Missouri Guidelines for School-Based Speech-Language Pathologists

MSHA

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MISSOURI SPEECH-LANGUAGE-HEARING ASSOCIATION

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Disclaimer

This document is intended to be provided as a guideline. If any portion of this document conflicts with laws or regulations, the law or regulation takes precedence.

Background Information

In 2016 and 2017, the Missouri Speech-Language-Hearing Association (MSHA) worked collaboratively with several stakeholders, including the Missouri Council for Administrators of Special Education (MO-CASE) and the Missouri Department of Elementary and Secondary Education (DESE), to formulate proposed changes to the speech-language eligibility criteria. During the course of this collaborative work, it became apparent that a handbook for Missouri's school-based SLPs would significantly increase understanding and consistency in practices across the state. 2017-2018 MSHA President, Elizabeth "Beth" McKerlie, pursued and MSHA was awarded an American Speech-Language-Hearing Association (ASHA) State Association Grant to assist in the development of this handbook.

The first edition of the handbook was published in November 2018 and revised in July 2020. This handbook is meant to serve as an optimistic beginning point for continued work and collaboration. MSHA will continue to lead and pursue revisions of this document as needed. The purpose of this handbook is to provide for guidance to Missouri school-based speech-language pathologists in order to:

1. Improve outcomes for children
2. increase consistency across the state
3. Ensure alignment of clinical practice to local, state and federal regulations
4. Ensure access to evidenced based practices

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Common Acronyms

AAC – Augmentative and Alternative Communication
ASD – Autism Spectrum Disorders
ASHA – American Speech-Language-Hearing Association
AT – Assistive Technology
AAC – Augmentative and Alternative Communication
BICS – Basic Interpersonal Communication Skills
CALP – Cognitive Academic Language Proficiency
CCC – Certificate of Clinical Competence
CF – Clinical Fellowship
CLD – Culturally and Linguistically Diverse
DESE – Department of Elementary and Secondary Education (DESE)
EBP – Evidence-Based Practices
ESSA – Every Student Succeeds Act
FAPE – Free Appropriate Public Education
FERPA – Family Educational Rights and Privacy Act
ID – Intellectual Disability
IDEA – individuals with Disabilities Education Act
IEP – Individualized Education Program
LEA – Local Education Agency
LEP – Limited English Proficiency
LRE – Least Restrictive Environment
L1 – First language of a child
L2 – Second language of a child
MSHA – Missouri Speech-Language-Hearing Association
MTSS – Multi-Tiered Systems of Support
PBIS – Positive Behavior Intervention Supports
PLEP – Present Level of Educational Performance
RtI – Response to Intervention
BoHA – Missouri Board of Healing Arts

Special Education Overview

The purpose of this section is to identify/clarify information specific to speech-language pathologists for purposes of special education under the Individuals with Disabilities Education Act (IDEA). This information is in no way intended as a substitute for the actual Missouri State Plan for Special Education. Speech-language pathologists are encouraged to routinely check the Missouri Department of Elementary and Secondary Education (DESE) website for updates and annual updates that occur every year in July: https://dese.mo.gov/special-education/compliance

Speech-language Screening Clarification

A number of questions have been posed regarding what kinds of speech-language screening activities are required and which trigger the need for IDEA compliant notice and consent for evaluation. The following clarification was reviewed by DESE and will hopefully help address the questions.

The IDEA and the Missouri State Plan require districts have in place a child find system that allows them to identify and evaluate all those children who need special education services. Decisions regarding when and how speech-language screening will be conducted is left to local district discretion. There are no specific requirements for mass screening to occur at a certain time or grade level, nor are their requirements for specific screening protocols to be used. A screening system based on teacher referrals is acceptable as is one that has SLPs observing the classroom for potential problems or one that involves mass screening with a specific screening protocol.

The determining factor in when a speech-language screening triggers IDEA notice and consent for evaluation is *when a disability is suspected*. If a screening procedure is conducted with a child who is not suspected of having a disability, but the results will be used to guide the provision of early intervening services, regular education supports, or other non-special education services, IDEA notice and consent for evaluation are not required. A screening procedure can be used with a specific student outside of mass screening without notice and consent, so long as a disability is not suspected.

Mass screenings, such as those conducted for all children enrolling in Kindergarten, do not require IDEA notice and consent for evaluation. Screening students who move into the district as part of standard enrollment procedures would not require IDEA notice and consent for evaluation unless for some reason the screening was done because a disability was suspected. Any time a child is suspected of having a disability, the procedures used (even if it is a screening protocol) will need notice and consent for evaluation.

Initial Evaluation

The eligibility team should apply eligibility criterion to the initial evaluation process if considering speech or language impairment as an eligibility category a result of an initial evaluation.

"…speech-language impairment means a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, that adversely affects a child's educational performance" (34 C.F.R. Section 300.8(c)(11)).

The speech-language pathologist plays a critical role in the assessment of students who are referred for an initial evaluation. An initial evaluation should involve the use of a variety of assessment tools and strategies to gather relevant functional and developmental information to assist in determining if the child is eligible for special education.

In the federal definition of a disability (IDEA), the determination of eligibility is two-fold:

(1) to determine if the child has an exceptionality based upon the criteria defined in the law; and

(2) does the child have a need for special education and related services as a result of this disability?

The identification of a speech-language impairment does not mean that the child needs special education services. This determination of eligibility is made by an eligibility team reviewing data from a variety of sources and whether the impairment adversely impacts educational performance. No one piece of data should be a determining factor in an eligibility decision. Similarly, a decision for eligibility solely based upon the expertise of the speech-language pathologist outside of the context of the interdisciplinary team is in violation of IDEA. (Power-de Fur, April 2011, ASHA Leader, *Special Education Eligibility: "When is Speech-Language Impairment also a Disability?"*, Vol. 16, 12-15).

Reevaluation

It is important to know that the initial eligibility criterion is not re-applied when a reevaluation is conducted. Rather, the team determines whether the child continues to show evidence of the impairment and continues to need special education services.

Related Services

A student must be found eligible for Special Education in order to receive a related service.

Related Services, as defined by Missouri State Plan for Special Education, “means transportation and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education and includes speech pathology and audiology services...” (page 5)

Speech-language pathology services are further defined in the Missouri State Plan for Special Education as “services includes identification of children with speech or language impairment, diagnosis and appraisal of specific speech or language impairments, referral for medical or other professional attention necessary for the habilitation of speech or language impairments, provision of speech and language services for the habilitation or prevention of communicative impairments, and counseling and guidance of parents, children and teachers regarding speech and language impairments.” (page 7)

Speech-language pathology services are considered both special education and a related service. Thus, a student may not meet eligibility criteria for Speech or Language Impairment but does meet eligibility criteria in another disability category and may receive speech and language services as a related service. For example, a student may be found eligible in the disability category of Other Health Impairment and require speech-language as a related service to address documented concerns in order to benefit from their Individualized Education Program (IEP).

Once a student has been identified as IDEA eligible through the evaluation process, and an IEP has been developed, the IEP team determines if related services are necessary. There are no categorical eligibility criteria for related services.

IEP Process

When the evaluation process is completed and the team determines that a student has a speech-language impairment that requires intervention as a primary special education or related service, an IEP is developed within 30 calendar days of the date of the student’s eligibility determination. The purpose of the IEP is to describe the special education services that are necessary to meet the individual needs of the student, as determined through the evaluations. The IEP addresses, where the student is currently functioning, what the goals are for the student, and what services and supports are needed in order to meet the goals.

Exit Criteria/Dismissal from Services

The State of Missouri does not specify exit criteria for when a student no longer requires special education and/or related services. The need for skilled instruction from a speech-language pathologist is no longer needed when the communication disorder no longer impacts a student academically or functionally. Progress monitoring data, informal observations, input by team members including the student and best evidence-based practices help inform teams about a decision to reevaluate for purposes of dismissal from services. A reevaluation is initiated in order to review data prior to exit/dismissal from all services.

ASHA's website contains resources for decision-making related to dismissal of services https://www.asha.org/NJC/Decision-Making-in-Termination-of-Services/.

Further, ASHA's website also indicates there is evidence to support services for students based upon cognitive age. https://www.asha.org/NJC/Relation-of-Developmental-Skills-to-Service-Eligibility/

Multi-Tier System of Support

Missouri has made strides in recognizing the Multi-Tier System of Support (MTSS) model as an effective and efficient approach to improving educational outcomes for students. MTSS is driven by systematic data collection regarding a student's progress in the general curriculum that prompts evidence-based intervention for those who fall behind in development of academic and/or behavioral skills. Intervention is provided in tiers of increasing intensity to those who need it, regardless of eligibility status for a particular entitlement program. Although academic and behavior problems often overlap, intervention systems have tended to focus on one or the other. With MTSS both are part of the same continuum of functioning and intervention. (adapted from MO-CASE, 2017)

Speech-language pathologists have an important contribution to district-wide and school-wide activities that are aimed at ensuring that all students develop language skills appropriately (ASHA 1999; Ehren & Nelson, 2005; Moore-Brown & Montgomery, 2001). These contributions can be evident in the SLP's participation in school improvement teams, data teams, problem solving teams and professional learning communities.

SLPs in Missouri school districts should play an active role in participating with building and district level teams to develop processes and procedures to address the needs of students within this model. The American Speech-Language Hearing Association (ASHA) has recommended that SLPs be involved in all parts of the Response to Intervention (RtI)/MTSS process. Some activities include:

(1) completing screenings,
(2) participating in collaboration,
(3) creating classroom interventions, and
(4) identifying and utilizing evidence-based interventions for students who are identified as having needs that require tiered support (Ehren, Montgomery, Rudebusch, & Whitmire, 2006).

Involvement in RtI and MTSS is often referenced in terms of tiered systems of support. Examples of a speech-language pathologists involvement at each of these tiers is as follows:

Tier I - All Students; Core Classroom Instruction

SLPs participate on teams that consider the progress of the student body through involvement in school wide efforts to design and implement monitoring programs in the area of reading. As the results are analyzed at the grade and school levels, the team may plan activities aimed at improving targeted areas for the grade level or school.

The SLP's role in prevention at the grade or classroom level can include a variety of responsibilities. The SLP may be utilized in direct and/or indirect methods at this level. Direct methods may include the SLP working with an at-risk student or groups of at-risk students on

specific curricular areas. Methods may also include co-teaching or direct classroom teaching. Indirect methods may include consultation with other regular or special education staff on specific skills training or modifications within classroom environments.

Tier 2: Supplemental instruction to address skill deficits identified through periodic screening

The SLP may conduct more in-depth screenings at this level, analyze curricular materials for modifications, assist in making decisions for supports, provide short-term instruction in a small group of students with spoken or written communication needs.

Tier 3: Intensive intervention guided by data-based individualization

At the tier 3 level, the SLP may assist in providing more frequent and intense instruction for students with spoken or written communication needs.

After general education staff has implemented supplementary strategies with the support of special education consultation and progress continues to be minimal, a decision may be made to further evaluate a student's linguistic behaviors. Processes for students suspected of having language difficulties should be the same as the district uses when there are suspicions of other disabilities.

If an SLP is involved in the pre-referral process such as this early intervening model of response to intervention, it increases the likelihood that a student will be correctly identified for speech and language services. Some states have found that lack of involvement of the SLP at the pre-referral level results in inconsistent qualification for language services across schools or districts.

There are a few considerations with respect to screening, identification, progress monitoring and fidelity of implementation:

1. Screening and frequent progress monitoring drive the MTSS and are essential components. These assessments should be brief and reliable and provide quantifiable data that can be easily graphed. The primary function is to provide an indication of progress toward a general outcome, rather than as a diagnostic tool.
2. Data decision making rules for identifying students in need of intervention and expected rates of improvement for establishing rigorous but realistic goals must be in place for MTSS to be operational. A data team with a set meeting schedule and structured agenda for making instructional changes based on data is an essential component of MTSS.
3. The intervention procedures and programs used in MTSS should be those that have evidence of being effective with most students. Ideally, the evidence comes from experimental design research.
4. Clear procedures and tools for checking the fidelity of implementation for all components of the MTSS must be in place.

MTSS Links & Flowchart

These links may be helpful in learning more about MTSS:

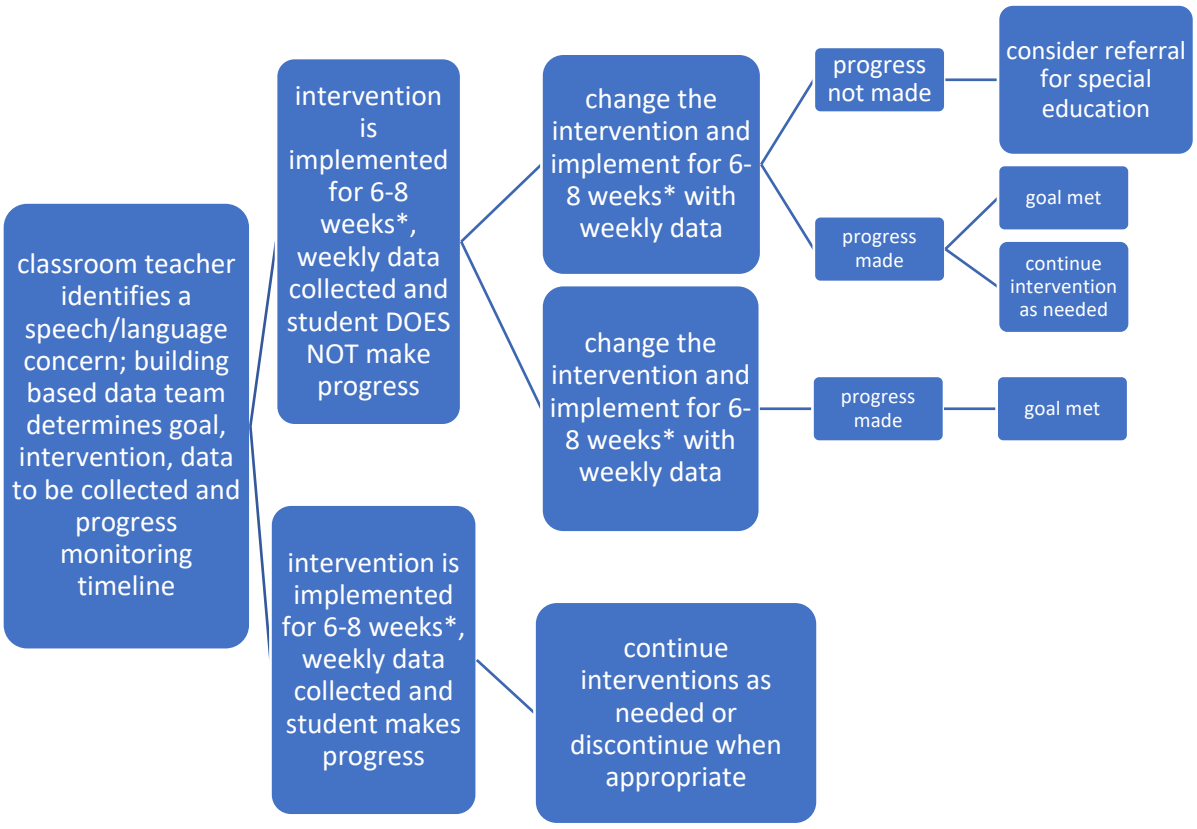
https://www.asha.org/slp/schools/prof-consult/rtoi/

https://leader.pubs.asha.org/doi/10.1044/leader.FTR1.23082018.44

https://dese.mo.gov/sites/default/files/RtIGuidelines08.pdf

https://www.asha.org/practice-portal

The flowchart below depicts a simplified process for MTSS:



*Intervention implementation is determined by procedures established by districts/buildings. In this flowchart, 6-8 weeks is merely a suggestion for a hypothetical intervention

Comprehensive Assessment & Evaluation

The terms assessment and evaluation are sometimes used synonymously. For purposes of this section, assessment means the process and instruments used during an evaluation of a student. Evaluation refers to the process under IDEA to determine special education eligibility.

The evaluation of a student to determine whether he/she has a speech-language impairment should be multifaceted and include multiple data sources (teachers, parents, students, other service providers), types of data (quantitative and qualitative), a variety of types of measures and procedures (authentic assessment strategies, criterion-referenced measures, norm-referenced tests, dynamic assessment procedures, etc.), and several environments (classroom, playground, home) as appropriate for each child. As a result of the evaluation, the eligibility team will need to have a complete picture of the student's communication abilities and needs.

A comprehensive speech-language assessment includes performance sampling across multiple skills, with multiple people using different procedures from varied contexts. The goal is to develop a picture of the communicative functioning in an educational program. Therefore, it is the responsibility of the school-based speech-language pathologist to assess the student using a variety of methods completed in a variety of contexts.

Norm-referenced tests are used as only one component to determine the possible presence of an impairment and are not achievement tests. Using norm-referenced tests for selecting goals or determining progress is not a valid practice.

It is critical that there not be an over-reliance on any one piece of information or assessment source in order to make an eligibility determination. It is also important that the tools selected accurately identify the presence or absence of a disorder. The appropriate interpretation of test results is also crucial, as past practices of cognitive referencing and the use of cut-off scores have been questioned in the literature and by the American Speech-Language-Hearing Association. Standard scores from norm-referenced speech-language tests should be only a small part of the assessment picture.

