# Delivering Individualized Instruction During Ongoing Classroom Activities and Routines

## Three Success Stories

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**A**s her first year of teaching came to a close, Ms. Mattie felt good about the time spent building relationships with her highly diverse group of children and their families, managing the classroom environment, and planning meaningful activities to fill the day. However, as she "came up for air" and started to reflect on what she would do differently the next year, she knew that she was not implementing many of the practices she had learned in college. Sure, she completed an assessment on each child as dictated by her school district, but she had to admit that she really hadn't used the data to help her plan what to teach.

While she knew the children enjoyed the activities she planned, she felt like she was teaching the same concepts from the district curriculum (e.g., colors, shapes, numbers) to all of the children without individualizing or differentiating. It worried her that some children were probably not ready to learn the concepts she was teaching. Likewise, she worried that some children were not being challenged enough.

But HOW in the world was she supposed to support everyone in her classroom in the way in which they needed to be taught? She had 20 children in her class and one teaching assistant to help her! The children ranged

*in age from 3 to 5 years. Of the 20 children, six children had disabilities, including two with Autism Spectrum Disorder. Although the remaining 14 children were "typically developing," three demonstrated challenging behavior and eight were English language learners. Ms. Mattie knew the importance of differentiating instruction, yet she struggled to find ways to address the more intensive needs of children in her classroom.*

Whether a first-year teacher, or a 20-year veteran, Ms. Mattie's situation is common in center-based early childhood programs[1] in the United States. As a country, the United States' population has become increasingly diverse, and subsequently, early childhood programs have become equally diverse. At least two other factors have diversified the makeup of children served in center-based programs. First, the mandate to serve infants and toddlers with disabilities in their natural environments has led to increased services delivered in community-based childcare programs. Second, increases in funding for pre-kindergarten (pre-K) programs, particularly for children who are at risk, has lead local education agencies to partner with community-based child care programs and Head Start programs in order to serve more children. With the increase in the diversity of children being served has come the increased need to diversify how programs operate, how they remain fiscally viable, and how best to deliver instruction.

One broad strategy has been to blend or combine resources, philosophies, and strategies. Programs following a blended approach commonly pull from a variety of sources in an effort to create a program that is as eclectic and versatile as the children and families served. For

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example, in a classroom following a blended approach a teacher may use real life materials in the kitchen area such as cereal boxes, menus from restaurants, and real cups and plates (pulling from the traditions of Maria Montessori). As well, she may also guide children through projects of interest to promote problem solving, creativity, and small group explorations (pulling from the traditions of Reggio Emilia). Lastly, she may promote learning and changes in behavior by systematically arranging the environment and providing individualized reinforcement to give children feedback (pulling from the traditions of classical and operant conditioning).

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[1] We define center-based early childhood programs as those that serve children between the ages of birth to 8 years of age and may include childcare programs, publicly funded preschool, and kindergarten.

The purpose of this article is twofold. First, we aim to describe two key practices associated with a blended approach designed to meet the learning needs of children diverse abilities served in center-based programs. Second, we provide three illustrations of how children, particularly those with intensive learning needs, can successfully acquire important outcomes when served in classrooms using a blended approach.

## Blended Programs and Classrooms

Grisham-Brown and colleagues (2005, 2013, 2014) define *blended programs* or *blended classrooms* as those having at least four defining characteristics. First, they serve a variety of children including those with identified disabilities, those from culturally and linguistically diverse backgrounds, and those from a wide range of socioeconomically situations. Second, they combine fiscal (e.g., Head Start funds; state pre-K dollars; IDEA Parts C and B 619 funds; and child care subsidies) and human resources to address the needs of children being served. Third, teachers in blended classrooms are ideally trained in the traditions of both early childhood education and early childhood special education. Finally, they combine philosophies and practices across four linked curricular elements including *assessment, scope and sequence, activities and instruction,* and *progress monitoring.* It is these four linked curricular elements, along with a supportive leadership team, collaborative partnerships, quality professional development, and an adherence to data-driven decision making, that comprise a blended approach, or what has been termed a "Curriculum Framework."

