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Quality Review and Rating of Early Intervention (QuaRREI)

Classroom-Based Services (QuaRREI-Classroom)

The QuaRREI (pronounced *quarry*) is a process for assessing the quality of early intervention (0-5) programs. It requires observation, interviews, and paperwork review. It has two parts: Home and Community Based and Classroom Based.

DIRECTIONS

The QuaRREI is a method for evaluating the quality of an early intervention (0-5) program through observation, interview, and document review. It builds on the research we have done using the FINESSE II, Families FINESSE, and checklist data, to determine program efficacy and how much a program hews to the Routines-Based Model (García-Grau, 2016; McWilliam, 2010; McWilliam & Er, 2003; Rantala, Uotinen, & McWilliam, 2009). To score the QuaRREI, an evaluator should spend at least one day with a program. The QuaRREI has a home- and community-based-services version (QuaRREI-Home) and a classroom-based-services version (QuaRREI-Classroom). The following guidelines provide a structure for how the QuaRREI assessment might be completed.

- Determine the program's interest in being evaluated for adherence to the RBM. If they exhibit interest in this evaluation, proceed.
- Have professionals complete the FINESSE II for home-based and the PIPERS for classroom-based.
- Schedule a visit.
- In home- and community-based programs, plan to observe one home visit and one classroom visit and to interview a family, a visited teacher, to interview the director, and to interview the service provider observed or another service provider. The most coherent informants would be the family, early interventionist, and teacher observed.
- For all programs, secure permission to review five intervention plans, including those of children whose visits are observed.
- For all programs, plan to examine databases for (a) staff development (e.g., checklists), (b) child progress (e.g., goal attainment or progress, child functioning, child development tests, curriculum-based assessments, child outcome summaries), and (c) family outcomes (e.g., family quality of life, satisfaction with home routines, federal-reporting data).
- For classroom-based services run by the program, plan to observe in the classroom and to interview a parent, a teacher, the director, and, if helpful, a visiting therapist.
- Proceed through the QuaRREI, using the items appropriate for the program. If a program could be carrying out practices in an item but isn't, score 1, not "NA" and don't leave it blank.
- The unusual maximum scores occur because of the weighting of items. No cutoffs have been established for summative categorization, such as acceptable and unacceptable. Until we have enough data to make reasonable cutoffs, the QuaRREI should be used as a discussion and planning tool. The four area scores (intervention planning, collaborative consultation to classrooms, Engagement Classroom Model, program improvement and evaluation) and the total score can be used for pre-post intervention data and for comparing across programs.

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Potential Classroom-Based Program Assessment Schedule

The following schedule shows how an evaluation visit can be made in 1 day. Evaluators or programs might prefer to divide activities over 2 days. Classroom observations shouldn't be scheduled during typical nap times.

Time	Activity
8:00-9:00	Interview director
9:30-11:30	Observe in classroom
12:00-1:00	Lunch and interview with teacher
1:00-2:30	Review individualized plans, files.
2:30-4:30	Interview therapist and parent
4:30-5:00	Review databases

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Intervention Planning (Max. = 51)

The program staff assess the needs of the child and family in both home and classroom, if appropriate, routines. They use this needs assessment to help the family choose the goals (sometimes "outcomes") for the plan. Child-level goals are written to emphasize the child's engagement or meaningful participation in routines. Family goals are written for needs related to the child as well as needs not directly related to the child. Program staff determine the family's informal and formal supports. This section applies to both home- and classroom-based services.

