

**Glenn County Office of Education  
Speech & Language Service  
Guidelines, Policies, and Best Practice**

For Educationally Based Speech Services in Glenn  
County Schools

**Glenn County Special Education Local Plan Area**  
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## **Introduction**

The information contained within these guidelines and policies serves as the best practices for delivery of speech and language services in the Glenn County Special Education Local Plan Area (SELPA). It is a collected work of all the county's and district Speech and Language Specialists and represents our agreed upon guidelines to assist in decision making about how to provide services and meet the needs of the students we serve.

Any questions about these guidelines should be addressed to:

Glenn County SELPA  
311 South Villa Avenue  
Willows, California 95988  
(530) 934-6575

## **Mission Statement**

*To provide and implement policies and procedures that will meet the speech and language needs of students in a uniform and consistent manner throughout Glenn County in compliance with federal regulations, state laws, special education codes, and professional standards of practice.*

***\*These guidelines are adapted from information from CASHA, North Carolina Guidelines, Tennessee Guidelines, Kansas Guidelines, Riverside SLP Guidelines, San Diego Unified SLP guidelines, Past Glenn County Office of Education Guidelines and Federal/State Education Codes.***

**Eligibility Criteria/Definitions for Speech and  
Language Disorders in Educational Settings  
Section I**

## **Eligibility Criteria/Definitions for Speech and Language Disorders**

### **Code of Federal Regulations- Title 34: Education**

Subtitle B- Regulations of the Office of the Department of Education  
Chapter III – Office of Special Education and Rehabilitative Services, Department of  
Education

Part 300 – Assistance to States for the education of Children with Disabilities  
Subpart a – General

**34 C.F.R. §300.7 Child with a disability.** (c) Definitions of disability terms. (11)  
**Speech or 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.

### **CALIFORNIA CODE OF REGULATIONS TITLE 5. EDUCATION**

Division 1. California Department of Education  
Chapter 3. Handicapped Children  
Subchapter 1. Special Education

#### **Article 3.1. Individuals with Exceptional Needs**

**3030. Eligibility Criteria.** A pupil shall qualify as an individual with exceptional needs, pursuant to Section 56026 of the Education Code, if the results of the assessment as required by Section 56320 demonstrate that the degree of the pupil's impairment as described in Section 3030 (a through j) requires special education in one or more of the program options authorized by Section 56361 of the Education Code. He decision as to whether or not the assessment results demonstrate that the degree of the pupil's impairment requires special education shall be made by the individualized education program team, including assessment personnel in accordance with Section 56341(d) of the Education Code. The individualized education program team shall take into account all the relevant material which is available on the pupil. No single score or product of scores shall be used as the sole criteria for the decision of the individualized education program team as to the pupil's eligibility for special education. The specific processes and procedures for implementation of these criteria shall be developed by each Special Education Local Plan Area and be included in the local plan pursuant to Section 56220(a) of the Education Code.

(a) A pupil has a hearing impairment, whether permanent or fluctuating, which impairs the processing of linguistic information through hearing, even with amplification, and which adversely affects educational performance. Processing linguistic information includes speech and language reception and speech and language discrimination.

(b) A pupil has concomitant hearing and visual impairments, the combination of which causes severe communication, developmental, and educational problems.

(c) A pupil has a language or speech disorder as defined in Section 56333 of the Education Code, and it is determined that the pupil's disorder meets one or more of the following criteria:

(1) Articulation disorder.

(A) The pupil displays reduced intelligibility or an inability to use the speech mechanism which significantly interferes with communication and attracts adverse attention. Significant interference in communication occurs when the pupil's production of single or multiple speech sounds on a developmental scale of articulation competency is below that expected for his or her chronological age or developmental level, and which adversely affects educational performance.

(B) A pupil does not meet the criteria for an articulation disorder if the sole assessed disability is an abnormal swallowing pattern.

(2) Abnormal Voice. A pupil has an abnormal voice which is characterized by persistent, defective voice quality, pitch, or loudness.

(3) Fluency Disorders. A pupil has a fluency disorder when the flow of verbal expression including rate and rhythm adversely affects communication between the pupil and listener.

(4) Language Disorder. The pupil has an expressive or receptive language disorder when he or she meets one of the following criteria:

(A) The pupil scores at least 1.5 standard deviations below the mean, or below the 7<sup>th</sup> percentile, for his or her chronological age or developmental level on two or more standardized tests in one or more of the following areas of language development: morphology, syntax, semantics, or pragmatics. When standardized tests are considered to be invalid for the specific pupil, the expected language performance level shall be determined by alternative means as specified on the assessment plan, or

(B) The pupil scores at least 1.5 standard deviations below the mean or the score is below the 7<sup>th</sup> percentile for his or her chronological age or developmental level on one or more standardized tests in one of the areas listed in subsection (A) and displays inappropriate or inadequate usage of expressive or receptive language as measured by a representative spontaneous or elicited language sample of a minimum of fifty utterances. The language sample must be recorded or transcribed and analyzed, and the results included in the assessment report. If the pupil is unable to produce this sample, the language, speech, and hearing specialist shall document why a fifty utterance sample was not obtainable and the contexts in which attempts were made to elicit the sample. When standardized tests are considered to be invalid for the specific pupil, the expected language performance level shall be determined by alternative means as specified in the assessment plan.

[Authority cited: Statutes of 1981, Chapter 1094, Section 25(a); and Section 56100(a), (g), (i), Education Code.] [Reference:20 U.S.C. 1401(a)(15) and 1412(5); 34 CFR 300.5(b)(7) and (9), 300.532(a)(2), (d) and (e), 300.533, 300.540, 300.541-43; and Sections 56026, 56320, 56333 and 56337, Education Code.]

### **3031. Additional Eligibility Criteria for Individuals with Exceptional Needs-Age Birth to Four Years and Nine Months.**

(a) A child, age birth to four years and nine months, shall qualify as an individual with exceptional needs pursuant to Education Code Section 56026(c)(1) and (2) if the Individualized Education Program Team determines that the child meets the following criteria:

(1) Is identified as an individual with exceptional needs pursuant to Section 3030, and

(2) Is identified as requiring intensive special education and services by

meeting one of the following:

(A) The child is functioning at or below 50% of his or her chronological age level in any one of the following skills areas:

1. gross or fine motor development;
2. receptive or expressive language development;
3. social or emotional development;
4. cognitive development; and
5. visual development.

(B) The child is functioning between 51% and 75% of his or her chronological age level in any two of the skills areas identified in Section 3031(2)(A).

(C) The child has a disabling medical condition or congenital syndrome which the Individualized Education Program Team determines has a high predictability of requiring intensive special education and services.

(b) Programs for individuals with exceptional needs younger than three years of age are permissive in accordance with Section 56001(c) of the Education Code except for those programs mandated pursuant to Section 56425 of the Education Code.

[Authority cited: Statutes of 1981, Chapter 1094, Section 25(a); and Section 56100(a), (g), (i), Education Code.] [Reference:20 USC 1401(a)(15); 34 CFR 300.5; Statutes of 1981, Chapter 1094, Section 25(a); and Sections 56026, 56030.5, 56333 and 56337, Education Code.]

### **3051.1. Language, Speech and Hearing Development and Remediation.**

(a) An individual holding an appropriate credential with specialization in language, speech, and hearing may provide services include:

(1) Referral and assessment of individuals suspected of having disorders of language, speech, or hearing. Such individuals are not considered as part of the caseload pursuant to Section 56363.3 of the Education Code unless an individualized education program is developed and services are provided pursuant to Section 3051.1(a)(2) and (3).

(2) Specialized instruction and services for individuals with disorders of language, speech, or hearing, including monitoring of pupil progress on a regular basis, providing information for the

review, and when necessary participating in the review and revision of individualized educational programs of pupils.

(3) Consultative services to pupils, parents, teachers, or other school personnel.

(4) Coordination of speech and language services with an individual's regular and special education program.

(b) Caseloads of full-time equivalent language, speech, and hearing specialists providing instruction and services within the district, special education local plan area, or county office shall not exceed a district-wide, special education local plan area-wide, or county-wide average of fifty-five (55) individuals unless prior written approval has been granted by the State Superintendent of Public Instruction.

**56363.3 Average caseload limits:** The average caseload for language, speech, and hearing specialist in special education local plan areas shall not exceed 55 cases, unless the local plan specifies a higher average caseload and the reasons for the greater average caseload (*Added by Stats.1982, c.1201, p.4360, 26, eff. Sept. 22, 1982. Amended by Stats.1987, c.1452, 485; Stats.2007, c. 56 (A.B.685), 58*) [*California Education Code*].

(c) Services may be provided by an aide working under the direct supervision of a credentialed language, speech, and hearing specialist if specified in the individualized education program. No more than two aides may be supervised by one credentialed language, speech, and hearing specialist. The caseloads of persons in subsection (b) shall not be increased by the use of noncertificated personnel.

[Authority cited: Section 56100(a) and (i), Education Code.] [Reference: Section 56363(b)(1), 56363.3, Education Code; and 34 CFR 300.13(b)(12).]

### **3051.2. Audiological Services.**

(a) In addition to provisions of Title 34, Code of Federal Regulations, Section 300.13 (b)(1), designated audiological instruction and services may include:

(1) Aural rehabilitation (auditory training, speech reading, language habilitation, and speech conservation) and habilitation with individual pupils or groups and support for the hearing-impaired pupils in the regular classroom.

(2) Monitoring hearing levels, auditory behavior, and amplification for all pupils requiring personal or group amplification in the instructional setting.

(3) Planning, organizing, and implementing an audiology program for individuals with auditory dysfunctions, as specified in the individualized education program.

(4) Consultative services regarding test findings, amplification needs and equipment, otological referrals, home training programs, acoustic treatment of rooms, and coordination of educational services to hearing-impaired individuals.

(b) The person providing audiological services shall hold a valid credential with a specialization in clinical or rehabilitative services in audiology.

[Authority cited: Section 56100(a) and (i), Education Code; 20 USC 1414(c)(2)(B); and 34 CFR 300.600.] [Reference: Section 56363(b)(2), Education Code; and 34 CFR 300.13(b)(1).]



**3065. Staff Qualifications- Related Services.** To be eligible for certification to provide designated instruction and services and related services to individuals with exceptional needs, nonpublic schools and agencies shall meet the following requirements:

(c)(1) "Audiological services" means aural rehabilitation (auditory training, speech reading, language habilitation, and speech conservation) and habilitation with individual pupils in the general classroom; monitoring hearing levels, auditory behavior, and amplification for all pupils requiring personal or group amplification in the instructional setting; planning, organizing, and implementing an audiology program for individuals with auditory dysfunctions, as specified in the IEP; or consultative services regarding test finding, amplification needs and equipment, otological referrals, home training programs, acoustic treatment of rooms, and coordination of educational services to hearing-impaired individuals.

(2) Audiological services shall be provided only by personnel who possess:

(A) a license in Audiology issued by a licensing agency within the Department of Consumer Affairs; or

(B) a credential authorizing audiology services.

(k)(1) "Language and speech development and remediation" means screening, assessment, IEP development, and direct speech and language services delivered to children with disabilities who demonstrate difficulty understanding or using spoken language to such an extent that it adversely affects their educational performance and cannot be corrected without special education related services.

(2) Language and speech development and remediation shall be provided only by personnel who possess:

(A) a license in Speech-Language Pathology issued by a licensing agency within the Department of Consumer Affairs; or

(B) a credential authorizing language or speech services.

[Authority cited: Sections 33031, 56100 and 56366, education Code].[Reference: Sections 2620, 2903, 2905, 4980.02, 4989.14, 4996.9 and 17505.2, Business and Professions Code; Sections 49422 and 56366.1, Education Code; 20 U.S.C. Section 1401, 34 C.F.R. Sections 300.18, 300.34 and 300.156(b)(1).]

#### **\*Chapter 4. Identification and Referral, Assessment, Instructional Planning, Implementation, and Review**

##### **Article 2.5. Eligibility Criteria for Special Education and Related Services on the Basis of Language and Speech Disorder or Specific Learning Disabilities**

**56333. Assessment of language or speech disorder; eligibility for special education and related services;** A pupil shall be assessed as having a language or speech disorder which makes his or her eligible for special education and related services when he or she demonstrates difficulty understanding or using spoken language to such an extent that it adversely affects his or her educational performance and cannot be corrected without special education and related services. In order to be eligible for special education and related services, difficulty in understanding or using spoken

language shall be assessed by a language, speech, and hearing specialist who determines that such difficulty results from any of the following disorders:

- (a) Articulation disorders, such that they pupil's production of speech significantly interferes with communication and attracts adverse attention.
- (b) Abnormal voice, characterized by persistent, defective voice quality, pitch, or loudness. An appropriate medical examination shall be conducted, where appropriate.
- (c) Fluency difficulties which result in an abnormal flow of verbal expression to such a degree that these difficulties adversely affect communication between the pupil and listener.
- (d) Inappropriate or inadequate acquisition, comprehension, or expression of spoken language such that the pupil's language performance level is found to be significantly below the language performance level of his or her peers.
- (e) Hearing loss which results in a language or speech disorder and significantly affects educational performance.

\* This portion of the document contains only the section that pertains to the eligibility criteria for a Language and Speech Disorder.\*

**\*Chapter 4.45. Special Education Programs for Individuals with Exceptional Needs Between the Ages of Three and Five Years, Inclusive**

**56441.7. Maximum caseload;** (a) The maximum caseload for a speech and language specialist providing services exclusively to individuals with exceptional needs, between the ages of three and five years, inclusive, as defined in Section 56441.11 or 56026, shall not exceed a count of 40.

**56441.11. Special education eligibility criteria; preschool children between three and five years; assessment;**

- (a) Notwithstanding any other provisions of law or regulation, the special education eligibility criteria in subdivision (b) shall apply to preschool children, between the ages of three to five years.
- (b) A preschool child, between the ages of three and five years, qualifies as a child who needs early childhood special education services if the child meets the following criteria:
  - (1) Is identified as having one of the following disabling conditions, as defined in Section 300.8 of Title 34 of the Code of Federal Regulations, or an established medical disability, as defined in subdivision (d):
    - (A) Autism.
    - (B) Deaf-blindness.
    - (C) Deafness.
    - (D) Hearing impairment.
    - (E) Mental retardation.
    - (F) Multiple disabilities.
    - (G) Orthopedic impairment.
    - (H) Other health impairment
    - (I) Serious emotional disturbance.
    - (J) Specific learning disability.

(K) Speech or language impairment in one or more of voice, fluency, language and articulation.

(L) Traumatic brain injury.

(M) Visual impairment.

(N) Established medical disability.

(2) Needs specially designated instruction or services as defined in Sections 56441.2 and 56441.3.

(3) Has needs that cannot be met with modifications of a regular environment in the home or school, or both, without ongoing monitoring or support as determined by an individualized education program team pursuant to Section 56431.

(4) Meets eligibility criteria specified in Section 3030 of Title 5 of the California Code of Regulations.

(c) A child is not eligible for special education and services if the child does not otherwise meet the eligibility criteria and his or her educational needs are due primarily to:

(1) Unfamiliarity with the English Language.

(2) Temporary physical disabilities.

(3) Social maladjustment.

(4) Environmental, cultural, or economic factors.

(d) For purposes of this section, “established medical disability” is defined as a disabling medical condition or congenital syndrome that the individualized education program team determines has a high predictability of requiring special education and services.

(e) When standardized test are considered invalid for children between the ages of three and five years, alternative means, including scales, instruments, observations, and interviews, shall be used as specified in the assessment plan.

\* This portion of the document contains only sections of the Special Education Programs for Individuals with Exceptional Needs Between the Ages of Three and Five Years, Inclusive in order to pertain to Speech-Language Services.\*

**\* Title 14. California Early Intervention Services Act**  
**Chapter 4. Eligibility**

**95014.** (a) The term “eligible infant or toddler” for the purposes of this title means infant and toddlers from birth through two years of age, for who a need for early intervention services, as specified in the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1431 et seq.) and applicable regulations, is documented by means of assessment and evaluation as required in Sections 95016 and 95018 and who meet one of the following criteria:

(1) Infants and toddlers with a developmental delay in one or more of the following five areas: cognitive development; physical and motor development, including vision and hearing; communication development; social or emotional development; or adaptive development. Developmentally delayed infants and toddlers are those who are determined to have a significant difference between the expected level of development for their age and their current level of functioning. This determination shall be made by qualified personnel

who are recognized by, or part of, a multidisciplinary team, including the parents.

- (2) Infants and toddlers who established risk conditions, who are infants and toddlers with conditions of known etiology or conditions with established harmful developmental consequences. The conditions shall be diagnosed by a qualified personnel recognized by, or part of, a multidisciplinary team, including the parents. The condition shall be certified as having a high probability of leading to developmental delay if the delay is not evident at the time of diagnosis.
- (3) Infants and toddlers who are at high risk of having substantial developmental disability due to a combination of biomedical risk factors, the presence of which is diagnosed by qualified clinicians recognized by, or part of, a multidisciplinary team, including the parents.

\* This portion of the document contains only sections of the Eligibility criteria in order to provide a definition of eligible infants and toddlers.\*

## **California Code of Regulations**

Title 17. Public Health

Division 2. State Department of Developmental Services

Chapter 2. Early Intervention Services

Subchapter 1. General Provisions

### **Article 1. Definitions**

#### **52000. Meaning of Words.**

(8) "Communication development" means the acquisition of expressive and/or receptive language skills which include understanding and/or using any of the following: gestures, facial expressions, speech reading, sign language, body postures and vocal and visual contacts with another person.

(12) "Early intervention services" means those services designed to meet the developmental needs of each eligible infant or toddler and the need of the family related to the infant's or toddler's development. The services include but are not limited to assistive technology; audiology; family training; counseling and home visits; health services; medical services only for diagnostic or evaluation purposes; nursing services' nutrition services; occupational therapy; physical therapy; psychological services; service coordination; social work services; special instruction; speech and language services; transportation and related costs; and vision services. Early intervention services may include such services as respite and other family support services.

(20) "Hearing impairment" means a condition, whether permanent or fluctuating, which impairs the processing of linguistic information through hearing, even with amplification, and which adversely affects an infant's or toddler's development. Processing linguistic information includes speech and language reception and speech and language discrimination.

## **Article 2. Eligibility for California's Early Start Program**

**52020. General.** An infant or toddler shall be eligible for early intervention services if he or she is between birth up to thirty-six months of age and meets one of the criteria specified in Section 52022 as determined by means of evaluation pursuant to Section 52082 of these regulations and need early intervention services.

[Authority cited: Sections 95009 and 95028, Government Code.] [Reference: Section 1432(5), Title 20, United States Code; Sections 95014(a) and 95016, Government Code; and Section 303.16, Title 34 Code of Federal Regulations.]

**52022. Eligibility Criteria.** (a) Developmental Delay- A development delay exists if there is a significant difference pursuant to 52082 between the infant's or toddler's current level of functioning and expected level of development for his or her age in one or more of the following developmental areas:

- (1) Cognitive;
- (2) Physical: including fine and gross motor, vision, and hearing;
- (3) Communication;
- (4) Social or emotional;
- (5) Adaptive.

### **44265.3 Credentials for speech-language pathologists; legislative intent; funding for and billing through Local Education Agency Midi-Cal Billing Option program**

(a) Commencing January 1, 2007, the Commission on Teacher Credentialing

shall issue the following credentials:

- (1) A preliminary credential in speech-language pathology, to an individual who has been recommended by a commission-accredited program sponsor and who holds or has been recommended for a master's degree in speech-language pathology from a program accredited by the American Speech-Language-Hearing Association's Council on Academic Accreditation. The preliminary credential shall be valid for a period of two years.
- (2) A professional clear credential in speech-language pathology to an individual who satisfies all of the following criteria:
  - (A) The individual holds a master's degree in speech-language pathology from a program accredited by the American Speech-Language-Hearing Association's Council on Academic Accreditation, or an equivalent degree or academic program, as determined by the American Speech-Language-Hearing Association.
  - (B) The individual has achieved a passing score, as determined by the American Speech-Language-Hearing Association's certification requirements on the Educational Testing Service's national teacher's Praxis series written test in speech-language pathology or successor exam.
  - (C) The individual has completed a mentored practical experience period, in the form of a 36-week, full-time mentored clinical

experience, or an equivalent supervised practicum, as deemed by the commission.

(D) The individual satisfies other typical commission credentialing processing requirements, including, but not limited to, forms, fees, and fingerprint clearance.

(b) It is the intent of the Legislature in enacting this section to align the state credentialing requirements for personnel standards for California speech-language pathologists with standards for Medi-Cal local educational agency reimbursement, in order to ensure continued funding for the Local Education Agency (LEA) Medi-Cal Billing Option Program.

(c) A credential issued by the Commission on Teacher Credentialing on or before January 1, 2007, authorizing speech, language, and hearing services, shall continue to be valid, subject to commission renewal requirements.

(d) Upon renewal of a credential initially issued on or before January 1, 2007, the credential holder shall have the option of renewing the credential under standards applicable prior to January 1, 2007, or to update the credential to satisfy the requirements of subdivision (a). At any time after January 1, 2007, the credential holder may update his or her credential, upon submission of an application and fee, and verification of requirements met in accordance with subdivision (a).

(e) To the extent allowable, as determined by the federal government, services provided by an individual with a credential for speech-language pathology, as specified in this section, shall be billable through the LEA Medi-Cal Billing Option Program. *(Added by Stats.2006, c. 581 (A.B.2837), 1, eff. Sept.28, 2006, operative Nov. 30, 2006.)*

**44831. Certification qualifications.** A governing board of a school district shall employ persons in public school service requiring certification qualifications as provided in this code, except that the governing board or a county office of education may contract with or employ an individual who holds a license issued by the Speech-Language Pathology and Audiology Board and has earned a masters degree in communication disorders to provide speech and language services if that individual meets the requirements of Section 44332.6 before employment or execution of the contract. *(Stats.1976, c. 1010, 2, operative April 30, 1977. Amended by Stats.1999, c. 623 (A.B.466), 7, eff. Oct. 10, 1999; Stats.2008, c. 518 (S.B.1186), 9.)*

Information obtained from:

*A Composite of Laws: California Special Education Programs.* 31<sup>st</sup> ed., California Department of Education, Sacramento, 2009.

