

# 2

## Components of MTSS

### Learning Objectives

After reading this chapter, you should be able to:

- Identify the four pillars of Multi-Tiered Systems of Support.
- Describe the three tiers of varying levels of evidence-based supports.
- Define universal screening.
- Explain progress monitoring.
- Discuss the importance of data-based decision-making.

### The Four Pillars of MTSS

Although MTSS is now a common term used in schools today, it was not always a buzzword known to educators. One of the earliest known uses of the term “multi-tiered systems of support” came out of the state of Kansas in 2008 as an effort to reduce confusion over initiatives to shift from standard response to intervention (RTI) to school-wide RTI (Kansas Technical Assistance Network, 2012; Pullen, van Dijk, Gonsalves, Lane, & Ashworth, 2018). Since then, the term has evolved to encompass a model that “houses” two or more intervention service delivery models or “systems,” such as RTI and school-wide positive behavior support (SWPBS). As mentioned in the previous chapter, the evolution of MTSS encompassing two or more intervention service delivery models was due to a growing recognition that critical components of response to intervention and SWPBS often mirrored and complemented one another (Freeman, Miller, & Newcomer, 2015). Such mirroring provided an outlet for initial efforts to merge common elements of RTI and SWPBS under MTSS (Eagle, Dowd-Eagle, Snyder, & Holtzman, 2015). Another reason for joining intervention service delivery models under MTSS is that a growing body of research suggests that integrated approaches under MTSS are associated with greater improvements in both academic and behavioral outcomes (Eagle et al., 2015; Stewart, Benner, Martella, & Marchand-Martella, 2007).

Intervention service delivery models, such as RTI and SWPBS, easily integrate and align under MTSS by sharing the four common components or “pillars.” These four pillars comprise the framework of building an effective MTSS “house” and include (1) varying levels of preventative evidence-based supports; (2) universal screening; (3) progress monitoring; and (4) data-based decision-making (Freeman et al., 2015; Harn, Basaraba, Chard, & Fritz, 2015; National Association of School Psychologists, 2016). Descriptions of the four pillars that form the framework of the MTSS “house” can be found below.

### Pillar 1: Varying Levels of Evidence-Based Supports

Like the three-tiered pyramid found in the public health model, the first critical element to building an effective MTSS “house” includes varying levels of evidence-based supports and instructional practices. Through varying levels of evidence-based supports and instructional practices, students are assigned to tiers (e.g., Tier 1, Tier 2, and Tier 3) that increase in intensity and duration based on their lack of responsiveness to interventions at a prior level (Schaffer, 2017). Typically, evidence-based supports and instructional practices are delivered in the form of interventions and programs.

As mentioned in chapter 1, **evidence-based interventions** consist of treatments or supports that have been peer-reviewed and demonstrate empirical support for effectiveness (D’Amato et al., 2011; King & Coughlin, 2016). Similarly, **evidence-based programs** have demonstrated empirical support but consist of many interventions, tend to be standardized, and are often sold commercially. An example of an evidence-based intervention would be using flash cards to help students with sight word recognition. An example of an evidence-based program would be using Road to the Code to teach early literacy skills. Evidence-based interventions and programs are used to varying degrees of intensity across the three tiers. The least intense interventions and programs are implemented at Tier 1, and the most intense interventions and programs are implemented at Tier 3 (Wexler, 2017). The following paragraphs briefly outline the varying levels of evidence-based supports across all intervention service delivery models that fall under MTSS.

**Tier 1**, or universal supports, refer to interventions and services that are available to all students across the academic, behavioral, or social-emotional domains (Gresham, Reschly, & Shinn, 2010; Harn et al., 2015; National Association of School Psychologists, 2016). Therefore, Tier 1 refers to the core curriculum and interventions delivered to all students and has a high likelihood of bringing most students to acceptable levels of proficiency (Averill & Rinaldi, 2011). Examples of Tier 1 supports include implementation of the core literacy curriculum, teaching and defining school rules and expectations, and employing a classroom-wide mental wellness program. Approximately 80%–85% of students are expected to respond to interventions at the Tier 1 level (Gresham et al., 2010; Harn et al., 2015; Wexler, 2017).

**Tier 2**, or targeted supports, is made available to some students who need additional interventions to assist them in overcoming their academic, behavioral, or social-emotional deficits (Wexler, 2017). Tier 2 services supplement core instruction and provide students with more time and opportunities to practice the skills they are struggling with (Wexler, 2017). Interventions and supports at Tier 2 are designed to require low effort from school personnel and tend to be structured around standardized protocol or prescribed curricula (Drevon, Hixson, Wyse, & Rigney, 2018; Joyce-Beaulieu & Sulkowski, 2020). At Tier 2, children tend to receive interventions and programs through push-in or pull-out groups (Schaffer, 2017). **Push-in group intervention** refers to small group instruction that occurs in the child’s classroom, while **pull-out**