*Teachers in blended classrooms may feel unable to abide by the preciseness of the procedures described in the literature due to the competing demands of their classrooms, including overcrowding, adherence to multiple state and federal mandates, and the diverse learning needs of children.*

A curriculum framework is one illustration of how blended programs can design and deliver learning opportunities for diverse groups and individual children. To learn more about the characteristics of blended programs, particularly the blending of curricular elements as part of a curriculum framework, see Grisham-Brown et al. (2005), Grisham-Brown and Pretti-Frontczak (2011), and Grisham-Brown and Pretti-Frontczak (2013). While it is beyond the scope of this article to go into detail regarding the four characteristics of blended programs or to further illustrate blending

through descriptions of a curriculum framework, we do describe two key aspects of blended programs: (1) *identifying outcomes* for each child in the classroom and (2) *selecting and delivering appropriate instructional strategies* to teach identified outcomes.

## Identifying Outcomes

One of the issues teachers face when working in a blended classroom is determining "who needs to learn what." Because of the linguistic, cultural, and individual diversity found in a blended classroom, teachers are challenged to determine outcomes for a group of children whose development may go from 6 months to 6 years. In addition, individual children may have varying needs. For example, a child may have strengths in some developmental areas (e.g., getting wants and needs met, playing with other children) but may struggle in other developmental areas (e.g., using numbers, being understood by others). Further, the blending of funds cause teachers to become accountable to a variety of "masters" who set forth what children should learn. For example, receiving state dollars for pre-K requires accountability toward state early learning standards, serving children with disabilities under IDEA requires accountability toward outcomes on individualized plans, and receiving Head Start funds requires to accountability toward their Early Learning Framework standards. The wide range of learning needs presented by the children and the wide range of learning outcomes presented by funding agencies causes teachers to make multiple and varied instructional decisions about what to teach diverse groups of children as well as each individual child.

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The curriculum framework, as previously noted, is one way in which blended programs can design, implement, and revise learning opportunities for groups and individual children. Within a curriculum framework, the "what is taught" is characterized by three tiers. At the bottom (the foundation), or what is often called tier 1, teachers are addressing common or universal outcomes that are often set forth by federal, state, and local agency standards. Examples of tier 1 outcomes for preschoolers include naming upper and lower case letters, developing motor control and balance when walking, running, and playing, and engaging in cooperative play with others. At tier 2, teachers are addressing outcomes for some children who may be struggling or for whom progress has stalled. Examples of tier 2 outcomes for preschoolers include gaining indepen-

dence, performing tasks more quickly or with more control, and learning to initiate as well as to respond in order to get wants and needs met. At tier 3, teachers are addressing foundational or prerequisite skills a child may be missing, or barriers that are preventing the child from accessing, participating, and making progress toward the common outcomes. Examples of tier 3 outcomes for preschoolers include learning how to establish joint attention, understanding and using objects in representational ways, maintaining calm and focused emotional states, and imitating single word utterances. Tier 3 outcomes may also include critical or pivotal skills that at first glance appear to be an expectation for all children (a tier 1 outcome). However, in many cases, despite maturation and instruction children do not acquire basic skills that become the building blocks to more complex skills as they age. For example, if a child is nearing the end of pre-K and is unable to identify letters, he or she may experience difficulty with reading and writing in kindergarten and first grade. The skills of identifying letters, while something that was once a tier 1 outcome for all children, is elevated to a tier 3 need because an individual child did not acquire the skill as expected and requires more intensive instructional efforts.

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Teachers in blended programs are responsible for delivering instruction across all three tiers of outcomes and, as much as possible, doing so within the same activity or routine. In other words, while in the block area, a teacher may encourage all children to learn about terms that describe the spatial relationship between objects/people (e.g., on, below, in front of, middle, near, far). At the same time, teach a few children who are struggling with spatial relations to be more accurate in identifying how objects are the same or different. Then, simultaneously, provide multiple opportunities for an individual child to better coordinate movement and vision as they explore the blocks and cars. Teachers need to have a clear sense of not only what they are teaching but what they are teaching all children, versus some children, versus an individual child.

## Instructional Strategies

The instructional strategies used to teach across tiers need match the desired outcome. In other words, instructional strategies used to address tier 1 outcomes need to be effective and efficient for addressing these

types outcomes; instructional strategies used at tier 2 need to be effective and efficient for addressing tier 2 types of outcomes, and so forth. This brings us to the second issue teachers face when working in a blended classroom, determining which instructional strategy is most effective and efficient for teaching which outcomes.