<u>Multiple Assessments</u>

A variety of measures and techniques must be used to determine eligibility or the presence of speech and language impairment. According to IDEA 2004, the determination of both a student's disability and eligibility for service must include, "...a variety of assessment tools and strategies..." (Section 300.304). In addition, IDEA 2004 mandates that "...no single procedure is used as the sole criterion..." for determining disability or eligibility for service (Section 300.304). A comprehensive assessment may include a variety of assessment procedures, such as: (a) input from teachers, parents, and the student; (b) review of relevant records and other information, (c) curriculum-based speech/language assessment; (c) dynamic assessment; (d) communication samples, narrative tasks, or portfolio assessment; (e) administration of standardized normative assessments; (f) observations of the student in the classroom

environment and (g) data collected from a response to intervention in a multi-tier system of support. These can be considered multiple assessments when documented in the speech and language evaluation report. Note that the requirement for multiple assessments is not interpreted as multiple standardized tests. This process can actually compound errors when attempting to correctly identify students with disabilities.

The requirements and guidelines vary widely across states. Some states do not use a specific cut-off or number of standard deviations. Those states that do have requirements used vastly different criteria. The committee involved in reviewing the current Missouri eligibility criterion and tasked with developing the proposed Missouri eligibility criterion surveyed several states and found a variety used including: 1.0 SD, 1.5 SD, 1.75 SD, and 2.0.

The practice for many years in the state of Missouri has been to use cognitive referencing. Speech-language pathologists are encouraged to educate themselves on the topic of cognitive referencing and why the goal of the proposed eligibility criterion is to move away from this practice. ASHA's website contains helpful information at: https://www.asha.org/SLP/schools/prof-consult/Cognitive-Referencing/.

Missouri currently has a requirement to apply eligibility criteria involving standard deviation criteria, and it remains in the proposed eligibility criteria. MSHA recommends that speech-language pathologists working in the schools familiarize themselves with standardized test technical manuals and the sensitivity and specificity of the currently available standardized tests. Sensitivity is the percent accuracy at identifying children with known disorders as having a language disorder. Specificity is the percent accuracy at identifying children with normal language and not having a disability. MSHA also recommends that school-based speech-language pathologists consider how standardized test results differ from performance in the classroom and other measures of educational assessment to ensure educational relevance.

Educational Relevance

In the educational model, a key feature of determining speech-language services is educational relevance. A speech-language pathologist is a critical member of a school-based data team. Decisions regarding evaluations are based on data in the general curriculum and the extent to which there is an "adverse effect on educational performance" in the general curriculum. The team determines what effect the impairment has on the student's ability to participate in the educational process. The educational process includes pre-academic/academic, social-emotional, and vocational performance (ASHA, 1999).

Medical Model vs. Educational Model

It is important for a school-based speech-language pathologist to recognize the difference of eligibility criterion related to the educational model rather than a medical model or clinical model for services. There are differences among criterion for various settings that are expected to be followed. Eligibility for services is based on the presence of a disability that results in the

student's need for special education and related services, not on the possible benefit from speech-language services.

Special Education Funding

Special education in Missouri is predominately funded with state and local dollars. Federal IDEA funding is only a small part of the cost of special education services (11% to 12%). The following provides a high-level overview of federal, state and local funding and any restrictions associated with such funding as relates to services provide by SLPs in the K-12 setting. Preschool services in Missouri are funded entirely with state and federal funds which is described in a separate section.

Federal IDEA Funding

When IDEA was first implemented, it allocated federal funding to states and school districts based on the "head count" of children who were identified as IDEA eligible. This created a financial incentive for children to be identified as IDEA eligible. Congress amended the funding structure of IDEA many years ago to instead allocate funds predominately on the basis of overall enrollment of students in a district with some adjustment for poverty. This effectively eliminated any financial incentive for schools to identify children as IDEA eligible.

Current federal funding is relatively small in comparison to the overall cost of special education services in Missouri school districts. As a result, most districts use their limited IDEA funds to support core special education services like self-contained special education classrooms or other clearly 100% special education services. As a result, the vast majority of special education staff, including SLPs, are NOT funded by IDEA dollars and do not have any restriction on the intervention or support services they can provide for students who are not IDEA eligible.

In a recent reauthorization of IDEA, a provision was added that allows for 15% of federal funding to be used for early intervening services (EIS) which are services provided for students who are not IDEA eligible. There are rather extensive reporting requirements associated with EIS however and most districts are able to easily allocate all of their IDEA dollars for special education services and choose to use non-IDEA dollars for such services.

State Funding

When special education first began in Missouri, there was categorical state funding (Exceptional Pupil Aid) that was allocated to districts based on each special education position employed. This created a financial incentive for schools to hire special education positions, especially those that paid the most, and these positions were restricted to only providing services to special education students since they were special education funded positions. Exceptional Pupil Aid was eliminated many years ago and there is no special funding associated now with special education positions. All core state funding is now allocated via the foundation formula (a complicated per pupil-based system). As a result, school staff (like SLPs) are not restricted to only serving students with disabilities because of state funding restrictions.

Local Funding

Local funding has never been associated with any special education services and there are no restrictions on how local funding can be used by a district.

Early Childhood Special Education (ECSE)

Special education services for preschool children (ages 3 through Kindergarten eligible) are funded with 100% state and federal dollars in Missouri (no local funds). The federal funds are IDEA dollars and the state funds are specially appropriated dollars exclusively for reimbursement of ECSE costs. Both are limited to supporting services for IDEA eligible children only.

This unique funding system occurred as the result of litigation under Missouri's constitutional requirement (Hancock amendment) that the state fully pay for any new mandate placed on local governmental entities like school districts. All staff, including SLPs, who are funded with ECSE dollars (federal or state) are relatively limited in providing services as stipulated in reimbursement guidelines from the Department of Elementary and Secondary Education. That is why there are extensive requirements for ECSE (like caseload standards) when there are none for special education services for school-aged students. Some districts do provide preschool services for preschool students who are not IDEA eligible with other funding sources (federal Title funding, Missouri Preschool Project state funding, etc.) In addition, districts can always use local funding to provide preschool services.

SLP Role Not Limited by Funding

Outside of the unique ECSE situation, SLPs in schools can and should be actively engaged in supporting both general and special education students in the areas of communication and literacy. SLPs can provide intensive interventions to remediate sound errors without identifying a student as IDEA eligible. They can provide phonemic awareness interventions for students who are struggling with foundational literacy skills even if those students are not IDEA eligible. SLPs should be part of general education teams implementing response to intervention and tiered interventions for students with language and literacy deficits.

The "Speech Room"

School personnel often have lingering questions about providing intervention services for students who are not IDEA eligible in a speech room or provide services in a group with other students who are IDEA eligible. Even if an SLP is 100% IDEA funded they can still serve IDEA eligible students along with non-IDEA eligible students in a small group as long as "they would already be performing these same duties in order to provide special education and related services to children with disabilities" Since most SLPs are NOT 100% IDEA funded, they certainly can provide interventions along with special education services to a mixed group of students (IDEA eligible and non-IDEA eligible).

For official guidance on the use of IDEA federal funds, please see the March 2013 Policy Letter from the Office of Special Education Programs.
https://sites.ed.gov/idea/idea-files/policy-letter-march-7-2013-to-troy-couillard/

Missouri's Speech/Language Eligibility Criterion as of July 30, 2019

The current criterion for the state of Missouri can be found at the following link to the state plan: https://dese.mo.gov/special-education/state-plan-special-education.

In addition, the standards and indicators can be found at the following link: https://dese.mo.gov/special-education/compliance/standards-indicators.

The current state plan eligibility criterion is as follows:

Speech or Language Impairment: Speech or Language Impairment means a communication disorder, such as stuttering, impaired articulation, language impairment, or voice impairment that adversely affects a student's educational performance.

A language impairment is present when a comprehensive communication assessment documents all of the following:

(1) The language impairment adversely affects the student's educational performance as documented by lack of response to evidence based interventions designed to support progress in the general education curriculum.

(2) The student's overall language functioning is significantly below age expectations as measured by two or more composite standard scores on standardized language assessments. The composite language score reflects both receptive and expressive language function in a single standard score. Significantly below is defined as 1.75 standard deviations below the mean for students who are kindergarten age eligible and older. A public agency may accept a second composite score allowing for the standard error of measurement when the criterion is met on the other composite score. The agency may adopt written procedures for utilization of reasonable variances that enable a student to meet the standard score criterion in highly unique situations such as English Learners.

(3) Young child with a developmental disability criteria (communication area) shall be used for eligibility determinations for children who are three (3) to five (5) years of age but not yet kindergarten eligible.

(4) The student consistently displays inappropriate or inadequate language that impairs communication in the student's educational environment as documented by structured qualitative procedures such as a formal language sample, classroom observations, curriculum based assessments, teacher/parent checklists/interviews, or other clinical tasks.

(5) The language impairment is not a result of dialectal differences or second language influence.

A Sound System Disorder, which includes articulation and/or phonology, is present when:

(1) The Sound System Disorder adversely affects the student's educational performance as documented by lack of response to evidence based interventions designed to support progress in the general education curriculum;

(2) The student exhibits a significant delay of at least one year in correct sound production based on the state designated normative data in the table below after administering a single word test and/or a sentence/phrase repetition task and a connected speech sample with consideration given to the type of error recorded (substitutions, omissions, distortions, and/or additions). These errors may be described as single sound errors or errors in phonological patterns. However, if the student does not exhibit a significant delay of at least one year in correct sound production, but there are multiple errors in the sound system which are collectively so severe that the student's speech is unintelligible, the public agency may establish the student as having a sound system disorder; and,

(3) The Sound System Disorder is not a result of dialectal differences or second language influence.

Phoneme	Chronological Age		Phoneme	Chronological Age		Word initial clusters	Chronological Age
/m/	3:0		/-f/	5:6		/tw kw/	5:6
/n/	3:6		/v/	5:6		/sp st sk/	7:0
/ŋ/ (ng)	7:0		/θ/ (th)	8:0		/sm sn/	7:0
/h/	3:0		/ð/ (th)	7:0		/sw/	7:0
/w/	3:0		/s/	7:0		/sl/	7:0
/j/ (y)	5:0		/z/	7:0		/pl bl kl gl fl/	6:0
/p/	3:0		/ʃ/ (sh)/	7:0		/pr br/tr dr/gr fr/	8:0
/b/	3:0		/tʃ / (ch)	7:0		/ θr/	9:0
/t/	4:0		/dʒ/ (j)	7:0		/skw/	7:0
/d/	3:6		/ʒ/ (zh)	8:0		/spl/	7:0
/k/	3:6		/l-/	6:0		/spr str skr/	7:0
/g/	4:0		/-l/	7:0			
/f-/	3:6		/r/	8:0			

A fluency impairment is present when a comprehensive communication assessment documents all of the following:

(1) The fluency impairment adversely affects the student's educational performance as documented by lack of response to evidence based interventions designed to support progress in the general education curriculum;

(2) The student's fluency is significantly below the norm as measured by speech sampling in a variety of contexts and impairs communication in the student's educational environment as documented by structured qualitative procedures such as classroom observations, curriculum based assessments, teacher/parent checklists/interviews, or other clinical tasks; and,

(3) The student consistently exhibits at least one of the following symptomatic behaviors of dysfluency:

a. sound, syllabic, or word repetition;
b. prolongations of sounds, syllables, or words;
c. avoidance;
d. blockages; or,
e. hesitations.

A voice impairment is present when a comprehensive communication assessment documents all of the following:

(1) The voice impairment adversely affects the student's educational performance as documented by lack of response to evidence based interventions designed to support progress in the general education curriculum;

(2) The student consistently exhibits deviations in pitch, quality, or volume;

(3) The student 's voice is discrepant from the norm as related to his/her age, sex, and culture and is distracting to the listener; and,

(4) The voice impairment is not the result of:

1. a medical condition that contraindicates voice therapy intervention;
2. a temporary condition such as: normal voice changes, allergies, colds, or other such conditions; or,
3. a dialectal difference or second language influence.

Questions & Answers Regarding the Updated Speech/Language Criteria

1. Why did Missouri recently change the Speech-Language (SL) eligibility criteria?

The previous Missouri criteria, especially Language Impairment, have not been updated in a very long time. In 2017, Missouri was the only state that continued to use cognitive referencing (a difference between cognition and language) as the criteria for IDEA eligibility in language impairment. One other state uses cognitive referencing for older children (9 and older) to align with the criteria for learning disabilities in the area of oral language but no other state uses such criteria for overall IDEA eligibility in the area of Language Impairment. Longstanding research has shown that cognitive referencing is an inappropriate approach to identifying language impairments in children.

2. How were recommendations for the new speech-language ("SL") criteria developed?

A few years ago, the Speech-Language Pathology (SLP) faculty of St. Louis University asked DESE to revise the SL criteria to eliminate cognitive referencing. A work group of SLPs from districts across the state along with representatives of Missouri Speech-Language-Hearing Association (MSHA), Missouri Council of Administrators of Special Education (MO-CASE), Missouri Association of School Psychologists, and DESE developed recommended changes to the SL criteria most of which are reflected in the proposed State Plan changes. The charge to this group was to ensure students identified as IDEA eligible under any of the four categorical SL criteria meets IDEA eligibility requirements – specifically the student has a documented disability (deficit) that adversely impacts their educational progress and requires special education services. The new criteria emphasize documentation of the availability of quality and robust general education services/interventions as necessary for determination of the adverse educational impact and need for special education. The work group recommendations were presented at multiple statewide conferences (MSHA, MO-CASE) and have been discussed at local professional development events across the state over the past three years.

3. Can the evidence-based interventions now required for all Speech-Language eligibility criteria be general education curriculum such as reading or math or do they need to be speech/language related?

Ideally, data from curricular areas (especially English-Language Arts/Reading) as well as speech and language areas would be readily available. Students who demonstrate a lack of response to interventions in a multi-tiered system of supports model especially in foundational literacy skills would meet this portion of criterion. For preschool children in districts who do not have any general education early childhood program, these interventions will be done at home, day care or other settings in which the child spends their day. The evaluation process for young

children in the area of speech and language will need to include provision of intervention recommendations and supports to families.

4. Who can provide evidence-based interventions?

The provider of evidence-based interventions will vary dependent on the intervention. Teachers, paraprofessionals, SLPs, SLP-Assistants, etc. could all provide different types of interventions based on their individual expertise. It is important to note that SLPs are not legally restricted to only providing services to IDEA eligible students unless the entire SLP position is funded with IDEA dollars. It is also important to remember that speech-language services that are billed for Medicaid reimbursement must be provided by SLPs who are NOT paid with IDEA funds. Given widespread Medicaid billing and the fact that IDEA only accounts for approximately 15% of special education costs nationally, it should not be a problem for LEAs to use non-IDEA funds for all SLP positions. While this Q&A cannot provide a comprehensive discussion of special education funding, outside of the unique early childhood special education (ECSE) funding situation in Missouri, there is nothing that prohibits an SLP from providing evidence-based interventions to school-aged students who are not IDEA eligible.

5. What comprehensive language tests have composite language scores inclusive of both receptive and expressive language function in a single standard score?

Without recommending or endorsing any specific commercial test, the following are examples of assessments that provide a composite standard score as described in the eligibility criteria - Comprehensive Assessment of Spoken Language, Clinical Evaluation of Language Fundamentals, Oral and Written Language Scales, Test of Integrated Language and Literacy Skills, and Test of Language Development. A similar overall receptive and expressive language score is required in the eligibility criteria for Young Child with a Development Disability (YCDD) and has been the requirement for a number of years. Districts should already have some language assessments identified they use to provide the overall language score required by the YCDD criteria in the area of communication. Note: Assessments which do not meet this composite score criterion may also be needed to gather information about an individual student's language development and functioning. Standardized assessments should be selected by the district and evaluator(s) as appropriate for the student.

6. Can a test like the Peabody Picture Vocabulary Test be used as a comprehensive language test score?

No. A test like the PPVT only considers vocabulary which is a single construct/system of language. A comprehensive test score for consideration of a disability would involve much more in-depth assessment than a vocabulary test. The revised LI criteria focuses on broad language deficits that will have a much greater impact on educational progress instead of deficits in discrete language structures.

7. Will fewer students qualify now as IDEA eligible in the category of language impairment?

A workgroup representing several districts throughout the state applied the new criterion to previous evaluations and found that the overall number didn't necessarily change. While some students who were identified as eligible using the current criteria would not be identified with the revised criteria, others who were determined not eligible previously would be now. The type of student who is eligible under the new comprehensive criterion is more likely to be a student demonstrating an actual language impairment which significantly impacts educational progress. These students may require more intensive direct services. While in some situations the number of students identified as eligible for services under IDEA may decrease, the level of service needed to provide a Free and Appropriate Public Education (FAPE) may increase. Particularly for districts that use a weighted approach to evaluate SLP caseloads, staffing needs should not be affected.

8. Is an IQ score required for LI eligibility determinations using the new criteria?

With elimination of cognitive referencing, a formal, standardized IQ score is no longer required as part of the eligibility determination for LI. The evaluation team will determine if formal assessment of that area of functioning is needed as part of the individual student's evaluation.

9. With cognitive referencing eliminated, can students now be "diagnosed" as both Intellectually Disabled (ID) and Language Impaired (LI)?

No. It is important to emphasize that schools do not use eligibility criteria to "diagnose" at all. Schools use the criteria to determine IDEA eligibility. Once a child is IDEA eligible, regardless of which criteria has been met, that process is finished and there is no reason to apply additional criteria for eligibility purposes (like making a secondary eligibility determination). Children who meet the criteria for the global condition of Intellectually Disabled should be identified under that category, rather than the specific category of Language Impaired.

It may be that a student identified under the category of Intellectually Disabled needs language services as part of the student's IEP in order to receive a FAPE. There are no eligibility criteria used to determine the need for related services. The IEP team decides what special education services are needed and related services are required for the student to benefit from special education. Assessment data should certainly be used to support decisions about the need for related services, but IEP teams should not be conditioning the provision of related services on meeting specific IDEA eligibility criteria. For example, the IEP team for a student who is determined to be IDEA eligible using ID criteria should decide what if any language goals and objectives will be part of the IEP and how those will be implemented through special education and related services regardless of whether or not that student meets LI eligibility criteria. Implementation of language goals for any IDEA eligible student is an IEP team decision and those goals may be implemented by an SLP or other providers as appropriate.