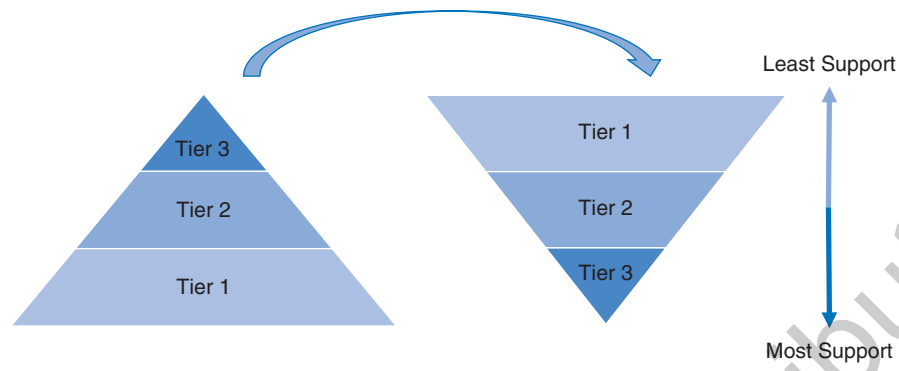
**group intervention** refers to group support that is provided outside the student's classroom (Simonsen, Britton, & Young, 2010). Both push-in and pull-out groups at Tier 2 supplement the core learning and behavioral curriculum. According to Kilanowski (2010), supplemental instruction involves delivering instruction to students outside of the core curriculum and features standard protocol interventions or programs. Therefore, supplemental interventions at Tier 2 are provided in addition to core Tier 1 instruction.

As mentioned, supplemental instruction at Tier 2 tends to involve the use of standard protocol interventions and programs (Kilanowski, 2010). **Standard protocol interventions and programs** provide educators standardized and readily available supports to address the most common weaknesses experienced by students (King & Coughlin, 2016). An example of a standard protocol program at Tier 2 would be Great Leaps for developing reading fluency in children or First Step to Success to assist at-risk children in meeting behavior expectations. Pending on the intervention service delivery model being implemented, typically three to eight children are placed in a group and receive services three to five times a week for thirty to forty-five minutes. Interventions and supports at this tier may include small group reading intervention, small group counseling, or behavior skills training (Harn et al., 2015; National Association of School Psychologists, 2016). Approximately 10%–15% of students receive Tier 2 interventions or services (Gresham et al., 2010; Wexler, 2017).

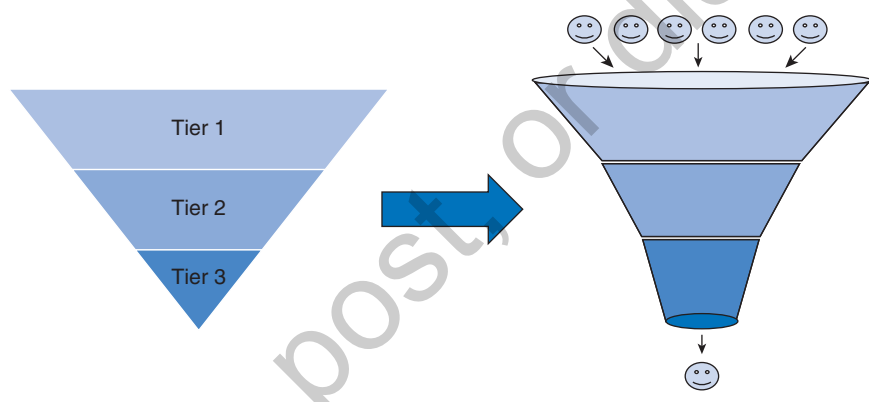
Finally, Tier 3, or tertiary interventions, are designed for 1%–5% of students with severe or chronic deficits that are beyond the capacity of Tier 1 or Tier 2 intervention efforts (Sugai & Horner, 2008; Wexler, 2017). Like Tier 2, Tier 3 is designed to supplement Tier 1 instruction and supports. However, unlike Tier 2, Tier 3 interventions and supports are only delivered through pull-out services and instruction. Therefore, Tier 3 interventions and supports are more intense and rigorous than those provided at Tier 1 or Tier 2 (Shinn & Walker, 2010; Wexler, 2017). Due to the intensity and individualization of interventions at Tier 3, supports are generally delivered to students through a problem-solving approach as opposed to the standard protocol method used at Tier 1 and Tier 2 (King & Coughlin, 2016). The problem-solving method utilizes specific and individually designed assistance to meet student's needs (King & Coughlin, 2016). For example, through the problem-solving method, although two students may be showing the same behavioral deficits, they may react differently to the interventions and supports provided. Therefore, each student may need their own specific set of interventions to assist them in remediating their unique challenges. Examples of Tier 3 interventions and services may include individualized instruction, FBA/BIP development, or one-to-one intensive counseling.

Traditionally, varying levels of preventative evidence-based supports and interventions within intervention service delivery models have been viewed as a three-tiered right-side-up triangle. However, a better understanding for how they operate may be to turn the triangle upside down and view them flowing from least to most intense interventions (see [Figure 2.1](#)). Such a view may be familiar to educators and in line with least restrictive environment as the upside-down triangle follows a continuum of services from least to most intense interventions. Additionally, a better understanding of how intervention service delivery models operate may be provided by turning the triangle upside down as they can be viewed as a funnel providing most children Tier 1 support, some children Tier 2 support, and very few children Tier 3 support (see [Figure 2.2](#)). [Figure 2.3](#) shows the foundation of MTSS, and the first pillar in constructing the MTSS “house.”

