Universal Screening: Answers to District Leaders’ Questions

John E. McCook, Ed.D.

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Dr. John E. McCook is a consultant on special education and Response to Intervention (RTI) for school systems across the nation. He has formulated practical RTI strategies for state departments and regional educational agencies in Kentucky, Georgia, Louisiana, Texas, New York, Ohio, and Alaska. His work has helped turn around schools and districts in Ohio and Louisiana. Additionally, he has served as the Director of Pupil Personnel, District Section 504 Compliance Officer, and Special Education Personnel Supervisor in the Knox County School District in Knoxville, Tennessee.

Dr. McCook is the author of two best-selling books about RTI—The RTI Guide: Developing and Implementing a Model in Your Schools, and Leading and Managing RTI: Five Steps for Building and Maintaining the Framework. His books are used in many state and district RTI manuals including those of Georgia, Virginia, Kentucky, and Ohio. Dr. McCook has been involved with RTI work throughout his more than 35 years in education and presents regularly at national meetings, including those of the National School Board Association, LRP National Legal Conference for Special Education, and the International Association of Pupil Personnel.
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Are you uncertain about the practical matters of Response to Intervention (RTI) universal screening in your school district? If so, you’re not alone.

A district-wide universal screening process must be in place to effectively implement your RTI strategy. But even with guidelines and policies from your state policy makers and the DOE, selecting universal screening tools can be confusing, and deciding how and when to use them can be challenging. In fact, research done at a leading university shows that essential practices are not in place in 80-95% of school districts.1

During an October 2011 online professional development webinar titled “The Five Common Myths of Universal Screening,”2 a national audience of district leaders—including curriculum directors, deputy superintendents and members of district RTI teams—had plenty of questions for RTI expert and consultant Dr. John McCook. Following are their questions and Dr. McCook’s responses.

QUESTION 1
What frequency is recommended for universal screening? Do we test all students each time?

Answer
All students are assessed three times per year in universal screening.

QUESTION 2
Should the same screening tool be used across an entire state?

Answer
In an ideal world, the state would provide a common universal screening assessment. However, this has not, and at this point will not happen, across the nation. There are isolated instances such as Florida where there is a common universal screening system.

QUESTION 3
What can administrators do to ensure that interventions are being used and that their staff understands the importance of using interventions?

Answer
Getting “buy-in” and making sure that we have fidelity in implementation are major issues. Buy-in is served by including staff in the discussion of whether what we are presently doing is working. Data show clearly that what we have been doing is not making our children globally competitive. If we continue to do the same thing we are doing, then we will continue to get the results we are presently getting.

Gaining commitment is an issue of the second phase of implementing RTI. If the carrot approach of better results for students is not enough, then the staff members must decide whether they wish to remain with the school/district that has decided to implement RTI.

The next portion of the question addresses fidelity. That which gets measured gets done is a true statement in this area. When a student has four consecutive data points below the aim line in progress monitoring, the instructional leaders in a building MUST randomly check (by physically visiting the intervention instructor) to make sure that the intervention is being done the WAY it is designed to be done and for the amount of time it is designed to be delivered.

1 Leading and Managing RTI: Five Steps for Building and Maintaining the Framework by Dr. John E McCook, p. 30.
2 http://eps.schoolspecialty.com/rti/
How often should you test Tier II students?

I suggest that students in Tier II should be progress monitored weekly. Some studies suggest that every other week is sufficient. However, this would take too much time to get the amount of data points needed to make a decision.

When we are looking at universal screening, are we considering the classroom, the school, the town, the district or the state?

Ideally what you want to be able to do is to begin with the individual child, compare that child to others in the classroom, and then compare that child to others in the same grade level in that building, in the district and nationally. You may think you are doing really well relative to a classroom, or relative to a district or state, and then find out that, relative to national norms, you are not doing well at all. Ultimately, being able to look at a global perspective is important, too.

Our school is Measures of Academic Progress® (MAP®) testing in the fall and spring, but not during the winter. Is this something that should be addressed in terms of universal screening? Are we defeating the purpose of using MAP data if we are not testing during the winter?

Universal screening is based on a model of testing three times a year. If I test in the fall and spring only, you don’t know what the growth rate is during the middle of the year, so you can’t make mid-year corrections. If I don’t know what the growth rate is for oral reading fluency, for example, between fall of year and January, I can’t tell whether the whole class is growing. If I just do fall and spring, September and May for instance, I start to look at formative testing, and it starts to look a lot like state testing that occurs twice a year. It’s better than once per year, but it’s not what we want in terms of universal screening results three times per year.