10. Why is there a recommendation to go back to one year beyond the normative data as eligibility for Sound System Disorder (SSD)?

Eligibility for Sound System Disorder indicates that the child has a disability under IDEA and that there is an adverse educational impact as described previously. The one year beyond benchmark aligns with the concept of an adverse educational impact and was the benchmark used originally when development sound norms were first adopted in Missouri. Districts can and should be providing general education interventions for children who have sound system errors at the developmental timelines of the Missouri Designated Normative Data. Children one year beyond are those who can be identified as needing "special education" and thus are IDEA eligible. For example, a child who has received general education interventions before age 9 for the /r/ sound that is not remediated by age 9 could continue interventions with or without changes in methodology and intensity or if a disability is suspected an IDEA evaluation could be conducted for eligibility determination.

11. How can schools serve children with speech delays that do not meet the criteria?

Children with speech delays that do not meet IDEA eligibility criteria may have access to general education intervention services, from an SLP or other appropriate provider, as part of the general education screening and intervention program (MTSS). There are many children who would benefit from speech intervention services but do not require special education as there is little to no educational impact from the speech delay. In fact, for many of these children it is problematic to find them disabled under the IDEA and provide services through an IEP for a condition which may be transitory and easily remediated. Services provided through the general education screening and intervention program may be implemented flexibly without the constraints and procedural requirements associated with an IEP.

12. Can a student who exhibits phonological processes be determined IDEA eligible?

A student who exhibits significant phonological processes can be IDEA eligible under Sound System Disorder if they meet the one year beyond criteria for at least one sound or if they have multiple errors that collectively render their speech unintelligible. Phonological processes in and of themselves are not used for sound system eligibility determinations. While there is no metric criteria for speech that is "unintelligible", districts are encouraged to establish consistent procedures for making this determination that are supported by documentation of how that unintelligible speech causes an adverse educational impact and the need for special education services. It is important to remember that sound system disorder (and all other) eligibility criteria are used to determine IDEA eligibility, NOT to dictate or prescribe specific intervention methodologies, placements or service delivery mechanisms.

13. Is a medical evaluation now required before a student can be determined IDEA eligible using the voice criteria?

The revised criteria do not necessarily require a medical evaluation, but they do require that the comprehensive assessment be able to verify that there is no medical condition that would contraindicate voice intervention. This is standard best practice in treatment of voice disorders and hopefully districts already have procedures in place that ensure this is part of the assessment process. Even though eligibility criteria do not apply to determination of the need for related services, if voice interventions are provided as a related service, best practice would include this same kind of documentation of no medical contraindication for such intervention.

14. Why was professional judgment eliminated in the eligibility criteria?

Professional judgment on the part of the speech-language pathologist, and other members of the evaluation team, is embedded throughout a comprehensive evaluation process. It is not intended to be utilized to override the qualitative and quantitative data produced during an evaluation. Careful record review across the state documented vast variability in how professional judgement was being utilized and extreme inconsistency in who was being determined eligible based on professional judgement. The revised criteria continue to allow for documentation of disability as variances within the quantitative portions of the eligibility criteria.

15. How do you apply SL eligibility criteria, especially any standardized test score requirements, to students who are learning English as a second language?

Both the current and the proposed revisions to SL eligibility criteria include a requirement that the language impairment or sound system disorder is NOT the result of a dialectal difference or second language influence. As a result, unless a student's lack of exposure to or lack of instruction in standard English can be ruled out as an influencing factor, the student will not meet the current or new LI or SSD eligibility criteria. Conversely, if it can be documented that a student has had sufficient exposure to and/or instruction in English so that those are not influencing factors, then using standardized assessments in English should provide valid information upon which to base an eligibility determination. Language intervention for students who are English language learners is best provided as targeted instruction outside of special education. It is important to remember that English language learners do not need to be IDEA eligible to receive language intervention services from an SLP as general education.

16. How do the changes in Speech/Language eligibility criteria impact eligibility determinations for young children not yet Kindergarten (K) eligible?

Most Missouri school districts opt to use both Young Child with a Developmental Disability (YCDD) eligibility criteria along with all of the categorical eligibility criteria in the State Plan for eligibility determinations for children not yet Kindergarten eligible. For districts who use categorical criteria in addition YCDD to determine eligibility for young children:

- There are no changes proposed to YCDD criteria in this State Plan. Those will be used with children not yet K eligible just as they are now.

- The proposed changes to sound system disorder, voice and fluency eligibility criteria in this State Plan will be used for children not yet K eligible as they apply across all ages.

- The proposed language impairment eligibility criteria do not apply to children not yet K eligible which is consistent with the current criteria. The revised LI criteria are only applicable to school aged eligible children because YCDD already establishes criteria for the developmental area of communication (overall receptive and expressive language) with a 2.0 standard deviation (SD) deficit requirement in that area alone or 1.5 SD deficit level requirement if paired with another developmental area. Applying LI criteria with a 1.75 standard deviation deficit to young children would create conflicting SD requirements for a deficit level in the same developmental area. The YCDD criteria are specifically applicable to young children and do not include the requirement for documentation of evidence-based interventions which is challenging when general education preschool is limited. Historically, the vast majority of IDEA eligible young children have been determined eligible using YCDD criteria (65%) and sound system disorder criteria (27%).

17. Will the new speech-language criteria reduce the number of 3-year-old children who will be IDEA eligible using the sound system disorder criteria?

If a district uses categorical criteria to identify young children as IDEA eligible then the earliest age a child will meet the normative criteria under sound system disorder is age 4 as these children demonstrate a disability and require specialized instruction which is the definition of IDEA eligibility. Three-year-old children who do not meet the normative criteria but who are "unintelligible" may be eligible if they meet all the other criteria including adverse educational impact and lack of response to evidence-based interventions.

18. What is "unintelligible" speech?

Speech intelligibility is a subjective, perceptual judgment that can vary across settings and other factors involved in communication between a speaker and a listener. "Unintelligible" speech means that the conveyed message is unable to be understood by an unfamiliar listener. For purposes of determining an adverse educational impact, unintelligible speech would be described as the student is unable to make basic wants and needs known through spoken communication. Frequently unintelligible speech creates a severe communication deficit with deficits in additional functional areas such as social, emotional, behavioral and general developmental which also serve to document an adverse educational impact. Students who are unintelligible would typically be considered candidates for alternative or augmentative communication to support the ability to communicate basic wants and needs at least on an interim basis.

19. How can districts provide evidence-based interventions for preschool students?

All of the revised SL categorical criteria require general education evidence-based interventions be provided as part of determining eligibility. Non-special education interventions can and should be available to support school aged and preschool children who are at but not yet one year beyond the developmental sound system norms. This could include providing interventions designed to be used by parents, day-care providers and others. Providing more robust interventions may be challenging for districts who have limited or no preschool services available outside of their early childhood special education (ECSE) program and its unique 100% state and federal special education funding structure. It is important to note that the YCDD eligibility criteria does not include this general education intervention requirement which makes it more aligned with Missouri's ECSE program and funding scheme.

20. How will the new SL criteria impact SLP caseload requirements.

There are no caseload requirements for any special education service providers (e.g. teachers, paraprofessionals, SLPs, PTs, OTs, etc.) for services for school-aged students. The ONLY caseload requirements are those associated with ECSE state/federal funding reimbursement. The changes to the SL eligibility criteria do not have any direct impact on ECSE reimbursement requirements as those are established by Special Education Finance. Questions specific to ECSE reimbursement standards, restrictions, and other specifics are best addressed by Special Education Finance staff.

Service Delivery Models

The service for speech and/or language on a student's Individualized Education Plan (IEP) must include 5 components (Missouri Office of Special Education Compliance Standards & Indicators/ Special Education Process). These include the following:

1. Specific special education **service** (i.e. speech or language)
2. **Amount of time** to be committed to each service
3. **Duration**
4. **Location** the service is delivered (i.e. special education classroom, regular education classroom, etc.)
5. **Frequency** delivering services

SLPs can use data that is collected through evidenced-based interventions and/or the evaluation process to determine best practice service models for individual students. Intervention data should be taken **frequently (further clarify how often/minimum?)** to judge the efficacy of the service delivery model and to adjust the model as needed to ensure student's progress towards IEP goals. Therapy service delivery models may consist of the following:

- Consultation (indirect) model
- Classroom-based model
- Community-based instruction
- Pull-out
- Telepractice

The consultative (indirect) service model consists of the SLP assisting the general education teacher in identifying classroom interventions or modifications for students. These interventions may be utilized either in addition to or in place of direct services by an SLP. Speech-language pathologists are skilled in helping school staff analyze, adapt, modify or create instructional materials.

The classroom-based model consists of the SLP providing speech and/or language therapy interventions to individual students or small groups of students within their general education and/or special education classroom settings. This model may also consist of the SLP co-teaching, or team teaching, with the general education or special education teacher using grade-level curriculum lessons and scaffolding to incorporate speech and/or language interventions with curriculum instruction. In this model, skills related to the classroom curriculum and carryover of speech/language skills are the intended focus.

The community-based instruction (CBI) model consists of supporting students that take part in work-related or community involvement experiences during their school day (e.g. structured

workshop, community outings to local businesses or events, etc.) with communication skills related to their speech and/or language IEP goals, as well as transition goals.

The pull-out service delivery model consists of pulling students from their general education classroom setting into a separate setting in order to provide more intensive speech and/or language therapy skilled intervention in either an individual or small group environment. This model is intended to be a short-term service delivery model as students work towards generalizing skills into other settings.

The telepractice service delivery model consists of "using technology to deliver professional services at a distance by linking professional to student or professional to professional for assessment, intervention, and/or consultation. Utilization of telepractice is governed by the Missouri professional licensing boards and by the policy, procedures, and practices for each profession (i.e. The American Speech-Language-Hearing Association, The American Occupational Therapy Association, The American Psychological Association, etc.)" (from Missouri State Plan). The SLP may provide speech and/or language therapy or consultation services using a secure web-based video conferencing/meeting system.

Roles and Responsibilities

In the school system, speech-language pathologists must be able to serve a range of students which includes students who are in general education to those with severe disabilities. Speech-language pathologists in the schools are expected to contribute to school goals for educational reform which includes preparation of communication skills necessary for college, the work place and society in general. Speech-language pathologists play a critical role in language and literacy development of students throughout their school career.

ASHA's board of directors created a position statement in 2010 with respect to the roles and responsibilities of school-based speech-language pathologists. This information can be found at: https://www.asha.org/policy/PI2010-00317/.

This document identified four components:

1. Critical Roles
2. Range of Responsibilities
3. Collaboration
4. Leadership

In order to implement these responsibilities, ASHA identified several factors as key components:

1. Role and Responsibility Realignment
2. Reasonable Workloads
3. Professional Preparation
4. Lifelong Learning

MSHA recognizes the roles and responsibilities of speech-language pathologists with respect to reading and writing. ASHA's position statement can be found at the following link: https://www.asha.org/policy/ps2001-00104/

The roles and responsibilities of speech-language pathologists in the schools are continuing to evolve.

Caseload/Workload

Caseload is a term often used when defining the number of students an SLP serves through direct and indirect services for students who have Individual Education Programs (IEPs), Individual Family Service Plans (IFSPs) and 504 plans.

Workload is defined as all the activities required to be performed by the SLP to fulfill all daily activities including the time spent providing services to students. The American Speech-Language-Hearing Association (ASHA) uses several factors to analyze factors related to caseload and workload and can be found at, https://www.asha.org/practice-portal/professional-issues/Caseload-and-Workload/. ASHA recommends a workload analysis approach to setting caseloads (ASHA, 2002).

In addition, characteristics of students should be taken in to account when determining the workload of an SLP. A student who receives services for articulation requires less planning, preparation and paperwork than a student who has an augmentative device and is physically and cognitively impaired.

Missouri does not set a minimum/maximum caseload for SLPs in the K-12 setting. However, ECSE SLPs should have a range of 35-50 students.

American Speech-Language-Hearing Association. (2002). *A workload analysis approach for establishing speech-language caseload standards in the school* [Position statement]. Available from https://www.asha.org/policy/PS2002-00122/

Medicaid Direct Services

In Missouri, the state Medicaid agency is called MO HealthNet Division (MHD) which is under the Department of Social Services. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate program, known as Healthy Children and Youth (HCY) in Missouri, ensures a comprehensive, preventative health care program for MO HealthNet eligible children under the age of 21 years. Under this mandate, school districts can seek MO HealthNet reimbursement for required therapies identified on the Individualized Education Program which includes Occupational Therapy, Physical Therapy and Speech-Language Therapy. MO HealthNet only reimburses for direct therapy services provided in accordance with the IEP; a school district cannot seek reimbursement for consultative services or meetings.

There are several requirements, by both MHD and under IDEA, that must be met before a school district can seek MO HealthNet reimbursement. Those requirements are as follows:

- The student must be eligible for MO Healthnet on the date of the service(s)
- The student must have an active IEP that requires the therapy service(s)
- The school district must obtain a one-time parent consent; see DESE model form Parental Consent to Access Public Insurance and to Release Personally Identifiable Information in order to access public insurance and release personally identifiable information
- The school district must provide annual written notification to parents of the districts intent to access their public benefits; see DESE model form Parental Notification to Access Public Insurance
- The school district and each therapy provider must be enrolled with MO HealthNet as active providers
- The student must have an annual prescription for Occupational, Physical and/or Speech-Language therapy services as required by the IEP

Speech-language pathologists working in Missouri districts will be directed to a point person within the actual school district who will assist the speech-language pathologist with items related to medicaid and billing.

National Provider Identification (NPI) Number

A therapist needs to apply for this in order to be able to bill medicaid. This number is the responsibility of the therapist and needs to be revalidated every 5 years.

Telepractice Medicaid

The law is not clearly defined indicating that any healthcare provider and service may be covered. It is left up to interpretation and/or will be determined by Medicaid. Clinician will have to contact Medicaid to determine if and how telepractice is covered.

SB 579

This act defines "telehealth" or "telemedicine" as the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth shall also include the use of asynchronous store-and-forward technology. Any licensed health care provider shall be authorized to provide telehealth services if such services are within the scope of practice for which the health care provider is licensed and if such services are provided under the same standard of care as services provided in person. Additionally, no originating site shall be required to maintain immediate availability of on-site clinical staff during the telehealth service, unless such is necessary to meet the standard of care for the treatment of the patient's medical condition when the treating health care provider has not previously seen the patient in person in a clinical setting, is not located at the originating site, and is not providing coverage for a health care provider with an established relationship with the patient.

http://www.asha.org/Advocacy/state/info/MO/Missouri-Telepractice-Requirements/

Additional resources regarding telepractice may be found in the special sections section of this handbook.

SLP Certification and Licensure

Important: The Missouri Speech-Language-Hearing Association is NOT a licensing agent. MSHA supports ASHA, the State Board of Healing Arts, and the Department of Elementary and Secondary Education, the agencies which license or credential professionals.

ASHA Certification Procedures

To obtain ASHA certification, individuals must submit a completed application, supporting documents, and the appropriate dues and fees. All applicants for certification must meet the currently published speech-language pathology standards and follow the published policies and procedures (2014 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology). Individuals who are in the certification process must abide by ASHA's Code of Ethics.

An application will be accepted after all the necessary academic course work and clinical practicum hours have been completed and after the required graduate degree has been awarded from a CAA-accredited academic program or a program admitted to CAA candidacy. As of August 2017, the following Missouri programs are accredited:

Fontbonne University, St. Louis, Missouri
Maryville University, St. Louis, Missouri
Missouri State University, Springfield, Missouri
Rockhurst University, Kansas City, Missouri
Saint Louis University, St. Louis, Missouri
Southeast Missouri State University, Cape Girardeau, Missouri
Truman State University, Kirksville, Missouri
University of Central Missouri, Warrensburg, Missouri
University of Missouri, Columbia, Missouri
Washington University, St. Louis, Missouri

An application should not be submitted if the degree has not been awarded. An application may be submitted before, during, or after the Clinical Fellowship experience. Remember that a Clinical Fellowship cannot be initiated if the academic course work and clinical practicum hours have not been completed.

Results of the Praxis Examination in Speech-Language Pathology submitted for certification directly to ASHA from ETS and must have been obtained no more than 5 years prior to the submission of the certification application. Scores older than 5 years will not be accepted for certification. Please refer to the ASHA website for more information.

State Licensure Procedures

SLP must be licensed to practice in the State of Missouri by the Board of Healing Arts (BoHA) pursuant to Missouri statute, Chapter 345. The basic requirements for SLP licensure are a Master's degree in SLP from an accredited program, passing score on the Praxis exam, completion of the application form and submission of required application fees, see https://pr.mo.gov/healingarts-application-forms.asp . The application form and instructions can be accessed at http://pr.mo.gov/boards/healingarts/375-0434.pdf . And a complete copy of the SLP licensure law and rules can be found at, https://pr.mo.gov/speech-rules-statutes.asp

There are only a few exceptions to the requirement for licensure to work in Missouri. One exception is for an SLP employed by a federal agency. Another is for an SLP employed by a public school but ONLY if they hold a current valid DESE SLP certificate that was NOT issued based on holding a valid BoHA license. If you hold a DESE certificate it is critical for you to know if that certificate was issued to you because you held a valid licensure or if you were issued that certificate as stand-alone credential (not connected to your license). If it was issued as a stand-alone credential it is likely a Speech-Language Specialist certificate or maybe even a Speech Correction certificate that was issued many decades ago. (See next section for more detailed information.)