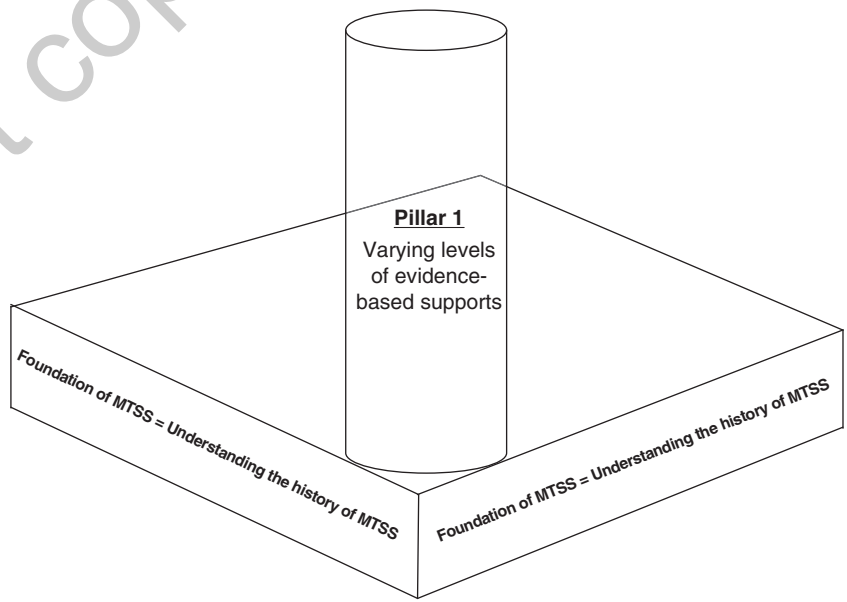
**FIGURE 2.1** ● Turning the Triangle Upside Down



**FIGURE 2.2** ● Viewing Intervention Service Delivery Models as a Funnel



**FIGURE 2.3** ● The Foundation to Constructing the MTSS “House” and Pillar 1



## Pillar 2: Universal Screening

A second critical component, or “pillar,” in facilitating an effective MTSS framework involves the use of **universal screening**. Similar to the fields of medicine and public health, universal screeners provide a quick and cost-efficient method for identifying students who may require additional interventions or supports (Pentimonti, Walker, & Edmonds, 2017). Universal screening involves the brief systemic assessment of the school population to determine children who are not responding to Tier 1 interventions and is the first step in identifying children at-risk for academic, behavioral, or social-emotional deficits (National Association of School Psychologists, 2016; Pentimonti et al., 2017). Universal screening the entire school population typically takes place in the fall, winter, and spring of each school year and is known as benchmarking (Jenkins, Hudson, & Johnson, 2007; Pentimonti et al., 2017). It is important to consistently administer universal screeners at predetermined times because some students may perform within the typical range at the start of the school year but struggle and fall into the at-risk range as the year progresses (Pentimonti et al., 2017).

Several features define universal screeners. First, universal screeners tend to be curriculum-based measures. **Curriculum-based measures (CBM)** are measures that are used by educators to quickly determine the level and rate of performance in acquiring necessary skills or content knowledge (Van Norman & Christ, 2016). CBMs are extremely sensitive to systemic change in student learning and provide ongoing insight as to whether the student is meeting basic grade-level expectations (Schaffer, 2017; Van Norman & Christ, 2016).

Second, measures used for universal screening should be selected to target skills appropriate to the grade level and be indicative of overall functioning in the area they are measuring, such as reading fluency (Arden & Pentimonti, 2017; Pentimonti et al., 2017). In other words, universal screeners should be aligned to the curriculum and measure the basic skills of what educators want students to know given that curriculum. Therefore, educators should administer universal screeners that are relevant in the area and grade levels taught. For example, a school should not have teachers administer a universal screener in early reading skills, such as letter-naming, to eighth-grade students who have more than mastered the skill. Likewise, a school should not have teachers administer universal screeners to students that are too advanced for their grade level, such as screening kindergarteners in comprehension before they can identify all the letters of the alphabet.

The third feature of universal screeners is that they are quick to administer and efficient to score (Pentimonti et al., 2017). Typically, administration time for most universal screeners is under ten minutes and rarely exceeds fifteen minutes (Schaffer, 2017). Universal screeners are designed to be quick to administer and score to make them less costly to districts compared to more comprehensive measures.

The fourth characteristic of universal screeners is that they must be valid and reliable tools that are extremely sensitive to measuring small degrees of change or growth in student performance (Pentimonti et al., 2017; Schaffer, 2017). In other words, universal screeners should be psychometrically sound and measure what they are designed to assess. Additionally, universal screeners should demonstrate that they are reliable measures through consistently showing their effectiveness for measuring minute learning and behavioral outcomes.

A final feature of universal screeners is that they allow for comparison to **national and local norms** (Pentimonti et al., 2017; Schaffer, 2017). To elaborate, universal screeners should enable users to compare student performance to children of the same age across the nation to determine whether they are meeting expectations (Schaffer, 2017). Additionally, if a district does not want to compare a student to national norms, they can compare the youth to how the student is performing on the universal screener to other students of the same age in the district by developing local norms.

Aside from the characteristics of universal screeners, such measures serve three primary purposes. As previously discussed, the first purpose of universal screening is to detect deficits early on to provide children timely and effective evidence-based interventions to overcome areas of concern. The second purpose is to provide data on the effectiveness of the core curriculum and whether students are responding appropriately to the curriculum put into place. The final purpose of universal screening is to reveal whether a core program is being delivered effectively by instructors.

Universal screening may be able to provide insight on the effectiveness of the core curriculum by showing whether a Tier 1 program is meeting the needs of students. For example, a district has selected Harcourt as a Tier 1 reading program to teach children in first-grade reading comprehension. However, after fall and winter universal screening, the district notices that 70% of its students continue to fall in the at-risk range in reading comprehension. Consequently, the district reconsiders whether Harcourt is an effective Tier 1 program for teaching its students in the area of reading comprehension. It has generally been recommended that if more than 20%–30% of students are found to be at-risk during fall, winter, or spring benchmarking, that core instructional practices at Tier 1 may need strengthening (Arden & Pentimonti, 2017; Bartholomew & De Jong, 2017).

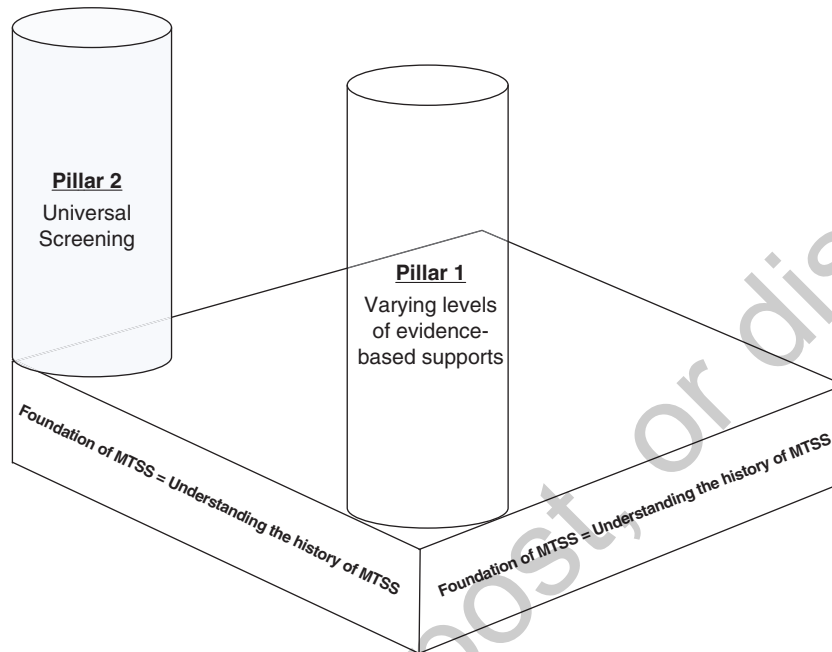
As mentioned, aside from indicating whether a program is effective at meeting the needs of students, universal screening may reveal whether a core program is being delivered effectively by teachers. For instance, within a school district, universal screening results show that most students are responding as expected to Harcourt reading instruction. However, further evaluation reveals that one classroom across the district has 60% of its students being deemed at-risk for reading comprehension deficits. As a result, educators may question whether the program is being implemented effectively and as outlined. When evaluating universal screening results, Pentimonti et al. (2017) suggest educators ask several questions of which include:

- Do most students appear to be benefiting from the core program as indicated by universal screening?
- What percentage of students require additional intervention beyond the Tier 1 supports being provided?
- Have the universal screening numbers changed from one benchmarking period to the next (e.g., winter to spring)?
- If students appear to not benefit from the core program as indicated by universal screening results, what factors may be contributing to the ineffectiveness of the program (e.g., core program is not a good fit for students' needs, core program is too difficult for teachers to implement with fidelity, instructors failing to understand or lacking training in how to utilize the program)?
- Is the universal screening measure a valid and reliable tool in the area it is assessing students in? In other words, does the universal screener measure what it is designed to measure, and has the universal screener demonstrated in the scholarly literature that it is a trustworthy assessment of the construct it is measuring?
- Are those administering the universal screener properly trained and comfortable in using it?

Aside from all these questions, it is important for educators to understand that no single measure, whether used for universal screening or progress monitoring, is currently comprehensive enough to examine students for all areas of educational risk. Nonetheless, screeners have been or are being developed to identify the academic, behavioral, and social-emotional needs of students. Examples of some of these measures include Aimsweb's Reading CBM,

Behavior and Emotional Screening System (BESS), Devereux Student Strengths Assessment-Mini (DESSA-Mini), and Systemic Screening for Behavior Disorders (SSBD) (Schaffer, 2017). Figure 2.4 shows the second pillar needed to build the MTSS “house.”

**FIGURE 2.4** • The Second Pillar Needed to Construct the MTSS “House”



### Pillar 3: Progress Monitoring

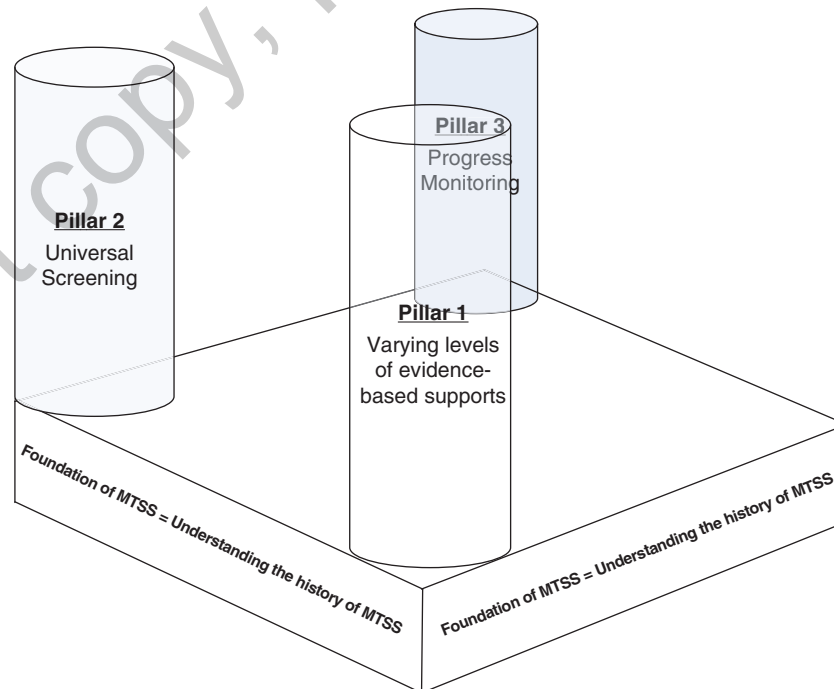
Another feature of an effective MTSS framework utilizes **progress monitoring**. Progress monitoring involves the repeated assessment of skills and strategies learned to determine whether a child is responding to the interventions and services being provided (Shapiro, 2013). Progress monitoring takes place at Tier 2 and Tier 3 of MTSS. Several features characterize measures used for progress monitoring. First, progress monitoring measures should be brief, valid, and reliable (Pentimonti et al., 2017). Next, assessments used for progress monitoring should be administered at regular intervals (Pentimonti et al., 2017). For example, at the Tier 2 level, progress monitoring tends to occur on a weekly or biweekly basis; while at the Tier 3 level, progress monitoring tends to occur on a weekly basis (Christ, Zopluoglu, Monaghan, & Van Norman, 2013; Pentimonti et al., 2017; Shapiro, 2013). A final characteristic of progress monitoring tools is that the data collected from them can be used to inform instructional decisions on whether the interventions being provided are working. For example, through collecting progress monitoring data over time, teachers can graph a student’s performance and calculate the growth the student has made in response to the interventions being provided. Additionally, educators can determine whether the student is on track toward remediating their learning or behavioral deficits or whether the child is in need of another intervention or more intense support.

To best determine whether students are making enough progress, there has been a general call by scholars to collect at least 12–14 weeks of data for measures of academic progress, such as Aimsweb’s Reading CBM or easyCBM Reading (Ardoin & Christ, 2009;

Ball & Christ, 2012; Shapiro, 2013; Van Norman & Christ, 2016). This recommendation would mean that for a student who is receiving intensive supports at Tier 3 level and being progress monitored on a weekly basis, 12 to 14 data points should be collected before a decision can be made as to whether the interventions provided are working. Although the time period for collecting progress monitoring data on screeners for behavioral and social-emotional deficits appears to be less stringent, there tends to be a consensus that more data points collected over a longer period of time will lead to a more accurate read as to whether the child is responding to intervention (Ball & Christ, 2012; Van Norman & Christ, 2016).

The ongoing call for collecting more data points over a longer period of time is based on findings that progress monitoring outcomes are highly unstable when interventions occur over periods of less than two months (Ball & Christ, 2012; Van Norman & Christ, 2016). Over a shorter period of time, progress monitoring tools may be unstable measures of a student's response to intervention because they are very sensitive to variations in performance attributed to examiner characteristics, delivery of directions, setting, and difficulty of content across measures (Ball & Christ, 2012; Van Norman & Christ, 2016). Due to these variables not being accounted for, the widely accepted belief that six to eight data points are enough to make an adequate decision of whether a student is responding to the supports provided is inaccurate. It is generally viewed that by collecting 12–14 weeks of data, a more stable read can be obtained on whether the student is truly responding to intervention (Shapiro, 2013). On the contrary, by failing to collect more data points over longer periods of time, students may prematurely be pulled from interventions they may have responded to or, even worse, the student could be quickly streamlined into receiving special education services (Van Norman & Christ, 2016). Figure 2.5 shows the third pillar needed to build the MTSS "house."

**FIGURE 2.5** ● The Third Pillar Needed to Construct the MTSS "House"





## Pillar 4: Data-Based Decision-Making

Finally, the proper implementation of MTSS involves making effective data-driven decisions. Before delving into what data-based decision-making entails, it is important to understand what data are in an educational context. Lai and Schildkamp (2013) defined educational data as information that is collected systemically and organized to represent some aspect of schooling. Data not only include information on assessment and student achievement but also encompasses both qualitative and quantitative data on the functioning of the school (Schildkamp, Poortman, Luyten, & Ebbeler, 2017). Some types of data collected by schools include input data (e.g., student background data), context data (e.g., information about the building or district), and process data (e.g., teacher interviews and classroom observations) (Schildkamp et al., 2017). Arguably, the most familiar type of data to educators is output data, such as student achievement data (Schildkamp et al., 2017).

In addition to the different types of data collected by school districts, data on school and district functioning and student achievement can be either formal or informal. Examples of formal data include curriculum-based measures, computer-adaptive tests, state exams, behavior rating scales, medical records, and student attendance data. Examples of informal data include classroom observations, teacher-developed assignments, tests, student work samples, teacher reports, school projects, staff interviews, district-developed staff questionnaires, and parent feedback. Each of these sources of data may play varying levels of importance in making data-based decisions at the district, school, class, and student levels.

**Data-based decision-making** refers to the continual process of collecting and interpreting data to alter and improve instructional and behavioral practices to best benefit learners (Prenger & Schildkamp, 2018). The term “decision” in data-based decision-making indicates that a variety of actions can be undertaken on the basis of data, such as adapting instruction and curriculum, setting goals, evaluating the effectiveness of programs and interventions, improving policy, and reallocating time, funds, and resources (van Geel, Keuning, Visscher, & Fox, 2016). Modern-day data-based decision-making in education can be attributed to an approach pioneered by Deno and Mirkin in 1977 called data-based program modification (DBPM) (Espin, Wayman, Deno, & McMaster, 2017). In DBPM, data-based systemic procedures were used to evaluate the effectiveness of interventions for students experiencing difficulties in school (Espin et al., 2017). Similar to Witmer’s problem-solving process outlined in chapter one, DBPM assumed that interventions designed to assist students are “hypotheses” that need to be “empirically tested” before a decision could be made about whether they were effective (Espin et al., 2017). For comparison, recall that Witmer’s original proposal called for the development of “hypotheses” concerning appropriate intervention. Additionally, Witmer’s proposed evaluating the intervention or “hypothesis” to establish an evidence-base as to whether it was effective at remediating the child’s area of deficit.

Since 1977, the importance of data-based decision-making being incorporated into everyday educational decisions and instructional practices has been increasingly highlighted by educational law and policy. More and more data are being used to evaluate district and school performance, teacher effectiveness, instructional methodology, and student achievement. With so much pressure and accountability being placed on data, educators have become wary, defensive, and exasperated by mere mention of the word—“data.” However, the use of data has numerous and profound benefits for educators and students. At the district and school level, data can be used to determine if yearly improvement goals are being met in the areas of academics, behavior, and attendance based on student learning results from state tests, universal screening data,

discipline data, and school attendance records. Additionally, data can be used to determine if core programs are effective at meeting state learning standards. For example, after using the core math program TouchMath, a district notes that 80% of students are meeting expectations during winter benchmarking, and first quarter student report cards further bolster universal screening results in that most students are responding to the curriculum.

At the classroom level, data allow educators to prioritize their time to target areas most needed (Hamilton et al., 2009; Schildkamp et al., 2017). For example, after reviewing universal screening results from the school psychologist and evaluating student performance on a recent quiz, a teacher may realize that a number of her students are still performing in the at-risk range on single-digit addition. Therefore, the teacher may decide to spend additional time re-teaching critical components to single-digit addition as opposed to moving onto double-digit addition. Additionally, teachers may use data, such as student interviews, homework, classroom observations, and in-class assignments, to improve their instruction, set learning goals, pace their lessons, differentiate instruction, and provide individual students and the class feedback on their learning progress (Prenger & Schildkamp, 2018; Schildkamp et al., 2017).

Finally, at the student level, data can be used to identify student strengths, weaknesses, and provide student feedback. This student feedback is critical to advancing the understanding of concepts taught, providing focus on areas of improvement, and differentiating instruction to meet learner's needs. For example, a teacher may write comments and correct errors on a student's research report or write down an example of how to correctly solve a problem on a child's homework. Additionally, progress monitoring data may provide insight on whether a student is responding to interventions being implemented or whether a change in supports is needed.

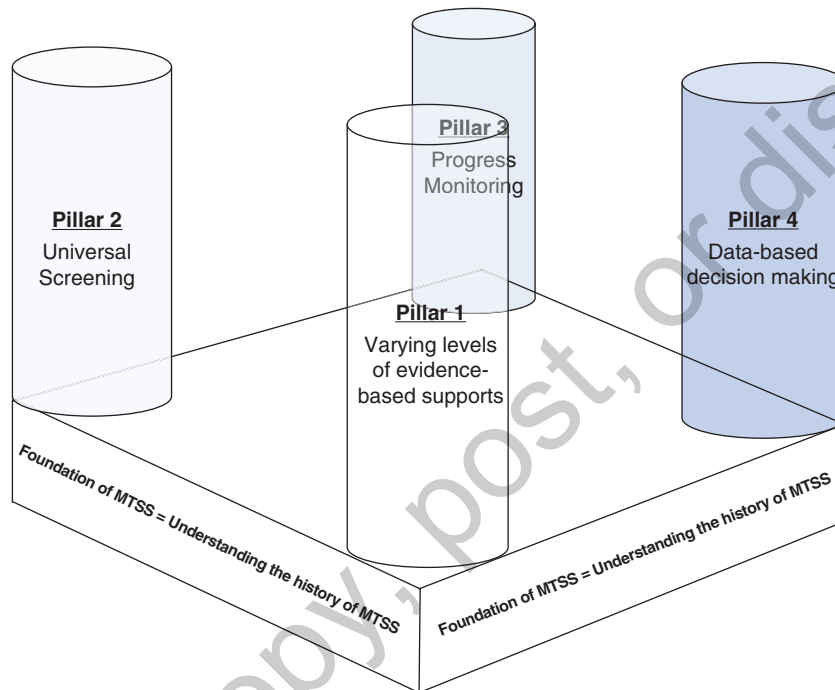
Data and data-based decision-making are critical in building and maintaining the overall quality of education. In regards to MTSS and interventions service delivery models, both formal and informal data play a significant role and support one another in determining whether a student is in need of more support or whether an intervention being provided is effective. Typically leading data-based decisions in the context of MTSS and movement of students to higher or lower levels of support in three-tier intervention service delivery models is the utilization of curriculum-based measures. Supplementing the formal data of curriculum-based measures may be informal data such as student work samples, discipline reports, nurse office visits for somatic complaints, and teacher report.

For example, after universally screening a class in mathematics, one student in the class was found to be at risk and in need of Tier 2 targeted intervention in hopes of remediating her math deficits. Before recommending the student to Tier 2, the school's child study team holds a meeting with the student's teacher to go over the results of the student's universal screening data and brainstorm possible interventions and supports available to the student. To further support the universal screening results, the teacher brings with him samples of the student's work on single-digit addition and subtraction, a recent quiz, and provides a verbal report. Each further bolsters why the student is in need of Tier 2 math support and which intervention may be best to remediate the child's deficits. Therefore, in this case, the student's informal data further add to the universal screening data that this student is in need of additional support.

On the contrary, in rare instances, formal universal screening data may identify a student at risk but informal data provided by the teacher may not support that the student is at risk and in need of Tier 2 intervention. In cases such as these, there are a number of factors that could be attributed to the student performing below expectations such as student motivation, whether the student was feeling well at the time screened,

examiner characteristics, and delivery of directions (Ball & Christ, 2012). Therefore, both formal and informal data are vital in providing insight in moving students to higher or lower levels of support within intervention service delivery models. In the following chapters, discussions will be held on how to effectively use data to move students through the tiers of the four most common intervention service delivery models: RTI, SWPBS, social-emotional RTI, and suicide prevention and intervention. Figure 2.6 shows the fourth pillar needed to construct the MTSS “house.”

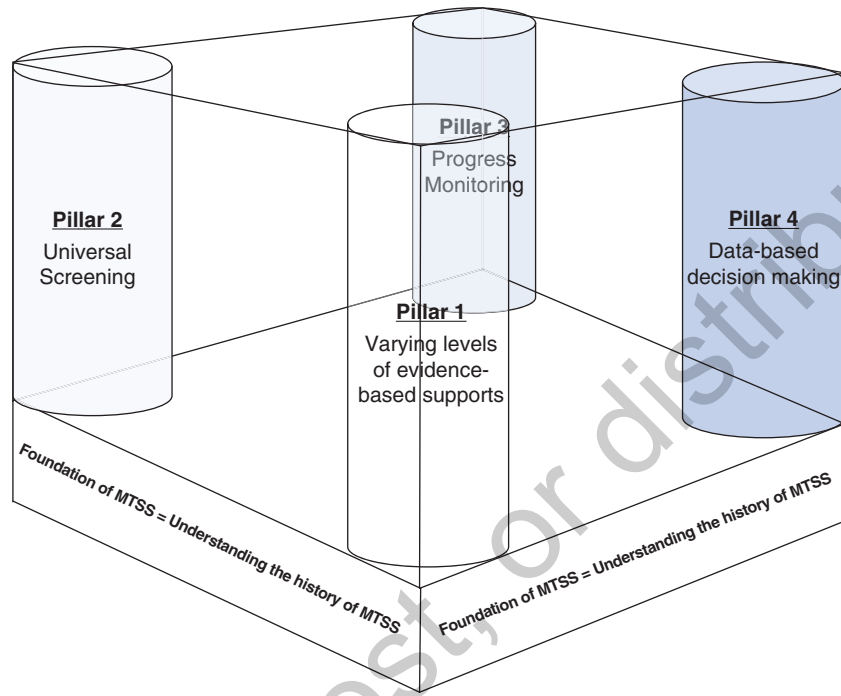
**FIGURE 2.6** • The Fourth Pillar Needed to Construct the MTSS “House”