One of the purposes of universal screening is to identify students who are at risk. We measure everyone’s skills and then we look at students who are aberrant relative to the population. The second function of universal screening is to look at a child’s growth. If I don’t know what the child’s growth is, say, in oral reading fluency or math problem solving skills between September and January, then I don’t know if I’m closing the gap. If I don’t measure between September and May, when I get May results, the year is over and then what am I going to do about it?

Why is universal screening necessary to the success of RTI? It seems that its purpose is to determine which students need intervention—is that correct?

The purpose of universal screening is to help determine which students need intervention. Some will say universal screening is the sole determinant, but that is really not true. If you use it as the sole determinant, then the worst scenario you have is that you provide help to children who don’t need help. No matter what skill you measure, there will always be children who will do poorly on a specific skill but who will have compensated in some way so they will do okay in other areas. You will have students who are slow readers on oral reading fluency who will look aberrant, but who are doing fine in the classroom or doing fine on state testing. Why would you intervene in a Tier II manner when you could intervene in a Tier I manner through differentiated instruction? Trying to address it that way is
better than automatically putting everyone who reads below “X” number in Tier II. You could be sending a lot of students to Tier II intervention that don’t need to be there.

At the same time, if the universal screening data you are using is the only data you are using, and you’re measuring oral reading fluency, for instance, there may be children who can read lots of words but who don’t have any comprehension. You might not be providing help to those children because they were not identified by universal screening, if that is the only thing you are using.

**QUESTION 8**

**What is a good universal screening tool?**

**Answer**

There are several good screeners. EPS’s RTI package for both Academy of READING® and Academy of MATH® are good screeners. There are AIMSweb®, Developmental Reading Assessment® (DRA), Dynamic Indicators of Basic Early Literacy Skills (DIBELS®), and Wireless Generation’s mCLASS®: DIBELS® Next literacy assessment for grades K-6 (mCLASS). Many publishing companies are now in the universal screening market.

Whatever screener you use, it should be directly tied to whatever you are going to use for progress monitoring. For example, you don’t want to use a universal screener that measures an actual oral reading fluency, and then use a tool for progress monitoring that only estimates oral fluency. That approach would have you measuring apples and oranges. What I suggest is vetting what’s out there for the skills you want to measure.

For PreK through grade 2, you are looking at moving from early literacy issues and early numeracy issues—that’s a number, how far can you count, what’s the missing number in a sequence—into mathematical calculation, problem solving and concepts. If you are looking at literacy for PreK-2, you are dealing with phonemic awareness and the five components and that whole continuum of reading.

As students get older, oral reading fluency is the best predictor of reading issues. The problem is that, at about middle school, oral fluency tends to flatten out, and then comprehension becomes more important than oral reading fluency. Fluency is still the best predictor statistically, but because it flattens out, we start looking at what other tools we will use. Many districts add in MAZE or the comprehension piece around the 4th grade and others 7th or 8th grade. Look at what the publishing companies have to offer in terms of universal screening tools. But whatever you choose, use something that has been vetted by the National Center for Progress Monitoring.

**QUESTION 9**

**When you are using a universal screening tool and progress is not being made, how does a teacher with 100 students find the time to give interventions when they also have other teaching responsibilities?**

**Answer**

This is a good question and one of the issues that comes up over and over again. The model for implementing Response to Intervention and using the universal screening data is different at the elementary level than it is at the middle and high school level. At the elementary level, the model says we should provide at least three 30-minute interventions per week, and use differentiated instruction to find the time. It boils down to the ability to develop an intervention period during the day that has the least impact on staff. Teachers can schedule it during the day and make effective use of their time if they are doing differentiation of instruction.

This question tells me that there is a problem with differentiation of instruction. The logistics
for middle or high school are usually about creating a time for intervention during the day.

For example, you could have a 9th grader reading at a third grade level. A reading specialist, is going to work with the student on his reading skills. If I’m the biology teacher, I have no responsibility for this student, even though he’s in my biology class. So I am going to continue teaching the way I always teach, even though I know that this student can’t read the assignment.

So at the secondary level, even though someone else may be providing the intervention, it starts to resemble a special ed type of model. As a classroom teacher, I have to change and differentiate instruction in my class. I need to find another way for the student with the reading problem to get the content of chapter three without having the student read chapter three.

A lot of secondary careers are built around read chapter three, four days of lecture, and then one day of test, and very little differentiation of instruction. It’s not the teacher’s fault. Teachers are not taught how to differentiate instruction in the pre-service model or in the universities and colleges, and it is left to the district to provide the way for teachers to learn how to differentiate instruction. With differentiated instruction you are able use the Tier I interventions that enable you to go forward.

QUESTION 10
Does universal screening take the place of teacher referral?

Answer
Universal screening won’t take the place of a teacher referral. You’ll see 85–90% of the students being considered for intervention based on data that brings the case to the table. But there will still be some referrals from teachers. A teacher will say that the oral fluency screener doesn’t show that the student has a problem, but the teacher knows the student has no clue what he is reading. We then investigate whether the data supports the belief that the student has a reading issue.

QUESTION 11
How is the RTI model implemented?

Answer
The first phase of implementing an RTI model is awareness of why we are using this approach. The second phase is commitment. There has to be commitment at the district level. I want central office staff first for training, then I want principals, and then I want the teams. Commitment from the instructional leadership is critical. Teachers are willing to do what they view as important at the district level and for the leadership at the building level.

Those of you who may have attended my workshops in the past know that I ask principals to identify themselves at the beginning of the meeting and then I tell them, “If RTI works it’s because of you and if RTI doesn’t work it’s because of you.” Commitment is the critical piece. Teachers will embrace RTI when they see that it gives them the information they need to deal with instruction in the classroom. How you present RTI to teachers is what matters. If how you present it is not user friendly and you present a bunch of numbers, teachers will not use it and will not see the need.

QUESTION 12
How do you convince a teacher to move away from “cardiac assessments” and embrace universal screening data?

Answer
You have to show teachers that universal screening data provides more information and is easier to deal with than “cardiac assessments.” If you go to the doctor because you are sick, the doctor will weigh you, take your temperature, and give you a blood pressure check. Those are all universal screeners. Every parent has taken a child to the pediatrician and
has seen the chart that shows where the child is on normal height and weight. That chart is a universal screener. Being able to show the teacher the data and break down the data so teachers can easily understand it is key. Once they see the data and can use it, then they will move from a cardiac assessment or state type assessment. It’s a slow process, but when we show them that it actually works, we see lights go on.

I was in New Jersey recently looking at how to interpret data. The teachers did their own “box and whisker charts,” which is just a way of looking at data, and all of a sudden it was like turning the lights on. They began to respond when they could see how the data could be used.

If you are in a site-based system, life is harder. But there are certain things in a RTI model that are district decisions and there are certain things that are building-level decisions. You can’t have building A using AIMSweb, Building B using EPS’s RTI package, and Building C using another program. That doesn’t mean all of K–12 has to use the same instrument, but you need consistency within buildings, otherwise you get a mish mash and then when students move from building A to building B you will be comparing apples to oranges.

School districts should open their closets to see what they have that is diagnostic. Sometimes multiple screeners and diagnostics are being used. It doesn’t make sense to replicate screeners or diagnostics. I don’t want to over evaluate students because if I do, I am taking time away from instruction. I want to use as much data as is necessary to make decisions objectively, but I don’t want to use so much data that I start to recount and confound the picture. So AIMSweb is obviously a good universal screener. EPS is a good universal screener. For MAP, there is a question as to whether it is a diagnostic or universal screener. But I don’t want to use more than is necessary to get the information.

One district I was working with was using DRA and NWEA both. We were able to convince the district, through data, that it was identifying the same children. We decided to use a screener on the front end and then diagnose using DRA and NWEA only with the students who had the fever. The district had been diagnosing students who didn’t need to be diagnosed.

**Question 13**

What diagnostic test do you recommend giving to students who place in the Tier II or Tier III program to see what those students’ needs are after they are universally screened?

*We use the Northwest Evaluation Association (NWEA) MAP test (3 times a year) and the AIMSweb MAZE and Fluency probes.*

**Answer**

There are several things you can look at from a diagnostic perspective before you put a student in Tier II or Tier III. Look at universal screening data, vet it with classroom data, and look at state testing data. We may know a student has a “fever” from looking at state testing data, but why does the student have a fever? Academy of READING, for example will delve down into the specifics of whether this is a phonics issue, a comprehension issue, or a vocabulary issue. You have things like DRA, NWEA, and EPS’s S.P.I.R.E.® that will also delve down into those issues. There are several tools on the market.

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