State Board of Education Student Services Certificate

As of August 1, 2019, the Department of Elementary and Secondary Education (DESE) stopped issuing the Initial Student Services Certificate in SLP to any individual who holds an unencumbered, undisciplined license from the Board of Healing Arts. For the last decade or more DESE has only issued its SLP certificate conditioned on and coupled to an individual holding licensure. All of the DESE certificates that are coupled to licensure are valid only as long as the license is valid. If you hold a "coupled" DESE certificate and you let your license lapse, your DESE certificate is invalid.

A DESE certificate has not been required to work in the schools since approximately 2008 as long as the SLP holds a BoHA license. For those SLPs who hold a DESE certificate, be sure to keep track of your renewal dates and continue to renew those certificates with DESE.

Certification of School Speech-Language Pathologists
Frequently Asked Questions and Answers (FAQ)

1. What credentials are available to school Speech-Language Pathologists (SLPs)?

On August 1, 2019 the Department of Elementary and Secondary Education (DESE) discontinued issuance of the Initial Student Services Certificate in Speech-Language Pathology. The Speech-Language Pathology license issued by the Missouri Board of Healing Arts is now the universal credential for working in all settings including public schools.

An SLP may hold a DESE certificate issued prior to August 1, 2019 that continues to be a valid credential for working in the schools (with or without a license). DESE SLP certificates may stand alone or may be coupled with (and dependent on) holding a valid Board of Healing Arts license. Typically, the Student Services Certificate in SLP is only valid as long as the SLP maintains a valid, "unencumbered" Missouri SLP license from the Board of Healing Arts. The prior DESE certificates, Speech-Language Specialist and Speech-Language Correctionist, were issued as stand-alone credentials and are not conditioned on holding a valid Missouri SLP license.

2. What credential does an SLP working in the public schools need?

SLPs can work in the schools with only their Board of Healing Arts (BHA) SLP License. SLPs can also work in the schools with a valid DESE SLP Certificate which could be a stand-alone credential (valid without a BHA license) or could be a DESE SLP Student Services Certificate that is only valid with a current BHA license.

3. What happens if I employ someone fully qualified who does not yet have their BHA SLP License while their licensure application is being processed?

They should not provide speech-language services until their license is issued. Missouri state law (RSMo. 345.025) prohibits anyone from practicing speech-language pathology without a Missouri license. The only exception in the law is for an individual who "holds a current valid certificate as a speech-language pathologist issued by the Missouri department of elementary and secondary education and who is an employee of a public school while providing speech-language pathology services in such school system." A person working as an SLP in the public schools without a valid BHA SLP license must have a valid DESE SLP certificate that stands without licensure (most likely a Speech Language Specialist or old Speech Correctionist Certificate) or they will be violating state law and it will be difficult for them to obtain their BHA SLP license because they practiced in violation of the licensure law. This includes individuals who do have their Masters degree in SLP, have passed the Praxis exam, and may even hold the Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA).

4. Is there any temporary credential available while an individual is waiting for their BHA SLP licensure application to be completed?

NO. It is important to remember that an individual MUST have either a valid BHA SLP License or a valid DESE SLP Certificate to work as an SLP in public schools. A Temporary Authorization Certificate (TAC) or other DESE education credential does not satisfy the statutory exemption requirement for a person to hold a DESE SLP credential and working with such would be a violation of the licensure law.

5. Does an SLP need to keep their BHA SLP Licensure current even if they also have a DESE SLP Certificate?

Mostly likely yes!! If the DESE credential is the Student Services SLP Certificate it was probably issued based on holding a BHA SLP License and the two credentials are forever linked so that the DESE credential is **ONLY** good if the BHA SLP License is also valid. If the SLP holds an older stand-alone DESE credential, then they do not need a valid license to work in public schools. The safest course is for all SLPs who are eligible for licensure to get a BHA license and keep it current. This also provides more flexibility and options for working after retirement and working outside public school employment where a BHA license is mandatory.

6. What are the renewal requirements for the BHA SLP License?

The BHA SLP license must be renewed every three years. Thirty hours of continuing education must be obtained in each three-year renewal cycle, of which a minimum of 20 hours must be provided by an approved organization such as DESE, Council for Exceptional Children or Missouri Speech-Language-Hearing Association. See http://pr.mo.gov/speech-rules-statutes.asp for more information. Please note that ASHA Certificate of Clinical Competence renewal is also on a three-year cycle but these renewal periods will not necessarily align for an individual SLP.

7. What are the renewal requirements for the DESE SLP Certificate?

For those individuals who obtained their DESE SLP Certificate by holding BHA SLP Licensure, the renewal requirements of the BHA SLP License must be followed. The Initial Student Services Certificate (issued based on the full BHA SLP License) is valid for 4 years. DESE reviews the licensure registry to confirm that the individual is maintaining their BHA SLP License and after 4 years with an Initial Certificate, the Career Student Services Certificate is issued (a 99-year certificate) which is valid so long as the BHA SLP License is kept valid. DESE issued Speech Language Specialist and Speech Correctionist certificates had their own renewal cycle and requirements. Individuals holding those credentials should all be at the maintenance level (continuous or lifetime validity).

8. If a person holds an out-of-state SLP License, do they qualify for a Missouri BHA SLP License based on reciprocity?

Yes, so long as the other state's licensure requirements are substantially similar to the Missouri BHA SLP License requirements or the person holds a current ASHA CCC in SLP. However, an individual CANNOT practice in Missouri until the BHA SLP license has been issued.

Continuing Education Requirements for Missouri Licensure

In 2019, the Missouri BoHA SLP licensure renewal cycle was changed to require 30 clock hours of continuing education in a 3-year period which will align with a new licensure renewal period of every 3 years. The period had previously been every two years. Of the required 30 clock hours, a minimum of 20 must be approved or sponsored by one of a list of approved entities and organizations including:

- Department of Elementary and Secondary Education (DESE)
- Council for Exceptional Children (CEC) – includes MO-CASE and all other CEC divisions
- American Speech-Language-Hearing Association (ASHA)
- Missouri Speech-Language-Hearing Association (MSHA)
- Missouri Academy of Audiology (MAA)
- American Medical Association (AMA)
- National Center for Hearing Assessment and Management
- Centers for Disease Control
- National Institute on Deafness and other Communication Disorders
- American Academy of Otolaryngology-Head and Neck Surgery
- American Academy of Pediatrics
- American Academy of Audiology (AAA)

A full list of organizations who can provide these 20 hours can be found on page 5 of the Rules previously cited.

The other 10 hours can be provided by any entity as long as the content is appropriate to the profession and documented by a third party such as a school district or the association or organization providing the professional development hour(s).

Academic coursework at a regionally accredited college or university in subject matter can also be used to satisfy the 30-hour requirement. Appropriate areas of academic study include basic communication processes, information pertaining to disorders (speech, language hearing), or related areas pertaining to the understanding of human behavior, theories of learning, professional ethics, clinical supervision, counseling, and interviewing.

Continuing Education Requirements for ASHA Certification

ASHA CCC renewal requires 30 clock hours of continuing education in a 3-year period which again corresponds to the renewal period for the CCC. (Please note that the CCC 3-year renewal period may not be the same as for Missouri licensure.) These 30 hours can be anything that

supports the SLP in providing speech language services. There is no specific list of organizations that must sponsor a specific number of these clock hours. The documentation requirements are almost identical to those for the state license, i.e. the clock hours must be documented by a third party which can be the school district or the entity/organization providing the professional development with information about the content, date, and clock hours attended. Beginning with the 2020-2022 certification maintenance interval, certificate holders will have to earn 1 of their 30 required certification maintenance hours (CMHs) in Ethics as well as 2 hours in supervision prior to supervising a clinical fellow, graduate student or SLP-A.

Supervision

According to ASHA's Position Statement by the Committee on Supervision for Clinical Supervision in Speech-Language Pathology and Audiology, November 1984, 13 tasks of supervisors and competencies of effective supervisors are addressed. https://www.asha.org/policy/PS1985-00220/ Specific supervision guidelines for school based SLP supervising duties are outlined below.

Graduate Student Supervision Requirements

Supervisor: A graduate student supervisor must maintain their Certification of Clinical Competence in Speech Language Pathology. Supervision of students must be provided by a clinical educator who holds ASHA certification in the appropriate profession, who has the equivalent of a minimum of 9 months of full-time clinical experience, and who has completed a minimum of 2 hours of professional development in clinical instruction/supervision after being awarded ASHA certification.

Role: The supervisor's role changes from directive to more collaborative during the supervision time block, however, the "supervisor is ultimately responsible for the primary management of the caseload." Universities often provide guidelines about specific requirements for observation and paperwork. The Basics of Supervision **Wren S. Newman** ***The ASHA Leader***, August 2005, Vol. 10, 12-31. doi:10.1044/leader.FTR4.10102005.12

Frequency specification: According to ASHA, "Direct supervision must be in real time and must *never be less than 25% of the student's total contact with each client/patient and must take place periodically throughout the practicum.* These are minimum requirements that should be adjusted upward if the student's level of knowledge, experience, and competence warrants." Additionally, "the amount of supervision must be appropriate to the student's level of knowledge, experience, and competence. Supervision must be sufficient to ensure the welfare of the client/patient."

Clinical Fellow Supervision Requirements

According to ASHA,

Supervisor: ASHA does not provide a specific amount of years of experience required to supervise a clinical fellow, but the supervisor should have sufficient knowledge and competency in the disorders and population in which they will be supervising. Refer to the ASHA Ethics Statement on supervision for more detailed information.

Certification: ASHA requires the supervisor to hold their Certificate of Clinical Competence (CCC).

Documentation: For specific information regarding documentation please review the SLP Clinical Fellowship Handbook. Also, the Clinical Fellowship Report and Rating Scale, includes the Clinical Fellowship Skills Inventory (CFSI) for Speech-Language Pathology and it provides evaluation and direction for fellows.

SLPA Supervision Requirements

According to MO Board Healing Arts 2013 - The Missouri Department of Elementary and Secondary Education does not certify or register Speech-Language Pathology Assistants. All registration and enforcement is conducted through the Missouri State Board of Healing Arts. The State Board can be contacted at https://pr.mo.gov/healingarts.asp. The Rules for registration of SLP-Assistants can be found at https://www.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c2150-4.pdf

Supervisor: The supervising SLP has the responsibility of

- Ensuring and protecting the interests of all patients, clients, or students at all times that the assistant is practicing or interacting with them. This responsibility includes both the supervisor's and the assistant's compliance with ethical standards of practice specified in rule 20 CSR 2150-4.080.
- Verifying assistants' Missouri registration
- Assuring assistants are practicing within the "approved scope of practice"
- Assuring assistants are trained and qualified to complete all that is requested of them by the supervising SLPs

Frequency specification:

- Direct supervision* must be provided for the initial SLPA contact with a patient
- Further direct supervision must be provided for each assistant minimally one hour per week or one of every three sessions for each patient, client, or student.
- Supervising SLP must be available to the SLPA for assistance or guidance (e.g. email, phone, etc.)
- If unavailable, another SLP qualified for supervision can be appointed. Documentation must be provided to the SLPA about the alternate.

*"Direct supervision is real-time observing and viewing the assistant and each patient/client/student when treatment is being provided. If an alternative arrangement is necessary, the supervising SLP must submit a proposed plan for the review of the advisory commission."

Documentation: The supervising SLP provides:

- Roles and functions of the SLPA in writing and retain this documentation for 8 years

- Written direction for continuing education activities to the SLPA
- A signature of the SLP-A's log of hours each month and all progress reports

Speech Implementer Supervision Requirements

DESE provides a Speech Implementer web page which includes the following:

- Speech Implementer Model Approval Application - form required annually to request approval to use the model with documentation that the district is unable to hire an SLP, SLP-A, or use teletherapy to provide required IDEA services. This form must be signed by the superintendent. (New for the 2020/2021 School Year.)
- Speech Implementer Model District Plan – required form accompanying the approval application that outlines specific activities that the supervising SLP and speech implementer perform, the training and supervision for the speech implementer, how program effectiveness will be monitored, and any adjustments of the SLP's job responsibilities due to using the Speech Implementer Model. This form must be signed by the supervising SLP. (New for the 2020/2021 School Year.)
- Speech Implementer Model – Requirements for Implementation – Narrative description of all the requirements for utilizing the Speech Implementer Model.
- Telepractice Guidance – overview of considerations and best practices in providing speech-language services via telepractice (developed by the Missouri School Boards' Association Medicaid Consortium).

Supervising SLP Qualifications: The supervising SLP must hold either a current Missouri certificate through DESE as a speech-language pathologist and/or a valid SLP license through the Board of Healing Arts and has been practicing as an SLP for at least one year.

Requirements specific to the supervising SLP:

1. A Speech Implementer Model District Plan must be developed and submitted to DESE. It will need to outline specific activities that both parties perform, the training and supervision for the speech implementer, how program effectiveness will be monitored, and any adjustments of the SLP's job responsibilities due to using the Speech Implementer Model. In addition to the requirements specified on the Speech Implementer Model District Plan and in the Standards and Indicators Manual, there may be additional activities that the SLP determines critical to the implementation of the program in the public agency. Those activities should be included in district plan. It is important that the description include the procedures the public agency has chosen to use to document the interaction between the SLP and the students seen by the implementer as well as the specific activities assigned to the implementer by the SLP. The implementer can only perform those activities for which he/she has been trained and receives appropriate supervision from the SLP.

2. Program supervision and training of the Speech Implementer in all assigned activities and periodic direct therapy sessions with the students served by the implementer.

3. Evaluation activities are the responsibility of the supervising SLP. Other qualified public agency diagnosticians may conduct assessments needed to determine eligibility for an IEP. An SLP is a required member of the eligibility determination team when speech and/or language disabilities are considered the primary disability category. The implementer may, at the discretion of the supervising SLP, be trained to administer certain screening instruments. However, the SLP must administer any procedure involving judgment decisions based upon student response.

4. IEP development is the responsibility of the SLP and includes writing, developing, and modifying the IEPs of all supervised students. The SLP is a required participant for all IEP meetings when speech and/or language services are considered.

5. Direct supervision by the SLP with each student on the implementer's caseload is required. The SLP is required to provide direct supervision (real-time observing/viewing of Speech Implementer and student) for initial student contact and provide continuing supervision of a minimum of one hour per week or one out of every three sessions thereafter. This interaction between the SLP and the SI's caseload must be documented in the Speech Implementer Model District Plan. One SLP can supervise a maximum of 3 full-time equivalent speech implementer positions at one time.

6. Periodic direct therapy by the SLP with each student on the implementer's caseload is required. The SLP is required to conduct periodic direct therapy sessions with the children assigned to the implementer. Through these periodic direct therapy sessions, the SLP will monitor progress, assess current needs, and evaluate the effectiveness of the program. This interaction between the SLP and the students must be documented in the Speech Implementer Model District Plan.

7. If the supervising SLP is employed by the public agency to provide direct services to a specific caseload of students, that caseload must be reduced to allow for the additional assessment, IEP responsibilities, and training/supervision for the implementer. If the supervising SLP is serving the public agency in some capacity other than as an SLP (e.g., administrator, process coordinator, teacher), those duties must be adjusted to allow for the additional responsibilities associated with the Speech Implementer Model. Finally, if the supervising SLP works for the public agency through a private contract, that individual's other responsibilities must be considered when determining the number of students, she/he will be available to supervise. For example, an SLP employed in public agency A and serving a full caseload in that public agency would not be available to public agency B to serve as the supervising SLP. With a full caseload in public agency A, the SLP would not have sufficient time to perform the duties required with this model during the regular school day.

Tele-supervision

"Tele-supervision, or e-supervision, refers to the use of two-way digital video conferencing technologies for the purpose of clinical supervision." In addition, it is important to note that "people engaged in e-supervision must be aware of and adhere to all ASHA requirements for supervision and certification as well as state requirements. State requirements for student supervision may differ from those of ASHA (2008)." -http://www.asha.org/Articles/Focusing-in-on-Tele-supervision/ 12/2012 by Carol C. Dudding, PhD, CCC-SLP

https://www.asha.org/Advocacy/state/info/MO/Missouri-Telepractice-Requirements/

Laws/Regulations: The use of tele-supervision is permitted for the below identified support personnel with prior approval. Missouri has no specific laws/regulations for the use of tele-supervision for the following: clinical fellows and student interns.

Tele-supervision of:

- Speech-Language Pathology Assistant

20 CSR 2150-4.201 Supervision Requirements [PDF]

"The supervising speech-language pathologist shall directly supervise the assistant's initial contact with each patient/client/student. Thereafter, direct supervision shall be provided for each assistant supervised a minimum of one (1) hour per week or one (1) out of every three (3) sessions for each patient/client/student. Direct supervision is defined as real time observing and viewing the assistant and patient/client/student when the treatment is being provided. *If an alternative arrangement is necessary,* the supervising speech-language pathologist must submit a proposed plan of supervision for the review of the advisory commission and board to determine if the supervision plan is acceptable. Supervision shall be distributed across the patient/client/student caseload as appropriate to ensure adequate oversight."

For further guidance, contact the following possible agencies such as universities, clinical settings, ASHA, state licensure boards, and state and federal laws and regulations.

SLP Retired from PSRS
Work after Retirement Summary

Missouri state laws have a unique impact on work after retirement for SLPs who retire from the Public School Retirement System (PSRS). The following provides an overview of these statute provisions and the options for work after retirement from PSRS for an SLP.

- **SLPs who hold ONLY a DESE SLP credential can only be employed by a public school and cannot work as an independent contractor or for a third part employer providing SLP services.**

  Explanation: The Speech Language Pathology Practice Act (RSMo 345.025) restricts an SLP who only holds a DESE SLP credential (Speech-Language Correctionist, Speech-Language Specialist, or SLP Student Services Certificate) to employment with a public school. A Board of Healing Arts SLP license is required to work as independent contractor or as a third-party employee providing speech-language services in any setting including public schools.