Instructional strategies can be placed on a continuum from low adult mediation/involvement to high adult mediation/involvement (Bredekamp & Rosegrant, 1995; Noonan & McCormick, 2014). Research has shown that outcomes focused more on child initiation are better matched with instructional strategies that require less adult mediation. Conversely, outcomes that are more focused on an individual child's response to a highly specific outcome are better matched with instructional strategies that require more adult mediation (Wolery & Wilbers, 1994). Thus, when teaching tier 1 *common* outcomes that are often focused on highly child initiated outcomes (e.g., counting objects, labeling the color of objects, problem solving), *universal* instructional strategies such as self-talk, environmental arrangement, and modeling can be used to ensure children's success. When teaching a subgroup of children who may be struggling with progressing toward tier 1 outcomes and, which are somewhat child initiated and somewhat adult specified (e.g., increasing response time when given directions), *targeted* instructional strategies such as differential reinforcement and small group instruction may be most effective (Grisham-Brown & Hemmeter, 2014). Finally, if a child is missing an adult-specified foundational/prerequisite skill or one that is preventing the child's access and participation, *intentional, intensive, individualized (III)* instructional strategies such as milieu teaching or response-prompting procedures might be needed (Odom & Wolery, 2003).

Unfortunately, while the implementation of III instructional strategies is necessary for ensuring progress toward tier 3 outcomes, they are not frequently used within blended classrooms. Odom (2009) shares a number of possible reasons why such instructional strategies, which do have a strong evidence base, may not be implemented on a regular basis. First, researchers who establish evidence base of III strategies often use well-controlled settings and highly structured procedures. Teachers in blended classrooms may feel unable to abide by the preciseness of the procedures described in the literature due to the competing demands of their classrooms, including overcrowding, adherence to multiple state and federal mandates, and the diverse learning needs of children. Second, the professional development provided to teachers in blended classrooms is often insufficient to ensure that they will implement III evidence-based strategies in their classrooms. Many teachers who work in blended classrooms have limited to no training early childhood special education (from where many III originate) and

likely do not implement III instructional strategies because they have never heard of them or they received only a "one shot" workshop on their use. Therefore, additional training and support through coaching and communities of process should be available to increase the probability of implementation of III within blended classrooms.

The ability to identify multiple and varied outcomes (determining who needs to learn what) and matching those outcomes to a full continuum of instructional strategies (determining which strategies are efficient and effective) is at the heart of quality blended programming. Once these initial decisions are made, teachers must then find ways to ensure sufficient learning opportunities are provided to promote children's learning and development across tiered outcomes. As mentioned earlier, a research to practice gap that persists, particularly in blended classrooms, is the ability to deliver III instruction for children in context of play and other ongoing classroom activities where tier 1 and tier 2 outcomes are also being taught. The following section provides three illustrations of how children with tier 3 needs successfully received III instruction during daily activities and acquired their individualized outcomes when served in blended classrooms.

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## Success Stories

The set of instructional strategies described in the three scenarios have a strong evidence base for supporting learning for children with disabilities. Initial research, however, suggests a promise of their utility in blended classrooms (e.g., Grisham-Brown, Pretti-Frontczak, Hawkins, & Winchell, 2009; Grisham-Brown, Ridgley, Pretti-Frontczak, Litt, & Nielson, 2006) and their utility for any child being served, not just those with identified disabilities. The stories provided are shared directly from the early interventionists/teachers who worked daily with the children. The children included a child with autism, a child with challenging behaviors, and a kindergartener who was struggling, with the two latter children not being eligible for special education services but having intensive needs. In addition to illustrating the implementation of III, each of the scenarios shows how III was implemented in three different blended classrooms: a childcare center, a Head Start classroom, and a kindergarten classroom. For each child, we describe the individualized

outcome, the context of delivery of III instruction, how the instruction was delivered, and the result.

## Alice and Miguel

Alice was an early interventionist serving children in an urban area through visits to homes and community childcare centers. One of the children on Alice's caseload was Miguel, a 27-month-old boy who received early intervention services due to delays in cognitive and communication development. Miguel interacted well with other children and was easily motivated when engaged in child-directed play. He sometimes used single word utterances to get his wants and needs met but was inconsistent and often difficult to understand. Alice concluded that Miguel's limited verbal communication skills were keeping him from accessing and participating in the daily routine and that he needed III instruction to learn the foundational skill of saying/signing "more". Thus, Miguel's individualized outcome was to respond to directions, answer questions, or say/sign "more" to indicate when he needed or wanted "more" of something. Approximations were allowed.

After a brief Internet search and review of evidence-based strategies designed to promote communication skills, Alice selected the "mand model" procedure as an effective and efficient instructional strategy to teach Miguel how to request more (Christensen-Sandfort & Whinnery, 2011; Dinehart, Kaiser, & Hughes, 2009; Harjusola-Webb, & Robbins, 2012; Ingersoll, Meyer, Bonter, & Jelinek, 2012; Yoder, Molfese, & Gardnera, 2011). In general, the mand model procedure can be used when a child is learning words, learning to request, and/or learning to respond to questions (Noonan & McCormick, 2014). The basic premise of the strategy is for adults to give mands (e.g., give directions, make requests, ask questions, make statements) that require a verbal response from the child. Alice felt that this evidence-based strategy would be both effective and efficient for use with Miguel and in collaboration with the childcare staff decided to use the strategy during snack and free-play time.

Baseline data were collected for 2 days during snack and free play. During baseline (before Alice and the childcare staff started to use the mand model procedure), Miguel was given six opportunities (three during snack and three during free play) to say or sign "more." During baseline, he signed "more" only one time during snack. Because of Miguel's consistent nonresponding during baseline, Alice and staff decided to begin delivering the mand model procedure 10 times during snack and 10 times during free play. For example, during snack, a few goldfish were presented to Miguel. When he was finished eating the goldfish, Alice and the childcare staff waited to see if he would indicate the need for more by making an

approximation or by signing or saying "more." Alice knew the opportunity was a match for using the mand model procedure because they waited until they had joint or mutual attention, which was on the empty plate. Then, when Miguel started looking from his plate to the box of goldfish crackers, a mand was delivered (i.e., Alice or the staff would say, "What do you want?" or "Say more"), and then would wait 3 seconds for Miguel to respond. If Miguel approximated or signed/said the word "more" after the mand, Alice affirmed by saying, "You want more crackers" and then gave him more crackers. If he did not sign or say "more" after 3 seconds, Alice or the staff modeled by signing or saying "more" and then gave Miguel more goldfish crackers if he modeled an approximation of the sign or word for "more." Following 4 days of III instruction during snack and free play, Miguel was signing or using the initial consonant ("m") following the mand, 8 of 10 opportunities during snack, and 10 of 10 opportunities during free play.

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The results demonstrate the importance of selecting the appropriate instructional strategy and ensuring that a sufficient number of embedded learning opportunities are provided. Prior to implementing the III instruction, the teacher had tried simply modeling the correct response for Miguel. However, the consistent delivery of the mand model procedure was needed in order for the child to learn an important foundational communication skill of saying/signing "more".

## Dot and James

Dot was a Head Start pre-K teacher in an urban area serving 20 children, including James, who was a 3-and-a-half-year-old boy. James had attended Head Start for 6 months. His development was on track in terms of verbal skills and was easily understood by his peers and other adults in the classroom. In addition, James's fine motor skills were a strength, as he could manipulate small toys, writing implements, and his toothbrush. Despite these strengths, James had clear challenges in his social development, although he did not have an identified social delay. Specifically, he struggled getting along with others during group activities and had difficulty attending to an activity for more than a few minutes. Additionally, while eating, he used his fingers to pick up food and put it in his mouth instead of using a fork or spoon. The expected social outcome for James

was to *use utensils during mealtimes instead of eating with his fingers and hands.* While James had the fine motor ability to manipulate the utensils, eating food with his fingers was both socially unacceptable and unsanitary.

Peer-Mediated Intervention (PMI) was used to teach James to use utensils. Prior to the implementation of PMI, no other strategies had been implemented to assist him with learning the skill of using utensils. PMI is a strategy frequently used in inclusive center-based settings whereby a more competent peer models appropriate social or communication skills to a child who has delays in one of those developmental areas (Harris, Pretti-Frontczak, & Brown, 2009). Research supports the use of PMI to teach social skills and support friendships between children with social delays and their peers (Frea, Craig-Unkefer, Odom, & Johnson, 1999; Sperry, Neltzel, & Englhardt-Wells, 2010; Strain, Danko, & Kohler, 1995). Because of its effectiveness in teaching appropriate social behavior to young children with social delays, PMI was identified as a match for teaching James to use utensils appropriately.

Prior to implementing the instructional strategy, Jenna, a 4-and-a-half year old, was identified as the peer. Jenna had attended Head Start for 2 years and had mastered the target behavior (i.e., using eating utensils at mealtimes). As well, Jenna had excellent fine motor, cognitive, and language skills and was well liked by her peers. After she was identified, Jenna was taught how to implement the intervention using role play. Once Jenna was trained to deliver PMI, baseline data were collected for 3 days during breakfast and snack to verify that James did not use a utensil to feed himself. During this baseline phase, James did not use eating utensils to feed himself across the 3 days; rather he used his fingers/hands.

Following baseline, PMI was implemented. During each meal, a fork or spoon was provided and Jenna would sit next to James at the table to model how to use a fork or spoon to eat his food. Jenna followed the steps she learned, including establishing joint attention with James, and then giving him a verbal clue: "Use your fork/spoon to scoop up your food," and praising him if he did. If James attempted to scoop up his food, but did not get it on his fork/spoon, Jenna praised him for trying and showed him how to scoop it up and said, "hold the spoon like this." If James used his fingers to pick up the food, Jenna reminded him to use a spoon to scoop up the food and place it in his mouth by demonstrating and saying, "Watch me, this is how you scoop up the food and eat it." PMI was implemented for 3 weeks. James showed progress by the third day of instruction when he began using his eating utensils with reminders. By the end of the third week, James was using his utensils with only occasional reminders from Jenna and teachers.

This second scenario illustrates how an effective and efficient instructional strategy was delivered during ongoing classroom activities by capitalizing upon one of the strengths of a blended classroom—using peers to deliver the instruction. In the scenario, Jenna, as a more competent peer, helped to deliver III instruction to support another child who needed to learn how to demonstrate more socially appropriate skills during meals. In this way, Dot was able to simultaneously deliver tier 1 instruction to all the children and ensure multiple and varied learning opportunities for James to acquire his individualized outcome.

## Cate and Kameron

Cate was a kindergarten teacher in an urban public school where the majority of the children lived in low-income family situations and many of the children were English Language Learners. One of Cate's children was Kameron, a 5-year-old who had been in kindergarten for 8 months and who did not have an identified delay. Kameron had not received out of the home or formal early care and education prior to kindergarten entry. Kameron's strengths included active engagement in learning, seeking help when needed, and working well during one-on-one activities. Throughout the school year, however, Kameron had difficulty in labeling upper and lower case letters of the English alphabet. Cate had implemented a variety of tier 1 and tier 2 instructional strategies to support Kameron in learning how to labeling letters including the use of hands-on materials, teaching in small groups, and scaffolding. However, as the end of the school year approached, Kameron could not consistently label letters, even those in her first name. Cate recognized that despite maturation and instruction Kameron was not acquiring the basic skill of letter identification. Because this skill serves as a building block to more complex literacy skills, Cate selected Kameron's tier 3 outcome as *to verbally label all seven letters in her first name*.

A progressive time delay procedure was then selected as the III to teach Kameron to label the letters in her first name. Progressive time delay (PTD) is characterized by a gradual delay interval, beginning at 0 second and increasing by 1 to 2 seconds, between the presentation of the task direction and the presentation of a prompt to support demonstration of the expected behavior (Walker, 2008). The procedure has been used to teach a variety of behaviors to young children with disabilities such as sight word identification (Casey, 2008), peer imitation (Wolery et al., 1993), and communication skills (Matson, Sevin, Box, Francis, & Sevin, 1993).

Baseline data were collected for 3 days, during a single 15-minute small group activity to verify that Kameron could not label upper and

lower case letters in her first name. On one occurrence during baseline, Kameron identified the uppercase letter K, but that was the only letter before III was delivered. During instruction, Kameron participated in a small group activity lead by Cate and another small group activity lead by the teaching assistant. PTD was delivered over 10 school days where the adult provided manipulatives with the letters (K-A-M-E-R-O-N) listed on them, where Kameron was prompted to label each letter. On the first day of instruction, after asking Kameron to label a letter, the adult immediately and verbally modeled how to say the letter name. In essence, at 0 second time delay, all that Kameron was expected to do was to repeat the model provided by the adult. On the second day, the adult again asked Kameron to label a letter and waited 1 second before verbally modeling how to say the letter. The delay interval was increased by 1 second each day until the delay was 3 seconds between the request for Kameron to label a letter and the verbal model of the letter was provided. By the end of 10 days of III, Kameron was able to label all of the letters in her name (upper and lower case). PTD was subsequently used to teach a new set of letters during the remainder of the school year. With III, Kameron labeled all of the letters of the alphabet before the end of the year.

This scenario illustrates that PTD, while a strategy that has primarily been used to teach children with disabilities, shows promise for teaching children who do not have delays but who are having difficulty learning critical or pivotal skills. In other words, despite maturation and quality tier 1 instruction, select children served in blended classrooms may not acquire basic skills that become the building blocks to more complex skills as they age and may require III.

## Summary

The purposes of this article were to describe two key practices associated with meeting the learning needs of children with diverse abilities served in blended center-based programs and to provide three illustrations of how children can successfully acquire individualized outcomes using a blended approach. While our stories do not demonstrate strict experimental control, or measure fidelity, each provides a glimpse into real classrooms where teachers are trying, on a daily basis, to address the challenges of working in blended programs.

From the work of these three teachers, two suggestions are offered for identifying outcomes and selecting instructional strategies. First, teachers need to have a strong understanding of developmental and learning trajectories that depict the interrelatedness of development, and the recognition that all children have needs that can be viewed as tiered

or varied (i.e., at any particular time a child may exhibit strengths, may struggle, and may have intensive needs). This awareness allows for the delivery of III even for children who may not qualify for some form of specially designed instruction but do require intensive support. Second, teachers need to cull from the research, the recommended practices, and professional wisdom that has evolved for intervening and teaching children both with and without identified disabilities and delays. Pulling from both traditions gives teachers a greater number of effective and efficient instructional strategies that can be better matched with desired outcomes.

Through the journey of these three teachers, it became obvious that beyond determining what and how to teach, those working in blended classrooms need to remain grounded in the core principles of child development. Teachers need to fully understand how children's developmental status impacts the type of support provided (e.g., if a child is still a concrete learner, actual objects may be needed to convey information to a child) and have an awareness of the children interests and preferences to ensure that materials and activities are used to promote engagement. Finally, it is important for teachers to understand differences in children's abilities to process and act upon information. Prompts and cues must be delivered in a format that children can understand and in a consistent manner in order for any instructional strategy to be effective.

Emerging lessons about the realities of blended classrooms suggests that children with a wide range of abilities, including those with disabilities and those from culturally and linguistically different backgrounds may be successfully educated together. In fact, the three stories of Alice, Dot, and Cate specifically illustrate how children with intensive needs can be served in blended classrooms. Their stories demonstrate the success of carefully selecting evidence-based instructional strategies, systematically implementing those strategies, and relying on data-driven decision making to determine the attainment of important outcomes.

**Note**
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**References**
Bredekamp, S. & Rosegrant, T. (1995). *Reaching potentials: Transforming early childhood curriculum and assessment* (Vol. 2). Washington, DC: National Association for the Education of Young Children.

Casey, S. D. (2008). A comparison of within- and across- session progressive time delay procedures for teaching sight words to individuals with cognitive delays. *Behavior Analyst Today, 9* (3/4), 162-171.

Christensen-Sandfort, R. & Whinnery, S. B. (2011). Impact of milieu teaching on communication skills of young children with autism spectrum disorder. *Topics in Early Childhood Special Education, 32*(4), 211-222. doi:http://dx.doi.org/10.1177/0271121411404930

Dinehart, L. H. B., Kaiser, M. Y., & Hughes, C. R. (2009). Language delay and the effect of milieu teaching on children born cocaine exposed: A pilot study. *Journal of Developmental and Physical Disabilities, 21*(1), 9-22. Retrieved July 10, 2014, from http://ezproxy.uky.edu/login?url=http://search.proquest.com/docview/85687003?accountid=11836

Frea, W., Craig-Unkefer, L., Odom, S. L., & Johnson, D. (1999). Differential effects of structured social integration and group friendship activities for promoting social interaction with peers. *Journal of Early Intervention*, *22*(3), 230-242.

Grisham-Brown, J. & Hemmeter, M. L. (2014). *Blended practices for teaching young children in inclusive settings* (2nd ed.). Manuscript in preparation.