*California Education Code, 2010.*

**Educational Service Delivery Approach  
Options  
Section II**

## Educational Service Delivery Approach Options

The Speech and Language Program offers a variety of educational service delivery approaches. Service delivery may change as the needs of the student changes. Flexibility is one of the most powerful attributes in providing the appropriate delivery system to benefit the student at a specific time. Please note these may occur in combination:

**Consultation:** SLP's provide education and support to the classroom teacher, paraprofessional, service providers and/or parents related to the needs of the students with speech and language impairments. Consultation is considered an indirect service delivery approach. Consultation services have proven as equally effective as direct services for some students as the intervention is: a) set in natural environments, b) embedded in class routines, c) use functional life skills to increase the efficacy of intervention, and d) increase the student's motivation to participate and achieve their IEP goals. Consultation services also increase the opportunities for collaboration and skill building among team members along with practice opportunities for the child.

**RTI/Collaboration (Blended Services Model):** The SLP works with the classroom/Special Education teacher/s and other service providers to implement an integrated, intervention program in the classroom for students with identified and possible speech and language impairments. The SLP suggest specific techniques for support personnel to use to assist in the carryover of the language skills into everyday life. Implementation of this model supports facilitation of functional communication skills and ways to integrate communication throughout the curriculum and home & school connection. Collaboration combines indirect service with shared decision making.

**Direct (Pull-out Model):** The SLP provides small group and/or individual intervention services that are aligned with classroom standards and curriculum outside of the classroom setting. Appropriate model when the student is learning new skills and needs more intense instruction. This model is the traditional model based on a clinical/medical model.

**Classroom Based:** The SLP with/without the classroom teacher provides direct services within the classroom or the natural environment by implementing activities integrated with the curriculum/communication needs. This model involves the use of curriculum in determining a student's communication needs, enhanced opportunity for generalization and carryover of language skills into everyday life. Often the delivery of choice for preschool and the severe students.

**Community Based:** The SLP provides services to students within the home/community (work site). Goals and objectives focus primarily on functional communication skills. Can be considered direct or indirect services.



## **What is Response to Intervention?**

- RTI is a well-integrated system that connects general, compensatory, gifted and special education in providing high-quality standards-based instruction and intervention for a specific and indicated amount of time, usually 3-6 month blocks of intervention.
- This instruction and intervention is matched to a student's academic, social-economic and behavioral needs.
- It may be use a problem-solving approach or an intense intervention and is designed to provide students the instructional opportunities they may have missed.
- Based on a 3 Tiered Model. Tier I is Universal problem solving within GE, Tier II is intensive instruction through GE and/or Special Ed and Tier III is generally Special Ed. Intensive support.

## **Implications for SLP's of Response to Intervention**

- Early Intervention-gives the opportunity for SLP's to intervene with children early without having to go through the special education process.
- Provides SLPs with increased opportunities to work collaboratively with GE and Special Education teachers
- Allows SLPs to conduct authentic/classroom-based assessments
- Increases the opportunities for SLPs to be part of school teams responsible for student achievement.
- Provides SLPs opportunities to support teachers' knowledge of speaking, listening and literacy.

## **SLP Possible Roles by RTI Tiers**

### **Tier I: Scientifically-Based Articulation & Language Classroom Instruction**

- Providing mostly indirect services to support GE instruction
- Educating Staff, parents
- Collaborating with Staff
- RTI Team member
- Offering assistance in designing interventions
- Co-Teaching in the literacy area

### **Tier II: A Combination of Direct Interventions (Small Group) and Indirect services in General Education**

- Collaborating/Consulting with GE/Sp.Ed staff
- Providing supplemental instruction
- Providing resources for documentation
- Providing small group intervention
- Providing data collection for special needs and at risk students
- Working on specific language goals within teacher's score and sequence
- Monitor and assess speech and language skills

Tier III: Mostly Direct Intervention and Identification Services (May also include IEP Services)

- Member of Intervention Team
- Function as part of the trans-disciplinary team providing full assessment
- Provide small and individual specialized instruction
- Collaborating with others to determine need for intensive intervention
- Determine eligibility for special education based on lack of responsiveness to prior intervention and other evidence.

At All Levels

Take a leadership role

Serve on problem solving teams

Conduct progress monitoring

Conduct observations

Assist with screenings/academic assessments

Provide staff development training

Provide resources to GE and Special Educators

# Referral and Evaluation Practices

## Section III

## Speech and Language Referral Process

When there are concerns that a child may be demonstrating difficulty understanding or using spoken language to the extent that it adversely affects his or her educational performance, the following guidelines should be followed whenever considering a child for special education services under the eligibility category of speech and language impairment for the Glenn County Office of Education (GCOE).

- A request for a meeting may be generated by the parents or general education teacher. Typically each school site has a referral form that is required to be filled out and the school site team will schedule the SST/CST meeting
- A referral to the Student Study/Child Study Team (SST/CST) does not automatically mean a speech/language special education evaluation will be done. Speech and Language assessment will be completed only when *need* is documented.
- The SST/CST team may include and not limited to the following team members: parent, referral teacher, SLP, administrator, and as needed school psychologist and other specialist/staff.
- During this meeting the following should be discussed: Strengths, Concerns, Known's, Modifications, Questions, Plans, and who will follow up. During this meeting pertinent information would be shared and discussed. The team members would formulate a plan of action including specific recommendations for speech and language accommodations to be implemented by the general education teacher/staff.
- A SST/CST team meeting may be rescheduled approximately 6-8 weeks after the initial meeting. At that time a final decision in regards to progress measured based on the implementation of the recommendations and accommodations, a recommendation to implement RTI services or the need for a speech and language assessment will be decided by the SST/CST team members.

**Referral from Parents:** Parents may request an evaluation in writing. This includes times when parents are requesting an evaluation and they bring to the school a prescription from a health care professional for special education services.

## Evaluation Practices

### **Purpose for Evaluation**

The purpose of the speech-language evaluation is to describe the student's communication behavior, including the nature and scope of any speech-language impairment and any ADVERSE EFFECT ON EDUCATIONAL PERFORMANCE to determine eligibility for speech-language as special education or related services. The following circumstances that require evaluation (formal or informal) of a student:

1. The student is suspected of having a speech and/or language impairment.
  2. Prior to the initial provision of speech-language services as special education or as a related service;
  3. At least every three years, or if conditions warrant a reevaluation, or if the teacher or parents request a reevaluation; or
  4. Before determining that a child no longer has a disability, except when termination of eligibility is due to graduation with a regular high school diploma or the student exceeding age eligibility for a free appropriate public education.
- \* Reevaluations do not always require formal testing.

### **Interpreting and Reporting Results**

The following recommendations address this standard and the need to provide important technical information to other professionals:

1. Compare the student's formal test results with those of the normative population in an appropriate and consistent format. Standard scores, which are typically based on a mean of 100 and a standard deviation of 15, are recommended for this purpose. If norms are based on something other than a nationally represented normative sample, the test user should consider whether it is appropriate to report quantitative test results and, if so, to qualify findings as needed.
2. To determine eligibility as a student with a language impairment, receptive, expressive and/or composite test scores shall fall at least 1.5 standard deviations below the mean (approximately the 7<sup>th</sup> percentile or a score of 78 or below) of the language assessment instrument(s) administered. This cutoff shall be applied to composite scores of receptive and/or expressive measures or to overall test scores rather than to individual subtest scores. When assessment results indicate a significant weakness in any skill area (i.e., receptive, expressive, auditory perception, pragmatic language), and the obtained score is not 1.5 standard deviations below the test mean, further assessment in the deficit area is required

3. Eligibility shall **not** be determined solely by comparing a composite or overall score to this cutoff level.
  - Evidence that the deviation has an adverse effect on educational performance must be gathered and considered along with background information before a determination of eligibility can be made.
  - Test scores shall be presented in a manner that conveys that some degree of error measurement is inherent in the score, thereby discouraging the inappropriate interpretation that test scores are fixed and are perfectly accurate representations of a student's functioning. (Refer to the technical manual of the test to obtain standard error of measure also referred to as confidence intervals.)
4. Eligibility for language impairment may **not** be determined on the basis of a predetermined discrepancy between language and cognitive measures. Appropriate cognitive assessment may be used, however, to supplement or support the findings of the speech-language evaluation. Collaboration between the school psychologist and the SLP in planning and implementing appropriate communication and cognitive assessments and interpreting their results will facilitate eligibility determination.

“There may be a role for intelligence measurement in intervention planning for children with developmental language impairments and for children with specific language impairments. Some measure of cognitive performance is needed to examine differences and similarities in etiology and performance for children with specific language impairments and for children with developmental language impairments. More research is needed in these areas. There is, however, no support for the continuation of cognitive referencing in the forms of IQ cutoffs or IQ-language discrepancy formulas as a clinical method of caseload selection or prioritization. IQ measures may reveal something about *how* children should be served, but they do not appear to be relevant in deciding *who* should be served.”

Cole, K.N. & Fey, M.E. (). Cognitive Referencing in Language Assessment. *Assessment of Communication and Language, Vol. 6*. Paul H. Brookes Publishing Co.: Baltimore, MD.

Another good reference is Casby, M. (1992). The cognitive hypothesis and its influence on speech-language services in schools. *Language, Speech, and Hearing Services in Schools, 23*, 198-202.

5. Age or grade equivalent scores shall not be used in making eligibility decisions. They do not account for normal variation around the test mean and the scale is not an equal interval scale. Therefore, the significance of delay at different ages is not the same. Furthermore, the different ages of students within the same grade make comparisons between students within

and between grades difficult. In addition, grade equivalents do not relate to the curriculum content at that level. While seemingly easy to understand, equivalent scores are highly subject to misinterpretation and should not be used to determine whether a child has a significant deficit.

6. Modifications of standardized test procedures invalidate the use of test norms, but may provide qualitative information about the student's language abilities. If test administration appears to be invalid for any reason, test scores should not be subjected to usual interpretations and the reasons for invalidation should be clearly stated in oral and written presentations of test results as explicitly addressed in federal regulations.
7. Test results are to be reported and interpreted using language that can be easily understood by teachers and parents. Consequently, technical terms such as standard deviation, percentiles and confidence intervals, are to be supplemented by understandable interpretations such as low average, below average, average, etc. Percentile scores should be reported in a manner that conveys that results are estimates of functioning (e.g., approximately 30th percentile or a range of the 10<sup>th</sup> to the 20<sup>th</sup> percentiles). They should not be used as the sole basis for eligibility decisions.

### **Guidelines for Reevaluation**

Federal and state regulations specify that reevaluation shall occur at least every three years or more frequently if conditions warrant or if the student's parents or teachers request it..

#### **Purpose of Reevaluation Review**

1. to focus on the student's progress in and/or access to the general education curriculum,
2. to focus on the student's progress in the special education program,
3. to address the student's IEP in meeting the unique needs of the student,
4. to investigate the need for further evaluation when the student is not progressing commensurate with his or her IEP goals and objectives, and
5. to determine continued eligibility.