- **An SLP retired from PSRS who has their Board of Healing Arts SLP license can work any amount of time as an independent contractor or third-party employee in a public school and receive their PSRS benefit at the same time.**

  Explanation: SB 62 (2017) limited work after retirement for all PSRS retirees to 550 hours / 50% of compensation regardless of how they are working for the district (as a direct employee, as an independent contractor or for a third-party employer) when the PSRS retiree is working in a position that requires a DESE credential. For most PSRS retirees this means they are limited to the 550 hour/50% compensation level regardless of how they work after retirement.

  Since the SLP position does not require a DESE credential, an SLP retired from PSRS who provide speech-language services for a public school can do so <u>for any number of hours and any amount of pay so long they are an independent contractor or an employee of a third-party employer</u> (e.g. Kelly services, a medical center or clinic, etc.) However, to work as an independent contractor or an employee of any organization/company other than a public school, an SLP must hold a MO Board of Healing Arts (BoHA) SLP license pursuant to RSMo 345.025.

- **An SLP retired from PSRS who does not have (and cannot obtain) their Board of Healing Arts SLP license can only work as a direct public school employee and will be limited to a $15,000 pay cap if they receive their PSRS benefit at the same time.**

  Explanation: SB 892 (2018) limits PSRS retirees who work after retirement as district employees in positions that do not require a DESE credential to a $15,000 cap in pay. While not specific to SLPs, this means that an SLP retired from PSRS employed directly by a district as an SLP will be limited to the $15,000 cap in pay to retain their PSRS benefit at the same time. Because the SLP position does

not require a DESE credential, a PSRS retiree cannot work in that position as a district employee under the 550 hour and 50% compensation limit after August 28, 2018.

NOTE: New SLPs who retire from PEERS will be subject to the 550 hour / 50% compensation cap on their work after retirement.

ASSISTIVE TECHNOLOGY AND AUGMENTATIVE AND ALTERNATIVE COMMUNICATION

Information for this section of the handbook has been obtained from the American Speech Language Hearing Association (ASHA) website, information from the Individuals with Disabilities Education Act (IDEA), and the Student Environment Tasks Tools Framework (SETT): The SETT Framework created by Joy Smiley Zabala, Ed.D.

Federal and state laws require an Individualized Education Program (IEP) to consider whether a child needs assistive technology devices and services. When considering technology and student needs, the broader term *assistive technology* may be used to address technology needs in all skill areas while the term *augmentative and alternative communication* may be used to specifically address technology needs for communication. This special considerations section is divided into parts. The first part addresses assistive technology and the second part addresses augmentative and alternative communication.

ASSISTIVE TECHNOLOGY (AT)

As defined in IDEA 2004, assistive technology devices are "…any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, customized, that is used to increase, maintain, or improve functional capabilities of individual with disabilities". (Authority 20 U.S.C.1401(1)).

As defined in IDEA, an assistive technology service is "…any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device**". As stated in IDEA, assistive technology services are provided to assist in the *selection, acquisition,* and *use* of an assistive technology device.** (Authority 20 U.S.C.1401(2)).

TOOLS FOR GATHERING AND ORGANIZING DATA

- The Student Environment Tasks Tools Framework (SETT): The SETT Framework (www.joyzabala.com)
- The Assistive Technology Resource Guide (2013) by OCALI: https://www.ocali.org/up_doc/AT_Resource_Guide_2013.pdf

ASSESSMENT TOOLS

- The Wisconsin Assistive Technology Initiative (WATI) Assistive Technology Assessment Guide (www.wati.org)
- The Georgia Project for Assistive Technology (GPAT) (www.gpat.org)
- The Oregon Technology Access Program (OTAP) (www.otap-oregon.org)
- Assistive Technology Internet Modules (ATIM) (www.atinternetmodules.org)

CONSIDERING SOLUTIONS

When considering the most appropriate AT solution, the IEP/AAC assessment team should select the option that most appropriately meets the student's needs. When considering assistive technology solutions, it is important to feature match. This process involves matching the features of tools and strategies to the student's unique strengths, abilities, and needs. The following are resources to use in consideration of solutions:

- The SETT Scaffold for Tool Selection (Feature Match) (www.joyzabala.com)
- The SETT Scaffold for Consideration of AT Needs (www.joyzabala.com)
- The WATI Assistive Technology Consideration Guide (https://iris.peabody.vanderbilt.edu/wp-content/uploads/modules/at/pdfs/at_04_link_WATI.pdf)
- The WATI Assistive Technology Assessment Checklist (www.wati.org)
- The GPAT Assistive Technology Consideration Resource Guide (www.gpat.org)

KEEP IN MIND: ASSISTIVE TECHNOLOGY FOR ONE STUDENT MAY JUST BE TECHNOLOGY FOR ANOTHER

AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC)

"Augmentative and alternative communication (AAC) is an area of clinical practice that attempts to compensate (either temporarily or permanently) for the impairment and disability patterns of individuals with severe expressive communication disorders (i.e., those characterized by severe impairments in speech, language, reading, and writing)." (www.asha.org). If communication is not functional, an AAC system should be considered.

AAC: KNOWLEDGE AND SKILLS FOR SERVICE DELIVERY

Information discussing the roles, knowledge base, and skills necessary for SLPs to provide a continuum of services to individual with limited natural speech and/or writing can be found at www.asha.org.

ASSESSMENT

AAC assessment and intervention is a dynamic process. The goal of the initial assessment is to design an initial system to meet the AAC user's current needs and abilities. The assessment process does not stop at this point; it is continually refined as the intervention is implemented and the users become familiar with the AAC techniques. There are many tools available to gather information for an AAC assessment. Careful consideration needs to be made regarding the needs of the student when selecting tools for assessment.

In the second phase of the assessment, a communication system must be developed that will support the user as they prepare to transition to new settings. The final phase of the assessment must help maintain an AAC system that meets the changing needs and abilities of the user. The

amount of follow-up necessary will depend on the stability of the user's abilities and life-style (Beukelman & Mirenda, 1992).

TEAM COLLABORATION SKILL DEVELOPMENT

No one professional is involved in an AAC assessment. It is a team process. Quality Indicators for Assistive Technology (QIAT) includes quality indicators, intent statements, and common errors for eight areas important to the development and delivery of assistive technology services. The eight areas include:

- Consideration of AT needs
- Assessment of AT needs
- AT in the IEP
- AT Implementation
- Evaluation of Effectiveness of AT
- AT in Transition
- Administrative Support for AT
- AT Professional Development

In addition, a set of self-assessment matrices have been developed for all of the Quality Indicators. These Matrices are designed to allow individual service providers and school districts to assess their current practices and plan for improvement: https://qiat.org/indicators.html

ASSISTIVE TECHNOLOGY INTERNET MODULES (ATIM)

ATIM provides high quality information and professional development on assistive technology (AT) for educators, professionals, families, persons with disability, and others. Each module guides you through case studies, instructional videos, pre- and post-assessments, a glossary, and much more. ATIM modules are available at no cost from: www.atinternetmodules.org

FEDERAL AND STATE REGULATIONS

Federal and state regulations can be found on the Missouri Department of Elementary and Secondary Education (DESE) website: www.dese.mo.gov

ADDITIONAL RESOURCES

MEDICAID APPROVED EVALUATION SITES

- **KANSAS CITY AREA**
  - The Rehabilitation Institute, Kansas City (816 751 7900)
- **MID MISSOURI AREA**
  - Ozarks Medical Center, West Plains (417 257 5959)
  - Theracare Outpatient Services, LLC, Springfield (417 890 4656)
  - Mizzou Therapy Services, Columbia (573 884 2642)

- **ST. LOUIS AREA**
  - Fontbonne University, St. Louis (314 889 1407
  - The Learning Center, Florissant (314 953 4995
  - The Rehabilitation Institute of St. Louis, St. Louis (314 454 6000
  - St. Louis Children's Hospital, St. Louis (314 454 6154)
  - Easter Seals Midwest, St. Louis (314 432 6200)

LOANER DEVICES AND SUPPORT SERVICES

- ✓ Missouri Assistive Technology (www.at.mo.gov) (816 655 6700)
- ✓ Missouri School for the Deaf (hearing aids and FM Systems) (www.msd.dese.mo.gov) (573 592 4000)

Cultural and Linguistic Diversity in the School Setting

School-based SLPs are increasingly involved in helping evaluation teams determine the speech and language proficiency for Culturally and Linguistically Diverse (CLD) students. Missouri criteria for Special Education state that eligibility in the area of Language Impairment (LI) is not a result of dialectal differences or second language influence. Likewise, eligibility for Sound System Disorder (SSD) cannot be the result of dialectal differences or second language influence. The fundamental distinction for the SLP and team is to determine when a student's performance is a reflection of language acquisition-related behaviors, and when an actual disability is suspected or present. The SLP helps distinguish between a speech-language difference and an actual disorder. Typically, when a true speech or language disorder exists, communication problems will be evident in both the student's primary language (L1) and in English (L2). Special education teams are tasked with ruling out language acculturation as the primary reason for any performance deficits. SLPs are critical members of these school-based teams and can provide perspective to the nuances and complexity of the information which is gathered on students who are culturally and linguistically diverse.

Norm-referenced standardized testing is problematic for students who are culturally and linguistically diverse. It is not appropriate to use norm-referenced tests which assess English proficiency when a student has not had enough time and exposure to learn the language. It typically takes ELL students 1-2 years to acquire Basic Interpersonal Communication Skills (BICS) and 5-7 years to develop Cognitive Academic Language Proficiency (CALP). Depending upon the student's prior academic experiences in the primary language, development of CALP may take up to 10 years. BICS tend to be highly contextualized, as they are used in meaningful social interactions, whereas CALP reflects the ability to use and understand language which is far more *de*contextualized. CALP essentially requires a double cognitive load where the child needs to learn English and needs to learn *in* English.

Problems arise when school staff mistakenly believe a child is sufficiently proficient in English (L2) because the child is communicating successfully in highly contextualized social interactions and settings. Even after a child becomes proficient in BICS, it will take significantly more time to become proficient in the academic language of school. Norm-referenced standardized testing in English during this acquisition period is unfair and will typically result in significant underestimation of the student's true facility with language. When available, standardized tests should only be used when the language of the assessment matches the primary or dominant language of the child. However, testing in English may be informative and descriptive once English has become the dominant language for the student, even though reporting normative scores may still be inappropriate.

Several assessment tools and strategies are available when norm-referenced testing is not an appropriate option for a given student, or when reporting standard scores is inappropriate/invalid. These options include the use Dynamic Assessment (DA), Growth Scale Values (GSV), and Conceptual Scoring. Dynamic Assessment (DA) is frequently cited as a valid

assessment tool for CLD children. DA typically utilizes a 'Test-Teach-Retest' format to determine whether a given student is having more than expected difficulty learning a novel task or skill. Dynamic Assessment measures both the modifiability, or degree of change for the student, as well as the level of examiner effort required during the 'teach' phase of the assessment (time needed for achievement, level and amount of cueing required for achievement, and perceived level of examiner effort needed). The GSV may be useful when norm-referenced scores are not, and can be used to more accurately reflect growth over time. Conceptual scoring is also a way to help determine when vocabulary knowledge or other linguistic knowledge is distributed *across* languages. Conceptual scoring allows credit for correct items, regardless of the language in which the student knows the item.

The careful gathering of a detailed case history is critical to understanding the academic and linguistic profile for CLD students. Of particular interest and importance is whether there are any concerns with the child's language development in the primary language and how the child compares to peers from the same linguistic community/environment. The school team may need to use the services of an interpreter to accurately gather this information. https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935334&section=Key_Issues and http://www.asha.org/Practice-Portal/Professional-Issues/Collaborating-With-Interpreters/ In addition, ASHA provides resources which compare and contrast various languages with English. Specific inventories for various languages such as Spanish, Vietnamese and others may be found by searching the ASHA website and typing in the key word phonemic inventory in the search bar.

Dialect and language diversity:

An often overlooked or misunderstood aspect of Cultural and Linguistic Diversity involves students who are native English speakers, but who use a nonstandard dialect of English, such as African American English (AAE), Southern White English (SWE), Spanish Influenced English (SIE) among numerous others. These dialects include phonologic, semantic and morpho-syntactic variations of English and can differ significantly from Standard or Mainstream American English (SAE or MAE).

As noted earlier, the Missouri eligibility criteria for Special Education state that the child's perceived impairment cannot be the result of dialectal differences. Misdiagnosis and overidentification occur when children who use nonstandard dialects are given speech or language assessments which are constructed to reflect Standard or Mainstream American English. Some standardized tests include scoring procedures which do not penalize the child for use of a nonstandard dialect. Unfortunately, these procedures are often included in appendices of test manuals and are not at the forefront of the resources and scoring guidelines provided to the examiner. A better option is to administer language tests which assess only the features of language which are shared across all dialects of that language, thus eliminating dialectal bias in standardized testing. SLPs need to be familiar with both contrastive and non-contrastive features of speech and language across various dialects. Again, resources are available from ASHA and can also be found in some test manuals.

DESE provides the following information with respect to English Learners:

https://dese.mo.gov/quality-schools/migrant-el-immigrant-refugee-education/english-learners

https://dese.mo.gov/special-education/compliance/ell-special-education

https://dese.mo.gov/communications/webinar/SpecEdELL06-02-14

https://dese.mo.gov/college-career-readiness/assessment/el-assessment

ASHA provides the following resources with respect to Multicultural Affairs:
https://www.asha.org/practice/multicultural/

TERMINOLOGY

- ***Acculturation***: the process by which an individual learns aspects of a new culture
- ***Additive Bilingualism***: the process of learning a new language where both languages are well supported by the home and community
- ***BICS (Basic Interpersonal Communication Skills):*** contextualized, informal 'everyday' language in which it typically takes 1-2 years to develop proficiency
- ***CALP (Cognitive Academic Language Proficiency):*** the *de*contextualized language of academic instruction which typically takes 5-7 years, and sometimes up to 10 years, to fully develop
- ***Culturally and Linguistically Diverse Students:*** Students who speak a language other than English regardless of English proficiency level. English-speaking students who have dialectical differences are not considered to be CLD.
- **Culturally Diverse:** When an individual or group is exposed to, and/or immersed in more than one set of cultural beliefs, values, and attitudes. These beliefs, values, and attitudes may be influenced by race/ethnicity, sexual orientation, religious or political beliefs, or gender identification.
- ***Code-Switching***: a normal process in which bilingual speakers use features of both languages during ongoing speech, or when a bidialectal speaker switches between dialects of a language
- ***Dialect:*** a regional variety of language distinguished by features of vocabulary, grammar, and pronunciation from other regional varieties and constituting together with them a single language

- ***Disproportionality***: the overrepresentation of certain groups of students in special education programs

- ***Dynamic Assessment***: a method of assessment whereby a 'Test-Teach-Retest' format is used to measure both the student's level of 'modifiability' and the examiners degree of 'effort'; Dynamic Assessment is a recommended strategy for helping determine if a CLD student is experiencing more than expected degree of difficulty learning new skills

- ***EL (English Learner)*** Refers to speaker of other languages in the process of learning English. This abbreviation may be used to indicate LEP students.

- ***ESL (English as a Second Language) or ESOL (English for Speakers of Other Language)*** A term for English-language programs that teach English language skills to speakers from non-English language backgrounds. The approach of choice for schools where bilingual teachers are not available, and where ELL students represent many languages. ESOL is another term for "English as a Second Language" or ESL.

- ***GSV (Growth Scale Value):*** The GSV is a transformation of the raw score to be used to measure change in performance across time. The GSV is not a normative score because it does not compare the child to a normative group, rather it documents an individual child's changing performance over time in a statistically accurate manner.

- ***Interference/Transfer***: the process whereby L1 interferes with L2, or L2 interferes with L1; features of either language are superimposed on the other

- ***L1***: an individual's primary or first language

- ***L2*****:** and individual's secondary language

- ***Language Dominance/ Dominant Language*** Determined by comparing skills in two or more languages; the dominant language is usually the language that is:

    - Stronger (i.e., more developed)
    - First developed
    - Used most easily
    - Preferred language used by the individual

    Consistently selected and used by the individual during conversation with bilingual individuals who speak the same dialect.

- ***Language Proficiency:*** An ELL's English language skills compared to the average English speaking student at the age-appropriate grade level; students must test proficient in all four language modalities: reading, writing, speaking, and listening.