Components and Method of Assessment	Unacceptable 1	Could Improve 2	Exemplary 3
1. Routines-Based Interview Interview professional & parent & review five or more plans Multiply by 5 (max. 15)	• General or nonfunctional information was obtained. • Only planned activities were discussed. • Routines when other caregivers than parents or teachers were not discussed. • Teachers were not asked about the goodness of fit. • Needs assessment was conducted only for classroom routines • Goals show general or irrelevant-sounding skills for children • Family needs are not included in goals • Plans have < 10 or > 15 goals	• Some details of EISR were asked but some general or nonfunctional information was obtained • All routines except arrival and departure were discussed. • Teachers were asked about the goodness of fit but not on a scale of 1-5. • RBI was conducted for some but not all settings where child spends > 15 hours/week • Some goals show specific functional skills but some show general or irrelevant-sounding skills. • The only family goals are those directly related to the child's development or learning • Plans have 6-10 goals	• Details of child engagement, independence, and social relationships were asked. • All routines, including arrival and departure, were discussed. • Teachers were asked to rate the goodness of fit between the child's interests/abilities and the demands of the routine on a scale of 1-5. • RBI was conducted for all settings where child spends > 15 hours/week (e.g., home, babysitter, other program) • Goals show specific functional skills for children • Goals include family needs • Plans have about 12 goals
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2. Ecomap Interview professional & parent and review file Multiply by 4 (max. = 12)	• Only child's name in the box in the middle • Informal supports arrayed on the bottom, and formal supports arrayed on the top • Insufficient informal supports included • Lines show little differentiation between levels of support • Only early intervention/ECSE supports included in formal supports	• Incomplete people living with the child in the box • Some informal and formal supports on the top and some on the bottom • Some extended family, friends, or neighbors included in informal supports, but some appear to be missing • Lines show two levels of support • Some medical, EI/ECSE, therapies, or financial supports in formal supports, but some appear to be missing	• Nuclear family in a box in the middle • Informal supports arrayed on the top, and formal supports arrayed on the bottom • Extended family, friends, BFF, and neighbors included in informal supports • Lines shown three clear levels of support and one level of stress (if appropriate) • Medical, early intervention/ECSE, therapies, and financial supports (if appropriate) included in formal supports
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3. Participation-Based Child Goals Goals on plans Multiply by 4 (max. – 12)	• No child-level goals written in terms of child's participation • Most goals written for nonfunctional skills (e.g., skills for clinical sessions) • Most goals written for meaningless or no acquisition criteria • Most goals written without reference to the number of routines in which the skill should be seen • Most goals written with no amount of time in which the skills should be observed	• Some child-level goals written in terms of child's participation • Some goals written for functional skills • Some goals written with a meaningful acquisition criterion • Some goals written with the number of routines in which the skills should be seen • Some goals written with the amount of time in which the skills should be observed	• All child-level goals (other than toilet training) written in terms of child's participation • All goals written for functional skills (i.e., skills needed for meaningful participation in regular routines) • All goals written with a meaningful acquisition criterion • All goals written with the number of routines in which the skills should be seen • All goals written with the amount of time in which the skill should be observed
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4. Family Goals Goals on plans Multiply by 4 (max. = 12)	• No child-level family goals are included • No family-level goals are included • Family goals have either meaningless of no criteria	• Only child-related family goals are included • Some family goals have meaningful criteria	• Child-related family goals are included • Family-level goals are included • Family goals have meaningful criteria
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Collaborative Consultation to Classrooms (CC2C) (MAX. = 33)

Visitors to classrooms integrate their expertise into the ongoing routines of the classroom, to maximize teachers' implementing strategies when visitors are not there. Visitors and classroom staff engage in collaborative consultation, where together they decide what the problem is, what the solution might be, and whether the solution worked.

Components and Method of Assessment	Unacceptable 1	Could Improve 2	Exemplary 3
5. Engagement, Independence, and Social Relationships (EISR) in Specialized Services Observe classroom, interview director and teacher, and review individualized plan and written program descriptions Multiply by 3 (Max = 9)	• Specialists focus on nonfunctional skills, including skills demonstrated in meaningless environments or routines (e.g., clinics). • Child performance talked about out of context of natural environments (e.g., in general or in clinic). • Program focuses primarily on federal outcomes, test score improvement, or individualized-plan goal attainment. • Child goals have nothing to do with EISR.	• Some service delivery focuses on consultation around EISR, but some focuses on nonfunctional skills. • Functioning sometimes discussed in context of a specific routine but sometimes out of context. • Program focuses on EISR to some extent, but not specifically mentioning these 3 functional outcomes. • Some child goals can be identified as associated with EISR but some have nothing to do with EISR.	• Collaborative consultation focuses on EISR (i.e., child functioning and meaningful participation in routines). • Functioning always discussed in context of a specific routine. • Program focuses on these functional outcomes (AKA foundations of learning), rather than *just* federal outcomes, test scores, or individualized-plan goals. • Child goals can be identified as associated with EISR.
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6. Collaborative Consultation/Integrated Therapy Observe in classroom and interview director and professional Multiply by 5 (Max. = 15)	• Professional comes to the classroom with his or her own agenda. • Professional either takes the child out of the room or takes him or her aside. • Professional does not communicate with the teaching staff through most of the visit. • Professional determines what the problem is—why they child can't do something. • Professional does not give suggestions or recommendations to the teachers, because *he or she* is the interventionist. • Professional does not demonstrate interventions to the teaching staff. • Professional does not give feedback to teaching staff on their intervening with the child.	• Professional asks staff if they have any issues but quickly moves to his or her agenda. • Professional stays in the room but is not engaged in the ongoing routine. • Professional communicates only at the beginning and end of the visit. • Professional interacts with the child but changes the focus of the child's engagement. • Professional gives suggestions before obtaining enough background (i.e., before 4 questions). • Professional understands collaboration but doesn't give suggestions. • Professional demonstrates interventions to the teaching staff without asking if they want a demonstration. • Professional does not ask teaching staff if they think the intervention will work. • Professional does not ask teaching staff if they think they'll be able to implement the intervention.	• Early intervention professional asks staff if they have any issues they want help with. • Early intervention professional joins the child in whatever the child is engaged with. • Early intervention professional communicates with teaching staff through much of the visit. • Early intervention professional talks to teaching staff about what the problem is—why the child can't do something. • Early intervention professional interacts with the child in the context of the existing routine either to understand more about the child's functioning or to try interventions. • Professional asks at least four questions of the teaching staff (Hoosier's Rule) to establish background and context. • Professional proposes an intervention. • Professional asks if the teaching staff want a demonstration. • Professionals asks if the teaching staff want to try the intervention. • Professional asks teaching staff if they think the intervention will work. • Professional asks teaching staff if they think they'll be able to implement the intervention.
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7. Inclusion Observation in classroom and interview with director and early intervention professional Multiply by 3 (Max = 9)	• Children with disabilities are in a classroom where < 50% of children are typically developing. • Children with disabilities are pulled out for specialized services. • Children with disabilities often participate in activities separate from those for typically developing children.	• Children with disabilities are in a classroom where at least 50% of children are typically developing. • Specialists work 1:1 in classroom with children with disabilities. • Children with disabilities sometimes participate in activities separate from those for typically developing children	• Children with disabilities are in a classroom where at least 80% of children are typically developing. • Children with disabilities stay in that room or with that group all day long. • Children with disabilities always participate in activities with typically developing children.
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ENGAGEMENT CLASSROOM MODEL (MAX = 51)

Classrooms operated according to the Routines-Based Model promote engagement through incidental teaching during developmentally appropriate routines, not by taking individual children aside and doing work baskets or discrete trials with them. The zone defense schedule is used to organize the space as well as the adults in the classroom, so adults are in charge of areas of the room. As with home visits, the focus is on children's engagement, independence, and social relationships (EISR). The ECM now adopts elements from the Reggio Emilia approach, to ensure classrooms are creative, enjoyable, family-friendly, beautiful for everyone in the room, artistic, and naturalistic (in the truest sense of the word—promoting naturism).

Components and Method of Assessment	Unacceptable 1	Could Improve 2	Exemplary 3
8. Incidental Teaching Observe in classroom and interview teacher Multiply by 5 (Max = 15)	• Teachers focus on compliance more than engagement. • Teachers set the agenda for what children should do. • Teachers mostly praise correct responding and correct children's errors, rather than eliciting more sophisticated behavior. • Teachers react to children's efforts, without using prompts. • Teachers acknowledge children's behaviors1 but don't ensure reinforcement2.	• Teachers actively promote some children's engagement. • Teachers inconsistently respond to children's interests. • Teachers occasionally elicit more sophisticated behavior but miss numerous opportunities. • Teachers prompt with little apparent method for order (e.g., least-to-most, timing, or fading). • Teachers praise but not at a high rate.	• Teachers actively promote all children's engagement. • One on one or in small groups, teachers respond to children's interests. • Teachers elicit more sophisticated forms of children's interests. • Teachers use effective prompting strategies, including the timing of prompts. • Teachers ensure teaching interactions are reinforcing for the child.

[1] *Behavior* is used in its neutral, technical sense: "That portion of an organism's interaction with its environment that is characterized by detectable displacement in space through time of some part of the organism and that results in a measurable change in at least one aspect of the environment" (Johnston & Pennypacker, 1993). "Behaviors" are not inappropriate or undesired unless qualified as such.

[2] Reinforcement: "If behavior is followed closely in time by a stimulus event and as a result the future frequency of that type of behavior increases in similar conditions, reinforcement has taken place" (Cooper, Heron, & Heward, 2007). Usually, reinforcement will be positive, such as praise or inherent enjoyment of

	• Teachers stay with one child for a long time or teach a large group for a long time. • Teachers use a low rate of incidental teaching.	• Teachers use incidental teaching with individual children for a long time. • Teachers miss opportunities for incidental teaching.	• Teachers use incidental teaching with numerous children. • Teachers use a high rate of incidental teaching.
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the activity or interactions, thus increasing the likelihood of future frequency of that type of behavior. Technically, it must result in increased frequency for the reinforcer to count as a reinforcer.

9. Zone Defense Schedule Observe in classroom and interview director and teacher Multiply by 5 (Max = 15)	• Room is arranged with no clear zones and with an open space in the middle of the room. • Schedule lists children's activities3 (i.e., one list). • At every activity, each adult is responsible for certain children. • Classroom assistants don't lead activities; they help the lead teacher. • When activities begin, materials are not yet set up. • Transitions occur with no warning to the children. • Adults do not communicate with each other about transitions: The lead teacher decides. • At transitions, often no adult is where the new activity will occur and children wait. • At transitions, the sending adult cleans up before the last child has made the transition.	• Some zones are marked and the middle of the room is an open space. • Schedule shows different responsibilities for different adults. • At every activity, one adult sets up the next activity before the previous one ends. • Classroom assistants lead activities. • The non-ZDS schedule is posted in the classroom. • Children receive a warning that a transition will begin. • Adults sometimes communicate with each other about transitions. • Children rarely have to wait for activities to begin after transitions. • At transitions, the sending adult sometimes stays in the zone until the last child has made the transition and sometimes cleans up.	• Room is arranged in clearly marked zones, with no open space in the middle of the room. • Schedule of responsibilities has one column for each adult. • At every activity, one person is scheduled for set up. • Each adult leads the activity following his or her set up. • The zone defense schedule (ZDS) is posted in the classroom. • Materials for activities are set up before activities begin. • Children receive a 2-minute warning that a transition will begin. • Adults communicate with each other about transitions. • At transitions, the receiving adult is in place and ensures children are engaged as soon as they arrive. • At transitions, the sending adult stays in the zone until the last child has made the transition.
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[3] In the ZDS, transitions are described as though activities were discrete teacher-planned events. In many play-based classrooms, much of the day is spent in free play, which children choosing their own transitions. The indicators in the ZDS rubric pertaining to transitions are applicable only to teacher-planned transitions, such as to snack, to outside (unless children have independent access to the outdoors), and to circle/morning meeting.

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10. **Engagement, Independence, and Social Relationships (EISR)--Classroom** Observe in classroom and interview director and teacher Multiply by 4 (Max = 12)	• Teachers and therapists (professionals) focus on nonfunctional skills, including skills demonstrated in meaningless environments or routines (e.g., therapy rooms, work areas). • Program focuses primarily on federal outcomes, test score improvement, or individualized-plan goal attainment. • Child goals have nothing to do with EISR. • Professionals focus on participating children and ignore nonparticipants. • Professionals help children unnecessarily. • Professionals work on communication primarily in structured "language" or "speech" sessions. • Professionals punish misbehavior instead of teaching prosocial behavior. • Professionals consequate misbehavior by using timed time out.	• Professionals focus on discrete skills in naturally occurring, normalized routines. • Program focuses on EISR to some extent, but not specifically mentioning these 3 functional outcomes. • Some child goals can be identified as associated with EISR but some have nothing to do with EISR. • Professionals sometimes ensure the child participates meaningfully and sometimes for an adequate amount of time. • Professionals support the child to be independent but miss some opportunities. • Professionals support the child to communicate but miss some opportunities. • Professionals support the child to get along with others but sometime punish misbehavior (other than sit and watch, which is considered teaching). • Professionals consequate misbehavior with sit and watch but don't let the child choose when to return.	• Professionals focus on EISR in naturally occurring, normalized routines, instead of nonfunctional skills. • Program focuses on these functional outcomes (AKA foundations of learning), rather than just federal outcomes, test scores, or individualized-plan goals. • Child goals can be identified as associated with EISR. • Professionals ensure the child participates meaningfully and for an adequate amount of time in routines. • Professionals support the child to be as independent as possible in routines. • Professionals support the child to communicate in routines. • Professionals support the child to get along with others in routines, including self-regulation and prosocial behavior. • Professionals consequate misbehavior with sit and watch (contingent observation).
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11. **Reggio-Emilia-Inspired Elements** Observe in classroom and interview director and teacher Multiply by 3 (Max = 9)	• Fluorescent lights. • Bright primary colors predominate. • Plastic materials are everywhere. • No live plants. • Walls decorated only with children's artwork or typical bulletin boards. • No objects from nature in the classroom. • No art area for independent access. • No light table. • Children make 2-dimensional art predominantly. • Teachers either follow a themed curriculum or no curriculum. • No documentation about projects is visible.	• Fluorescent lights used but good natural light also. • Mixture of muted and bright colors. • Mixture of natural and plastic materials. • Mixture of children's artwork and attractive decorations other than children's artwork on walls. • A few objects from nature in the room. • Children have independent access to art area.	• Incandescent lights or natural light, instead of fluorescent. • Muted colors instead of bright, primary colors. • Natural materials instead of plastic. • Live plants in the room. • Attractive decorations on walls—not just children's artwork or typical bulletin boards. • Many objects from nature in the classroom. • Mini atelier in the classroom or atelier in the center. • Light table. • Opportunities for children to make things (art, structures, sculptures, etc.). • Project approach. • Documentation of evolution of projects.
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Program improvement and Evaluation (Max = 48)

An effective program collects data and uses them to make decisions, particularly about staff development and changes in practices. Because the Routines-Based Model is family centered, programs should measure the extent to which they result in improved family quality of life and satisfaction with home routines. Child functioning in routines is another hallmark of the model, so measuring this is necessary. The backbone of the individualized plan is the list of goals, so attainment of those goals should be measured. Finally, the implementation of the model to fidelity, which requires professionals' performance to be exemplary, must be measured.

Components and Method of Assessment	Unacceptable 1	Could Improve 2	Exemplary 3
12. Evaluating Support to Families Interview director and review files and the database Multiply by 4 (Max = 12)	• Family quality of life (FQoL) is not measured. • Family satisfaction with home routines is not measured. • Family outcomes data are not kept.	• Federal family outcome data are collected (e.g., through the Family Outcomes Survey or the NCSEAM Family Survey). • Federal family outcome data are entered at least at the factor/subscale and total level for each family into a spreadsheet (at most, at the item level). • Program leaders review aggregate federal family outcome data to determine where staff need additional training or where program needs to change procedures. • Program leaders review federal family outcome data, disaggregated by subgroups, to determine where staff need additional training or where program needs to change procedures.	• Family quality of life (FQoL) is measured, annually, with a psychometrically sound family-completed rating scale (e.g., the FEIQoL). • Family satisfaction with home routines is measured every 6 months, either with the RBI or with the Satisfaction with Home Routines Evaluation (SHoRE). • FQoL and SHoRE data are entered at least at the factor/subscale (for FEIQoL) and total level for each family into a spreadsheet (at most, at the item level). • Program leaders review aggregate FQoL and SHoRE data to determine where staff need additional training or where program needs to change procedures. • Program leaders review FQoL and SHoRE data, disaggregated by subgroups, to determine where staff need additional training or where program needs to change procedures.
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13. Evaluating Child Functioning in Routines Interview director and review files and database Multiply by 4 (Max = 12)	• Professionals do not monitor progress. • Program director make decisions about staff development and policy/procedure changes in the absence of data. • Professionals do not use data to inform their federal-child-outcome reporting.	• Professionals monitor progress through curriculum-based assessments or developmental tests. • Program directors use data on child progress or status to make decisions. • Professionals use curriculum-based assessment or developmental-test data to inform their federal-child-outcome reporting.	• Natural caregivers (e.g., parents, teachers) rate children's engagement in naturally occurring, normalized (i.e., not "therapeutic," "clinical," or self-contained—disabilities-only) routines (e.g., with the MEISR or ClaMEISR). • Natural caregivers report on children's independence in naturally occurring, normalized routines. • Natural caregivers report on children's social relationships in naturally occurring, normalized routines. • Program directors use data on child functioning in routines to make decisions, especially about staff development and policy/procedure changes. • Professionals use data on child functioning to inform their federal-child-outcome reporting.
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14. Evaluating Goal Attainment Interview director and professional and review files and database Multiply by 3 (Max = 9)	• No data are collected on goal attainment. • Every time a goal is discussed, only descriptive narrative reports are made. • When goal is completed, professionals stop the intervention. • When individualized plan is revised, the team examines no data. • Program doesn't document its effectiveness. • Program director has no knowledge of differential outcomes by demographic variables.	• Data are collected on child and family goals but not on a a common metric. • Professionals collect goal attainment data on a schedule, not ongoing. • When goal is completed, professionals assume they should continue working on the skill until the next formal review. • Instead of GAS, the program uses a goal progress rating scale, such as the Therapy Goals Information Form (TGIF)[4]. • Goal progress data are examined when individualized plan is revised. • Goal progress data are presented to document program effectiveness. • Goal progress data are disaggregated by demographic variables.	• All child and family goals are defined on a 5-point goal-attainment scale (GAS): -2, -1, 0, +1, +2; alternatively, 1-5, with 5 being *attained*. • GAS completed every time (a) a professional discusses a goal with the natural caregiver or (b) the teachers and therapists address that goal. • When goal is completed (0 on the traditional scale), professionals ask family whether to continue or stop interventions. • GAS data are examined when individualized plan is revised. • GAS data are presented to document program effectiveness. • GAS data are disaggregated by demographic variables (e.g., SES, severity of disability, race).
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[4] A 5-point rating scale of the frequency with which the child does the targeted skill and the independence with which he or she does the skill (McWilliam, 2005).

15. Evaluating Fidelity to the Model and Professionals' Performance Interview director and professional and review employee files and database Multiply by 5 (Max = 15)	• Staff do not receive ongoing observation and feedback (i.e., training). • Staff performance consists of an annual meeting with a supervisor who has no observed information on the staff member's performance. • No spreadsheet with data on professionals' performance is available. • Program director has no data on good or poor performance. • Program director has no data on treatment fidelity. • Staff have no opportunity to report their typical and ideal practices. • Program director reports treatment fidelity or makes staff development decisions in the absence of data. • Program has no data on what practices families experience. • Program has no data on the quality of visits to classrooms.	• Staff know what they should do but receive no systematic feedback. • Staff receive less than useful feedback, including few suggestions for improving performance. • Performance data are not entered on a spreadsheet. • Staff talk to program director about their typical practices, but these practices are not quantified. • Program director uses reports of typical practices to consider and report apparent treatment fidelity and to make staff development decisions and policy/procedure decisions. • Program obtains nonquantitative family perceptions of practices they experience and consider important. • Program director uses family perceptions of practices experienced and considered important to make staff development decisions and policy/procedure decisions. • Staff nonquantitatively self-report their typical and ideal practices in collaborative consultation to child care/preschool. • Program director uses perceptions of typical and ideal practices in	• Staff are trained with performance checklists, to a criterion of 85% correct on 2 consecutive observations on each checklist. • Staff are monitored 4 times a year, unless they need more (consistently scoring < 85% correct) or less (consistently scoring > 85% or more). • Checklists are completed by people who score with rigor and give honest feedback. • Feedback givers provide suggestions for improving performance. • Checklist data are entered on a spreadsheet. • Program director monitors checklist data to ensure everyone is getting feedback and to identify problems in quality. • Program director uses checklist data to analyze and report treatment fidelity. • Staff self-report their typical and ideal practices (e.g., FINESSE II). • Program director uses data on typical and ideal practices to analyze and report treatment fidelity and to make staff development decisions and policy/procedure decisions.

		collaborative consultation to make staff development decisions and policy/procedure decisions.	• Families report practices they experience and consider important (e.g., Family FINESSE). • Program director uses family perceptions of practices experienced and considered important to make staff development decisions and policy/procedure decisions. • Staff self-report their typical and ideal practices in collaborative consultation to child care/preschool (e.g., ProPerCECIS). • Program director uses data on typical and ideal practices in collaborative consultation to analyze and report treatment fidelity and to make staff development decisions and policy/procedure decisions.
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SCORES

Area	Item	Rubric Score	Weighting	Score
Intervention Planning	1. RBI		x 5	
	2. Ecomap		x 4	
	3. Participation-Based Child Goals		x 4	
	4. Family Goals		x 4	
			Total area score (max = 51)	
Collaborative Consultation to Classrooms (CC2C)	5. Engagement, Independence, and Social Relationships (EISR) in Specialized Services		x 3	
	6. Collaborative Consultation/ Integrated Therapy		x 5	
	7. Inclusion		x 3	
			Total area score (max = 33)	
Engagement Classroom Model	8. Incidental Teaching		x 5	
	9. Zone Defense Schedule		x 5	
	10. EISR—Classroom		x 4	
	11. Reggio-Emilia-Inspired Elements		x 3	
			Total area score (max = 51)	
Program Improvement and Evaluation	12. Evaluating Support to Families		x 4	

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	13. Evaluating Child Functioning in Routines		**x 4**	
	14. . Evaluating Goal Attainment		**x 3**	
	15. Evaluating Fidelity & Performance		**x 5**	
			Total area score (max = 48)	
			Total QuaRREI-Classroom score (max = 183)	