#### **A Formal, Comprehensive Reevaluation Should Be Considered**

1. when the validity and/or reliability of the initial or previous evaluation are in question,
2. when standardized test results are questioned,
3. when previous evaluation results indicate external variables affecting the reliability of the previous assessment data, for example -- the child was easily distracted, situational crises in the home or school environment, or frequent change of schools,
4. when significant discrepant results were obtained by the student on two previous evaluations with no other explanation of this discrepancy,

5. when the results of the “Reevaluation Summary Report” indicate discrepancies or pose questions regarding the student's progress in his/her special education program and the IEP team determines there is a need to obtain more information through formal assessment,
6. when a comprehensive reevaluation is requested by the student's parent or other members of the student's IEP team, and/or
7. when the student has made progress and consequently, may no longer meet the eligibility standards for a speech-language impairment.

#### Components of a Reevaluation Review Summary

##### Background Information

- a. Review of medical and sensory information
- b. Educational Review
  - Disability information
  - Special education services provided currently and in the past three years
  - Review of other aspects of the student's progress that may be impacting the success of the educational program, including attendance, number of schools attended, school retention, behavior and discipline review
2. Review of Previous Assessment Information
  - a. Previous evaluation information
  - b. IEP team determination of the validity and reliability of previous evaluations
3. Current Classroom-Related Assessment
  - a. Input from the parent, General Education, Special Education and/or Related Services Teacher
  - b. Review of statewide and/or district-wide assessments
4. The IEP *Reevaluation Summary Report* considers whether
  - a. There are no further data needed to determine eligibility for services
  - b. The parent has been informed of the reasons for no further assessment
  - c. The parent understands that further assessment can be made if the parent wishes to request additional assessment
  - d. The parent has received a written copy of the Reevaluation Summary Report
  - e. The parent has been informed of and received a copy of the *Handbook on Parents’ Rights* (NCDPI publication).
  - f. The date of the IEP team meeting and signatures of the parent and other IEP team members have been documented.

#### Eligibility Determination

- (a) Upon completing the administration of tests and other evaluations—
  - (1) A group of qualified professionals (IEP team) and the parent of the child must determine whether the child is a child with a disability; and
  - (2) The public agency must provide a copy of the evaluation report and the documentation of determination of eligibility to the parent.



- (b) A child may not be determined to be eligible under this part if—
  - (1) The determinant factor for that eligibility determination is
    - (i) Lack of instruction in reading or math; or
    - (ii) Limited English proficiency; and
  - (2) The child does not otherwise meet the eligibility standards.
  
- (c) (1) A public agency must conduct a reevaluation meeting to evaluate a child with a disability before determining that the child is no longer eligible for services. This meeting will determine whether or not formal testing is needed.
- (2) The evaluation described in (c)(1) is not required before termination of student's
- (3) The evaluation described in paragraph (c)(1) of this section is not required before eligibility under due to graduation with a regular diploma, or exceeding the age eligibility for FAPE under State law.

## Glenn County Speech and Language Dismissal Considerations

The following guidelines should be followed whenever considering dismissal of a student from special education services for a speech-language impairment.

- Guideline 1** The criteria for exit from services for speech and language impairments should be discussed with IEP team members at the beginning of intervention.
  
- Guideline 2** The decision to dismiss is based upon IEP team input (i.e., parent, teacher, etc.) initiated by the SLP or any other team member.
  
- Guideline 3** If progress is not observed over time, changes must be made in the interventions/accommodations/IEP. If continued lack of progress is shown, specific goals and intervention approaches must be re-examined. *If additional progress is not observed, dismissal may be warranted.*
  
- Guideline 4** If gains are general and cannot be attributed to direct intervention, dismissal should be considered.
  
- Guideline 5** If it can be determined that new skills would not greatly improve education-based speech and language skills of students with severely impaired communication or cognitive systems, and no specific special education goals remain, dismissal should be considered.
  
- Guideline 6** The student's current academic level, behavioral characteristics and impact on educational performance should be considered when determining dismissal.

“All of these criteria emphasize the necessity of having data...To run accountable programs, we must require consistent, data-based dismissal criteria”.

Diane L. Eger, “Accountability in Action: Entry, Exit, Measurement.”  
Seminars in Speech and Language, Vol. 9, #4

Gantwerk, B. (1985b). Issues to address in criteria development. In Caseload issue in schools—How to make better decisions. Rockville, MD: ASHS 43-45.

### DISMISSAL FACTORS

|                                   | RATIONALE   |
|-----------------------------------|---|
| <b>Current Level</b>              | <input type="checkbox"/> Goals and objectives have been met.<br><input type="checkbox"/> Maximum improvement and/or compensatory skills have been achieved.<br><input type="checkbox"/> Communication skills are commensurate with developmental expectations.<br><input type="checkbox"/> Successful use of augmentative or assistive communication device.  |
| <b>Behavioral Characteristics</b> | <input type="checkbox"/> Limited carryover due to lack of physical, mental or emotional ability to self-monitor or generalize to other environments.<br><input type="checkbox"/> Other disabilities or interfering behaviors inhibit progress; please specify _____.<br><input type="checkbox"/> Conflict arises in goals set by public and private SLTs/teams.<br><input type="checkbox"/> Limited potential for change. |
| <b>Educational Impact</b>         | <input type="checkbox"/> Communication skills no longer adversely affect the student's education performance.<br><input type="checkbox"/> Communication skills no longer cause frustration or other social, personal, emotional difficulties.   |

*When considering dismissal, remember a reevaluation is necessary if the student will no longer be receiving special education services in speech or language. The reevaluation review process should be followed prior to consideration of a comprehensive assessment. The IEP team may determine sufficient information is documented and a comprehensive reevaluation is not required. Parents must be part of the decision process and must give consent when a formal, comprehensive assessment is requested.*

**Articulation/Phonological  
Enrollment & Exit Criteria  
Section IV**

## **SPEECH SOUND PRODUCTION** (Articulation & Phonological Processes)

### **SPEECH SOUND PRODUCTION CONSIDERATIONS**

An articulation impairment is the “atypical production of speech sounds...that may interfere with intelligibility” (ASHA, 1993, p. 40). Problems with sound production result from *organic* (a known physical cause) or *functional* (no known physical cause) etiologies. Organically based production errors may be related to hearing impairment, cleft lip or palate, cerebral palsy, ankyloglossia (tongue-tie) and others. The accompanying articulation deficits are the direct result of structural or neurologic anomalies and are not developmental in nature. Children with functional sound production problems present with adequate hearing acuity and intellectual abilities. They show no signs of significant structural abnormalities or neurological dysfunction. The specific errors vary from one child to the next and are not as readily predictable as those found in organically based disorders.

***The IEP team may not identify a child as speech impaired who exhibits any of the following:***

- mild, transitory or developmentally appropriate sound production difficulties that students experience at various times and to various degrees;
- speech difficulties resulting from dialectal differences, learning English as a second language, temporary physical disabilities or environmental, cultural or economic factors;
- a tongue thrust which exists in the absence of a concomitant impairment in speech sound production;
- elective or selective mutism or school phobia without a documented speech sound production impairment; and
- **the errors do not interfere with educational performance.**

Production of sounds in connected speech is a series of complex maneuvers. Oral communication requires exact placement, sequencing, timing, direction and force of the articulators. These occur simultaneously with precise airstream alteration, initiation or halting of phonation and velopharyngeal action. Consequently, assessment of speech sound production is a multi-faceted procedure requiring a good deal of skill and knowledge.

### **CONDUCTING A SPEECH EVALUATION FOR ARTICULATION OR PHONOLOGICAL PROCESSES**

- Conduct hearing screening.
- Obtain relevant information from the parents/guardian.
- Obtain information from teachers related to progress in the general curriculum, communication skills, behavior and social interactions. Information may be gathered from educators: these educators may include the student’s classroom teacher as well as another professional. For preschoolers, obtain this information from child care providers or adults who see the child outside the family structure.

- Review school records, e.g., grades, test scores, special education records, documentation of pre-referral strategies/interventions and discipline and attendance records.
- Complete an oral-peripheral mechanism examination.
- Administer an articulation test and/or a test of phonological processes. If a preschooler is unable to participate in assessment using standardized measures, document the attempt and obtain a phoneme inventory from a speech sample.
- Conduct stimulability probes to determine how well the student can imitate correct production of error sounds. Stimulability refers to the student's ability to produce a correct (or improved) production of the erred sound given oral and visual modeling. Most articulation tests include this step on the test form.
- Obtain and analyze a speech sample to determine intelligibility of conversational speech and consistency of error patterns. (Refer to norms of dialectal patterns and resources for ELL and assessment guidelines ).
- **Document how sound production errors adversely affect the student's educational performance in the general education classroom or the learning environment.**
- Finalize and submit a written report to the IEP team.

## COMPONENTS OF THE ASSESSMENT

### Articulation or Phonological Processes Assessment

Generally, errors in sound production are classified as either motor-based or cognitive/linguistic-based (Bernthal and Bankson, 1988).

- Articulation Errors  
Articulation errors (substitutions, distortions, omissions, and/or additions) are typically considered motor-based errors. Articulation, which refers to the actual movements of the articulators during speech production, is subsumed under the generic term phonology. An articulation problem may be defined as difficulty in producing a single or a few sounds with no pattern or derivable rule. It is considered to be the result of phonemic, rather than phonological, inadequacy (i.e., the problem results from the student's not having "learned" all of the sounds). Articulation testing is concerned primarily with identifying those sounds that the student has difficulty producing. Intervention is focused on correcting individual error sounds, one by one.
- Phonological Process Deviations  
Phonological process deviations are considered to be cognitive/linguistic-based. Students with phonological process problems demonstrate difficulty in acquiring a phonological system, not necessarily in production of the sounds. The phonological system of a language governs the ways in which sounds can be combined to form words. A phonological process is a systematic sound change that affects classes of

sounds or sound sequences and results in a simplification of production. Errors have logical and coherent principles underlying their use. The errors can be grouped on some principle and thus form patterns. The student's patterns of "simplification" of sound usage severely affect intelligibility. In contrast to articulation testing, phonological assessment is concerned not only with production skills, but also with the way sounds are sequenced and used contrastively to signal meaning differences. Philosophy, assessment and method of intervention addressing phonological processes must necessarily differ markedly from traditional approaches to either functional or organic articulation problems. The goal of phonological intervention is not to perfect individual sounds, but rather to eliminate phonological processes. It aims at a reorganization of the student's phonological system, thereby improving intelligibility.

Some SLPs as well as some of the professional literature classify phonological process errors as a language-based impairment. However, for purposes of these guidelines, phonological process errors are included, along with articulation errors, under the category of *Speech Sound Production*. The decision to administer an articulation test versus a phonological process analysis is based on the examiner's professional judgment. If the errors are non-organic (i.e., not due to structural deviations or neuromotor control problems) the most discriminating factor to aid in the decision is that of **intelligibility** – the more unintelligible the student's speech, the greater the need for phonological process analysis. When evaluating students whose intelligibility factor is moderate to severe or profound, tests of phonological processes will prove more diagnostically valuable than traditional articulation tests.

An articulation assessment and phonological process analysis can be derived without the use of a published standardized assessment instrument.