- ***LEP (Limited English Proficiency).*** Limited English proficiency is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

- ***Primary Language***: the first language an individual learns

- ***Sequential Bilingualism***: the process when an individual has a foundation in a single language first, and then has a second language introduced later

- ***Silent Period***: often a normal occurrence in the initial phases of second language acquisition

- ***Simultaneous Bilingualism***: the process whereby an individual is exposed to and learns two languages simultaneously from birth

- ***Subtractive Bilingualism/Language Loss***: the loss of skills in L1 experienced by some individuals when they are immersed in L2; language loss often occurs when one language is perceived as having more or less prestige than another language

Autism in the School Setting

Autism is defined as a developmental disability significantly affecting verbal or nonverbal communication and social interaction, generally evident before age three (3), that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. (Missouri Department of Elementary and Secondary Education)

Speech-Language Pathologists (SLPs) play a central role in the screening, assessment, diagnosis, and treatment of persons with Autism (Autism Spectrum Disorders, ASD). The professional roles and activities in speech-language pathology include clinical/educational services (diagnosis, assessment, planning, and treatment); prevention and advocacy; and education, administration, and research. See AHSA's Scope of Practice (2016): https://www.asha.org/policy/sp2016-00343/

Appropriate roles for SLPs include

- Providing information to individuals and groups known to be at risk for ASD, to their family members, and to individuals working with those at risk;
- Educating other professionals on the needs of persons with ASD and the role of SLPs in diagnosing and managing ASD;
- Screening individuals who present with language and communication difficulties and determining the need for further assessment and/or referral for other services;
- Conducting a culturally and linguistically relevant comprehensive assessment of language and communication, including social communication skills;
- Assessing for the need for and requirements for using augmentative and alternative communication (AAC) devices as a mode of communication;
- Diagnosing the presence or absence of ASD (typically as part of a diagnostic team or in other multidisciplinary collaborations);
- Referring to other professionals to rule out other conditions, determine etiology, and facilitate access to comprehensive services;
- Making decisions about the management of ASD;
- Participating as a member of the school planning team (e.g., whose members include teachers, special educators, counselors, psychologists) to determine appropriate educational services;
- Developing treatment plans for speech and language services, including social language goals and goals for literacy development and for assisting the student with self-regulatory and social interactive functions to allow him/her to participate in the mainstream curriculum to as great an extent as possible;
- Providing treatment, documenting progress, and determining appropriate dismissal criteria;

- Providing training in the use of AAC devices to persons with ASD, their families and caregivers, and educators;
- Counseling persons with ASD and their families regarding communication-related issues and providing education aimed at preventing further complications related to ASD;

As indicated in the ASHA Code of Ethics, https://www.asha.org/Code-of-Ethics/ SLPs who serve this population should be specifically educated and appropriately trained to do so.

Dyslexia

According to the International Dyslexia Association/National Institute of Child Health and Human Development (2002), "Dyslexia is a specific learning disability that is neurobiological in origin. It is characterized by difficulties with accurate and/or fluent word recognition and by poor spelling and decoding abilities. These difficulties typically result from a deficit in phonological components of language that is often unexpected in relation to other cognitive abilities and the provision of effective classroom instruction. Secondary consequences may include problems in reading comprehension and reduced reading experience that can impede growth of vocabulary and background knowledge."

The Department of Elementary and Secondary Education (DESE) developed the Legislative Task Force on Dyslexia (Task Force) in 2016 to assist in providing guidance to address the issue of dyslexia within the school setting in the areas of 1) screening, 2) evidence-based reading instruction, 3) intervention, 4) preservice and in-service professional development, 5) teacher certification, 6) recommendations for a process for reporting of data, and 7) the study and evaluation of current practices for diagnosing, treating, and educating students.

Role of the SLP

- "It is the position of the American Speech-Language-Hearing Association (ASHA) that Speech-Language Pathologists (SLPs) play a critical and direct role in the development of literacy for children and adolescents with communication disorders, [1] including those with severe or multiple disabilities. SLPs also make a contribution to the literacy efforts of a school district or community on behalf of other children and adolescents. These roles are implemented in collaboration with others who have expertise in the development of written language and vary with settings and experience of those involved. [2]"
  (American Speech-Language-Hearing Association. (2001). Roles and responsibilities of speech-language pathologists with respect to reading and writing in children and adolescents [Position Statement]. Available from www.asha.org/policy.)

- The SLP may assist special education and general education staff in implementing remedial programs that should include specific instruction in decoding, fluency training, vocabulary, and comprehension. (American Academy of Pediatrics, 2011)

Dysphagia Management in School Settings

ASHA states, feeding and swallowing disorders (also known as **dysphagia**) include difficulty with any step of the feeding process—from accepting foods and liquids into the mouth to the entry of food into the stomach and intestines. A **feeding** or **swallowing disorder** includes developmentally atypical eating and drinking behaviors, such as not accepting age-appropriate liquids or foods, being unable to use age-appropriate feeding devices and utensils, or being unable to self-feed. A child with dysphagia may refuse food, accept only a restricted variety or quantity of foods and liquids, or display mealtime behaviors that are inappropriate for his or her age.

Dysphagia can occur in any phase of the swallow. Although there are differences in the relationships between anatomical structures and in the physiology of the swallowing mechanism across the age range (i.e., infants, young children, adults), typically, the phases of the swallow are defined as

Oral Preparation Stage—preparing the food or liquid in the oral cavity to form a bolus-including sucking liquids, manipulating soft boluses, and chewing solid food.
Oral Transit Phase—moving or propelling the bolus posteriorly through the oral cavity.
Pharyngeal Phase—initiating the swallow; moving the bolus through the pharynx.
Esophageal Phase—moving the bolus through the cervical and thoracic esophagus and into the stomach via esophageal peristalsis (Logemann, 1998).

In the school setting the number of students needing management for dysphagia is increasing. Speech-language pathologists need to have an understanding of how Individuals with Disabilities Education Act applies. IDEA considers a disorder "educationally relevant" if the disability interferes with the student's ability to gain access and participate in the educational curriculum.

Roles and Responsibilities

Speech-Language Pathologists play an essential role in the assessment, diagnosis, and treatment of infants and children with swallowing and feeding disorders. The professional roles and activities in speech-language pathology include clinical/educational services (diagnosis, assessment, planning, and treatment), prevention and advocacy, education, administration, and research. See ASHA Scope of Practice in Speech-Language Pathology, https://www.asha.org/policy/sp2016-00343/

Appropriate roles for SLPs include:

- Providing prevention information to individuals and groups known to be at risk for pediatric dysphagia and feeding disorders, as well as to individuals working with those at risk;

- Educating other professionals on the needs of children with dysphagia and the role of SLPs in diagnosing and managing pediatric dysphagia;
- Making decisions about management of pediatric dysphagia;
- Recommending a swallowing and feeding plan for daily management of swallowing and feeding activities that is referenced in the Individualized Education Program (IEP), Individual Family Service Plan (IFSP), or 504 Plan;
- Recommending related services when necessary for daily classroom management and therapy;
- Counseling children and their families and providing education aimed at preventing further complications related to dysphagia;
- Serving as an integral member of an interdisciplinary feeding and swallowing team;

As indicated in the ASHA Code of Ethics, www.asha.org/Code-of-Ethics/, SLPs who serve this population should be specifically educated and appropriately trained to do so.

Considerations for Evaluation in the School Setting

School-based SLPs often play a significant role in the management of students with swallowing and feeding problems in school settings. The Rehabilitation Act of 1973 (Section 504) (U.S. Department of Labor, n.d.) and the Individuals with Disabilities Education Improvement Act (IDEA 2004)mandate services for health-related disorders that affect the ability of the student to access educational programs and participate fully.

Team Approach

The school-based dysphagia team consists of members who serve in the school system. Core members of the team, who are responsible for decisions regarding dysphagia, include the SLP who specializes in swallowing and feeding, family /caregiver, classroom teacher, nurse, occupational therapist, physical therapist, and school administrator. Additional members can include the school psychologist, social worker, and cafeteria staffer.

Selective Mutism in the School Setting

ASHA states, Selective Mutism is a complex childhood anxiety disorder characterized by a child's inability to speak and communicate effectively in social settings, such as a school setting. The individual pattern of mutism can vary from never talking outside of the home, to speaking with only a specific person and/or persons. Students with selective mutism typically do not speak in the school setting, which interferes with academic, educational, and/or social performance. ASHA http://www.asha.org/Practice-Portal/Clinical-Topics/Selective-Mutism/

Appropriate roles for SLPs include but are not limited to:

- Educating other professionals on the needs of persons with selective mutism and the role of the SLP in diagnosing and managing selective mutism;
- Screening individuals who present with language and communication difficulties to determine the need for further assessment and/or referral for other services;
- Conducting a comprehensive, culturally and linguistically appropriate assessment of speech, language, and communication;
- Aiding in diagnosing the presence or absence of selective mutism with an interdisciplinary team;
- Referring to other professionals to rule out other conditions, determine etiology, and facilitate access to comprehensive services;
- Making decisions about the management of selective mutism;
- Developing treatment plans, providing treatment, documenting progress, and determining appropriate dismissal criteria;
- Counseling persons with selective mutism and their immediate and extended families regarding communication-related issues and providing education aimed at preventing further complications relating to selective mutism;
- Consulting and collaborating with other professionals, family members, caregivers, and others to facilitate program development and to provide supervision, evaluation, and/or expert testimony, as appropriate;
- Remaining informed of research in the area of selective mutism and helping advance the knowledge base related to the nature and treatment of selective mutism;
- Advocating for individuals with selective mutism and their families/caregivers at the local, state, and national levels; and
- Serving as an integral member of an interdisciplinary team working with individuals with selective mutism and their families/caregivers.

As indicated in the ASHA Code of Ethics, http://www.asha.org/Code-of-Ethics/ , clinicians who serve this population should be specifically educated and appropriately trained to do so.

Stuttering and Cluttering: Guidelines for Assessment and Treatment in the School Setting

Intro:

Stuttering and Cluttering are two of the most common forms of Fluency Disorders. Both conditions can have a profound impact on the ability of a child or adult to communicate. There are certain core principles that are key to assessing and treating these conditions. These principles are addressed here, with references to additional resources that can assist the Speech-Language Pathologist and/or Audiologist in assessment and treatment.

Stuttering

Description:

Stuttering is "an interruption in the flow of speaking characterized by repetitions (sounds, syllables, words, phrases), sound prolongations, blocks, interjections, and revisions, which may affect the rate and rhythm of speech" (ASHA 2017). The person who stutters may also develop "physical tension, negative reactions, secondary behaviors, and avoidance of sounds, words, or speaking situations" (ASHA 2017). Many of the overt speech behaviors of stuttering (such as eye-blinks, head nods, excessive laryngeal tension) may be "secondary behaviors." These are behaviors that the person who stutters develops themselves in an attempt to struggle with the stutter. These behaviors may become habitual and therefore a component of the overt speech behaviors.

Stuttering most commonly begins in childhood between the ages of about 2 ½ to 5 years of age (ASHA 2017). Stuttering may appear in older adolescents, and can appear in adults due to neurological or psychological conditions.

Stuttering-like disfluencies differ from the more typical disfluencies produced by non-stutterers. Examples of typical disfluencies include "whole-word repetitions (e.g. "*But*-but I don't want to go"), and phrase repetitions or revisions (e.g., "*This is a*- this is a problem") (ASHA 2017). Other examples of more typical disfluencies include "hesitations, such as silent pauses, and interjections of word fillers (e.g. "The color is *like* red) and nonword fillers (e.g., "The color is *uh* red")" (ASHA 2017).

The following chart may help an SLP to distinguish typical disfluency from stuttering:

Typical Disfluency	**Stuttering**
Speech Characteristics: **Multisyllabic whole-word and phrase repetitions** **Interjections**	**Speech Characteristics:** **Sound or syllable repetitions** **Prolongations**

Revisions	Blocks
Other Behaviors: **No physical tension or struggle** **No secondary behaviors** **No negative reaction or frustration** **No family history of stuttering**	**Other Behaviors:** **Associated physical tension or struggle** **Secondary behaviors (e.g. eye blinks, facial grimacing, changes in pitch or loudness)** **Negative reaction or frustration** **Avoidance behaviors (e.g. reduced verbal output or word/situational avoidances)** **Family history of stuttering**

(ASHA 2017) http://www.asha.org/Practice-Portal/Clinical-Topics/Childhood-Fluency-Disorders/Characteristics-of-Typical-Disfluency-and-Stuttering/

Assessment:

Stuttering is a multifactorial condition that can deeply affect an individual's speech, their feelings about their communication abilities, and their ability to function effectively in their environment. A complete assessment will address these various aspects of stuttering, including, but not limited to:

1) overt speech behaviors, that is, the repetitions, prolongations and blocks that comprise the core behaviors of stuttering,
2) the feelings and attitudes that can develop as a result of stuttering,
3) secondary behaviors that can develop as a result of stuttering. These can include physical behaviors such as head nodding, excessive muscle tension, or situational behaviors such as avoiding speaking situations,
4) the impact that stuttering is having on the ability of the person who stutters to function in their environment.

Many assessment instruments include tools for measuring these various aspects of stuttering. For instance, the Stuttering Severity Instrument-4th Edition (SSI-4) includes a section for measuring the overt speech behaviors of the client (repetitions, prolongations and blocks). The SSI-4 also includes a section for measuring some secondary behaviors, referred to in the test as "physical concomitants," such as head movements or tension in the jaw muscles.

The SSI-4 also contains a set of scales called the "Clinical Use of Self-Reports" (CUSR). These can be used to measure the feelings and attitudes of a person who stutters, and also measure many aspects of how the person who stutters is functioning in their communicative environment. The CUSR can be used during assessment and throughout therapy. Another option to measure

the impact that the disfluency is having on the ability of the client to function is the "Observational Rating Scales" contained in the Test of Childhood Stuttering.

When doing an initial assessment of stuttering, it is important to consider whether the client has characteristics that may be a risk factor for persistent stuttering. A non-exhaustive list includes:

1) Is there a family history of stuttering?
2) Does the client exhibit negative reactions about the disfluency?
3) Does the client exhibit physical tension and/or secondary behaviors such as eye blinking or head nodding?
4) Are there other speech or language concerns present?
5) Is the child experiencing negative reactions from family members or peers?
6) Is it difficult for the client to communicate in an efficient, effective manner?
7) Is there parental concern?

(ASHA 2017)

Not all of these characteristics need to be present, and the foregoing list is not exhaustive. (ASHA 2017).

Treatment:

As in assessment, a complete treatment approach for a person who stutters will address the many aspects of the disorder, including, but not limited to:

1) overt speech behaviors, that is, the repetitions, prolongations and blocks that comprise the core behaviors of stuttering,
2) the feelings and attitudes that can develop as a result of stuttering,
3) secondary behaviors that can develop as a result of stuttering. These can include physical behaviors such as head nodding, excessive muscle tension, or situational behaviors such as avoiding speaking situations,
4) the impact that stuttering is having on the ability of the person who stutters to function in their environment.

Many resources are available for the SLP who wants to work on these aspects of stuttering. For instance, the National Stuttering Foundation has many free resources available at https://www.stutteringhelp.org/ . These include brochures with tips for parents or teachers who want to improve the communication environment for a person who stutters.

Also available are materials such as the workbook The School-Age Child Who Stutters: Working Effectively with Attitudes and Emotions by Chmela and Reardon. This workbook contains numerous activities for the SLP who wants to address these aspects of stuttering with their client.

Cluttering

Description of Cluttering:

Cluttering is a fluency disorder that results in a decrease in intelligibility from a "perceived rapid and/or irregular speech rate" (ASHA 2017). Cluttering is characterized by the "deletion and/or collapsing of syllables (e.g., "I wanwatevision") and/or omission of word endings (e.g., "Turn the televisoff")" (ASHA 2017). A person who clutters may also display pauses during their sentences. Actually, people who clutter do not always speak at a rate more rapid than typical speakers (ASHA 2017). Their rate is perceived to be rapid due to the speech disfluencies.

Unlike people who stutter, people who clutter are typically not able to perceive their own disfluency (ASHA 2017). However, they will typically report that others have difficulty understanding them (ASHA 2017).

Treatment:

A person who clutters can usually increase intelligibility by adjusting their speaking rate. Slowing the speaking rate, increased pausing, and careful articulation of multisyllabic words are all techniques that may be effective (ASHA 2017). Because the person who clutters is often unable to perceive their own disfluency, auditory feedback may also be an effective technique to improve self-monitoring.

Helpful Resources:

American Speech-Language Hearing Association practice portal page for Childhood Fluency Disorders, located at https://www.asha.org/Practice-Portal/Clinical-Topics/Childhood-Fluency-Disorders/

National Stuttering Association Webpage, located at http://www.westutter.org/

The Stuttering Home Page of Minnesota State University, located at http://www.mnsu.edu/comdis/kuster/stutter.html

References:

American Speech-Language Hearing Association, *Childhood Fluency Disorders*, Retrieved December 15, 2017 from https://www.asha.org/Practice-Portal/Clinical-Topics/Childhood-Fluency-Disorders/

Speech Sound Disorders: Guidelines for Assessment and Treatment in the School Setting

Definition:

Speech Sound Disorder is defined as "an umbrella term referring to any combination of difficulties with perception, motor production, and/or the phonological representation of speech sounds and speech segments that impact speech intelligibility" (ASHA 2017). Speech sound disorders include articulation and phonology as well as disorders that cause speech sound disorders such as Childhood Apraxia of Speech (CAS), dysarthria, syndromes, hearing impairment, and cleft. Some of these speech sound disorders have no known cause while others are based from sensory, motor, or structure problems.

Speech sound disorders can negatively impact both academics and social interactions. Academically, children need to engage in class discussions, oral reading, class presentations, and interact with others. Socially, children need to be able to express their thoughts, feelings and communicate their needs to others. Children need to socially interact with one another and poor speech skills may cause negative reactions from peers.

Speech-Language Pathologists (SLP's) manage screening, assessment, diagnosis, treatment and progress of children with speech sound disorders (ASHA 2016 Scope of Practice in Speech-Language Pathology). The SLP also makes appropriate referrals for possible other services, especially if the student exhibits co-occurring characteristics. Cultural and linguistic considerations must be made when evaluating and treating speech sound disorders, especially with bilingual/multilingual populations.

Assessment:

A full speech sound assessment addresses the following:

1. Normative speech assessment (i.e. GFTA-3; HAPP-3; AAPS-4)
2. Deep testing of sound errors (i.e. lateral lisp; frontal lisp)
3. Connected speech sample to assess speech intelligibility
4. Stimulability assessment
5. Oral-motor examination
6. Hearing screening
7. Obtain a case history
8. Caregiver and Teacher Questionnaires to provide information on child's speech sound use

When reviewing existing data and educational impact, the effects of speech sound errors should be considered for its impact on literacy assessment and expressive language assessment.

