TOPICAL BRIEF 3
Scientific Research-Based Interventions

Connecticut's Framework for Response to Intervention

ADDRESSING THE NEEDS OF THE WHOLE CHILD:
Social, Emotional, Behavioral, and Physical Health, as well as Academic Achievement, in Connecticut's SRBI Process

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This topical brief is the third in a series designed to clarify and assist the work of Connecticut educators engaged in implementing Scientific Research-Based Interventions (SRBI). The term SRBI was adopted by the Connecticut State Department of Education (CSDE) in August 2008 (Connecticut's Framework for Response to Intervention [RTI]) and is synonymous with the term RTI. RTI is the term used nationally to describe the practice of providing high-quality instruction and interventions matched to student needs, monitoring progress frequently to make decisions about changes in instruction or goals, and applying data to inform educational decisions (National Association of State Directors of Special Education, 2008). The purpose of RTI or SRBI is, of course, to ensure that all students learn and acquire the behavioral and academic competencies that they will need to be successful in school and in society.

Studies over the past decade have consistently demonstrated that in order for students to achieve at high academic levels, schools, families and communities must focus on the child's social, emotional, physical and behavioral health as well as the acquisition of academic skills, strategies and content. These studies have shown that a coordinated approach to school health can reduce absenteeism and classroom behavior problems, improve classroom performance, better prepare students to be productive members of their communities, establish lifelong health practices, make schools more engaging, and address staff wellness needs (Connecticut State Board of Education Position statement on a Coordinated Approach to School Health, 2009). The focus of this brief is on using the SRBI process to address the needs of the **whole child** to remove non-academic barriers to academic achievement and ensure that students achieve their full potential.

In 2008, the CSDE convened Department and State Education Resource Center (SERC) representatives to develop a plan for addressing student needs in the areas of social, emotional, physical and behavioral health. After meeting and discussing how best to move forward, the committee decided to draw upon existing practices rather than to develop an entirely new and different initiative. Connecticut districts were already becoming familiar with, and committed to, the SRBI process and were at various stages of implementation. The "Underlying Principles and Critical Features of SRBI" (Connecticut's Framework for Response to Intervention [RTI], 2008, pp. 14-19) were consistent with "assumptions that provide a solid foundation for addressing the needs of the **whole child** for successful learning" (see "Appendix A" on page 10). Furthermore, upon examination, it was clear that the SRBI framework provided precisely the kind of continuum for developmental, preventative, remedial and support services that research has shown to enhance the capacity of schools to address the affective and health domains effectively (Connecticut State Board of Education Position statement on Student Support Services, 2010). Integrating evidence-based practices that address the development of the social, emotional and physical health areas into the three-tiered SRBI framework was the next appropriate step for developing supporting documents to assist schools in developing comprehensive SRBI programs for their students.

To better understand the vision of the committee, it is helpful to examine the SRBI framework. The framework is based on a multistep approach to providing services and interventions through increasing levels of intensity, as needed. The progress that students make at each stage of intervention is closely monitored using data and data teams (see Topical Brief 1 at www.sde.

ct.gov/sde/lib/sde/pdf/curriculum/cali/topical_brief_1.pdf). Data teams meet regularly to monitor student progress using a five step process that includes: 1) conducting universal screening and ongoing collection of data; 2) analyzing assessed strengths and challenges to determine root causes; 3) establishing, reviewing and revising SMART (Specific, Measurable, Attainable, Realistic and Timely) goals; 4) selecting scientific, research-based interventions; and 5) progress monitoring through the use of assessment and data. The results of this monitoring are used to make decisions about the need for further research-based interventions, changes in setting, frequency and intensity in the delivery of the interventions, and to ensure that the process is cyclical. A more comprehensive description of the SRBI process can be found in Connecticut's Framework for RTI at http://state.rti4success.org/index.php?option=com_resource&view=single&cid%5B%5D=207.

SRBI is not new. It simply provides a framework for ensuring successful student learning, and opportunities to refine and improve much of what districts and schools are already doing. As previously highlighted, it is essential to focus on the **whole child**. The concept of a child's "wholeness" includes not only academic functioning but also all the components affecting the child's well-being and overall health—specifically the social and emotional, behavioral and physical health of the child.

If you have begun to implement SRBI in academic areas, you will already have the structures of the framework in place to incorporate social, emotional, behavioral and physical health into the SRBI framework. In addition, by keeping good data, as the SRBI process requires, you may find that some of the services you are presently providing are not as effective as anticipated. By identifying the most effective services, your efforts will have greater impact. Addressing student needs in these areas can, and should, be incorporated into district-level, building-level, and grade-level data team meetings. Data team members for each of these levels, and in each of the tiers, may include administrators, teachers, specialists (e.g., health educator, special education teacher, behavioral health specialist, nutritional consultant, and nurse), parents, and when appropriate, a dietician and noncertified staff members. With respect to grade-level data team meetings, while it is not possible for every staff member to be at every data team meeting for all grade levels, all specialists and teachers should be a member of at least one data team that meets on a regularly scheduled basis, and attend others on an as-needed basis.

The following provides a more detailed description of the SRBI tiers and practical application examples that address the development of social-emotional, physical, and behavioral health in students.

TIER 1

Tier 1 refers to the general education core curriculum and instruction, the overall school climate, and the system of schoolwide social-emotional learning and behavioral and physical health supports for all students. High-quality, evidence-based practices that build foundational skills and knowledge for all students must be provided in Tier 1. If districts and schools effectively implement appropriate programs and services in Tier 1, there will be fewer students who need

the additional supports offered through Tier 2 and Tier 3. While it is beyond the scope of this brief to provide a detailed description of what a high quality Tier 1 looks like in each of the areas being discussed, some key components will be highlighted. A more detailed description can be found in the corresponding Connecticut State Board of Education policy guidance and position papers (see references).

TIER 2 AND TIER 3

Tiers 2 and 3 are the newest parts of the process for parents and for many teachers. Tier 2 and Tier 3 are for students who, based on the data, do not attain important benchmarks despite the services that have been provided in Tier 1. In the event of a large number of students not attaining the expected benchmarks through Tier 1 services, teams should review their data carefully and consult with subject matter experts to improve the supports and programming delivered in Tier 1.

Tier 2 interventions are short term (e.g., eight to 20 weeks) and remain part of the general education system with supports from specialists. Interventions must be research-based as much as possible, be reasonably feasible for educators to use, and accurately target the student's area(s) of difficulty" (Connecticut's Framework for RTI, 2008, pp. 34). Tier 3 interventions may be different and more specialized; however, "the primary difference between Tier 2 and Tier 3 interventions generally involves the intensity and/or individualization of the intervention. Greater intensity can be achieved with a smaller teacher-student ratio, a longer duration of instruction/services and more frequent progress monitoring" (Connecticut's Framework for RTI, 2008, p. 41). As in Tier I, obtaining and analyzing solid data, on a highly regularized schedule, are the underpinnings for all decision-making in both Tier 2 and Tier 3. If at any point it appears that the student is making little or no progress, the team needs to make appropriate modifications to the intervention and/or initiate a new intervention.

The frequency and intensity of the collaboration between the school and parents increase at these levels. The characteristics of good communication should have been established in Tier 1, and must continue in Tier 2 and Tier 3. Such communication is characterized by creating authentic two-way communication; using plain language; focusing on strengths; remaining positive, upbeat and success-oriented; building on families' desires for their children to succeed; and perhaps most importantly, recognizing the invaluable knowledge that families can bring to the school.

PRACTICAL APPLICATION EXAMPLES

Physical Health

With the exception of the physical education program, physical health is an area that has not generally been thought about when implementing SRBI. The framework, however, is an excellent vehicle to ensure that appropriate programs and services in this area are in place for all students, and to provide more individualized interventions when needed. The district and school-based data teams can play an important role in evaluating the effectiveness of existing physical health programs and services at the Tier 1 level.

Tier 1 (physical activity): Tier 1 in the physical education arena is similar to other academic areas in that one of the most important features is the implementation of a regularly scheduled physical education curriculum that is aligned with state standards for physical education. Differentiated instruction using small flexible grouping is essential to provide additional practice or explicit instruction to students of varying skill levels. Providing additional age-appropriate times for physical activity (e.g., classroom instruction, recess, and before- and after-school programs) and encouraging students to participate in physical activities in ways that promote self-discipline and personal responsibility are also important elements in Tier 1. Schools and districts should provide parent education programs about the importance of physical activities and encourage adults to model healthy behavior by participating in wellness programs, and in physical activity programs with their children or students. Besides the school-based programs, districts and schools should encourage community partners and families to provide structured physical activity programs and opportunities for unstructured physical activity for students outside school.