### **Developmental Information/Profile**

Norms are helpful for estimating approximately how well a student's sounds are developing. Although norms are extremely useful, there are limitations to over-relying on or using them exclusively to identify a sound production impairment.

See California Hearing and Speech Association Articulation Manual as a resource.

### **Phonological Processes**

The following are **minimal requirements** for qualifying a sound change error as a phonological process:

1. A process must affect more than one sound from a given sound class. For example, the omission of [t] from the end of words does not necessarily signal the process of final consonant deletion. Deletion of at least one additional plosive [p, b, d, k, g] must also be observed.
2. The sound change or process must occur at least 40% of the time. An inconsistent sound change indicates only a potential phonological process. In other words, if the

student uttered ten words containing final consonants, s/he must delete the consonant in at least four of those words in order for the pattern to be considered as that of final consonant deletion. An inconsistent sound change may also signal that the student is in a transition phase of development, i.e., the student is gradually eliminating the process on his/her own as sound productions become more developmentally appropriate.

### **Stimulability Probe of Errors**

Stimulability refers to the student's ability to produce a correct or improve production of the erred sound given oral and visual modeling.

The assessment of stimulability provides important prognostic information. Moreover, those behaviors that are most easily stimulated can provide excellent starting points for intervention. They often lead to intervention success quicker than other, less stimutable behaviors.

### **INTERPRETING AND REPORTING EVALUATION RESULTS**

#### • Sound Development Norms

There are many factors that can negatively influence intelligibility, including:

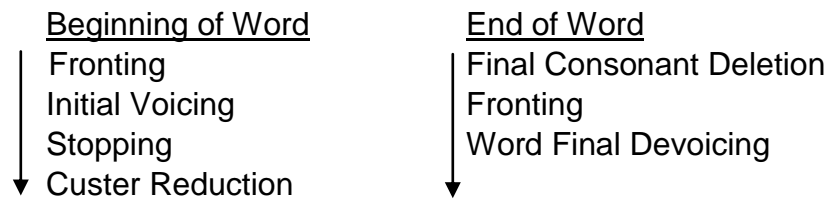
- *Number of errors*
- *Types of sound errors*
- *Inconsistency of errors*
- *Vowel errors*
- *Rate of speech*
- *Atypical prosodic characteristics of speech*
- *Length and linguistic complexity of the words and utterances used*
- *Student's anxiety about the testing situation and/or fatigue*

#### **Analysis of Errors**

- *Error Types* – The types of errors identified by traditional articulation tests generally fall into four major categories: (1) Substitutions (2) Omissions (3) Distortions, and (4) Additions. Typically, the presence of omissions and additions affect intelligibility to a greater degree than substitutions and distortions. In addition to providing descriptive information as to the problem, analyzing error types also helps to select, prioritize and plan intervention targets.
- *Form of Errors/Error Patterns* – An inventory of phonological processes is most valuable when evaluating students who have poor speech intelligibility due to multiple articulation errors. Phonological processes describe what children do in the normal developmental process of speech to simplify standard adult productions. When a student uses many different processes or uses processes that are not typically present for his/her developmental age, intelligibility will be affected. The following list of error patterns is arranged in descending order from most to least



effect on intelligibility.



- *Consistency of Errors* – The assessment data and/or speech sample should be analyzed for consistency of errors between the speech sample and the articulation test/phonological process assessment within the same speech sample and between different speech samples. A student may be able to produce a designated sound correctly at the single word level, yet correct productions may break down as the length and complexity of utterances increase. Typically, more sound errors will be identified during the connected speech sample.
- *Frequency of Occurrence* – Frequency of occurrence refers to the relative frequency or percentage of occurrence of a sound in continuous speech. It should be noted that the sounds [n, t, s, r, d, and m], cumulatively represent nearly one-half of the total consonants used. When misarticulated, these sounds will have a greater negative effect on speech intelligibility than the less frequently occurring sounds such as /zh/, /ch/, /j/, and voiceless /th/.

### **Rate of Speech**

Occasionally a student's speech rate can directly affect articulation and intelligibility. The average rate of speech is 125 words per minute to 142 words per minute (Purcell & Runyan, 1980).

### **Oral Peripheral Mechanism Examination**

The purpose of the oral-facial examination is to identify or rule out structural or functional factors that relate to speech impairment. Diadochokinetic rates, which measure a student's ability to produce rapidly alternating articulatory movements, may also be assessed.

Several common areas to assess during an oral peripheral examination are: face, lips, tongue, palate, weak or absent gag reflex, mouth breathing, and poor intraoral pressure.

## **Considerations for Enrollment**

*California Code of Regulations, Title 5, Section 3030 © 1*

### **GCOE Enrollment Criteria**

*A student is eligible for IEP services if all three criteria are met:*

1. Significantly interferes with communication
2. Attracts adverse attention
3. Adversely affects educational performance

### **GCOE General Enrollment Considerations**

1. Developmental level (intellectual ability, adaptive and motor skills), stimulability, consistency of error and level of intelligibility.
2. A lateral lisp may be considered at any age.
3. Multiple errors
4. Errors in all three positions of the words
5. Unintelligible speech which interferes with academic, social and emotional functioning.
6. Organic or physical disorders that affect prognosis such as dysarthria, apraxia, development anomalies, hearing impairment, cerebral palsy, oral motor difficulties or cleft palate.
7. The normal process of second-language acquisition, as well as manifestations of dialect and sociolinguistic variance shall not be diagnosed as having a speech disorder. Production errors caused by the developmental acquisition of speech, dialectical differences, or unfamiliarity with the English language may not indicate an articulation disorder.
8. Students demonstrating an abnormal swallowing pattern without a corresponding articulation disorder are not eligible for services.

### **Consideration for Exit**

There are several factors to consider when making decisions regarding exit from services. The IEP team will make the final recommendations regarding services. They are as follows:

1. Correct production of the target(s) is reached with the speech sample at 80% accuracy or better. The student has met their articulation IEP goal based on supporting data in a variety of settings.
2. The student's speech sound disorder no longer significantly impacts the student's educational performance in the general education or special education program.
3. Articulation skills are determined to be commensurate with chronological and/or developmental age.
4. After two years of direct services, there is a lack of significant progress as evidenced by probes, therapy notes and/or data, and teacher/parent report.

5. The student consistently demonstrates behaviors that are not conducive to therapy such as lack of cooperation, motivation or chronic absenteeism. The IEP team may also explore alternative services or strategies to remedy interfering behaviors/conditions.
6. The student reaches the age of 22 years (age eligibility defined in California Special Education Programs A Composite of Laws 56026 (A)).
7. Parent and/or student over 18 years of age refuses to allow the continuance of special education services.

## ***GCOE Response to Intervention for Articulation Support***

Ideal Candidates for the GCOE RTI Articulation Class (Adopted from the San Diego Unified School District)

1. 2/3<sup>rd</sup> grade (ideally around age 7 which leaves 1.5 years before the speech normalization boundary) (except for lateralized productions and cluster reduction after 5.5 years)
2. Mild Articulation needs (may be one sound or more).
3. Three IEP criteria not met-intelligibility, adverse attention and educational impact
4. Nonstimulable for target sound (monitor kids who are stimulable for the sound in any position/level)
5. Motivated and willing to practice at home.

RtI Class will be available at every school site and is open to any grade level if the student is motivated to learn and will complete homework. A maximum of five (5) RtI articulation cases per Speech and Language Pathologist. A waiting list will be developed and monitored by the SLP if more students meet the criteria for the RTI articulation class. The 5 RTI articulation class students should be counted in the SLP's average caseload numbers. Parent permission is required for a student to participate in the RTI Articulation class.

Procedures for the RTI Articulation Class

1. Parents sign permission form
2. Asks teacher to fill out Describing Speech Misarticulations form.
3. SLP gets a conversational sample and administers the Speech Improvement Sound Inventory for the target sound for baseline information.
4. Student is placed in the RTI Articulation Class. Attendance and homework completion will be monitored. Poor homework completion or attendance may result in the students exit from the class.

Students will be provided home practice opportunities and be periodically checked on progress and the SLP will communicate with the parents and teacher on progress and carryover of student's sound use. Upon class completion the SLP will re-administer the Speech Improvement Sound Inventory and/or conversational speech sample, and complete the Artic. Class completion form in the child's cumulative file. Research suggests a maximum of four students per group for the maximum amount of practice for each student. RTI and IEP students may be in the same group and services can carry over into the next school year. ASHA NOMS project suggests that it takes approximately 20 hours to remediate a single sound. Recommended intensive services for a student in the RTI articulation class is two 30 minute sessions initially. As the student acquires the error sounds, focus on carryover is recommended in different settings with different lengths of time.

**Language Impairment  
Entrance and Exit Criteria  
Section V**

# LANGUAGE IMPAIRMENT

## LANGUAGE ASSESSMENT CONSIDERATIONS

The school environment places heavy demands on students to comprehend, interpret and use all aspects of verbal and nonverbal communication. Students must be able to communicate with others who have different communication skills, styles and backgrounds and for a variety of purposes in different settings. They must be competent in listening, speaking, reading and writing to learn the curriculum and interact with others. Consequently, the speech-language pathologist must conduct a comprehensive assessment that includes an appropriate balance of formal and informal procedures. The comprehensive assessment uses procedures that identify areas of strength and weakness and examine how the student functions communicatively in the environments in which s/he participates.

Both formal (standardized) and informal (descriptive) assessment tools are to be used to evaluate language.

### The following measures are to be used:

1. a criterion and/or norm-referenced evaluation,
2. a language/communication sample.

### At least one standardized, comprehensive measure of language ability is to be included in the evaluation process.

- A **standardized test** is an evaluation tool that is administered in a prescribed way for a specific population. Criterion-referenced and norm-referenced tests are examples of standardized tests.
- A **comprehensive measure** is defined as a measure that yields a receptive, expressive and total language score.
  - A norm-referenced test that yields a receptive language quotient, an expressive language quotient and a total language quotient is preferred whenever possible. Receptive and expressive vocabulary tests alone do not meet this requirement.
  - Norm-referenced tests selected for administration should be the most recently revised versions of such tests.
  - Norm-referenced tests measure decontextualized communication skills using formalized procedures. They are designed to compare a particular student's performance against the performance of a group of students with the same age and other characteristics identified by the test author(s) in selecting the normative population. They yield standard scores that are usually based on a mean of 100 and a standard deviation of 15. They are not designed to describe particular characteristics of children as they engage in the process of communication.

## **CONDUCTING A LANGUAGE ASSESSMENT**

1. Conduct hearing screening.
2. Obtain relevant information from the parents when possible: concerns about communication skills, developmental history, etc.
3. Gather information from the student's teacher. For preschoolers, obtain this information from child care providers or other adults who see the child outside of the family structure. Obtain information from teachers related to progress in the general curriculum, communication skills, behavior and social interactions. General curriculum for preschoolers is developmentally appropriate activities.
4. Review school records, e.g. grades, test scores, special education files, documentation of pre-referral strategies/interventions and discipline and attendance records.
5. Select and administer at least one comprehensive norm-referenced test that is appropriate for the student's age and yields receptive, expressive and total language quotients whenever possible.