Assessment indicates:

- Type, number, context and consistency of speech sound errors
- Speech intelligibility level in connected speech
- Stimulability of errored sounds
- Specific speech sound disorder/differential diagnosis

Treatment:

Provide Evidence Based Practice (EBP) for speech sound disorders. The SLP chooses appropriate treatment approaches and strategies dependent on disorder, severity of disorder, number and type of errors, child's age, and overall speech intelligibility. All treatment approaches focus directly on improving speech production and speech intelligibility. The ASHA 2017 Practice Portals for Articulation and Phonology as well as Childhood Apraxia of Speech outline treatment approaches.

ASHA 2017 indicates criteria for determining eligibility for services in a school setting are detailed in IDEA 2004. A comprehensive evaluation determines if a speech sound disorder is present; if the speech sound disorder negatively impacts academics resulting from the disorder; and if any special education services are needed to help the student function in the classroom. The student receives an individualized education program (IEP) which identifies the special education and related services to be provided. The student is dismissed from special education services in school when the speech sound disorder no longer affects academics and social performance.

References:

American Speech Language Hearing Association (ASHA) 2017 Practice Portals

- http://www.asha.org/Practice-Portal/Clinical-Topics/Articulation-and-Phonology/
- http://www.asha.org/Practice-Portal/Clinical-Topics/Childhood-Apraxia-of-Speech/

Comparison of Childhood Apraxia of Speech, Dysarthria and Severe Phonological Disorder. Compiled by Ruth Stoeckel, M.A., CCC-SLP and David Hammer, M.A., CCC-SLP; March 2001, Childhood Apraxia of Speech Association of North America (CASANA); http://www.apraxia-kids.org.

McLeod, S. and Baker, E. (2017). *Children's Speech: An Evidence-Based Approach to Assessment and Intervention.* Pearson Education: Boston, M.A.

Murray, E., McCabe, P., et al. (2014). A Systematic Review of Treatment Outcomes for Children with Childhood Apraxia of Speech. *American Journal of Speech-Language Pathology*, 23, 486-504.

Yorkston, K., Beukelman, D., Strand, E., & Hakel, M. (2010). *Management of Motor Speech Disorders in Children and Adults, 3rd Edition*. Pro-Ed: Austin, TX.

Hearing Impairment in the School Setting

It is important to consider a team approach to management of the student with a hearing impairment in the school system. Speech-language pathologists, audiologists, teachers of the deaf and hard of hearing, and others may be part of a school team needed to address the needs of students with hearing loss. Together, they can promote language skills and communication access that is essential for participation and learning in today's educational environments. The Educational Audiology Association has developed a position statement regarding the collaborative roles for purposes of providing support to students who are deaf and hard of hearing. This information is found at: http://www.edaud.org/position-stat/15-position-02-18.pdf.

Many Missouri school districts do not have direct access to audiologists and teachers of deaf and hard of hearing and as a result the speech-language pathologists may take the lead in providing communication interventions/supports to children with hearing loss in a district. Students with a hearing loss who require special education because of that hearing loss, should be identified eligible in the category of hearing impairment/deafness regardless of who is implementing the services identified in the IEP which could be a special education teacher, teacher of the Deaf and Hard of Hearing, SLP, and others). An SLP can but does not need to be the case manager for a student just because they have been determined IDEA eligible in the category of hearing impairment.

In the state of Missouri, Missouri School for the Deaf and Blue Springs Multi-District Deaf/Hard of Hearing Programs are two resources that can be utilized by school districts. A few additional districts have audiologists on staff. DESE has also funded Missouri State University to provide free consultative support for districts serving students with cochlear implants.

Telepractice

Telepractice Considerations

Clinical Ethics:
Telepractice continues to grow by many measures - accessibility and acceptability, ease of use, the amount of resources for use in digital environments, and the creative ways clinicians are adapting their engagement style with digitally-native children and students.

It is an alluring prospect to be able to use one's specialized skill set, secure full-time or per diem employment, and work from the comfort of one's home. Every clinician, however, must maintain compliance to the guidance and requirements set forth by the American Speech-Language-Hearing Association: use of telepractice must be equivalent to the quality of services provided in person and consistent with adherence to the Code of Ethics, state and federal laws (e.g., licensure, the Health Insurance Portability and Accountability Act, and ASHA policy (American Speech-Language-Hearing Association, 2010).

In other words, the speech-language pathologist providing telepractice services has the same responsibilities as a clinician providing intervention in a more traditional setting: assessment, documentation, participation in IEP program design, teacher consultation and collaboration, parent communication, and treatment. With confidence, training and flexibility, many speech-language pathologists are proving telepractice to be a feasible and effective model for service delivery.

Telepractice, like technology, is constantly evolving. There is no shortage of resources, in both digital and traditional formats, that can be adapted for clinical application. And while there is a growing body of research showing the acceptance and equivalency of outcomes associated with telepractice settings, research is also highlighting the need for adequate training among clinicians (Tucker 2012).

Telepractice In Schools

Technology Considerations:
The number of schools taking advantage of telepractice options appears to increase every year. It can be a quick and easily-implemented solution for meeting the challenges of therapist shortages, and IEP compliance requirements. The basic equipment needed, assuming a telepractice clinician is available, consists of a computer connected to a network that provides reliable internet access, a webcam, speakers, microphone, and a secure video conferencing platform that ensures encrypted communication meeting HIPAA standards and requirements. The selection of the video conferencing platform is typically a matter of agreement between a school district and the therapy vendor. Although tablets and small laptop computers are ubiquitous in many school districts today, a larger monitor, external speakers, and properly

placed microphones can enhance the engagement between clinician and students. Every effort should be made to create an environment for students to participate with the same considerations made for traditional service delivery: appropriate levels of privacy, lighting, and seating or appropriate accessibility options in a setting that is conducive to individualized instruction.

Facilitator Considerations:
In addition to the technical and physical logistics, an effective telepractice program will typically require the services of a dedicated and trained professional who facilitates student participation. This role may be fulfilled by a parent or caregiver if services are received in the student's home, or by a staff member at a school who acts as part of the special education services team. This role does not require licensure or certification. The individual should, however, be oriented on the expectations regarding day-to-day responsibilities, which include:

- student support;
- modeling positive behaviors;
- encouraging participation and turn-taking by following the therapist's lead; and
- teacher and on-site staff communication, especially for program scheduling.

A facilitator is not expected to have access to IEP proceedings, or the details discussed in IEP meetings, but they are a part of a child's school day experience and community, so they can assist with certain details like meeting dates, deadlines, approaching testing dates, and test administration. The clinician providing telepractice services should assume all responsibility for parent/caregiver and teacher contact regarding IEP matters bound by confidentiality requirements.

Informed Consent:
Prior to initiating telepractice, a school district has the responsibility of providing parents and caregivers with an informed consent option and acknowledge that every student's needs may not be met by a telepractice model. Administrators are sometimes faced with the dilemma of not having another service delivery option available.

ASHA suggests, informed consent, "…may include a description of the equipment and services to be delivered, how services via telepractice may differ from services delivered in person, the individual's right to revert to traditional face-to-face care at any time, any modifications that will be made in assessment protocols, and potential confidentiality issues. Documentation may also include the type(s) of equipment used, the identity of every person present, the location of the client and clinician, and the type and rate of transmission." (From: ASHA, 2020).

Alignment To IEP:
Clinicians who are admittedly new to the telepractice model often wonder about frequency of services and session length, but these considerations are not determined by the choice or implementation of telepractice. These factors are determined by the student's Individualized Education Plan (IEP), and the input of each member of the student's IEP team. It is true that many speech-language pathologists anecdotally report higher levels of focusing, attending and

completion of tasks from their students in telepractice settings. This observation alone does not justify any decision imparted by the clinician to modify the frequency and session length required under the student's current individualized plan. The correct strategy is to share these observations with the IEP team according to program procedures and generate consensus among team members to implement any proposed changes.

Caseload and Logistical Considerations:
In school settings, caseload size is typically not determined by the clinician or vendor. School-based clinicians providing telepractice services will find themselves managing caseloads that have the same expectations, responsibilities and challenges that are typical in on-site service delivery.

The following recommendations will hopefully assist some clinicians and program administrators ensure maximal outcomes for students receiving services:

- Limit groups to a maximum of three students, whenever possible.

- Students do not always need to be positioned at a computer in the same manner that an individual user would. Not all participation involves direct input using the computer keyboard. (With the exception of writing tasks, most opportunities to use the keyboard and mouse take away any need for verbal participation.) Students positioned side-by-side or in an arc approximately three to four feet from the computer monitor and speakers will typically have adequate access to the visual and audio content of the session and will be able to participate in turn-taking group activities. Environmental factors in the room may prove otherwise, so use the assistance of the facilitator to determine the best arrangement.

- Most webcams contain an internal microphone, but the quality of the clinician's voice will always be enhanced when a microphone is used. Always use a noise-cancelling microphone or headset during sessions.

- Headsets may improve the quality of the audio signal for the students, and "splitters" are available to accommodate up to three headsets. If headsets are used, they must include a microphone. This option, however, cuts off communication between the clinician and the facilitator. The use of headsets may present sensory challenges for some students. If so, consider the use of high-quality external speakers that can be placed on the table near the students, and the use of a tabletop microphone. Devices that combine the functions of a speaker and a microphone in one compact unit are available.

- Facilitators should never be asked to make decisions regarding the selection or appropriateness of specific therapy materials, activities, or methods, but they can be asked to moderate the activity being completed by one or more students (a writing

activity on a printed worksheet, for example) while other students focus on materials presented by the clinician.

- Caseload numbers tend to ebb and flow in every school. Some students will be withdrawn throughout the school year, and new students will become eligible. Never expect your schedule to remain static or constant for the duration of an entire school year.

- Build rapport with program administrators at an early stage. This may make it easier to approach the stakeholders and decision makers when it comes time to suggest changes and different approaches.

Successful telepractice implementation is driven in large part by the clinician's ability to be flexible, creative and adaptable. Telepractice is not a new form of intervention. It is simply an alternative mode of communicating. This is always an important observation that may be worth sharing with teachers, parents and administrators when you are confronted with a skeptical or doubtful perspective regarding telepractice services. It is the clinical decision-making skill and expertise of the SLP that makes telepractice a success, not the technology or digital resources.

Clinicians may find themselves questioning the ability of a particular student to benefit from services provided in a telepractice setting. With experience, your ability to provide a level of intervention that is equivalent with on-site services will develop. But when you suspect a student may not be receiving the full benefit of intervention, consider the following suggestions and actions to ensure that every student is on the path toward an optimal outcome:

- Don't rush to judgement. If telepractice is the only current option available, the proper approach to designing a program will likely unfold as a process; the solution lies within a process - not one single decision.

- Gather as much information as you can about the student, their learning preferences, their tolerance and attending levels for participation in a telepractice setting, and the routines that are likely to contribute to their success. Consult with teaching staff, caregivers and team members to gather this information. You will likely discover or learn something that you had not considered on your own.

- Synthesize this information into an action plan or a set of options. Options might include adjusting the frequency of therapy and/or the length of sessions. Making changes to the student's environment to make telepractice intervention more accessible (or making the environment either less demanding or more structured, depending on the needs of the student), could also be beneficial.

- Present your findings and recommendations, formally, at a scheduled time with the IEP team. Always use the IEP process to introduce proposed changes to the student's program.

Missouri Standards and Considerations:
Currently, the state of Missouri does not have licensure laws or regulations dictating the use of telepractice. More information can be obtained from https://www.asha.org/advocacy/state/info/MO/Missouri-Telepractice-Requirements/

However, there is regulation for Medicaid reimbursement. Information can be obtained from https://www.asha.org/uploadedFiles/Telepractice-Requirements-and-Reimbursement.pdf

DESE has provided guidance for schools considering the use of telepractice for direct service, as well as, supervision of SLP-As. This guidance can be obtained from the Missouri School Board Association Medicaid Consortium (3/2020): https://dese.mo.gov/sites/default/files/se-compliance-telepractice-considerations-2020.pdf

It is important to note, that while Missouri does not have licensure laws or regulations for telepractice, it is the SLP's ethical duty to adhere to State and Federal guidelines, follow ASHA guidelines and maintain best practice throughout the diagnostic and therapy process.

Conclusion:
The telepractice service delivery model option appears to be developing into a permanent fixture in our current education system. The body of evidence supporting this model is already well documented (Gabel et al. 2013, Grogan-Johnson et al, 2010) and continues to develop with promising options for the future.

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Additional Telepractice Considerations

Laws and regulations

ASHA's website
https://www.asha.org/uploadedFiles/State-Laws-and-Regulations-for-School-Based-Telepractice.pdf

MSHA's website
https://showmemsha.org/covid-19/

Research

ASHA's Practice Portal
https://www.asha.org/practice-portal/professional-issues/telepractice/

ASHA Journals' Telepractice Articles
https://pubs.asha.org/special-collections/telepracticeresources

Helpful Tips and Resources

ASHA's Telepratice Checklist for School-Based Professionals
https://www.asha.org/uploadedFiles/ASHA-Telepractice-Checklist-for-School-Based-Professionals.pdf

ASHA's Perspectives
https://www.asha.org/SLP/schools/School-Speech-Language-Services-During-COVID-19-State-Perspectives/

Evaluations and assessments via telepractice
https://www.asha.org/SLP/clinical/Considerations-for-Speech-Language-and-Cognitive-Assessment-via-Telepractice/.

Clinical Fellow supervision
https://www.asha.org/Certification/COVID-19-Guidance-From-CFCC/

SAMPLE FORMS

In an effort to assist school-based speech-language pathologists with the updated speech-language eligibility criterion, the following sample forms may be beneficial for use while implementing MTSS/RtI tiered supports and conducting special education evaluations. The sample forms are a collection of forms from various districts that may have previously been in use, shared, adapted, etc. This handbook will be modified from time to time to include additional resources. While the sample forms may be viewed in their entirety as part of this handbook, a word version is available for download/editing on the MSHA website.

Sample Forms include:

Speech-Language Observation Form – Long Form
Speech-Language Observation Form – Short Form
Tier 1 Speech Strategies
Tier 2 Speech Behaviors Checklist
Tier 3 Speech Behaviors Checklist
Tier 1 Language Strategies (2 pages)
Tier 2 Language Behaviors Checklist
Tier 3 Language Behaviors Checklist
Parent Permission form for General Education Speech Intervention Services
Parent Permission to Provide Speech Articulation RtI Services
Parent Permission to Provide Speech Fluency RtI Services
Parent Permission to Provide Speech Voice RtI Services
Dismissal from RtI Speech Articulation Services
Dismissal from RtI Speech Fluency Services
Dismissal from RtI Speech Voice Services

Speech and Language Observation

Student:_____ Student's Age:_____ Date:_____/_____/_____

Grade:_____Time:_____Length of Observation (15+ minutes): _____

Reason for Observation: _____

Setting (classroom, playground, cafeteria, etc.): _____

Where is student seated?

❑ At table ❑ At desk ❑ On chair ❑ On floor
❑ In group ❑ At center Other: _____

Is the student's proximity to teacher appropriate? Yes No

Where is the teacher?

❑ At board ❑ Front of room ❑ Center of room ❑ Back of room
Other: _____

Auditory Environment: background noise / outside noise / quiet

Additional Comments - Setting: _____

_____

Instructional strategies and/or behavioral supports used during the instruction:

❑ Wait time ❑ Repetition of directions ❑ Visual supports ❑ Graphic organizers

❑ Manipulatives ❑ Redirection ❑ Positive reinforcement
Other _____

Did the student appear to comprehend the auditory commands of the activity? Yes No Not Observed

Did the student respond appropriately to verbal demands of the activity? Yes No Not Observed

Is the student's communication comparable to the other students? Yes No

Grammatical errors observed:

❑ Present progress. ❑ Pronouns ❑ Regular past ❑ Irregular past
❑ Regular plurals ❑ Irregular plurals ❑ Articles ❑ Word order
❑ Incomplete sent. ❑ Other: _____

Comments/Example Utterances: _____

_____

Speech Language Observation

Student: _____ Student's Age:_____ Grade:_____
Date:_____Time:_____Length of Observation (15+ minutes):_____

Speech-Language Pathologist:_____

Reason for Observation:

Setting (classroom, playground, cafeteria, etc.):

Auditory Environment (background noise, outside noise, etc):

Language Demands of the activity/classroom instruction:

Comprehension: Low High
Verbal demands: Low High

Is the student's communication comparable to other students in the classroom? Yes No

Comments:

TIER 1
SPEECH STRATEGIES IN THE REGULAR EDUCATION CLASSROOM

ARTICULATION

- ❑ Create a non-verbal cue with child to let the student know you are listening, (e.g. put hand on shoulder, before you call on them to read aloud.)
- ❑ Highlight words on classroom worksheets that contain sounds that the child is misarticulating.
- ❑ If a consistent sound error is detected, and student can produce the sound correctly most of the time, provide student with list of words to "practice" with adult partner.
- ❑ If the student's response contains a known sound error, it's important to repeat what the child said with an appropriate model.

STUTTERING/FLUENCY

- ❑ Allow the student to complete his/her thoughts without interrupting or completing the sentence for them.
- ❑ It is important not to ask the child to stop or start over their sentence. Asking the student to 'take a breath' or 'relax' can be felt as demeaning.
- ❑ Maintain natural eye contact with the student. Try not to feel embarrassed or anxious as the student will pick up on your feelings and could become more anxious.
- ❑ Use a slow and relaxed rate with your own speech, but not so slow that you sound unnatural. Using pauses in your speech rate is an effective way to slow down your speech rate as well as the students.
- ❑ Give the student your full attention when they are speaking so that they know you are listening to what they have to say.
- ❑ After a student completes a conversational turn, it would be helpful for you to rephrase what they said in a fluent manner to demonstrate active listening and a fluent model.
- ❑ Try to call on the student in class when you feel that they will be successful with the answer (when the student raises his/her hand) versus putting the student on the spot when they have not volunteered information.