Typically, the data from strategic school profiles, physical fitness benchmark assessments, teacher assessments and body composition indicators, in pertinent situations, may be used at the Tier 1 level by data teams to evaluate and make decisions about the progress of students.

Tier 2 (physical activity): Examples of Tier 2 interventions for students who have problems due to physical inactivity include small groups of students who meet weekly or bi-weekly during school hours with a physical education teacher for physical activity (PA) goal setting and progress monitoring, PA incentives, social support, and point-of-decision reinforcement (e.g., during recess and before/after school activities); provision of special assignments/challenges related to PA, such as ways to be more active outside school; more individualized and intensive instruction related to PA and nutrition; assistance with accessing appropriate after-school facilities and programs; and family collaboration to assist in ways for students to be more active outside school.

Interventionists may include members of a coordinated school health team, including but not limited to administrators, teachers, nurse, noncertified staff members (e.g., cafeteria workers) and family. Examples of assessments may include pedometer steps, Perceived Levels of Physical Exertion Scale, body composition indicators and behavioral referral data.

Tier 3 (physical activity): Examples of Tier 3 interventions for students who are experiencing challenges as a result of physical inactivity include implementation of before- and after-school programs to engage identified students in PA three to five times per week; implementation of programs in which students and parents are involved together in extensive training and PA activities; individual counseling; and implementation of adapted physical education strategies.

Interventionists and assessment data might be similar to data used in Tier 1 and Tier 2, with more frequent and targeted progress monitoring.

Tier 1 (health and wellness): In Tier 1, district and school data teams need to implement and assess health policies and practices to ensure that the physical health needs of all students are addressed, including but not limited to those who are at risk for chronic diseases and health

conditions such as overweight, obesity, diabetes and asthma; HIV; sexually transmitted diseases; drug and alcohol use and abuse; and teen pregnancy (Policy Guidance for the Position Statement on a Coordinated Approach to School Health, 2009). A comprehensive prekindergarten through Grade 12 school-health education curriculum with well-established standards and benchmarks should be in place and taught by certified, highly qualified health education teachers. School grounds should be smoke free, meet air quality standards and be regularly checked for potential safety hazards. Information should be provided to school staff members so they understand triggers and early warning signs of special health needs (e.g., asthma), and have action plans to implement in emergencies. The school nurse should be available to work with teachers to assist them in making appropriate modifications to accommodate health issues (e.g., opportunities for frequent rest intervals in the form of static skill stations for students with asthma). Programs and protocols should be available to help students to learn and apply self-care management skills, when appropriate, and a two-way family communication system should be in place regarding school health/nursing services to coordinate information.

The data teams must be able to evaluate the impact of Tier 1 programs in these areas to add, delete or modify programs and to plan interventions for individual students, as needed. Examples of assessments that might be used include attendance data, health services referrals, parent and child questionnaires, physical education performance data, self-medication assessments, and assessments developed for specific medical conditions (e.g., asthma).

Tier 2 (health and wellness): Examples of Tier 2 interventions for students with special health needs such as asthma include developing protocols for students to make up schoolwork due to absence from school; working with the school medical adviser and school nurse to plan school health programs on asthma; enlisting community partners (e.g., American Lung Association, local physicians) to provide appropriate after-school programs; and implementing weekly or bi-weekly small group sessions with the physical education educator and school nurse to develop self-management skills, PA goal-setting, and progress monitoring.

Interventionists may include members of a coordinated school health team, including but not limited to administrators, teachers, nurse, health assistants, respiratory therapists, noncertified staff, and family. Examples of assessments may include health service referrals, attendance data, physical education performance, PA data, self-medication assessments, asthma action-plan assessments, asthma assessment sheets and Students with Asthma Tracking Form.

Tier 3 (health and wellness): Examples of Tier 3 interventions for students with special health needs such as asthma include referrals of students who exhibit signs of unmanaged asthma to primary care physician; implementation of before- and after-school programs to engage students in weekly asthma self-management skill-building programs; implementation of student and parent together programs for skill-building and individualized healthcare plan development; individual counseling; and implementation of asthma family support groups.

Interventionists and assessment data might be similar to data used in Tier 1 and Tier 2, with more frequent and targeted progress monitoring.

Tier 1 (nutrition): In Tier 1, district and school data teams need to ensure that the school health education curriculum includes nutrition education and specifically addresses the importance of all meals, including breakfast. Federally funded school breakfast programs and national school lunch programs should be implemented in eligible schools to provide age appropriate, nutritionally balanced meals. Individualized modifications of foods offered in the school nutrition program should be available to meet the medical requirements of students, and culturally appropriate food selections should be available to all students. A two-way family communication system should be established to support healthy meals at home and to provide opportunities for families to contribute nutritious food selections to various school events.

Tier 2 (nutrition): Examples of Tier 2 interventions for students with special nutrition requirements include implementation of an alternative meal delivery method to increase participation in the school breakfast program (e.g., breakfast in the classroom, grab and go breakfast, breakfast after first period); provision of specific nutrition or ingredient information to students with identified medical and/or nutritional needs; school staff collaboration to provide safe food environment throughout the school setting for students with special nutritional needs (e.g., allergies); implementation of small group meetings with the food services director, dietitian or school nurse on food selection and meal management; provision of resources for supplemental nutrition programs such as food bank and food stamps; and assist families with identification of community resources available to help with acquiring healthy foods for the household.

As with other areas, the data teams must be able to evaluate the impact of Tier 1 programs in these areas in order to add, delete or modify programs and to plan interventions for individual students, as needed. Examples of assessments that might be used include attendance data, health services referrals, parent and child questionnaires, breakfast and lunch meal counts, physical education performance data, self-medication assessments and assessments developed for specific medical conditions (e.g., asthma).

Interventionists may include members of a coordinated school health team, including but not limited to food services director or staff, dietitian administrators, teachers, nurse, social worker, noncertified staff, and family. Examples of assessments might include breakfast meal counts, lunch meal counts, production records (which record the specific foods selected by students in the school meal programs), attendance data, nurse visits and behavioral referral data.

Tier 3 (nutrition): Examples of Tier 3 interventions for students with special nutrition requirements include provision of specialized educational opportunities for students and families with specific nutritional needs (e.g., obesity, eating disorders, diabetes, food allergies); implementation of before- and after-school program to engage students in nutrition self-management programs; individual nutritional and/or psychological counseling; parent support groups; and training for parents and students regarding the development of an individualized health care plan.

Interventionists and assessment data might be similar to data used in Tier 1 and Tier 2, with more frequent and targeted progress monitoring.

SOCIAL AND EMOTIONAL HEALTH

Tier 1: As stated in Connecticut's Framework for RTI, "school and district personnel not only must provide teachers with high-quality curriculums and specific academic benchmarks for students, but also with a comprehensive, schoolwide system of social-emotional learning and behavioral supports" (2008, p. 24). This kind of comprehensive system is not limited to addressing overtly disruptive, noncompliant behaviors. It must also be designed to ensure a safe and secure educational environment and a positive school climate, so that nonacademic barriers to learning are removed and students can develop the prosocial skills that positively affect their motivation to achieve.

Several essential elements must be included in Tier 1. In order to establish a safe and secure educational environment, schools need to ensure that their school safety and emergency response systems are reviewed regularly and updated, as needed, to meet current needs. Codes of conduct delineating behavior/social standards and expectations, including strict prohibitions regarding bullying and harassment, should be clear, concise and consistently enforced in the school and classroom environments. Discipline policies and practices should be designed and implemented to encourage students to stay in school rather than excluding them, and should include specific procedures for prevention as well as intervention. Professional development for school personnel should be provided to assist them in addressing behavioral issues effectively, explicitly including those associated with bullying and harassment.

To create a positive school climate of warmth and mutual respect, districts and schools should engage in practices that foster understanding and respect for cultural diversity and celebrate the contributions of diverse groups. Educators should implement research-based and culturally competent/responsive curriculums that support student engagement, involve students as decision makers and problem solvers, and promote the acquisition of prosocial behaviors. Reinforcement activities that support behavioral and social development (i.e., self-awareness, self-regulation, decision-making, respect for others) can be co-taught with social workers, psychologists, school counselors, health educators, school nurses or others, as deemed appropriate. Adults in the school should take care to model the behaviors they are teaching when they interact with each other and with the students.

Finally, as in all other areas, schools should be engaging in a two-way communication with families and communities in supporting the development and maintenance of these social and emotional health skills. Initiatives should foster information sharing, as appropriate, and encourage the building of peer relationships and support networks.

Some of the assessments that data teams can use to develop and evaluate the effectiveness of these programs and interventions in this area are school climate questionnaires, suspension and expulsion rates, incidence of bullying and harassment, as well as other disciplinary data, schoolwide or classroom rating scales and checklists, attendance rates, work completions rates, and classroom observations.

Tier 2: Examples of Tier 2 interventions for students who need improvement in social behaviors include: implementation of small group instruction using research-based programs that support behavioral and social development; behavior management programs targeting specific behaviors; behavior contracts; check-in, check-out activities, and implementation of home-school collaboration activities. Interventionists may include general education teachers, school psychologists, school social workers, school counselors, school nurses, administrators and/or other support service specialists trained in specific intervention strategies. The interventions may take place in the general education classroom or a non-classroom setting, if appropriate.

Some examples of assessments in Tier 2 include pre and post measures of behavior checklists, observations, discipline referrals, student self-monitoring records of goals and progress and parent information data.

Tier 3: Examples of Tier 3 interventions for students who need improvement in social behaviors include more frequent implementation of small group instruction using research-based programs that support behavioral social development; more frequent monitoring and feedback with behavioral contracts; individual counseling; collaboration with community providers; more intensive home-school collaboration; and additional parent support services.

Interventionists may include school psychologists, school social workers, school counselors, administrators and/or other support service specialists trained in specific intervention strategies. The interventionists work in collaboration with general education teachers and in some instances community providers. The interventions generally take place in a nonclassroom setting.

In addition to the type of assessments used in Tier 1 and Tier 2, a functional behavior analysis might be a typical example of an assessment at this level.

SUMMARY

Both school personnel and families can embrace SRBI as an opportunity to make a substantial improvement in a child's learning and health when needed. Clearly, additional questions will arise as schools and parents become increasingly experienced, sophisticated and proficient in their implementation of SRBI. Most often, there will not be one "right answer" to these questions, as resolutions are often situation specific and there may be many paths to the same goal. Using those practices with research-based foundations will ensure the effectiveness of interventions adapted to the individual needs of students. Ideally, as teams become more experienced in considering the needs of the **whole child**, the teams themselves will generate responses and effective solutions to the questions that arise during efforts to individualize programs, practices and services through a collaborative problem-solving process. For your convenience, a planning template illustrating the development of comprehensive programming to address the needs of the whole child that includes social, emotional, behavioral, and physical health, as well as the academics has been included in Appendix B of this document. Several references have also been included within this template that teams will find useful as they implement the SRBI framework to address the needs of the whole child.

REFERENCES

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APPENDIX A

Assumptions Underpinning *Addressing the Needs of the Whole Child: Social, Emotional, Behavioral, and Physical Health, as well as Academic Achievement, in Connecticut's SRBI Process*

The assumptions below provide a solid foundation for *Addressing the Needs of the Whole Child* and successful student learning. They articulate the unerring belief that a comprehensive system must provide strong universal and coordinated supports regarding social, emotional, behavioral, mental, and physical health for all students as well as academics. The assumptions also reinforce a system closely aligned and linked with the goals of the State Board of Education in addressing high quality preschool education, high academic achievement, and secondary school reform. Appendix 3 provides a list of further readings that support these assumptions.

A comprehensive system that insures positive outcomes for all children:

1. Addresses the "whole child," that is, the child's social, emotional, behavioral, mental, and physical well-being as well as a child's academic needs.
2. Provides a framework that is multifaceted and flexible. In other words, it does not present a "one size fits all" approach, but rather is responsive to the varied needs of different learners.
3. Is results-based and data driven
4. Includes mechanisms to ensure accountability at all levels.
5. Is proactive, addressing both prevention and intervention.
6. Ensures responsible personnel have the appropriate knowledge, skills, abilities, supports and resources to implement both prevention and intervention strategies.
7. Interfaces with families through a strengths-based approach.
8. Is culturally responsive and both celebrates and values the diversity that all children and families bring to the educational process.
9. Builds on the foundation of existing initiatives, adding new elements and recognizing that these elements may require new funding, legislation, services and supports, personnel and/or personnel with new skills.
10. Includes expectations, skill development, and procedures/strategies that are consistent across schools/program, districts, and communities.
11. Links to community resources beyond the CDSE, districts, and schools.

