training and sitting still while changing his diaper. When I asked the caregivers what they would like to work on today they said ‘getting him to put his shoes on.’ I don’t think that I responded as well to this as I redirected them back to what they had said that they wanted to work on at the last home visit. I acknowledged what they had said and then said something to the effect of ‘last time you wanted to work on ____, did you want to work on this’ and they indicated that they did. I do think that I could have said ‘last time you identified ___ and I hear you saying that you would like to work on ____, what you would like the focus of our session to be today?’ This would put the decision making back into their hands and I would feel confident that I was working on their plan rather than my plan. (Journal entry, 2.1.16)

Limitations

This study supports previous research that coaching strategies can be taught to professionals who have previously used direct service models (Woods, Kashinath, & Goldstein, 2004; Knoche, Kuhn, & Eum, 2013). However there are some limitations to my study. The sample size was small. The total number of home visits completed using the FGRBI and Key-Indicators was 12. The research was conducted for 45 days. This was a short amount of time to determine whether changes maintained over time.

The IA-DMM training began in October 2015 and is scheduled to be completed in June 2016. This research was conducted after the middle of the training rather than after the training. This could be seen as either positive or negative as the self-study data was able to be collected at that time. If it had waited, information about my changes as I did the study would not have been
recorded. If I had waited until the end of the IA-DMM training, I would have more data and I would have had the benefit of three more months of training.

Another limitation is that to replicate this study the researcher would need to be engaged in training in the Distance Mentoring Model. This is a training that is not always available for professionals.

A baseline is generally made of three to five data points. This data has one baseline, as that was what was collected for the IA-DMM. This did not affect the data collected after the baseline, but a more accurate baseline would help in determining how much progress was made. A true baseline would give a more accurate picture of where my skills were prior to training and implementing research methods.

**Conclusions and Recommendations**

From my research I found that it is possible to make changes in practice from directive teaching strategies to coaching strategies, but that there must be a number of supports in place. The Iowa Distance Mentoring Model with the use of the Key Indicators and the Family Guided Routines Based Intervention practices was instrumental in learning why coaching is valuable to families and how to begin to use coaching in provider practices. IA-DMM provided learning through introducing, illustrating, practicing, evaluating, reflection and mastery. This learning included not only evaluating one’s progress but also evaluating the progress of others within a learning community through the process of observing and reviewing the videotapes of ourselves as well as our peers. We worked as investigative colleagues by meeting monthly and providing video feedback. IA-DMM provided individual assistance and continuous learning through webinars, monthly video feedback sessions and two, two-day training sessions in the fall and spring. Adult learning strategies were used and shared throughout the training.
I found that the self-study methods of having dialog with critical friends and colleagues provided me with support within my GHAEA learning community. Writing one-page journal entries allowed me to document my progress along the way, offering me an additional way to monitor my progress in changing to a coaching model. In reviewing the 13 guidelines for self-study by Bullough and Pinnegar (2001), I was able to engage several guidelines by increasing the learning situation not only for myself but for others, attending to the people, context and setting, and questioning the relationships, contradictions and limits of the views presented. I feel that with an open mind, the willingness to learn and the above-mentioned supports, even a well seasoned early intervention provider like me can assimilate the coaching strategies and practices into her provider practices.

In completing future studies based from this research, at least 20 home visits should be completed with the use of the Family Guided Routines Based Intervention Key Indicators in order to increase the size of the sample and increase the length of the study as well. To see changes in practices in providers who have been working in the field and providing direct instruction, a baseline of three to five data points should be collected prior to intervention. This would provide a more accurate picture of provider skills prior to the start of the research and in comparison of the end results. A research-based professional development program such as Distance Mentoring Model which is grounded in adult learning practices and theory is ideal. Using self-study journal writing and critical colleague dialogue in examining any problem of practice allows experienced professionals to develop a critical eye for identifying and using recommended practices. Ongoing continued support should be put in place to ensure providers maintain changes and continue to coach caregivers once the IA-DMM training is completed.
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