### **VI. Best Practice suggests completion of the following:**

- A. Obtain information about the student's functional communication skills either informally or formally.
- B. Use standardized measures and/or a language sample (formal or informal) to assess:
  - a. Morphology: the understanding and usage of word endings, inflections, prefixes, suffixes and compound words.
  - b. Syntax: the set of rules, which govern how words, phrases, and clauses are combined to form sentences, mean length of utterance.
  - c. Language content or semantics: the manner in which words and word relationships represent one's knowledge and ideas about the world of objects and events, total number of words.
- C. Assess pragmatic language skills: understanding and using language in communicative interactions.
- D. Consider play skills when evaluating preschool children since the developmental level of play reflects underlying cognitive knowledge, and play provides a social context for interaction and language learning
- E. Interview the student, when appropriate, to determine his/her perception of communication abilities and difficulties especially as related to classroom and other educational settings. Probe the student's awareness and use of strategies that s/he has attempted and probe for self-evaluation of their effectiveness.
- F. Document how the student's language impairment adversely affects educational performance in the classroom or the learning environment. For preschoolers, document how it adversely affects their ability to participate in developmentally appropriate activities.
- G. Finalize and submit a written report to the IEP team.

## **Enrollment Criteria**

In order to be identified as a student with language impairment, the language difficulties must be determined to have an adverse affect on educational performance. Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance. The presence of any deviation in language does not automatically indicate an adverse effect on the student's ability to function within the educational setting. The deviation must be shown to interfere with the student's ability to perform in the educational setting before a disability is determined. The effect on educational performance is, therefore, best determined through classroom observations, consultation with classroom teachers and special educators and interviews with parents and the student. Teacher checklists are useful for determining specifically how language problems affect educational performance.

### **A student will be considered to have a language disorder when:**

1. The student's scores at least 1.5 standard deviation below the mean or below the 7<sup>th</sup> percentile for his chronological age or development on TWO or more standardized tests in one or more of the following areas: morphology, syntax, semantics, or pragmatics and language sample **OR**
2. one or more standardized tests and demonstrates inappropriate or inadequate use of expressive or receptive language as measured by a spontaneous or elicited language sample of a minimum of fifty utterances.

## **Considerations for Enrollment**

There are a number of factors to consider when making a determination of whether or not a student has a language disorder and/or needs direct services provided by a SLP. They are as follows:

1. Developmental level of functioning.
2. Social-emotional functioning.
3. Degree of remediation available through other school resources.
4. Other disabling conditions.
5. Deaf/HOH students using a total communication approach, the student demonstrates difficulties acquiring language skills as compared to other deaf/HOH and his/her needs cannot be fully met by the classroom teacher or other service providers.
6. Pertinent considerations for Second Language Acquisition. Accented English or dialectic is not a disorder and accent/dialect correction is not appropriate for services. Normal language loss can occur after exposure to a second language, resulting in depressed language abilities in BOTH the primary and secondary language (Shiff-Myers, 1992).

There is a natural process in second language acquisition:

- a. *Initial Active Listening Period:* requires at least two years of active listening, minimal expression is produced.



- b. *Basic Interpersonal Communication Skills/BICS*: three-four years to acquire, basic vocabulary established with phonology, morphology and syntax acquired and conversational proficiency only.
  - c. *Cognitive Academic Linguistic Proficiency/CALPS*: seven or more years, cognitive language skills for handling academics
7. Educational, cultural, economic, or environmental factors do not constitute a language disorder according to state eligibility guidelines.

### **Considerations for Exit**

1. The student demonstrates receptive and expressive language skills within the range expected for his/her developmental level and the disability no longer negatively affects academic performance in general education and/or special education program(s).
2. The student has met his/her IEP objectives/goals. These goals/objectives are to be written to reflect the most recent California General Education Performance Standards.
3. The student no longer meets the qualifications criteria for a speech and language disorder under which he/she is receiving language services as a direct or related/DIS service.
4. There is a lack of progress in language skills within two years time as evidenced by formal tests, therapy records, observations, teacher, parent/guardian consultation/report or other documentation.
5. The student consistently demonstrates behaviors that are not conducive to therapy, such as a lack of cooperation and motivation. In these circumstances the IEP Team should reconsider the initial eligibility decision since these behaviors may reflect social, emotional, cultural or economic factors rather than an actual disability. The IEP Team may also explore alternative services or strategies to support the interfering behaviors/conditions.
6. The student's communication skills are best reinforced and monitored in a classroom setting.
7. The student uses augmentative or compensatory communication aids appropriately, effectively and independently.
8. The student reaches the age of 22 years (CA SPED 56026A)
9. Parent or student over the age of 18 refuses to allow the continuance of special education services.

### **English Language Learners**

As our population becomes more diverse, educators are developing and infusing alternative strategies to supplement the instructional methods used to meet the needs of culturally and linguistically diverse students (Cheng, 1996). The knowledge of the linguistic rules of many dialects allows the speech and language pathologist to assist the regular and special education teachers with the instruction of these students. It is important that educational teams understand social dialects that are rule-governed linguistic systems which, if there are concerns, can be evaluated for a language disorder versus a language difference.

A clear understanding of the points noted above is just the first step for the SLP when understanding the monolingual and bilingual language acquisition process. The SLP must become familiar with current norms for the phonological, morphological, syntactic, semantic and pragmatic development of students from limited English backgrounds. If possible, ASHA recommends consultation with a bilingual SLP, ELL instructors and/or directors within district or the county office of education.

Supports/interventions the speech and language pathologist can provide are as follows:

- Assist student, who is eligible for services, to acquire the structure, meaning and use of English
- Assist the classroom teacher in acquiring an understanding of the differences in the communication styles of limited English proficient student
- Assist parents in obtaining skills to provide appropriate modeling and language stimulation activities
- Refer student for additional services and/or programs as appropriate

### **Testing African American Students**

The Larry P. decision continues to guide SLPs with regard to assessment of African American students. Tests that directly or indirectly purport to measure IQ are prohibited. If the construct validity of the test is partially or fully determined through the correlation with an IQ test, it too is considered banned.

When assessing African American students, SLP must keep in mind the following:

1. In lieu of IQ tests, alternative means of assessment should be utilized. Alternative means should be utilized whenever there is a professional concern about the validity of the test;
2. Nondiscriminatory techniques, methods and materials should be used for ethnic and culturally diverse children;
3. Assessment personnel must be competent and appropriately trained to administer and interpret test results and, when necessary, be knowledgeable of and sensitive to the cultural and ethnic backgrounds of students;
4. When an assessment has been completed, a written report must be developed which addresses an effects of environmental, cultural, or economic disadvantages, where appropriate; and

5. When appropriate, the IEP should contain linguistically appropriate goals and objectives.

NOTE: "Banned" assessment tools cannot be used even if at parent request.

To identify those students who truly require speech and language services, be sure to check the following:

- Carefully listen to the history shared by the parent/guardian when describing differences in development of the student in comparison to other students (universal aspects of speech and language development, [CSHA, Position Paper, pg. 83])
- Document medical and/or health concerns
- Look at dialect patterns that do not resemble normal development of students from similar backgrounds

*For further information, go to the California Speech and Hearing Association's website and read their position paper on the Larry P. decision at the California Speech-Language-Hearing Association [www.csha.org](http://www.csha.org).*

**Fluency  
Enrollment & Exit Criteria  
Section VI**

## FLUENCY ASSESSMENT CONSIDERATIONS

Fluency is a speech pattern which flows in a rhythmic, smooth manner. Dysfluencies are disruptions or breaks in the smooth flow of speech. Even speakers who are normally fluent experience dysfluencies. A speaker is dysfluent when unintentionally repeating a sound, word or phrase, prolonging a sound, or experiencing a block of airflow/phonation. It is the speech-language pathologist's responsibility to differentiate between normal dysfluencies and a fluency disorder (ShIPLEY & McAfee, 1998). Stuttered-like dysfluencies may include repetitions, prolongations and/or blocks while nonstuttered dysfluencies may include stater sounds/words, insertions of sounds, revisions, etc.

### CONDUCTING A SPEECH EVALUATION FOR FLUENCY

- Conduct hearing screening.
- Obtain relevant information from the parents: concerns about communication skills, developmental history, etc.
- Obtain information from teachers related to progress in the general curriculum, communication skills, behavior, and social interactions. General curriculum for preschoolers is developmentally appropriate activities.
- Review school records, e.g. grades, test scores, special education files, documentation of pre-referral strategies/interventions, and discipline and attendance records.
- Complete an oral-peripheral mechanism examination.
- Measure fluency using formal/informal assessments for frequency, descriptive assessment and speaking rate.
- Finalize and submit to the IEP team a *Speech and Language Evaluation Report*.

### ENROLLMENT CRITERIA

1. A student will be recommended for fluency therapy when a formal assessment indicates:
  - A. Frequency: At least 10 dysfluent words per 100 words with some atypical non-fluent words present and part word (sound and/or syllable) repetitions with an average of 2-5 repetitions per word
  - B. Duration: Prolongations, hesitations, and/or blocks with duration of at least 1 second.
  - C. Intensity: As determined by SLP
  - D. Secondary characteristics, such as facial grimaces
  - E. Negative effects on communication, such as avoidance.

### GCOE Considerations for Enrollment for Fluency Services

- Student's perception and the perception of the listener of the student's

fluency/dysfluency.

- Changes in dysfluencies relative to settings, audience and contexts
- Normal non-fluencies may be present up through age five/kindergarten, however, when 10% or more total dysfluencies with some atypical non-fluencies present, signs of effort/ struggle or unwillingness to talk and not improving over a 6-9 month period after teacher/parent have attempted suggestions/accommodations at home warrant concern.
- Development of the student's dysfluencies over time.
- Changes in dysfluencies relative to setting, audience and contexts.
- Family and/or student history, including therapy.

### **GCOE Exit Criteria**

1. The student has met fluency goal/s as stated in the IEP and/or the student's disability no longer negatively affects his/her educational performance in the general education/special education program. The student no longer meets the qualification criteria for a speech and language disorder under which he/she is receiving fluency therapy.
2. The student has made minimal progress toward goals over two years with exposure to a variety of therapeutic techniques.
3. The student consistently demonstrates behaviors that are not conducive to therapy such as: chronic absenteeism, lack of cooperation/motivation. The IEP team may explore alternative services or strategies to remedy interfering behaviors or conditions.
4. The student reaches 22 years of age (age eligibility defined in CA Special Ed. Program: A composite of Laws 56026A)
5. Parent and/or student age 18 requests exit from the program

## Severity Rating Scale of Fluency

|   | <b>Normal</b>                                     | <b>Mild</b>   | <b>Moderate</b>  | <b>Severe-<br/>Profound</b>                                    |
|---|---|---|--|--|
| <b>Fluency</b>                                | Predominate fluent speech                         | Stuttering may be episodic  | Stuttering is consistent                                 | Stuttering is consistent                                       |
| <b>Frequency of nonfluencies</b>              | <2% of LTT<br>>10% MTT                            | 3-8% of LTT<br>10-15% MTT   | 8-15%<br>Greater number of MTT than LTT                  | 12% or more<br>Significantly high number of MTT                |
| <b>Types of nonfluencies</b>                  | Whole word, phrase and some part word repetitions | Primarily part word repetitions, prolongations appearing          | Part word repetitions, prolongations and postural blocks | Whole word, part word, prolongations, tension in blocks        |
| <b>Number of repetitions per word</b>         | 1-3   | 1-5   | 1-8  | 1-10   |
| <b>Duration of nonfluencies</b>               | 1 second or less                                  | Average 1 second  | Average 2 seconds  | 1-20 seconds   |
| <b>Phonation</b>                              | Easy effortless repetitions                       | Signs of visible/audible tension with multiple stutters occurring | Audible visible tension                                  | Abrupt initiation of phonation. Severe audible/visible tension |
| <b>Substitution of Schwa vowel</b>            | Absent  | Observable  | Present on irregular basis                               | Present in repetitive block                                    |
| <b>Associated Motor Behaviors</b>             | Absent  | Absent  | Observable   | Consistent with release device used                            |
| <b>Use of Starters and postponements</b>      | Absent  | Absent  | Beginning to occur                                       | May be frequently employed                                     |
| <b>Word Avoidance</b>                         | Absent  | Absent  | Beginning to occur                                       | Frequent occurrences   |
| <b>Circumlocutions/situational avoidances</b> | Absent  | Absent  | Noticeably concerned                                     | Frequent occurrences   |
| <b>Listener Reactions</b>                     | No concern  | No concern  | Concerned  | Noticeably uncomfortable                                       |
| <b>Rate of Speech</b>                         | No concern  | No concern  | Negatively affects communication                         | Noticeably uncomfortable                                       |

Normal Speakers: 2 or less stutters in 100 syllables or 2 or less stutters in 1 minute of speaking sample. These are Less Typical Type (LTT): sound/syllable/whole word repetitions, blocks and prolongations OR 8 or less dysfluencies in 100 syllables is normal. These include the more typical types (MTT) interjections, revisions, phrase/word repetitions (Per Systematic Dysfluency Analysis).

Adapted from Russell Morley, April 1982

**Voice Entrance and Exit Criteria  
Section VII**



## VOICE

There are multiple aspects to consider when evaluating voice impairments:

- pitch,
- loudness
- quality, including resonance.

Many disorders of voice or resonance have an organic etiology with a related medical history. Other disorders are functionally based, caused by “faulty usage” or behavioral histories. For assessment and instructional purposes, classifying voice disorders by vocal behaviors or symptoms provides the most useful information for the speech-language pathologist. Boone and McFarlane (1988) suggest that “Patients with voice quality and resonance problems generally require some medical evaluation of the ears, nose, and throat as part of the total voice evaluation. A laryngeal examination must be made before a patient can begin voice therapy for problems related to quality or resonance. Voice therapy efforts should be deferred until a medical examination (which would include laryngoscopy) is concluded, because there are occasional laryngeal pathologies, such as papilloma or carcinoma, for which voice therapy would be strongly contraindicated.” No child should be enrolled for voice therapy without prior otolaryngological examination. However, the presence of a medical condition (e.g., vocal nodules) does not necessitate the provision of voice therapy as special education or a related service – nor does a prescription for voice therapy from a physician. No child should be enrolled in voice therapy for an extended period of time without showing significant improvement. If this is the case, then further follow up with the physician should be considered.

### Disorders of Resonance

Speech resonance is the modification of a vibrating airstream by the pharyngeal, oral and nasal cavities. Therefore, resonance disorders are not “voice disorders” and should not be treated as such. There are several types of resonance disorders that may be observed in school age children. In the overwhelming majority of the cases, the etiologies of the resonance problem are structural in nature. It is, therefore, unlikely that speech intervention will have any long-term benefit for the child. In most cases, referral to a cleft palate team is the most appropriate recommendation.

Hypernasality: excessive nasal resonance during production of vowels and semivowels. Hypernasality is typically the result of some type of velopharyngeal inadequacy (VPI). The most common causes are cleft palate (unrepaired or inadequately repaired), sub mucous cleft palate, occult sub mucous cleft palate, neurologic impairments and excessive pharyngeal depth. In many cases, the presence of or extent of VPI cannot be determined by an intraoral examination. Rather, endoscopic and pressure flow evaluations are needed. Hypernasality can range from mildly inconsistent to consistently severe and a variety of rating scales can be used to assess the degree of

impairment. In general, hypernasality cannot be improved through traditional speech intervention. Most individuals with hypernasality resulting from VPI require physical management in the form of surgery or prosthetic appliances.

Nasal emission: excessive nasal airflow during the production of pressure consonants. Nasal emission is not technically a resonance disorder, but an articulation disorder resulting from inadequate velopharyngeal closure. However, it frequently occurs in individuals with hypernasality. In most cases, nasal emission results from VPI and cannot be improved with traditional speech intervention. Rather, physical management (i.e., surgery) is needed to correct the underlying cause of velopharyngeal dysfunction.

Hyponasality: reduced nasal resonance during production of nasal semivowels [m, n, ŋ] and the vowels adjacent to these sounds. Hyponasality usually results from an obstruction in the nasal cavity, the nasopharynx, or the oropharynx. These obstructions may be temporary (e.g., allergic reactions) or permanent (e.g., large tonsils and adenoids). The cause of the obstruction may not be visible on oral inspection; therefore, an endoscopic evaluation may be needed to determine the etiology, location and extent of the obstruction. Hyponasality can range from mildly inconsistent to consistently severe and a variety of rating scales can be used to assess the degree of impairment. Speech therapy cannot reduce hyponasality that results from a permanent obstruction. Medical management will be needed to alleviate this resonance problem.

Mixed resonance: a combination of hypernasality and hyponasality during connected speech. Mixed resonance is the result of both VPI and upper airway obstruction. Endoscopic and radiographic assessment may be necessary to delineate the causes of this resonance disorder. Medical management will be needed to alleviate this resonance disorder.

## **CONDUCTING A SPEECH EVALUATION FOR VOICE**

- Conduct hearing screening.
- Obtain relevant information from the parents: concerns about communication skills, developmental history, etc.
- Information must be gathered from two educators: the student's classroom teacher as well as another professional. For preschoolers, obtain information from child care providers and other adults who see the child outside the family structure.
- Obtain information from teachers related to progress in the general curriculum, communication skills, behavior, and social interactions. General curriculum for preschoolers are developmentally appropriate activities.
- Review school records (e.g., grades, test scores, special education file, documentation of pre-referral strategies/interventions, and discipline and attendance records).
- Complete an oral-peripheral screening.
- Obtain medical report from an otolaryngologist, ENT

- Collect a representative sample of the student's speech.
- Analyze voice, pitch, intensity and quality.
- Document how the student's voice impairment adversely affects the student's educational performance in the general education classroom or the learning environment. For preschoolers, document how the voice dysfunction adversely affects their ability to participate in developmentally appropriate activities.
- Complete the *Voice Severity Rating Scale* and consider voice severity.

## **INTERPRETING AND REPORTING EVALUATION RESULTS**

For more detailed information regarding procedures for assessing fundamental frequency/habitual pitch, breathing patterns and breath support, and the s/z ratio for respiratory/phonatory efficiency, refer to [Assessment in Speech-Language Pathology: A Resource Manual](#) (Shiple and McAfee). Procedures for the identification of resonance problems including hypernasality, hyponasality and assimilation nasality and assessment of velopharyngeal functioning can be found in this resource manual as well. The impairment must not be related to unresolved upper respiratory infection or allergies that are not being actively treated by a physician.

### **GCOE Enrollment Criteria:**

A student will be considered to have a voice disorder when all of the following conditions are met:

1. Laryngeal involvement has been verified by a physician examination and the physician's referral has been received.
2. The evaluation reveals voice deviations in pitch, loudness or quality.
3. There is a total of 4 or more points on the *Voice Severity Rating Scale*.

## **USING THE VOICE SEVERITY RATING SCALE**

The *Voice Severity Rating Scale* is to be used as a tool after a complete assessment of the student's voice. The scale is designed to assist the examiner with interpretation and documentation of the results of voice assessment findings in terms of severity (pitch, intensity, quality and resonance). This scale is not a diagnostic instrument and should not be used in the absence of assessment data.

In order to be identified as a student with a speech impairment with voice difficulties, the severity of voice dysfunction must be determined to have an "adverse effect on educational performance." The rating scale serves three purposes:

- 1) to document the presence of voice dysfunction and to what extent

*Mild:* Inconsistent or slight deviations, casual listener does not note voice disorder. Student may be aware of problem.

*Moderate:* Voice disorder is consistent and noted by casual listener

*Severe:* There is a significant deviation in voice and the casual listener notes voice

- disorder and the student, teacher and/or parents are aware of problem
- 2) to indicate the absence or presence of adverse effects on educational performance, and
  - 3) to determine whether or not the student meets eligibility standards for a speech impairment in voice.

“Educational performance” refers to the student’s ability to participate in the educational process and must include consideration of the student’s social, emotional, academic and vocational performance. The presence of voice dysfunction does not automatically indicate an adverse effect on the student’s ability to function within the educational setting. The voice dysfunction must be shown to interfere with the student’s ability to perform in the educational setting before a disability is determined. The effect on educational performance is, therefore, best determined through classroom observation, consultation with classroom teachers and other special educators, and interviews with parents and the student. Teacher checklists are useful for determining how the voice dysfunction affects educational performance.

#### **GCOE CONSIDERATIONS FOR EXIT**

There are several factors for the IEP Team to consider when making decisions regarding exit from voice therapy. They are as follows:

1. The SLP’s professional judgment indicates that the student’s voice is within normal limits as related to age, gender, and culture and no longer negatively affects his/her educational performance in the regular education or special education program.
2. Other associated and/or disabling conditions prevent the student from benefiting from further therapy: e.g., dental abnormalities, allergies, velopharyngeal insufficiency, or inadequate physiological support for speech as well as no progress within two years.
3. Persistent inappropriate vocal behaviors prevent the student from benefiting from therapy.
4. The student consistently demonstrates behaviors that are not conducive to therapy such as a lack of cooperation, motivation, or chronic absenteeism. These behaviors may reflect social maladjustment, environmental, cultural, or economic factors rather than an actual disability. The IEP team may also explore alternative services or strategies to remedy interfering behaviors or conditions.
5. He/she graduates from high school.
6. Parent (or student over 18 years of age) refuses to allow the continuance of special education services.
7. The student reaches the age of 22 years (CA SpEd Laws 56026A)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Voice Severity Rating Scale**

| Degree of Severity            | 0  | 1   | 2   | Score 0,1,2 |
|-------------------------------|--|---|---|-------------|
| <b>Perception of Severity</b> | Normal-slight variation not perceived by parents or teachers | Clinician perceived deviation.  | Multiple referrals, and/or clinician determines voice interferes with communication.            |             |
| <b>Resonance</b>              | Nasality is within normal limits                             | Assimilation nasality or upper respiratory infection-related acute denasality. There is a noticeable difference in nasality which may be intermittent | There is a persistent, noticeable hyper or hyponasality, or mixed nasality                      |             |
| <b>Pitch</b>                  | Pitch is within normal limits                                | Speaking above/below optimum pitch  | There is a persistent, noticeable inappropriate raising or lowering of pitch for age and gender |             |
| <b>Quality</b>                | Quality is within normal limits                              | Apparent hoarseness or breathiness  | Spastic or whispered; chronic hoarseness and pitch breaks                                       |             |
| <b>Intensity</b>              | Intensity is within normal limits                            | Intensity is too loud or soft   | Loudness varies unpredictably and inappropriately   |             |
| <b>Air Supply</b>             | Air supply appears adequate and is within normal limits      | Observable reverse breathing and/or speaking on residual air  | Inadequate air supply resulting from a physical disability                                      |             |
| <b>Tension</b>                | Face, Neck and shoulder tension within normal limits         | Lax or excessive tension  | Lax or excessive tension  |             |

\*Do not include regional or dialectal differences when scoring. If the total scores is 4 or more points, therapy is indicated, however, determination of eligibility is made by the IEP Team.

**Both of these statements above must be checked YES:**

*Based on compilation of the assessment, this student scores in the Mild, Moderate or Severe range Voice Disorder: Yes \_\_\_ No \_\_\_*

*There is documentation/supporting evidence of adverse effects of the Voice disorder on educational performance: Yes \_\_\_ No \_\_\_*

## Considerations for Voice Severity

|                                | <u>No Apparent Problem</u>                                      | <u>Mild</u>   | <u>Moderate</u>  | <u>Severe</u>   |
|--------------------------------|---|---|--|---|
| <b>Description of Voice</b>    | Pitch, quality, intensity, rate, and resonance are not unusual. | Noticeable differences that may be inconsistent in pitch, quality, intensity, rate, and resonance.  | Persistent noticeable differences noted in voice production quality (tension, resonance), pitch, intensity, or rate.   | *Consistent noticeable extreme differences noted in voice production quality (tension, resonance), pitch, intensity, or rate.   |
| <b>Informal Assessments</b>    |   | Voice difference including hoarseness, nasality, denasality, pitch, or intensity inappropriate for the student's age is of <i>minimal</i> concern to parent, teacher, student, or physician.                  | *Voice difference <i>is of concern</i> to parent, teacher, student, or physician.<br>*Voice is <i>not appropriate</i> for age and gender of the student.   | Voice difference is of <i>concern</i> to parent, teacher, student or physician. Voice is <i>distinctly abnormal</i> for age and gender of student.  |
| <b>Effect on Communication</b> |   | *The voice difference is <i>not severe enough to interfere</i> with communication.<br>*The student's awareness may affect communication.  | The voice difference may interfere with communication and impair intelligibility or both.  | The voice difference impairs communication and intelligibility or both.   |
| <b>Effect on Education</b>     |   | *Voice <i>rarely</i> distracts listeners from message.<br>*Minimal impact on social, emotional, and/or academic functioning.<br>*Minimal listener and/or speaker reaction as noted by two familiar listeners. | *Voice <i>does</i> distract listener from message.<br>*Moderate listener and/or speaker reaction and concern as noted by two familiar listeners.<br>*Interferes with social, emotional, and/or academic functioning. | *Voice <i>does</i> distract listener from message.<br>*Avoidance of speaking situations may be observed.<br>*Seriously limits social, emotional, and/or academic functioning due to limited ability to communicate appropriately. |

# **Feeding &Swallowing Considerations Section VIII**

## Feeding & Swallowing Considerations

Adequate swallowing assessment conclusion and intervention are not possible without medical evaluation and treatment by appropriately trained professionals. The SLP acts as a member of a collaborative team that's made up of school-based and/or medical professionals (ASHA, 2004a). It is important to remember that feeding and swallowing also fall within the scope of practice of other professionals (i.e. occupational therapists); therefore during assessment planning and after interventions are indicated, teams must make decisions regarding which team member should focus on this area.

IDEA supports the need for dysphagia therapy when it affects educational performance. ASHA's *2007 Guidelines for Speech-Language Pathologists Providing Swallowing and Feeding Services in Schools* addresses this issue, providing conditions when therapy for swallowing and feeding disorders is educationally relevant and therefore the school districts' responsibility under IDEA. Conditions that would support the need for dysphagia therapy include (a) assurances of safety when eating to address the risks of choking and aspiration during oral feeding, (b) provision of adequate nourishment and hydration to support the attention needed to fully access the curriculum, threatened by (c) decreasing susceptibility to illnesses related to malnutrition and hydration to increase student ability to attend school, and (d) supporting students to learn skills that will enable them to participate in meal and snack time with peers safely and in an appropriate amount of time. In many of these situations, school-based SLP's will need to collaborate with medical teams to be effective and ensure the safety of their students (Lefton-Greif & Arvedson, 2008).

According to the American Speech-Language-Hearing Association (ASHA, 2004a) assessment should be conducted to identify and describe:

1. Underlying strengths and deficits related to body/structural factors that affect swallowing and feeding performance;
2. Effects of swallowing and feeding impairments on the individual's activities (capacity and performance in everyday contexts);
3. Contextual factors that serve as barriers to or facilitators of successful eating for individuals with impairment. Similarly, intervention should be designed to:
  - A. Capitalize on strengths and address weaknesses related to underlying structures and functions that affect swallowing;
  - B. Facilitate the child and family's performance of activities and participation in social events by helping the child/caregiver to acquire new skills and strategies;
  - C. Modify contextual factors to reduce barriers and enhance facilitators of successful swallowing and feeding.
  - D. Provide appropriate accommodations and other supports, as well as training in how to use them (ASHA, 2004b):
    - Supporting adequate hydration and nutrition;
    - Minimizing the risk of pulmonary complications;
    - Facilitating coordinated movements of the oral/pharyngeal mechanism and respiratory system;
    - Techniques for managing behavioral and sensory issues that interfere with feeding and swallowing (ASHA, 2004b)
    - *\* This information is a compilation of Kansas State Department of Education, Speech & Language Guidelines, 2005 and the Glenn County Office of Education Guidelines for Speech & Language Services-Best Practice Guidelines, 2004.*



**Section VIII**

**Hearing Screening Guidelines**

## Hearing Screening Guidelines

### Purposes and Rationale

The goal of hearing screening is to identify peripheral Hearing Impairments that may interfere with the development of speech and/or language in students with suspected Speech or Language impairments who have been referred for eligibility determination for special education services. The screening for a Hearing Impairment is a pass/refer procedure to identify those students who may require further audiological evaluation or other assessment.

School-age children with even minimal Hearing Impairments are at risk for academic and communicative difficulties (Tharpe & Bess, 1991). Due to the critical importance of identifying any hearing difficulties that may affect the student's speech and language, the minimal screening level of 25 dB HL. General education hearing screening is part of the early intervention process and may be completed prior to initiation of the speech and language evaluation and during initial and triennial IEP's and/or through parental request. If a hearing screening has not been completed through the general education screening process, screening by the SLP does require individual parental permission.

Hearing screenings for mandated grades (1<sup>st</sup>, 2<sup>nd</sup>, 5<sup>th</sup>, 8<sup>th</sup>, and 10<sup>th</sup>) is done yearly by a hearing service for the district service schools and special education classes. After the mass screening is completed, the School Nurse will compile a list of those students who were absent or failed the screening for the SLP assigned to each school. The SLP Therapists will re-screen those students who failed the screening in six weeks. If the student fails again, the Therapist will communicate to the parents in written form for consideration for follow-up. Each Therapist is responsible for charting the results in the student's health cum record. The Therapist can screen those students who were absent when the student returns to school. If they pass, chart the results in the student's health cum record. If they fail, follow the same procedures as outlines above.

### Considerations

Screening procedures for the purpose of assessment for Speech or Language Impairments may be conducted by the SLP. As a part of the case history obtained for all referred students, indicators of possible Hearing Impairment should be investigated by obtaining information regarding:

1. Family history of hereditary childhood hearing loss;
2. In utero infection such as cytomegalovirus, rubella, syphilis, herpes and toxoplasmosis;
3. Craniofacial anomalies, including those with morphological abnormalities of the pinna and ear canal;
4. Ototoxic medications;
5. Bacterial meningitis and other infections associated with sensorineural hearing loss;
6. Stigmata or other findings associated with a syndrome known to include sensorineural and/or conductive hearing loss;
7. Head trauma associated with loss of consciousness or skull fracture;
8. Neurofibromatosis type II or neurodegenerative disorders;
9. Recurrent or persistent otitis media with effusion for at least three months;

10. Exposure to high levels of environmental noise associated with noise-induced Hearing Impairments;
11. Functional listening skills as observed by parents in the home setting and by teachers in the classroom.

### **Screening Procedures**

#### *Setting/Equipment Specifications*

1. Conduct screening in a quiet environment with minimal visual and auditory distractions. Ambient noise levels must be sufficiently low to allow for accurate screening (American National Standards Institute, 1991). Ambient noise levels should not exceed 49.5 dB SPL at 1000 Hz, 54.5 dB SPL at 2000 Hz, and 62 dB SPL at 4000 Hz when measured using a sound level meter with octave band Filters centered on the screening frequencies.
2. Meet ANSI and manufacturer's specification for calibration (American National Standards Institute, 1996) and regulatory agency specification for electrical safety of all electroacoustical equipment.
3. Calibrate audiometers to ANSI – S3.61996 specifications regularly, at least once every year, following the initial determination that the audiometer meets specifications.
4. Perform daily listening check to rule out distortion, cross talk, and intermittence and determine that no defects exist in major components.

### **Screening Protocol**

1. Visually inspect the ears to identify risk factors for outer or middle ear disease such as drainage and abnormalities of the pinna or ear canal.
2. Conduct screening in a manner congruent with appropriate infection control and universal precautions (Occupational Safety and Health Administration, 1991).
3. Condition the student to the desired motor response prior to initiation of screening. Administer a minimum of two conditioning trials at a presumed suprathreshold level to assure that the student understands the task.
4. Some preschool children ages 3-5.5 years may be able to reliably participate in conditioned play audiometry, a form of instrumental/operant conditioning in which the child is taught to wait and listen for a stimulus, then perform a motor task such as dropping a block in a box in response to the stimulus. The motor task is a play activity, which serves as a reinforcement. Other preschool students may be able to participate in conventional audiometry without the reinforcement of the play activity.
5. Screen the student's peripheral hearing under earphones using 500, 1000, 2000, and 4000 Hz tones at 25 dB HL in each ear.
6. At least two presentations of each test stimulus may be required to assure reliability in school-age children.

### **Pass/Refer Criteria**

1. "Pass" if a student's responses are judged to be clinically reliable at the criterion decibel level of 25 dB HL at each frequency in each ear. Note that for preschool children at least two presentations of each test stimulus may be required to assure reliability. If a school age child does not respond at the 25 dB criterion level at any frequency in either ear, repeat instructions, reposition the earphones and rescreen

within the same screening session in which the student fails. Pass the student who passes the rescreening. In order to rule out temporary hearing deficits of school-age children who fail the first screen, rescreen session due to allergies, colds, etc. conduct a follow-up screening in six weeks.

2. Report to Parent if:

- a) The preschool student does not respond at least 2 out of 3 times at the criterion level of 25 dB HL at any frequency in either ear;
- b) The school-age student has failed both first and second screening sessions; or
- c) The student cannot be conditioned to the screening task.

3. Document specific results from hearing screening on the *Hearing Screening* form.

# Speech-Language Pathology

## Flowchart Guidelines