Grisham-Brown, J. L., Hemmeter, M. L., & Pretti-Frontczak, K. (2005). *Blended Practices for Teaching Young Children in Inclusive Settings*. Baltimore: Brookes Publishing.

Grisham-Brown, J. & Pretti-Frontczak, K. (2011). *Assessing young children using blended practices*. Baltimore: Brookes Publishing.

Grisham-Brown, J. & Pretti-Frontczak, K. (2013). A curriculum framework for supporting young children served in blended programs. In V. Buysse and E. Peisner-Feinberg (Eds.). *Handbook of response to intervention (RtI) in early childhood*. Baltimore: Brookes Publishing.

Grisham-Brown, J. L., Pretti-Frontczak, K., Hawkins, S., & Winchell. B. (2009). An examination of how to address early learning standards for all children within blended preschool classrooms. *Topics in Early Childhood Special Education, 29*(3), 131-142.

Grisham-Brown, J. L., Ridgley, R., Pretti-Frontczak, K, Litt, C., & Nielson, A. (2006). Promoting positive learning outcomes for young children in inclusive classrooms: A preliminary study of children's progress toward pre-writing standards. *Journal of Intensive Behavior Intervention, 3*(1), 171-190.

Harjusola-Webb, S. & Robbins, S. H. (2012). The effects of teacher-implemented naturalistic intervention on the communication of preschoolers with autism. *Topics in Early Childhood Special Education, 32*(2), 99-110. doi:http://dx.doi.org/10.1177/0271121410397060

Harris, K. I., Pretti-Frontczak, K., & Brown, T. (2009). Peer-mediated intervention: An effective, inclusive strategy for all young children. *Young Children, 64*(2), 43-49.

Ingersoll, B., Meyer, K., Bonter, N., & Jelinek, S. (2012). A comparison of developmental social-pragmatic and naturalistic behavioral interventions on language use and social engagement in children with autism. *Journal of Speech, Language, and Hearing Research, 55*(5), 1301-1313. Retrieved July 10, 2014, from http://ezproxy.uky.edu/login?url=http://search.proquest.com/docview/1315888852?accountid=11836

Matson, J. L., Sevin, J. A., Box, M. L., Francis, K. L., & Sevin, B. M. (1993). An evaluation of two methods for increasing self initiated verbalizations in autistic children. *Journal of Applied Behavior Analysis, 26*(3), 389–398.

Noonan, M. J. & McCormick (2014). *Teaching young children with disabilities in natural environments*. Baltimore: Brookes Publishing.

Odom, S. (2009). Evidence-based practice, implementation science, and outcomes for children (2009). *Topics in Early Childhood Special Education, 29*(53), 53-61.

Odom, S. & Wolery, M. (2003). A unified theory of practice in early intervention/early childhood special education: Evidence based practices. *Journal in Special Education, 37*(3), 164-173.

Sperry, L., Neltzel, J., & Englhardt-Wells, K. (2010). Peer mediated instruction and intervention strategies for students with autism spectrum disorders. *Prevention of School Failure, 54*(4), 256-264.

Strain, P. S., Danko, C. D., & Kohler, P. (1995). Activity engagement and social interaction development in young children with autism: An examination of "free" intervention effects. *Journal of Emotional and Behavioral Disorders, 3*(2), 108-123.

Walker, G. (2008). Constant and progressive time delay procedures for teaching children with autism: A literature review. *Journal of Autism and Developmental Disorders, 38*(2), 261-275.

Wolery, M., Holcombe-Ligon, A., Brookfield, J., Huffman, K., Schroeder, C., Martin, C. G., Fleming, L. A. (1993). The extent and nature of preschool mainstreaming. A survey of general early educators. *Journal of Special Education, 27*(2), 222-234. doi:http://dx.doi.org/10.1177/002246699302700205

Wolery, M. & Wilbers, J. S. (1994). Introduction to the inclusion of young children with special needs in early childhood programs. In M. Wolery & J. S. Wilbers (Eds.), *Including children with special needs in early childhood programs* (pp. 1-22). Washington, DC: National Association for the Education of Young Children.

Yoder P., Molfese, D., & Gardner, E. (2011). Initial mean length of utterance predicts the relative efficacy of two grammatical treatments in preschoolers with specific language impairment. *Journal of Speech, Language, and Hearing Research*, *54*(4), 1170–81.