VOICE/VOCAL QUALITY

- ❑ Allow them to have a water bottle at their desk for the student to take frequent sips when needed.
- ❑ Discuss healthy ways for students to use their voices, i.e. drink water, no yelling or making strange noises, or to use a more quiet voice (not a whisper voice).
- ❑ Provide a positive comment to a student for using good vocal hygiene, such as not shouting to get attention.
- ❑ Place a visual cue on the students' desk (like a picture of someone talking or a simple rating scale such as 1-3). When you hear vocal misuse, touch the picture or rating scale on the desk to help remind the student to use good vocal techniques.

TIER 2
SPEECH BEHAVIORS CHECKLIST

Name:_____ Teacher:_____ Grade:_____ Date:_____

The following behaviors are indicators of possible problems in speech, voice or fluency. Please check the behaviors that describe this student most of the time. Then return to the Speech-Language Pathologist in your school. Thank you.

Articulation Behaviors
___ Speech is difficult to understand most of the time
___ Speech is difficult to understand unless the topic is known
___ Difficulty making speech sounds
___ Difficulty with phonemic awareness
___ Shows awareness of communication problems
___ Errors interfere with academic areas (ex. reading, writing, phonics)

Voice Behaviors
___ Voice is hoarse
___ Nasal voice (sounds like the student is talking through their nose)
___ Voice is too loud or too quiet (please specify in comments section)
___ Pitch is too high or too low for age and gender (please specify in comments section)
___ Voice is monotone (no sign-song quality)
___ Student loses voice occasionally

Fluency Behaviors
___ Repeats words or phrases or parts of them in speech
___ Prolongs a sound that begins a word, phrase or sentence
___ Gets "stuck" on words or sounds
___ Student seems reluctant to speak due to dysfluencies
___ Others seem to notice and react to dysfluencies
___ Uses "um", "a," "you know" excessively while speaking

If you placed a checkmark next to any of the above behaviors, please further specify the impact with respect to academic areas in the classroom:
_____

_____

_____

TIER 3
SPEECH BEHAVIORS CHECKLIST

Name:_____ Teacher:_____ Grade:_____ Date:_____

The following behaviors are indicators of possible problems in speech, voice or fluency. Please check the behaviors that describe this student most of the time. Then return to the Speech-Language Pathologist in your school. Thank you.

Articulation Behaviors

___ Has physical abnormalities of the face, mouth, nose or teeth
___ Has difficulty saying many sounds correctly – 3 or more sounds
___ Has difficulty saying just one or two sounds – errors are consistent or inconsistent
___ Cannot repeat sound correctly even with a model
___ Does not use sound correctly in conversational speech, but can repeat the sound after a model
___ Talks in an unusual way, but individual sound errors are not consistent

Voice Behaviors

___ Voice is hoarse or breathy often, not just during cold/allergy season
___ Does not use quiet voice, is always loud even with reminders
___ Cough or clears throat continuously (lasting over a month)
___ Voice sounds "wet", like he or she needs to clear throat
___ Pitch is not appropriate for age and gender (too high or too low)
___ Student sounds like he/she has a cold and is congested – consistent over time

Fluency Behaviors

___ Even with extra time to respond, the student cannot seem to get answer out
___ Secondary behaviors (eye blinks, twitching) exist with word or sound repetitions
___ Speaks at a rapid rate
___ Speech is difficult to understand, but cannot determine the specific issue
___ Peers seem to be bothered by dysfluencies – sometimes "talks" for student
___ Student hesitates to speak in class

If you placed a checkmark next to any of the above behaviors, please further specify the impact with respect to academic areas in the classroom:

_____

_____

_____

_____

TIER 1
LANGUAGE STRATEGIES IN THE REGULAR EDUCATION CLASSROOM

GENERAL STRATEGIES

- ❑ Simplify verbal directions. Breaking directions down in a step-by-step presentation prevents the student from becoming overwhelmed by the overall task.
- ❑ Post rules, directions, classroom routines, etc. in a visible place. A child who demonstrates language weaknesses often has difficulty processing information auditorily. They are more often visual learners, rather than auditory learners.
- ❑ Obtain the child's attention prior to giving a direction. For example, provide verbal prompts such as, "I'll give you directions now," or "get ready to listen." A student with language delays does not always recognize that it is time to listen when the teacher begins talking.
- ❑ Ask the student to repeat the directions back to the teacher, or have the student explain the directions to another student. Provide prompts and fill in missing pieces of information as needed. Asking the student if he has any questions is not the same thing as having the student repeat the directions back. A child having difficulties with language will most likely not have any questions for the teacher.

FOLLOWING DIRECTIONS

- ❑ When giving directions, repeat directions in a variety of ways by using different vocabulary and/or modes of presentation. The variety will help the child will understand the directions. Using gestures and physical prompts when giving directions can also be beneficial because it utilizes The visual channel.
- ❑ Be specific when giving directions.
- ❑ If possible, give a visual cue. For example, if making an activity you can demonstrate the steps as you go along. Showing the completed project would also provide them assistance.
- ❑ When working with projects that have multi-step directions, it may be helpful to write the directions on the board or use visuals of steps.
- ❑ The student may benefit from sitting next to an individual who would be willing to provide assistance with multi-step tasks.
- ❑ Create a list on common directions used throughout the day. When needed, laminated and place on the board for the entire class, or make smaller to be placed on the individual's desk.

PROCESSING INFORMATION

- ❑ Provide adequate time for the child to process what you have asked and form their answer. If the child does not respond after a given period of time, ask the question in a different way.
- ❑ Use several modalities when teaching materials (speaking, reading, writing, listening, visual, hands-on).
- ❑ Do frequent comprehension checks when teaching. Stop periodically and discuss the information you have presented.
- ❑ Encourage the child to ask for help.
- ❑ Provide additional support for writing down information, such as assignments and related directions in the student's homework notebook.

TIER 1
LANGUAGE STRATEGIES IN THE REGULAR EDUCATION CLASSROOM
CONTINUED

GRAMMAR/SENTENCE STRUCTURE

❑ If the child says something incorrectly repeat it for them correctly in a natural way. Be sensitive about not calling negative attention to their language. For example, if the child says "I goed to the store." You'd say, "Oh, you went to the store."

❑ When the child's speech or writing contains grammar or word order errors, show them in writing the correct form.

❑ When working with the child individually with written or oral language, repeat the error and ask the child how the sentence sounds. For example, the child says or writes, "I goed to the store." You say, "I goed to the store? Does that sound right?" If the child is unable to correct it, give them a choice. For example, "which sounds better, 'I goed to the store.' Or 'I went to the store.'"?

❑ For frequent occurring errors, build it into daily oral language as practice for the entire class.

VOCABULARY/WORD MEANINGS

❑ Prior to introducing new units/stories, compile a list of key vocabulary words. Discuss words and possible meanings with students to preteach vocabulary.

❑ When introducing words, try using a graphic organizer or visual mapping to come up with word relationships including antonyms, or synonyms.

❑ When possible, pair a visual picture with the vocabulary words. When vocabulary is abstract and pictures are not available, try to relate the words to a personal experience for students to relate to.

❑ Place words and definitions on note cards. Use cards to play games such as matching or memory.

❑ Create word list with vocabulary and definitions to display in a visible place within the classroom.

❑ Provide student with vocabulary list including definitions one week prior to beginning a new unit.

❑ Encourage use of word games with family. (Tribond, etc)

SOCIAL LANGUAGE SKILLS/PRAGMATICS

❑ Visual schedules assist students with transitions and expectations for the day.

❑ Allow student to work in a group with students who are accepting and supportive.

❑ Search for opportunities that support appropriate social interactions to model appropriate interactions for students and allow for practice of social skills.

❑ Board games and card games promote turn-taking and sportsmanship.

❑ Comment on positive models for targeted social skill when used by other students in the classroom. (Jenny, I really like how you raised your hand instead of interrupting me when I was talking to the class.)

TIER 2
LANGUAGE BEHAVIORS CHECKLIST

Name:_____ Teacher:_____ Grade:_____ Date:_____

The following behaviors are indicators of possible problems with receptive and expressive language skills. Please check the behaviors that describe this student most of the time. Then return to the Speech-Language Pathologist in your school. Thank you.

Comprehension Behaviors
___ Has difficulty following directions (spoken/written) or asks to have repeated
___ Trouble understanding new information, especially information heard
___ Difficulty asking or answering questions
___ Difficulty in drawing conclusions, making predictions, or inferring information
___ Easily distracted by sounds, noise or other students
___ Confuses similar sounding words
___ Has trouble understanding humor, sarcasm or other figurative language
___ Does not ask questions even though it appears child does not understand concept
___ Does not understand or use grade level vocabulary

Verbal Expression Behaviors
___ Is not able to tell ideas verbally or incorrect sequential order
___ Requires large amount of "wait time" before responding to questions
___ Uses incorrect word order in conversation
___ Incorrect use of grammatical structures (inappropriate for environment)
___ Has trouble formulating questions
___ Cannot maintain topics during a conversation or written ork
___ Difficulty using question forms correctly
___ Has difficulty with vocabulary – synonyms, antonyms, multiple meaning words
___ Difficulty misnaming or finding correct words to use, uses "thingy", "stuff"

Social Language Behaviors
___ Does not take turns in conversation
___ Does not greet or respond to greetings appropriately
___ Uses limited or no eye contact with communication partner
___ Has trouble using language to request info, persuade, direct others appropriately
___ Rarely initiates conversations with others or avoids interaction with others
___ Trouble with following classroom routines or rules
___ Difficulty reading non-verbal signals from others (facial expression, body language)
___ Talks in an unusual way (robotic voice or strange accent, etc.)

If you placed a checkmark next to any of the above behaviors, please further specify the impact with respect to academic areas in the classroom:

_____

_____

TIER 3
LANGUAGE BEHAVIORS CHECKLIST

Name:_____ Teacher:_____ Grade:_____ Date:_____

The following behaviors are indicators of possible problems with receptive and expressive language skills. Please check the behaviors that describe this student most of the time. Then return to the Speech-Language Pathologist in your school. Thank you.

Comprehension Behaviors
___ Given directions one-to-one, student still has difficulty following them
___ Asks for information to be repeated consistently
___ Seems "lost" during class; difficulty staying caught up with class
___ Has trouble learning the meaning of classroom vocabulary words
___ Cannot sequence events of a story
___ Cannot identify cause and effect relationships
___ Seems to "mishear" or misunderstand what is said to him/her
___ Answers given to teacher questions are not on topic
___ Has trouble recalling facts and ideas from things we read aloud or I say in class

Verbal Expression Behaviors
___ Cannot retell the details of or the beginning, middle, end of stories heard or events
___ Has difficulty answering questions that require student to make an inference
___ Has difficulty categorizing or classifying objects or items
___ Has difficulty generating complete sentences when speaking
___ Has word finding difficulties, uses words like "thingy" or "you know"
___ Difficulty stating solutions to problems presented
___ Difficulty using question forms correctly
___ Sentences contain numerous grammatical errors not typical for student's age (i.e., verb tenses, plurals, word order, etc.)

Social Language Behaviors
___ Interrupts others conversations continuously
___ Switches the topic of a conversation without warning
___ Does not request help when having difficulties in class
___ Cannot accept the decision of others
___ Even with reminders, does not follow rules of the classroom
___ Cannot handle a change to schedule
___ Does not appear to understand the actions of others even when explained
___ Difficulty making a friendship OR maintaining one even after initiated by a peer

If you placed a checkmark next to any of the above behaviors, please further specify the impact with respect to academic areas in the classroom:

_____

_____

_____

Request for Parent Permission to Provide Speech Intervention

Student: _____ Grade: ____ Date of Birth: _____

Informal screening indicates that your child has the following concerns with speech production: .

We would like to provide speech interventions at school for your child to try and correct these problems. Speech interventions would be provided by on a periodic basis outside the regular classroom in an individual or small group setting. A speech/language pathologist and your child's classroom teacher would plan together to determine the best time for your child to receive this intervention.

This is a plan for intervention, and is not a special education or related service under the Individuals with Disabilities Education Act (IDEA). If your child's response to this intervention indicates a long-term problem which may negatively impact educational performance, a referral would be made for evaluation. You may also request an evaluation.

Your permission is requested in order to provide speech interventions. Please mark your choice where indicated and return this form to the school office. A copy is provided for your records. Contact us if you have any questions about speech services or this request.

_____, Principal Phone: _____

_____, Speech Therapist Phone: _____

____ I agree to speech interventions for my child to address speech concerns.

____ I would prefer that my child not receive speech intervention at this time.

_____ Date: _____
Parent/Guardian Signature

Parent Permission to Provide Speech Articulation RtI Services

Student: Date:

Date of Birth: Grade: School:

Informal screening indicated your child has the following delays and errors in speech articulation:

We would like to provide RtI speech services at school for your child to try and correct these speech errors. The RtI speech services would be provided by a qualified Speech-Language Pathologist employed by the school district. Services would be on a periodic basis in an individual or small group setting. The Speech-Language Pathologist and your child's classroom teacher would plan together to determine the best time for your child to receive this instruction.

This is a plan for intervention, and is not a special education or related service under the Individuals with Disabilities Education Act (IDEA). If your child's response to this intervention indicates a long-term problem which may negatively impact educational performance, a referral will be made for evaluation. You may also request an evaluation.

Your permission is requested in order to provide RtI speech services. Please mark your choice where indicated and return this form to the school office. A copy is provided for your records. Please contact us if you have any questions about speech interventions or this request.

, Principal

, Speech-Language Pathologist

Phone:

_____ I agree to RtI speech services for my child to address errors in speech.

_____ I prefer that my child not receive RtI speech services at this time.

_____ _____

Parent/Guardian Signature Date

Parent Permission to Provide Speech Fluency RtI Services

Student: Date:

Date of Birth: Grade: School:

Informal screening indicated your child has a speech fluency difficulty that is considered non-developmental.

We would like to provide RtI speech fluency services at school for your child to try to correct this fluency difficulty. The RtI speech fluency services would be provided by a qualified Speech-Language Pathologist employed by the school district. Services would be on a periodic basis in an individual or small group setting. The Speech-Language Pathologist and your child's classroom teacher would plan together to determine the best time for your child to receive this instruction.

This is a plan for intervention, and is not a special education or related service under the Individuals with Disabilities Education Act (IDEA). If your child's response to this intervention indicates a long-term problem which may negatively impact educational performance, a referral will be made for evaluation. You may also request an evaluation.

Your permission is requested in order to provide RtI speech fluency services. Please mark your choice where indicated and return this form to the school office. A copy is provided for your records. Please contact us if you have any questions about speech fluency interventions or this request.

, Principal

, Speech-Language Pathologist

Phone:

_____ I agree to RtI speech services for my child to address fluency difficulties in speech.

_____ I prefer that my child not receive RtI speech services at this time.

_____ _____

Parent/Guardian Signature Date

Parent Permission to Provide Speech Voice RtI Services

Student: Date:

Date of Birth: Grade: School:

Informal screening indicated your child has a voice difference (in pitch, loudness, and/or quality of voice) that is considered non-developmental. I encourage you to have this checked by your child's doctor and/or an Ear Nose and Throat physician.

Once I receive documentation from a physician that it would be appropriate for me to provide voice services for your child's voice difference, we would like to provide RtI voice services at school for your child to try to alleviate and/or decrease his/her voice difference. The RtI voice services would be provided by a qualified Speech-Language Pathologist employed by the school district. Services would be on a periodic basis in an individual or small group setting. The Speech-Language Pathologist and your child's classroom teacher would plan together to determine the best time for your child to receive this instruction.

This is a plan for intervention and is not a special education or related service under the Individuals with Disabilities Education Act (IDEA). If your child's response to this intervention indicates a long-term problem which may negatively impact educational performance, a referral will be made for evaluation. You may also request an evaluation.

Your permission is requested in order to provide RtI voice services. Please mark your choice where indicated and return this form to the school office. A copy is provided for your records. Please contact us if you have any questions about voice interventions or this request.

, Principal

, Speech-Language Pathologist

Phone:

_____ I agree to RtI voice services for my child to address his/her voice difference.

_____ I would prefer that my child not receive RtI voice services at this time.

_____ _____

Parent/Guardian Signature Date

Dismissal from RtI Speech Articulation Services

Student: Date:

Date of Birth: Grade: School:

I am pleased to inform you that your child's response to RtI Speech Articulation Services has been incredibly positive. Your child no longer exhibits speech concerns that are considered to be non-developmental. Your child is able to correctly produce the ____ sound at the conversation level with at least 85% accuracy across 3 to 4 days. This level of mastery is considered age appropriate for your child. Therefore, your child will not continue to see the Speech-Language Pathologist for RtI Speech Services. Please contact us if you have any questions.

, Principal

, Speech-Language Pathologist

Phone:

Dismissal from RtI Speech Fluency Services

Student: Date:

Date of Birth: Grade: School:

I am pleased to inform you that your child's response to RtI Speech Fluency Services has been incredibly positive. Your child no longer exhibits a fluency difficulty that is considered non-developmental. Therefore, your child will not continue to see the Speech-Language Pathologist for RtI Speech Fluency Services. Please contact us if you have any questions.

, Principal

, Speech-Language Pathologist

Phone:

Dismissal from RtI Speech Voice Services

Student: Date:

Date of Birth: Grade: School:

I am pleased to inform you that your child's response to RtI Speech Voice Services has been incredibly positive. Your child no longer exhibits a voice difference that is considered non-developmental. Therefore, your child will not continue to see the Speech-Language Pathologist for RtI Speech Voice Services. Please contact us if you have any questions.

, Principal

, Speech-Language Pathologist

Phone: