Data Collection for Family Child Care PBIS

Why are data important?

What makes a good consultant? Someone who is effective at creating change in the behavior of others to achieve desired results. As child care consultants, your job is to support providers making changes so children grow in healthy, safe and successful ways.

The process of making change and making a difference in the lives of others revolves around making smart decisions. A smart decision is one that is effective and relevant. It leads to doing or saying the right thing at the right time. So how do you make smart decisions? By understanding the situation, knowing what the appropriate options for actions are, and having the skills to follow through on those actions. Also, it comes from learning from those times when your decisions were not so smart.

Only with data can you increase your understanding, know when you were effective, and learn from your experience. Data leads to smart decisions, and smart decisions are the basis of effective consultation. In short, data is essential for good consultation.

How to think about data?

In Fox, Veguilla & Binder’s “Data Decision-making and Program-Wide Implementation of the Pyramid Model” (available online at http://challengingbehavior.fmhi.usf.edu/do/resources/documents/roadmap_7.pdf), the authors remind readers that data are used to answer two questions: Are we doing what we intend to do? Is it making a difference? These questions should guide not only what data need to be collected, but how to look at those data. They propose a Look-Think-Act process to analyze data, moving from just information to having that information inform our understanding of what is going on and what needs to happen as a result. In a family child care settings, it makes sense for both the consultant and the provider to go through the process together, creating shared understanding of what is happening and the implications.

In the Look phase involves studying the data (looking at it) and seeing what it might mean. That can be things like looking for patterns, making comparisons, where are results similar or different, and what additional questions are being raised.

In the Think phase, is about drawing conclusions from the data. The consultant and the provider start to ask themselves so what does this information tell us about what we are doing and what difference it is
making. It is about what new understanding do I have about the provider and her practices as a result of looking at the information. Why is a particular child exhibiting challenging behaviors during meals? Why have behavioral expectations been created but not the explicit teaching of those expectations? What other information do I need to collect?

The final phase, Act, is about what is intended to be done as a result of looking at the data and drawing conclusions. The coaching process described below begins with goal setting and action-planning. A good understanding of the data is essential for that to happen. So this part of the process is about changes that will be made, strategies to address issues, specific actions that can be taken.

How are data used in the consultation process?

An important characteristic of good consultation is asking questions. What is happening? How do I know this? Is it creating desired results? What should be happening that is not? The more accurate your answer to these questions, the better your understanding of the situation, the smarter your decisions about what support to provide and how, and the more likely your support is to be effective. The better your data, the better your answers; the better your answers, the better your consulting.

The core of EC-PBIS consultation lies with its model of practice-based coaching. Each of the key phases in this coaching process in this model is based on data.

Practice-Based Coaching Model

Practice based coaching has three phases:
1. Shared Goals and Action Planning
2. Focused Observation
3. Reflection and Feedback

Let’s examine each of these phases and how data helps you accomplish those phases.

**Phase one: Shared Goals and Action Planning** is accomplished in three steps.

1. Practice-based “needs assessment”
2. Set goals: specify priority teaching practices
3. Action plan: guide coaching and implementation of teaching practices

The decisions that are made during this phase of the coaching process are best if based on data, especially information that assesses the needs or issues that could be addressed. All the key data collection processes recommended by EC-PBIS for Family Child Care Providers will help you during this phase of coaching.

**Phase two: Focused Observation**

This phase involves observing, gathering and recording information about practices specified in the action plan. Focused observation is, in fact, data collection designed to answer the question *What is happening?* The phase also includes displaying or summarizing the data which simply means looking at numbers, trends, and information in simple ways that both the consultant and the provider can understand and that helps create deeper knowledge of what is happening and what might be next steps.

**Phase three: Reflection and feedback**

This phase of the coaching involves reflecting together on the data, providing feedback, supporting and problem-solving, and identifying additional supports and resources. Data that addresses how well providers are reaching their goals are part of this phase. And what the data mean must be made in conversation between the consultant and provider so both share in their interpretation and their implications.

**Key Messages**

Before examining in detail how to use the data tools and the data that emerge from using them, here is a summary of the important things to understand about the use of data. These are things consultants should be sure providers understand about this process from the very beginning.

*Key messages*

- The goal for the provider should be to improve her practice and data can help you do that.
- The goal for the consultant should be to help the provider get better at her practice and data can help you do that.
- Providers can learn to collect and use data.
- Providers need to know why they are collecting data.
- Collecting data may seem like a lot of extra work, but with careful planning it is much easier to collect than you may think, and well worth the time you invest doing it.
How do I use each data tool to improve practice?

In this part, each of the three data tools being used with Family Child Care Providers will be discussed in length. For each phase of the practice-base, suggestions and direction for how the data collected by each tool can be used will be discussed.

Benchmarks of Quality

What are Benchmarks of Quality?
The Benchmarks of Quality are a list of specific practices that help anchor the work providers do to implement the specific practices taught in the FCC PBIS Modules. There are 42 specific practices divided into eight “critical elements”

Why do we collect Benchmarks of Quality data?
For any practices to be successful, they need to occur in a context that will reinforce, promote, remind and otherwise ensure all the things a provider needs to do to implement the Pyramid Model with fidelity in a child care home setting are being done. So there are really two sets of practices: the Pyramid Model Practices and the Benchmarks of Quality.

The Pyramid Model practices are those which are taught directly to providers in the FCC PBIS Modules. They are designed to promote and support the desired behaviors in children. They directly support children. They are listed in the Implementation Guide as Foundational Practices, Module 1 Practices and Modules 2 Practices.

The Benchmarks of Quality are supportive and contextual practices that are designed to promote and support the Pyramid Model Practices. They are divided into eight areas (42 total practices indicated in parentheses):

1. Establish and Maintain a Plan for Implementation (5)
2. Family Involvement (4)
3. Program-Wide Expectations (4)
4. Strategies for Teaching and Acknowledging the Program-Wide Expectations (3)
5. Implementation of the Pyramid Model is Demonstrated in All Environments (6)
6. Procedures for Responding to Challenging Behavior (6)
7. Professional Development and Staff Support Plan (8)
8. Monitoring Implementation and Outcomes (6)

Here is the first page of Benchmarks for Family Child Care providers:

How often are the Benchmarks of Quality data collected?
- The form is filled out by the consultant during the first consulting visit.
- The form is filled out again after at least 8 months of consulting.

Who fills out the Benchmarks of Quality form?
- The form is filled out by the consultant in conversation with the provider.

How is the data collected?
1. Fill out the top part of the FCCH Benchmarks of Quality Form. It is important to include the date so when it is filled out a second time it is clear which was done first.
2. Meet with the provider and read over the each item.
3. Decide together if the practice listed something that:
   - Is not in place (isn’t happening, hasn’t occurred, etc.)
   - Partially in place (some parts or aspects have occurred, but there is more than can and should be done
   - In place (this has or is occurring).
4. Mark on the form which box (is not in place, partially in place, in place) best describes the current state of affairs.
Important things to note:

- Most providers will have very few of these elements in place on the first visit. If they did, there would be no need for consultation. It is not a sign of poor quality or some latent problem. It merely indicates where future growth can occur.
- Be sure to read over the benchmarks in advance so you are clear what they mean. Ask for help if something is unclear. You must be able to explain what each means and be able to provide practical examples.

How is the BOQ data used during consultation?
The Benchmarks of Quality can help support the consultation process at each phase of Practice-Based Coaching:

1. Shared Goals and Action Planning
   - Once you have identified practices that are partially in place or not at all in place, use those as possible goals for your consultation.
   - Select a few that can be clustered into possible goals. This way you are prioritizing from the Benchmarks those things you want to work on.
   - Once you agree on the goals based on the Benchmarks, the Benchmarks can be part of the action planning (i.e., what actions you will take to reach the goal).
     For example, you may set a goal to establish behavioral expectations. But your action steps might involve implementing benchmarks under both Program-Wide Expectations and Strategies for Teaching and Acknowledging the Program-Wide Expectations critical elements: there are only 2-5 selected, they work for both children and adults, they are developmentally appropriate, they are posted, they are shared with parents, etc.

2. Focused Observation
   - During subsequent visits, you will want to review your goals and action steps to assess your progress.
   - Go back to your Benchmarks to identify things you might observe or ask about on your visit.
     For example, if the provider has developed behavioral expectations, are there the right number of expectations? Are they in your professional opinion suitable for adults and children as well as being developmentally appropriate? Are they posted? Have they been shared with parents?

3. Reflection and Feedback
   - Based on your observations or the answer to your questions, tell the provider what you saw or heard that might relate to the Benchmarks of Quality which have been incorporated into your goals and action steps.
Reflect together on where success and progress have occurred.
Provide constructive feedback on what else could happen to help the provider reach agreed-on goals.
Ask about any support, clarification, suggestions or encouragement the provider might need to take the next desired actions to address the goals.
Praise the provider for the commitment and evident hard work in making important improvements in her/his child care business.

Sample completed Benchmark of Quality form

<table>
<thead>
<tr>
<th>Critical Elements</th>
<th>Benchmarks of Quality (BOQ)</th>
<th>Check Off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish and Maintain a Plan for Implementation</td>
<td>1. Provider has committed to active problem-solving to ensure the success of the Pyramid Model initiative and the initiative is visibly supportive of the adoption of the model.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>2. Provider has established a clear mission/purpose. The purpose or mission statement is written. The provider is able to clearly communicate the purpose of the Pyramid Model.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Provider has regular meetings with constituent(s), when applicable, or planning time at least 1x per month for a minimum of 1 hour. Monthly planning is consistent.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>4. An implementation plan that includes all critical elements in the BOQ and using the FCC Implementation Guide is established. A written implementation plan guides the work of the FCC. The plan is reviewed and updated each month. Action steps are identified to ensure achievement of the goals.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>5. FCCCH reviews and revises the plan at least annually and shares with families.</td>
<td>X</td>
</tr>
</tbody>
</table>

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### Critical Elements

<table>
<thead>
<tr>
<th>Critical Elements</th>
<th>Benchmarks of Quality (BOQ)</th>
<th>Check One</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Collection in Family Child Care</strong></td>
<td><strong>Early Childhood PBIS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Family Involvement</strong></td>
<td>1. Family input is solicited as part of the planning process. Families are informed of the initiative and asked to provide feedback on the Pyramid Model adaptation and mechanisms for promoting family involvement in the initiative.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>2. There are multiple mechanisms for sharing the Pyramid Model plan with families including “town hall” forums, conferences, and parent meetings to ensure that all families are informed of the initiative.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>3. Family involvement in the initiative is supported through a variety of mechanisms including home teaching suggestions, information on supporting social development, and the outcomes of the initiative. Information is shared through a variety of forums (e.g., meetings, home visits, discussions, newsletters, open houses, websites, family friendly handouts, workshops, roll-out events).</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>5. Families are involved in planning for individual children in a meaningful and proactive way. Families are encouraged to team with FCCH staff in the development of individualized plans of support for children including the development of strategies that may be used in the child’s home and community.</td>
<td>X</td>
</tr>
<tr>
<td><strong>Program-Wide Expectations</strong></td>
<td>10. Positive and normal program-wide expectations are developed.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>11. Expectations are stated in a way that applies to both children and adults. When expectations are discussed, the application of expectations to program staff and children is acknowledged.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>12. Expectations are developmentally appropriate and linked to concrete rules for behavior within activities and settings.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>13. Expectations are posted in all learning areas (inside and outside) and in common areas in ways that are meaningful to children, staff, and families.</td>
<td>X</td>
</tr>
</tbody>
</table>

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### Critical Elements

<table>
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<tr>
<th>Critical Elements</th>
<th>Benchmarks of Quality (BOQ)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies for Teaching and Acknowledging the Program-Wide Expectations</strong></td>
<td>14. Instruction on expectations is embedded within large group activities, small group activities, and within individual interactions with children.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>15. A variety of teaching strategies are used: teaching the concept, talking about examples and non-examples, scaffolding children’s use of the expectations in the context of ongoing activities and routines. Instruction on expectations and rules occurs on a daily basis.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>16. Strategies for acknowledging children’s use of the expectations are developmentally appropriate and used by all adults, including co-teacher and provider and any adults who interact with children and meet in the home, etc.</td>
<td>X</td>
</tr>
<tr>
<td><strong>Implementation of the Pyramid Model is Demonstrated in All Environments</strong></td>
<td>17. Provider(s) have strategies in place to promote positive relationships with children, each other, and families and use these strategies on a daily basis.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>18. Provider has arranged environments, materials, and curriculum in a manner that promotes social-emotional development and guides appropriate behavior.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>19. Provider is knowledgeable in teaching social and emotional skills within daily activities in a manner that is meaningful to children and promotes skill acquisition.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>20. Provider responds to children’s problem behavior appropriately using evidence-based approaches that are positive and provide the child with guidance about desired appropriate behavior.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>21. Provider provides targeted social emotional teaching to individual children or small groups of children who are at-risk for challenging behavior.</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>22. Provider initiates the development of an individualized plan of behavior support for children with persistent challenging behavior.</td>
<td>X</td>
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<th>Critical Elements</th>
<th>Benchmarks of Quality (BOQ)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Procedures for Responding to Challenging Behavior</strong></td>
<td></td>
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</tr>
<tr>
<td>21.</td>
<td>Strategies for responding to problem behavior in the classroom are developed. Provider uses evidence-based approaches to respond to problem behavior in a manner that is developmentally appropriate and teaches the child for expected behavior.</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>A process for responding to crisis situations related to problem behavior is developed. Provider can identify how to request assistance when needed. A plan for addressing the child’s individual behavioral support needs is included following requests for crisis assistance.</td>
<td>X</td>
</tr>
<tr>
<td>25.</td>
<td>A process for problem solving around problem behavior is developed. Provider can identify a process that may be used to gain support in developing ideas for addressing problem behavior within the classroom (e.g., peer support, classroom mentor meeting, brainstorming session).</td>
<td>X</td>
</tr>
<tr>
<td>26.</td>
<td>A team-based process for addressing individual children with persistent challenging behavior is developed. Provider can identify the steps for initiating the team-based process including fostering the participation of the family in the process.</td>
<td>X</td>
</tr>
<tr>
<td>27.</td>
<td>An individual or individuals with behavioral expertise are identified for coaching providers and families throughout the process of developing and implementing individualized intensive interventions for children in need of behavior support plans.</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Strategies for partnering with families when there are problem behavior concerns are identified. Provider has strategies for initiating parent contact and partnering with the family to develop strategies to promote appropriate behavior.</td>
<td>X</td>
</tr>
</tbody>
</table>

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An analysis of the BOQ sample
What might this sample tell us about this provider? Using the Look-Think-Act process, let’s see how we examine these data and how might they help us in the coaching process.