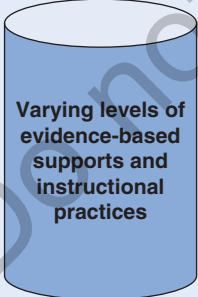
## Conclusion

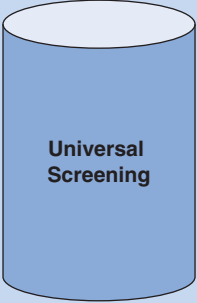

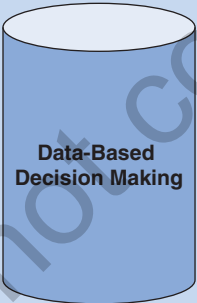
Understanding, outlining, and implementing the four “pillars” that link all intervention service delivery models is critical to building MTSS. Without each of the pillars being implemented accordingly across intervention service delivery models, a true MTSS framework is not able to be executed properly. Therefore, in order to link intervention service delivery models and align them under MTSS, it is vital that the four pillars of varying levels of preventative evidence-based supports and interventions, universal screening, progress monitoring, and data-based decision-making are put into place. Figure 2.7 shows all the pillars linked together to form the framework to the MTSS house. Table 2.1 provides a brief summary of all the pillars in the MTSS “house.”

**FIGURE 2.7** ● All the Pillars Linked Together to Form the Framework to the MTSS “House”



**TABLE 2.1** ● Summary of the Four Pillars of MTSS

Four Pillars of MTSS	
<ul style="list-style-type: none"> <li>• <u>Varying levels of preventative evidence-based supports and interventions</u></li> </ul> <p style="text-align: center;"><b>Pillar 1</b></p>  <p style="text-align: center;">Varying levels of evidence-based supports and instructional practices</p>	<p><i>Levels of evidence-based supports and interventions within an intervention service delivery model are based on student need and include the following:</i></p> <ul style="list-style-type: none"> <li>• <b>Universal Interventions (Tier 1):</b> 80%–85% of children will respond to Tier 1 interventions that apply to <u>ALL</u> students and tend to be more generalized interventions and less specific (i.e., general class reading instruction, posting classroom rules, teaching mental wellness skills to all children, etc.).</li> <li>• <b>Targeted Interventions (Tier 2):</b> 10%–15% of students will not respond to Tier 1 interventions and as a result may require more intensive supports under Tier 2. Tier 2 interventions tend to occur outside of core instruction time three to five times per week with groups of three to six children receiving more intense and explicit instruction (i.e., reading groups, behavior support groups, or social-emotional support groups). Group intervention time varies from 20 to 40 minutes.</li> <li>• <b>Intensive Interventions (Tier 3):</b> 1%–5% of students will not respond to Tier 2 interventions and as a result may require tertiary support. Tier 3 interventions tend to occur outside core instruction in which the student is pulled from the classroom and receives 1:1 instruction in their area of deficit. Recommended tertiary intervention time is 45–60 minutes, five days per week.</li> </ul>

Four Pillars of MTSS	
<ul style="list-style-type: none"> <li>• <b>Universal Screening</b> Pillar 2</li> </ul>  <p style="text-align: center;"><b>Universal Screening</b></p>	<p><b>Universal screening</b> is typically conducted three times per year and is used to identify or predict children who may be at risk for poor learning outcomes or developing social, emotional, or behavioral deficits. Universal screeners are typically brief (under eight minutes to administer) and completed by all students at a grade level to determine which students are at risk.</p>
<ul style="list-style-type: none"> <li>• <b>Progress Monitoring</b> Pillar 3</li> </ul>  <p style="text-align: center;"><b>Progress Monitoring</b></p>	<p><b>Progress monitoring</b> provides an ongoing assessment to evaluate whether an at-risk student is benefiting from more intense levels of intervention (Tier 2 or Tier 3). At the Tier 2 level, progress monitoring should take place on a bimonthly basis or more. At Tier 3, progress monitoring should occur on a weekly to biweekly basis.</p>
<ul style="list-style-type: none"> <li>• <b>Data-Based Decision-Making</b> Pillar 4</li> </ul>  <p style="text-align: center;"><b>Data-Based Decision Making</b></p>	<p><b>Data-Based Decision-Making</b> entails the ongoing process of collecting and using screening, progress monitoring, and other forms of data (grades, office referrals, etc.) to make decisions about whether a student is benefiting from their instruction, movement to within a three-tiered intervention service delivery model, and disability determination. If the data indicate that a student is not responding to the interventions provided, a change in the supports and strategies used may be warranted or, after all interventions have been exhausted fail, a special education referral may be considered.</p>

### Discussion Questions

1. Why do you think it is important to have varying levels of evidence-based supports and interventions available to children?
2. Do you think universal screening is an effective method for identifying children who may need additional interventions or supports? Why or why not?
3. Why do you think it is important to compare student performance to national or local norms within a school district?
4. How can progress monitoring be used to inform instructional decisions on whether the supports being provided are helping struggling learners?
5. Why is it important for educators to make decisions based on data?

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