### Look

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
</table>
| 1. Look at the quality of the data. When was it collected? Is all the data there? What else is happening that would affect the results? | • The data is complete  
• This is the first BOQ conducted at the beginning of the consultation process. |
| 2. Look at the results by Critical Element. Each section usually has some good news (benchmarks in place) and areas for improvement (partially or not in place). | Establish and Maintain a Plan for Implementation  
• Has some elements in place  
• Deeper planning elements not yet in place  
Family Involvement  
• Beginning this work, but with some elements already in place.  
Program-Wide Expectations  
• Has 3 elements in place. All benchmarks are at least partially in place. Has started this work  
Strategies for Teaching and Acknowledging the Program-Wide Expectations  
• All benchmarks partially in place.  
Implementation of the Pyramid Model is Demonstrated in All Environments  
• Half benchmarks partially in place, and half not in place.  
Procedures for Responding to Challenging Behavior  
• Most of these benchmarks not in place, but partially for two.  
Professional Development and Staff Support Plan  
• Most of these benchmarks not in place, but partially for two.  
Monitoring Implementation and Outcomes  
• Most of these benchmarks not in place, but partially for one.  
Most in place elements: Establishing expectations and teaching them.  
Least in place elements: addressing challenging behavior, professional development, and monitoring implementation. |
### Think

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
</table>
| 1. Look at the summary of results (Look section) and ask what conclusions you can make and their implications. | • There is good news here: Expectations and teaching in place  
• There are areas of growth: specific policies to address challenging behavior, more planned approach to professional development, and beginning to monitor activities.  
• Beginning with more careful and thorough implementation planning may make sense since a number of those benchmarks are not fully in place and logically that is a good place to start: plan and then do. |

### Act

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
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</table>
| 1. What are possible actions that could emerge from the “think” analysis?     | • We could fully implement the element of behavioral expectations by just posting them “indoors.” Is that easy to do?  
• Are there specific things that can be done to put fully in place the practices of teaching expectations across the schedule, using a variety of teaching strategies, and a variety of strategies to acknowledge children’s use of the expectations?  
• Which benchmarks around implementation planning are doable and best set the stage for future implementation? |

| 2. Among possible actions, which ones are the most important or desirable to commit to? | In the next month:  
• Let’s do one easy thing: indoor posting of expectations.  
• And then work on benchmark planning  

Next month, let’s try to get work on strategies to address challenging behavior (especially if the provider is struggling to manage the behavior of some children in her care) or professional development planning such as identifying professionals to help with challenging behavior and finishing the |
Data Collection in Family Child Care Early Childhood PBIS

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
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<tbody>
<tr>
<td></td>
<td>implementation guide to see if there are unaddressed training or skill needs.</td>
</tr>
</tbody>
</table>

*Behavior Incident Report*

**What are Behavior Incident Reports?**
Behavior Incident Reports are short, half-page and formatted note sheets that document an incident of challenging behavior.

**Why do we collect Behavior Incident Reports?**
Most providers are interested in how they can better manage behaviors of young children, particularly if that behavior is dangerous, destructive of property, or otherwise aggravating and irritating. The FCC PBIS Modules have many great suggestions for helping to manage behavior, and so do countless other books and training. But, frankly, the only thing that matters to providers are tips and strategies that help address the specific behaviors of the children in their care. So all these ideas and tips must be applied only after we understand the specific behaviors of our children.

As is taught in the FCC PBIS modules, all behavior is purposeful and communicative. That means children behave the way they do for a purpose (to accomplish something) and all behavior communicates something. Any appropriate and effective response to children’s behavior should be based on a good understanding of the why the child is behaving the way s/he is or what is being communicated by the behavior. That turns us all into detectives to find and interpret the clues we have so we can figure out the reason for the challenging behavior.

Besides the behavior itself, an important source of clues is what happens before and after the behavior incident. This is sometimes thought of as the ABCs of behavior since all behaviors have them:

- **A**nteecedent (what happened before the behavior), **B**ehavior (the behavior itself), **C**onsequence (what happened afterwards).

The Behavior Incident Report is like a detective notebook where you write down the clues you have about the behavior. Like any detective you want as much information as you can and you want the information to be as accurate as it can be.

Here is the first page of Behavior Incident Report (BIR) for Family Child Care providers:
These reports are half-page sheets with a form to fill out on the front page and instructions on the back. There is also a longer document about how to fill the BIR out called “Behavior Incident Report Instructions.” It includes definitions and examples of the problem behaviors.

How often are the Behavior Incident Reports collected?

- The form is filled out anytime there is a challenging behavior.
- The form should be filled out if the behavior is an example of aggression, fleeing or intentional self-injury.
- The form should be filled out anytime there is a behavior that repeatedly occurs despite efforts to redirect.
- The form may be filled out for other behavior that a provider would like to address because it is otherwise causing problems or distress.
- The provider should fill out one form for each separate incident. If multiple behaviors are occurring simultaneously (like hitting another child and then running out of the room), fill out two forms.
- The provider should not fill out a form for behaviors that are developmentally expected. If the provider is not sure what kinds of behavior is developmentally expected, take time to explain what is developmentally expected behavior.

Who fills out the Benchmarks of Quality form?

- The form is filled out by the provider.

How is the data collected?

1. The provider fills out the half-page form, including child’s name, the date and time. Time is important because it helps pinpoint behavior in connection with the provider’s schedule. It also allows the provider and consultant to determine if there is a pattern of challenging behaviors occurring at the same time.
2. The provider notes the behavior and what was happening at the time the behavior occurred. Notice that this gives us the A and the B of the ABC formula.
3. The provider then makes a brief note about how she responded to the incident (the C of the ABC formula). Care should be taken to fill out all parts of the form.
4. The provider keeps the completed forms in folder or notebook, and reviews them with the consultant at the next consultation visit.

**How is the BIR data used during consultation?**

The Behavior Incident Reports can help support the consultation process at each phase of Practice-Based Coaching:

1. **Shared Goals and Action Planning**
   - After the idea of filling out BIRs has been presented to the provider and the BIRs forms have been made available, the consultant should ask about them at each visit to make sure that the provider is collected them at least for the major behaviors that trigger their use: aggression, fleeing, intentional self-injury, and repeated behaviors that are not successfully managed.
   - If the provider is not filling them out regularly, then adding the use of BIRs as a consultation goal would be a good idea.
   - If the provider is filling them out, the consultant should review them to identify patterns and issues. If the patterns and issues suggest a new goal, the consultant and provider together should agree if that is something these are things they might address. For example, if a child has trouble sitting at the table during snack time with the other children, working on the skills and strategies to address that problem might be added as a consultation goal. But the consultant should connect the issue to the larger preventive strategies that should be in place and are suggested in the Benchmarks of Quality. In this case, has the provider established behavioral expectations around snack time? Does snack time occur on a predictable basis based on a schedule that is visible to children? In other words, efforts should be made to take the specific issues that arise and connect with the larger practices (both Pyramid Model practices and Contextual/Supportive practices).

2. **Focused Observation**
   - One of the observation practices a consultant can do, is to read the BIRs.
   - The consultant could try to summarize and analyze the BIRs using probing questions:

<table>
<thead>
<tr>
<th>Summarizing data points questions</th>
<th>Analyzing data questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many BIRs are there?</td>
<td>Is this more or less than in previous months?</td>
</tr>
<tr>
<td></td>
<td>Are the number of incidents increasing or decreasing as more Pyramid Models practices at put into place?</td>
</tr>
<tr>
<td>How often are particular children included in the reports?</td>
<td>Which children are exhibiting what kinds of behaviors?</td>
</tr>
</tbody>
</table>
What kinds of solutions might solve a behavioral challenge across multiple settings?

<table>
<thead>
<tr>
<th>What kinds of behaviors are most common?</th>
<th>Are these behaviors because of how the provider is behaving or because of circumstances with the child?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the behaviors normal and expected behavior or unusual?</td>
<td>Is the provider recording behaviors that are not really “challenging behaviors”? That may indicate that the provider does not have a good understanding of developmentally appropriate behavioral expectations. Is the child displaying behavior that may suggest more individualized behavioral supports or even referral to outside professionals is needed?</td>
</tr>
<tr>
<td>What kinds of things were happening when the reported behaviors occurred?</td>
<td>If problem behaviors are occurring at the same time each day, what changes might the provider make to better guide activities during that time? What additional skills from the FCC PBIS Module training might be retaught to strengthen the provider’s effectiveness?</td>
</tr>
<tr>
<td>How did the provider respond? Was it in an appropriate way?</td>
<td>Does the provider know how to respond to the behaviors reported? Does the provider have “Procedures for Responding to Challenging Behavior” (a Benchmark critical element)? Are there additional strategies or ideas the consultant can suggest to provider more options for response?</td>
</tr>
</tbody>
</table>

- In some cases, a simple discussion about these issues may suffice. In others, it may warrant more intensive retraining. In still others, it may mean the issue is part of a goal or action step that can be followed up on over the course of consultation.

3. **Reflection and Feedback**

- Based on the BIR data and their analysis, offer ideas of issues you think might be worth discussing.
- Invite their reflections on the information in the BIRs and what they may mean.
- Provide constructive feedback on what else could happen to help the provider address challenging behaviors.
- Ask about any support, clarification, suggestions or encouragement the provider might need to take the next desired actions to address the goals.
- Praise the provider for the commitment and evident hard work in making important improvements in her/his child care business. Meeting the needs of children, including
social emotional needs, is perhaps the most important service a child care provider provides.

Other uses of the BIRs
Covering the bottom layers of pyramid will naturally reduce the amount of chaos and number of challenging behaviors. For a provider to also do other things to better address the behaviors she specifically encounters, there is no substitute to collecting information. These data help consultants provide technical assistance that is directly relevant to a particular provider and the children in her care. A history of documentation about individual’s child’s behavior can be very helpful in diagnosing even serious behavioral concerns. If a child needs the support of outside professionals, those professionals will find any information you collect to be useful in finding appropriate solutions or interventions.

In general, as consultants approach the BIRs and the incidents of challenging behavior they represent, their analysis and support should move in two directions: Toward the provider and Toward the child. Toward the provider means that we are looking at provider behavior and the practices that can best promote positive behavior and prevent challenging behavior. This means we are building the Pyramid from the bottom up and emphasizing the practices that should, if done with fidelity, reduce the number of challenging behaviors and therefore the number of BIRs. This is first and most important approach. If the provider is engaging in many of the practices and challenging behaviors persist, then it makes sense to move your analysis and support toward the child. This means using the BIR data to understand the reasons for the behavior, and start to introduce replacement behavior through clarification of behavioral expectations, teaching new skills and positive reinforcement.
Sample completed BIR forms

**Behavior Incident Report**

**Child’s Name:** A. B.  
**Date:** 3/19/15

**Time of Occurrence:** 11:15am

**What happened?**

**Problem Behavior (check most intrusive)**

- Physical aggression
- Self injury
- Stereotypic Behavior
- Disruption/Tantrums
- Inconsolable crying
- Centers/Indoor play
- Diapering

- Inappropriate language
- Verbal aggression
- Non-compliance
- Social withdrawal/isolation
- Running away

**Property damage**  
**Unsafe behaviors**  
**Trouble falling asleep**  
**Other**

**What was going on when it happened?**

- Arrival
- Routine job
- Circle/Large group activity
- Small group activity
- Centers/Indoor play
- Diapering

- Meals
- Quiet time/Nap
- Outdoor play
- Special activity/ Field trip
- Self-care/Bathroom
- Transition

- Departure
- Clean-up
- Therapy
- Individual activity
- Other

**Provider response:** Helped child that was hit first. Asked A.B. what was going on. Listened, then helped him think of other ways to handle the situation.

---

**Behavior Incident Report**

**Child’s Name:** C. S.  
**Date:** 4/2/15

**Time of Occurrence:** 7:50am

**What happened?**

**Problem Behavior (check most intrusive)**

- Physical aggression
- Self injury
- Stereotypic Behavior
- Disruption/Tantrums
- Inconsolable crying

- Verbal aggression
- Non-compliance
- Social withdrawal/isolation
- Running away

**Inappropriate language**  
**Property damage**  
**Unsafe behaviors**  
**Trouble falling asleep**  
**Other**

**What was going on when it happened?**

- Arrival
- Routine job
- Circle/Large group activity
- Small group activity
- Centers/Indoor play
- Diapering

- Meals
- Quiet time/Nap
- Outdoor play
- Special activity/ Field trip
- Self-care/Bathroom
- Transition

- Departure
- Clean-up
- Therapy
- Individual activity
- Other

**Provider response:** Reminded C.S. that our expectations are to be kind and be respectful and that those words are hurtful. Pointed out facial expression of other child
An analysis of the BIR sample

What might this sample tell us about what is going on with this provider? Using the Look-Think-Act process, let’s see how we examine these data and how might they help us in the coaching process.

**Look**

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The key thing to look for with BIRs are trends:</td>
<td>• Based on the graph (not the 2 samples above which is just a single BIR) BIRs are being collected on a regular basis. Might want to confirm that October and February were not dropping because BIRs were not filled out.</td>
</tr>
<tr>
<td>• number per month</td>
<td></td>
</tr>
<tr>
<td>• number per time of day (early am, late am, early pm, late pm)</td>
<td></td>
</tr>
<tr>
<td>• number per child</td>
<td></td>
</tr>
<tr>
<td>• number per problem behavior</td>
<td></td>
</tr>
<tr>
<td>• number per incident setting</td>
<td></td>
</tr>
<tr>
<td>2. How many total BIRs were collected? If more than a month’s worth are being analyzed, then how many each month? You may want to use a line graph to give a visual look at the trends. Here is one on the number of BIRs per month:</td>
<td>• Data is complete for both.</td>
</tr>
<tr>
<td><img src="image_url" alt="Provider A: BIRs" /></td>
<td>• The two BIRs are for two separate months. Is this more or less than usual? Is the provider regularly reporting on all challenging behavior?</td>
</tr>
<tr>
<td>3. Look at the quality of the data. Is the BIR completely filled out with child name, date, time, problem behavior, setting, and response?</td>
<td>• The two BIRS here are for two different children. Looking at patterns I do not see them across children, dates, times, behavior problems, settings or provider responses.</td>
</tr>
<tr>
<td>4. Look at the elements each BIR: child, date, time, problem behavior, setting, and response. Are there patterns across each?</td>
<td>• With child AB, the provider first attended to the hit child and then discussed the issues with the hitting child. Asked a question. Supporting thinking of other ways to handle the situation</td>
</tr>
<tr>
<td>5. What was the provider response? What did she do? Say?</td>
<td>• With child CS, reminded about specific expectations (kindness, respect). Noted</td>
</tr>
</tbody>
</table>
### How to analyze? | What is the data in this sample saying?
--- | ---
| **Think** | 
| **How to analyze?** | **What is the data in this sample saying?** |
| What could be learned by the facial expression of the other child. | 
| Look at the summary of results (Look section) and ask what conclusions you can make and their implications. With BIRs, after looking for patterns then think about what those patterns might mean. | - Since there are no clear patterns and the incidents appear isolated, there may not be a lot to conclude. But let’s think about the implication if patterns were observed.  
- No pattern of consistently challenging behavior from a single child. Probably nothing noteworthy here. (Everyone is entitled to a bad day!) If the same child had been exhibiting challenging behaviors on a regular basis (with several BIRs), I may want to look deeper into what is triggering the behavior (like if it is happening at the same time of day, same settings, involving the same children.)  
- The two BIRS have different dates, two weeks apart. No real pattern of challenging behavior occurring in the home setting. If behaviors were occurring at multiple times each day or over a several days in succession, that would lead me to look deeper, ask more questions, about what is occurring.  
- Both events occurred in the morning but one in the early morning, one in the later morning. Probably not indicating a trend. If all problems were occurring in the morning, I might want to think about why. Perhaps it might be because of morning routines that are not engaging children or some children arriving sleepy or not having a successful transition from family member to provider home.  
- One child showed physical aggression, the other verbal aggression. Again, no clear pattern. Patterns of similar aggression tell me that a child or children are using the same strategy to get needs met. I now want to know what needs are met. |  
| Patterns across children | 
| Patterns across dates | 
| Patterns across time of day | 
| Patterns across types of behavior |
### How to analyze?

<table>
<thead>
<tr>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
<tbody>
<tr>
<td>trying to be met and what might replacement strategies be.</td>
</tr>
</tbody>
</table>

### Patterns across setting

- One behavior took place during centers/indoor play. The other at meals. Again, no clear pattern. If the same setting shows up repeatedly in the BIRs, I might want to know more about how the routines and activities around that setting are done. Maybe some changes could minimize the problem behaviors.

### Appropriateness of provider responses

- The descriptions of the provider response tell me the provider acted appropriately. I want to note areas of strength that reinforce Pyramid Model practices. They emphasize aiding the hurt child first, and then in talking with the perpetrator connecting to (perhaps) a skill that is being worked on such as the other way “to handle the situation.” I might want to make sure the provider is focusing on replacement strategies (that is, what the child can do to get her/his need met besides hitting) and the skill development related to that strategy.

- In the case of the verbal aggression by CS, using the event to reinforce or reteach behavioral expectations and emotional literacy, are clear strengths. A thorough addressing of the issue also requires understanding what preceded the verbal aggression, and is this a pattern of conflict between CS and the other child.

---

**Act**

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
</table>
| 1. What are possible actions that could emerge from the “think” analysis? | - Since there are only two BIRs it is hard to see many patterns or know what then to do. But I might talk to the provider to make sure they are capturing all the incidents of challenging behavior so they can be effectively addressed.  
- If we assume that some patterns were observed, here might be some actions for each BIR element. |
<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patterns across children</td>
<td>• Talk with the provider about behavior triggers, issues going on with an individual child, and the child’s strengths (when is the child’s behavior not challenging).&lt;br&gt;• Suggest some changes to reduce triggers, take into consideration issues related to the child or other changes to support positive behavior.</td>
</tr>
<tr>
<td>Patterns across dates</td>
<td>• Talk with the provider about when the pattern of regular challenging behavior began and possible reasons (new routines, changes in environment or other children coming or leaving.)&lt;br&gt;• Suggest some changes to routines or some proactive actions to better prepare children for changes in the environment or with other children.</td>
</tr>
<tr>
<td>Patterns across time of day</td>
<td>• Talk with the provider about what happens during the time of day when the behaviors occurred. What is going on with the schedule? What events occur during that time of the schedule, what exactly is happening, and what does the provider do to prepare children for the event, lead it, and transition out of it?&lt;br&gt;• Suggest some changes in how the provider managers those events.</td>
</tr>
<tr>
<td>Patterns across types of behavior</td>
<td>• Talk with the provider what needs are being met by the behavior and what possible replacement strategies can be suggested.&lt;br&gt;• Suggest some possible replacement strategies and demonstrate how to teach the skills to use the strategy.</td>
</tr>
<tr>
<td>Patterns across setting</td>
<td>• Talk with the provider about what happens during that setting or time of the day. Have her describe as accurately as possible what she is doing. Have her also describe what she does to prepare children for the activity, lead it, and transition out of it?&lt;br&gt;• Suggest some changes in how the provider manages those activities with the settings.</td>
</tr>
</tbody>
</table>
How to analyze? | What is the data in this sample saying?
---|---
Appropriateness of provider responses | • Identify the strengths you observed and provide specific praise about what the provider did and why you thought it was appropriate. Link to recommended practices (see Implementation Guide) whenever possible.
• If the responses are clearly inappropriate (such as a TPOT or TPITOS red flag) bring that to her attention and suggest what else could be done.

Monthly Program Actions

What are Monthly Program Actions?
Monthly program actions a tally of the frequency five specific actions occur in a given month:

1. Calls to Families about child’s behavioral concerns
2. Dismissal from program due to child’s behavioral concerns (with no transfer to alternate program)
3. Transfer to different program due to child’s behavioral concerns
4. Requests for assistance from mental health consultant, psychologist, or other professional due to child’s behavioral concerns
5. Family conferences scheduled to address child’s behavioral concerns

The number of times each of these incidents occurs can be kept track of on a Monthly Program Incident Tracking Form.
Why do we collect Monthly Program Actions?
Besides the BOQs and the BiRs, another sign of the ability for providers to manage the behavior of the children in their care is the frequency with which five program actions occur. These five items can be arranged in order of seriousness or extremeness:

- Calls to Families
- Meeting with Families
- Bring in outside professionals
- Transfer to another program
- Dismiss from program

By tracking the frequency, it becomes clear how often children’s behavior reaches a point where the provider is taking decisive action to engage individuals outside the program. It also becomes clear whether the provider is moving right to transfer or dismissal or is first taking time to consult with the families or other professionals. This information allows the consultant to identify serious issues in a timely way and better provide direct technical assistance on key issues.

How often are the Monthly Program Actions recorded in the Monthly Program Incident Tracking Form?
- The form is filled out once a week preferably, but at least once a month, by the provider. However, if the form has not been filled out, the consultant can fill it out as a series of questions during monthly consultation.
- The form allows for weekly tabulation, but for many family child care programs these incidents may be rare enough that a monthly accounting is plenty.

Who fills out the Monthly Program Incident Tracking Form?
- The form is filled out by the provider. But it may also be filled out by the consultant.

How is the MPA data collected?
1. Once a week the provider makes a note of how many times each of the five actions on the form has taken place as best s/he can from memory.
2. The consultant collects these forms during the monthly consulting visit and reviews the information with the provider.
3. Any time an action has been taken and noted on the form, the consultant should ask questions about the circumstances that preceded that action and the current status of the action. These five actions suggests a provider is struggling with the behavior management of a particular child.

How is the MPA data used during consultation?
The Behavior Incident Reports can help support the consultation process at each phase of Practice-Based Coaching:
1. Shared Goals and Action Planning
2. Focused Observation
3. Reflection and Feedback

1. Shared Goals and Action Planning
• As noted above, any time one of the five actions recorded in the Monthly Program Incident Tracking Form has occurred, the consultant should engage in a conversation about what caused the provider to take the action, and what was the result of the action taken.
• The consultant should consider what Pyramid Model practices or Benchmarks of Quality items might help the provider better manage the behavior that led to one of the five MPAs to occur.
• The consultant should then in conversation with the provider determine if a goal or action plan step should be added or changed to respond to behaviors that precipitated the action by the provider (e.g., calling the parent, meeting with the parent, etc.). This may mean that a consultation goal may need to be changed or made a more important part of the action plan.

2. **Focused Observation**

• One of the observation practices a consultant can do, is to look at Monthly Program Incident Tracking Form.
• The consultant may want to spend time observing the child or children who were subjects of the monthly program action. Having additional insights or information will help the consultant reflect on the children and their behaviors, the circumstances around the behavior, and new or different strategies to respond to the behaviors, begins with your own observations of the child or children.

3. **Reflection and Feedback**

Based on the information collected through observation or in conversation with the provider, the consultant should:

• Invite their reflections on what the situation (e.g., “You told me you called Sarah’s father because of how much trouble you were having getting her to sleep. Did he give you any useful information? Why do you think Sarah is having trouble falling asleep?)
• Provide constructive feedback on what else could happen to help the provider address the situation.
• Discuss if the changes the provider would like to see should be part of the consultation goals or action planning.
• Ask about any support, clarification, suggestions or encouragement the provider might need to take the next desired actions to address the goals.
• Praise the provider for the commitment and evident hard work in making important improvements in her/his child care business.
Sample completed BIR forms

An analysis of the MPA sample

What might this sample tell us about what is going on with this provider? Using the Look-Think-Act process, let’s see how we examine these data and how might they help us in the coaching process.

**Look**

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The first thing to look at is the totals column.</td>
<td>• Based on the sheet provided, I see that three types of actions occurred: calls to families, request for assistance, and family conference. The most common was calls to families at 5.</td>
</tr>
<tr>
<td>2. The second thing is to chart the number of each type of action over time, month by month. For example:</td>
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<tr>
<td>How to analyze?</td>
<td>What is the data in this sample saying?</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>3. The next thing to do is to look at each of the types of actions where the total for the month is greater than 0.</td>
<td></td>
</tr>
</tbody>
</table>

**Think**

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
</table>
| MPAs track significant, even extreme, actions a provider might take in response to a child’s behavior. Anytime such an action occurs, a consultant will want to know more about what happened to trigger that and the outcomes of these actions. Obviously some actions are more significant than others: calls or conferences with families are less extreme, but removing or transferring the child is extreme indeed. The appearance of any of these actions occurring should be cause for a conversation with the provider. | - I see that the most common action was a call to families (5 times this month) which suggests that there is persistent challenging behavior occurring. Assuming these calls are to the same family about the same child, it might also suggest that the calls to the family are not reducing the incidents of challenging behavior.  
- The other two actions that occurred are call for assistance and a family conference. This suggests that the provider is trying to do more to address the situation, assuming all these are related to a single family or child. |
| There are circumstances in which any of these actions may be appropriate, but as a consultant you want to know more about the situation so you can provide guidance and support. We want to reduce the number of times a child is transferred or removed from the program. It is also important to assure yourself that the provider has a plan for what to do when she is no longer able to effectively manage challenging behavior. Increasing her skills through Pyramid Model training is the first step, but connecting her to a circle of support from peers, consultants and even mental health professionals is also important. | - Providers should know about where they can go to request assistance due to behavioral concerns about a child. That should be part of the training or implementation of the Pyramid Model practices (see also BOQ items 23-28.) |

**Act**

<table>
<thead>
<tr>
<th>How to analyze?</th>
<th>What is the data in this sample saying?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are possible actions that could emerge from the “think” analysis?</td>
<td>- Talk with the provider about the actions and whether they were effective.</td>
</tr>
</tbody>
</table>
How to analyze? | What is the data in this sample saying?
---|---
Verify that BIRs are being collected so we can continue to collect information about frequency and context for the behaviors.

Calls or conferences with families | Often calls or conferences with families can be difficult conversations to have and frequently put families on the defensive. Additional support, guidance, skill-building or training on how to have such conversations would a useful support to a provider when these actions are occurring.

Requests for assistance | Verify that the provider has people they can request assistance from. If not, be sure you as the consultant have that information available based on the resources available from your program or in the community.

Removal or transfer from program | These were not issues in the sample. If they were, I would immediately contact the provider and discuss the circumstances.

---

**Addressing other barriers to data collection**

The consultant does not really understand the importance of data collection in implementing the Family Child Care EC-PBIS.

It is essential for the CCRR home consultants to be completely bought into the usefulness and function of the data collection or the process falls apart. Part of their responsibility as a consultant is to support data collection by providers and convince them of its necessity. They must also believe in the usefulness of data as part of the consultation process. Though the Single Points of Contact are collecting the data, the data are primarily for the consultants to use in their work. It is the responsibility of the Single Points of Contact to make sure that the consultants understand the importance of data collection and how to support the consultants in collecting and using data in their consultation work.

Data is so central to good consulting that those who don’t appreciate its importance may not be doing other parts of the consultation process very well. When a consultant is choosing not to use data, ask her/him to describe the process they go about to provide consulting to providers. Look for places where data help them determine what the issues are and how to respond. Point out how lack of information leads can lead to incorrect assumptions or lengthy trial and error. Finally, describe how changes in data can provide the only concrete evidence they have that their work is making any difference.

Consultants and providers are feeling overwhelmed by the data.
The goal of consultation is improvement not perfection. The entire process in talking with consultants and providers alike is answering two questions: What is happening now? What can we do differently so we can move in the direction of higher quality? So if consultants are not meeting monthly with providers, what has to change to make sure those monthly meetings are taking place? If they are meeting monthly, then have they done the BOQs and is that data informing their consultation and support? If not, what has to change so that can happen? If they are doing the BOQs, then can they also do the MPA and BIRs to help address critical issues for providers and give them immediate support? Notice how we are moving from one good practice to two, and from two to three, and so on. We are not interested in quick, superficial fixes, but in lasting solutions.

When any task appears big and overwhelming, break it down into smaller pieces that seem simpler and more practical. If you actually look at each of the data collection tools and procedures, they are really pretty simple:

- **Benchmarks of quality**: A checklist you review with the provider during your visits.
- **Behavior Incident Reports**: A half-page note card to record an incident you want to talk about later.
- **Monthly Program Actions**: A list of five questions to ask.

The first and the last do not require the provider to do anything and can be handled during a consultation visit. The BIRs will appear burdensome and tricky at first, but with practice providers will learn to fill those out quickly. If you actually use them to analyze the behaviors that are driving providers crazy, completing them will seem a small price to pay to identify a successful and permanent solution.

*The data collection process is confusing*

The data collection process should be much less confusing after you read this. The process is broken down into simple steps here. But if some parts still seem confusing, or you run into problems that are not addressed here, remember that the consultants are there to support the providers. The Single Points of Contact are there to support the consultants. The leadership at the state level is there to support you. Everyone has someone supporting them. If you are confused or overwhelmed, ASK FOR HELP! Please communicate that to the consultants. Do not become frustrated and give up or just stop doing things. ASK FOR HELP! And you need to give that message to the consultants. And the consultants need to give it to the providers. We are all in this together.
APPENDIX: DATA COLLECTION TOOLS

Family Child Care Homes (FCCH)
Program-Wide PBS Benchmarks of Quality

Provider Name: ___________________________ Address: ___________________________ Date: _____________________

Team Members: ___________________________________________________________________________________________
_________________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Critical Elements</th>
<th>Benchmarks of Quality (BOQ)</th>
<th>Check One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish and Maintain a Plan for Implementation</td>
<td>1. Provider has committed to active problem-solving to ensure the success of the Pyramid Model initiative and the initiative is visibly supportive of the adoption of the model.</td>
<td>Not in Place</td>
</tr>
<tr>
<td></td>
<td>2. Provider has established a clear mission/purpose. The purpose or mission statement is written. The provider is able to clearly communicate the purpose of the Pyramid Model.</td>
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<td></td>
<td>3. Provider has regular meetings with consultant(s), when applicable, or planning time at least 1x per month for a minimum of 1 hour. Monthly planning is consistent.</td>
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<tr>
<td></td>
<td>4. An implementation plan that includes all critical elements in the BOQ and using the FCC Implementation Guide is established. A written implementation plan guides the work of the FCCH. The plan is reviewed and updated each month. Action steps are identified to ensure achievement of the goals.</td>
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<tr>
<td></td>
<td>5. FCCH reviews and revises the plan at least annually and shares with families.</td>
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</tr>
<tr>
<td>Critical Elements</td>
<td>Benchmarks of Quality (BOQ)</td>
<td></td>
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<tr>
<td>------------------------</td>
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<td></td>
</tr>
<tr>
<td><strong>Family Involvement</strong></td>
<td></td>
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</tr>
<tr>
<td>6.</td>
<td>Family input is solicited as part of the planning process. Families are informed of the initiative and asked to provide feedback on the Pyramid Model adoption and mechanisms for promoting family involvement in the initiative.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>There are multiple mechanisms for sharing the Pyramid Model plan with families including &quot;notes sent home,&quot; conferences, and parent meetings to ensure that all families are informed of the initiative.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Family involvement in the initiative is supported through a variety of mechanisms including home teaching suggestions, information on supporting social development, and the outcomes of the initiative. Information is shared through a variety of formats (e.g., meetings, home visit, discussions, newsletters, open house, websites, family friendly handouts, workshops, roll-out events).</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Families are involved in planning for individual children in a meaningful and proactive way. Families are encouraged to team with FCCH staff in the development of individualized plans of support for children including the development of strategies that may be used in the child’s home and community.</td>
<td></td>
</tr>
<tr>
<td><strong>Program-Wide Expectations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>2-5 positively stated program wide expectations are developed.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Expectations are written in a way that applies to both children and adults. When expectations are discussed, the application of expectations to program staff and children is acknowledged.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Expectations are developmentally appropriate and linked to concrete rules for behavior within activities and settings.</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Expectations are posted in all learning areas (inside and outside) and in common areas in ways that are meaningful to children, staff and families.</td>
<td></td>
</tr>
<tr>
<td>Critical Elements</td>
<td>Benchmarks of Quality (BOQ)</td>
<td>Check One</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Strategies for Teaching and Acknowledging the</strong></td>
<td>14. Instruction on expectations is embedded within large group activities, small group activities, and within individual interactions with children.</td>
<td></td>
</tr>
<tr>
<td><strong>Program-Wide Expectations</strong></td>
<td>15. A variety of teaching strategies are used: teaching the concept, talking about examples and non-examples, scaffolding children’s use of the expectations in the context of ongoing activities and routines. Instruction on expectations and rules occurs on a daily basis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>16. Strategies for acknowledging children’s use of the expectations are developmentally appropriate and used by all adults, including owner/lead provider and any adults who interact with children and assist in the home, etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>Implementation of the Pyramid Model is Demonstrated</strong></td>
<td>17. Provider(s) have strategies in place to promote positive relationships with children, each other, and families and use those strategies on a daily basis.</td>
<td></td>
</tr>
<tr>
<td><strong>in All Environments</strong></td>
<td>18. Provider has arranged environments, materials, and curriculum in a manner that promotes social-emotional development and guides appropriate behavior.</td>
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<tr>
<td></td>
<td>19. Provider is proficient at teaching social and emotional skills within daily activities in a manner that is meaningful to children and promotes skill acquisition.</td>
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<tr>
<td></td>
<td>20. Provider responds to children’s problem behavior appropriately using evidence-based approaches that are positive and provide the child with guidance about the desired appropriate behavior.</td>
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<tr>
<td></td>
<td>21. Provider provides targeted social emotional teaching to individual children or small groups of children who are at-risk for challenging behavior.</td>
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<tr>
<td></td>
<td>22. Provider initiates the development of an individualized plan of behavior support for children with persistent challenging behavior.</td>
<td></td>
</tr>
</tbody>
</table>
### Critical Elements

#### Procedures for Responding to Challenging Behavior

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>23.</td>
<td>Strategies for responding to problem behavior in the classroom are developed. Provider uses evidence-based approaches to respond to problem behavior in a manner that is developmentally appropriate and teaches the child the expected behavior.</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>A process for responding to crisis situations related to problem behavior is developed. Provider can identify how to request assistance when needed. A plan for addressing the child’s individual behavior support needs is initiated following requests for crisis assistance.</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>A process for problem solving around problem behavior is developed. Provider can identify a process that may be used to gain support in developing ideas for addressing problem behavior within the classroom (e.g., peer-support, classroom mentor meeting, brainstorming session).</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>A team-based process for addressing individual children with persistent challenging behavior is developed. Provider can identify the steps for initiating the team-based process including fostering the participation of the family in the process.</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>An individual or individuals with behavioral expertise are identified for coaching provider and families throughout the process of developing and implementing individualized intensive interventions for children in need of behavior support plans.</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Strategies for partnering with families when there are problem behavior concerns are identified. Provider has strategies for initiating parent contact and partnering with the family to develop strategies to promote appropriate behavior.</td>
<td></td>
</tr>
</tbody>
</table>
### Critical Elements

#### Professional Development and Staff Support Plan

<table>
<thead>
<tr>
<th>Critical Elements</th>
<th>Benchmarks of Quality (BOQ)</th>
<th>Check One</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. A plan for providing ongoing support, training, and coaching on the Pyramid Model practices is developed and implemented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. A data-driven coaching model is used to assist staff with implementing the Pyramid Model practices to fidelity.</td>
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<tr>
<td>31. Outside professionals responsible for facilitating behavior support processes are identified and trained.</td>
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<tr>
<td>32. A needs assessment is conducted to determine training needs on the adoption of the Pyramid Model.</td>
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<tr>
<td>33. Individualized professional development plans is developed by and for provider.</td>
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<tr>
<td>34. Group and individualized training strategies are identified and implemented.</td>
<td></td>
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<tr>
<td>35. Plans for training new support staff/substitutes are identified and developed.</td>
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<tr>
<td>36. Incentives and strategies for acknowledging staff (when applicable) and families’ involvement are identified.</td>
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<td></td>
</tr>
</tbody>
</table>

#### Monitoring Implementation and Outcomes

<table>
<thead>
<tr>
<th>Critical Elements</th>
<th>Benchmarks of Quality (BOQ)</th>
<th>Check One</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Process for measuring implementation fidelity is used (i.e., Implementation Guide)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Process for measuring outcomes is developed.</td>
<td></td>
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</tr>
<tr>
<td>39. Data are collected and summarized.</td>
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<tr>
<td>40. Data are shared among provider, consultants and families.</td>
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<td></td>
</tr>
<tr>
<td>41. Data are used for ongoing monitoring, problem solving, ensuring child response to intervention, and program improvement.</td>
<td></td>
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</tr>
<tr>
<td>42. Implementation Plan is updated/revised as needed based on the ongoing data.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Behavior Incident Report

Child’s Name: _______________________________ Date: ______________________

Time of Occurrence: ________________________

What happened?

**Problem Behavior (check most intrusive)**

- Physical aggression
- Self injury
- Stereotypic Behavior
- Disruption/Tantrums
- Inconsolable crying
- Inappropriate language
- Verbal aggression
- Non-compliance
- Social withdrawal/isolation
- Running away
- Property damage
- Unsafe behaviors
- Trouble falling asleep
- Other_______________________

What was going on when it happened?

- Arrival
- Routine job
- Circle/Large group activity
- Small group activity
- Centers/Indoor play
- Diapering
- Meals
- Quiet time/Nap
- Outdoor play
- Special activity/ Field trip
- Self-care/Bathroom
- Transition
- Departure
- Clean-up
- Therapy
- Individual activity
- Other_______________________

Provider response: __________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Behavior Incident Report Instructions

Always complete when a child engages in the following kinds of behaviors

- Aggression to another child or adult that results in physical pain or harm to that person (includes kicking, hitting, biting, scratching)
- Running out of room, out of yard, or from group without responding to the calls of the adult
- Intentionally injuring self in manner that may cause serious harm (severe head banging, biting self)

Also complete when a child continues to engage in problem behavior despite efforts to redirect to use alternative skills. On these occasions, complete the form for children who are persistent in problem behavior and their problem behavior appears to be unresponsive to the child guidance procedures you use in your family child care. The form will not be completed if the behavior has not occurred before or if the behavior may be developmentally expected (e.g., 2-year olds who tussle over a toy). These behaviors may be:

- Tantrums
- Inappropriate language
- Hitting
- Property Destruction
- Disruptive Behavior
BEHAVIOR INCIDENT REPORT DEFINITIONS:

**Problem Behavior**

This category refers to the most serious behavior exhibited by the specific child. Only circle the *ONE* behavior that is the most intense; the behavior that lead the provider to complete the BIR form.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical Aggression</td>
<td>Making physical contact with an adult or peer where injury may occur</td>
<td>Striking, pulling hair, biting, scratching, pulling clothes, kicking, spitting</td>
</tr>
<tr>
<td>2. Self-injury</td>
<td>Physically abusing self</td>
<td>Self-scratching, head banging, selfbiting, skin picking</td>
</tr>
<tr>
<td>3. Stereotypic Behavior</td>
<td>Engaging in repetitive actions, verbal or physical</td>
<td>Spinning objects, body rocking, flapping hands, mouthing objects repetitively</td>
</tr>
<tr>
<td>4. Disruption/Tantrums</td>
<td>Causing an interruption in class or activity</td>
<td>Throwing items, loud vocalizations, crying, screaming, cussing</td>
</tr>
<tr>
<td>5. Inconsolable crying</td>
<td>Crying for an extended period of time. All typical comfort strategies are unsuccessful</td>
<td>Crying, isolating self, refusing typical comfort strategies implemented by adults</td>
</tr>
<tr>
<td>6. Inappropriate language</td>
<td>Using words or phrases that are offensive or rude; not always directed at a person</td>
<td>Profanity, insults</td>
</tr>
<tr>
<td>7. Verbal aggression</td>
<td>Threatening, offensive, or intimidating words directed towards an adult or peer</td>
<td>Screaming, name calling, profanity, use of threats</td>
</tr>
<tr>
<td>8. Non-compliance</td>
<td>Refusing to follow direction</td>
<td></td>
</tr>
<tr>
<td>9. Social withdraw/isolation</td>
<td>Non-participation in classroom activities with peers/adults or withdraw from play or social interactions with peers or adults Extreme lack of participation or interest in classroom activities, games, songs, etc.</td>
<td>Refusing to join activity, refusing to participate in activity, no eye contact, no conversation. For toddlers, hanging at the door for extended periods of time waiting for parent, falls asleep in response to attempts to engage, turns face or eyes away from interaction, etc. Wandering aimlessly/ “In own world”</td>
</tr>
<tr>
<td>10. Running away</td>
<td>Leaving the unsupervised area alone and without permission</td>
<td>Leaving the room, playground, or group without permission or supervision</td>
</tr>
<tr>
<td>11. Property damage</td>
<td>Deliberately impairing or destroying items</td>
<td>Tearing paper, breaking items, writing on items</td>
</tr>
<tr>
<td>12. Unsafe behaviors</td>
<td>Engaging in dangerous acts with materials</td>
<td>Standing on furniture, inappropriate use of classroom materials</td>
</tr>
<tr>
<td>13. Trouble falling asleep</td>
<td>Showing signs of fatigue, yawning, rubbing eyes, irritable but not able to close eyes and rest</td>
<td>Will not lay on mat, restlessness, tossing, fidgeting</td>
</tr>
</tbody>
</table>
## Monthly Program Incident Tracking Form

### Family Child Care Monthly Program Action Tracking Form

<table>
<thead>
<tr>
<th>Actions</th>
<th>Week 1 Date</th>
<th>Week 2 Date</th>
<th>Week 3 Date</th>
<th>Week 4 Date</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls to Families about child’s behavioral concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requests for assistance from mental health consultant, psychologist, or other professional due to child’s behavioral concerns (e.g. CCR&amp;R Consultant, AEA, local school district staff)</td>
<td></td>
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<tr>
<td>Family conferences scheduled to address child’s behavioral concerns</td>
<td></td>
<td></td>
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<tr>
<td>Transfer to different program due to child’s behavioral concerns</td>
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<tr>
<td>Dismissal from program due to child’s behavioral concerns (with no transfer to alternate program)</td>
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</tr>
</tbody>
</table>

*Please place a 0 in any of the categories if there were no occurrences*

1. Only record phone calls that are not routine and are specifically conducted to address topic of child’s problem behavior.
2. Only record requests for assistance that are focused on addressing an individual child’s problem behavior, not general technical assistance.
3. Only record conferences that are convened to discuss child’s problem behavior, not routine family conferences where behavior may be discussed.