These supporting principles are consistent with and build on the "Underlying Principles and Critical Features of SRBI" as articulated on pages 14-19 of the CSDE document, *Using Scientific Research-Based Interventions (SRBI): Improving Education for All Students*, August 2008. Districts are encouraged to put a comprehensive system in place over the next three to five years.

APPENDIX B

Examples of Applying the Three-Tiered Template for *Addressing the Needs of the Whole Child: Social, Emotional, Behavioral, and Physical Health, as well as Academic Achievement, in Connecticut's SRBI Process*

As articulated in the Assumptions section of this document, a tiered approach to the social, emotional, behavioral, mental and physical health needs of students must be a coordinated and integrated system. This approach allows for programs and services that meet the physical and mental health needs of all students as well as allowing for additional strategies for students who need greater support. The following examples are representative of health issues observed within school districts.

Tier 1: Universal – the general education core curriculums, instruction and social/behavioral and health supports for all students; differentiated instruction is the norm.

Tier 2: Targeted – short-term interventions for students who require supplemental supports to the core curriculums and differentiation; it is part of the general education system.

Tier 3: Intensive – more intensive or individualized short-term interventions for students who need supports beyond Tier I and/or Tier 2 interventions; it is also part of the general education system.

These examples relate to the following outcomes:

1. Students and adults will be physically active.

2. Students will self-manage their asthma.

3. Students will select and consume a nutritious, well-balanced diet daily.

4. Students will demonstrate prosocial behaviors.

EXAMPLE RELATED TO OUTCOME: Students and adults will be physically active

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Focus	General education core practices A coordinated approach to school health with a foundation in physical education and comprehensive health education.	Supplement core practices with interventions for targeted students (those who tend to be physically inactive).	Supplement core practices and Tier 2 interventions with dedicated intensive interventions for targeted students (those who demonstrate inadequate progress in Tier 2).
Setting	Districtwide All students, parents and families.	Districtwide Small number (+/- 15 percent) of students.	Districtwide Small number (+/- 5 percent) of students.
Curriculum and Instruction	Research-based practices based on US Dept. of Health and Human Services guidelines* and CSDE guidelines** for physical activity. Implement physical education curriculum during regularly scheduled physical education instructional program. Curriculum alignment with state standards for physical education. Provide physically active physical education (≥ 50 percent moderate to vigorous physical activity [MVPA]). Provide in-school opportunities for physical activity (recess, before and after school physical activities, include physically active learning throughout comprehensive curriculum, all subjects) for students and adults.	Additional, more individualized and intensive instruction related to physical activity and nutrition provided in small groups during the school day.	Continued individualized, intensive instruction and additional before/after school program in which families are involved.

Key: *PA – physical activity; SSP – Strategic School Profile; physical fitness data – students meeting health-related physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance); BMI – body mass index; MVPA – moderate-to-vigorous physical activity; individual health-related physical fitness profile – physical fitness data including body composition and physical activity data; OT/PT – occupational therapist/therapy / physical therapist/therapy.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Interventions	Encourage students to be physically active during recess. Implement schoolwide programs and approaches for creating a healthy recess environment that protects students and teachers, promotes safety, conflict resolution and violence prevention, and encourages self-discipline and personal responsibility. Adults participate as models in PA activities and programs with other adults and with students. Provide or empower staff members to implement staff wellness program. Engage community partners (i.e. municipal departments, youth-oriented clubs and agencies) to provide before- and after-school physical activity programs, and ensure student access to same. Implement districtwide and schoolwide wellness polices. Implement comprehensive education and professional development to emphasize the importance of physical activity in student achievement and success.	Small groups of students meet weekly or bi-weekly during school hours with physical educator for PA goal-setting and progress monitoring, PA incentives, social support, point-of-decision reinforcement (during recess and before/after-school activities). Special assignments/challenges related to physical activity, such as ways to be more active outside school. Assistance with accessing appropriate after-school facilities and programs.	Before- and after- school program to engage identified students in PA three to five times per week. Students and parents involved together in extensive training for students and parents in relation to healthy levels of PA, and activities in which families can engage in PA together (active games and pursuits). Pair identified students with peer or adult PA model or partner. Individual counseling Implement adapted PE strategies as needed.
Interventionists	Coordinated School Health Team, including but not limited to administrators, teachers, nurse, all school staff members, families, volunteers.	Coordinated School Health Team, including but not limited to administrators, teachers, nurse, all school staff members, targeted students' family, volunteers.	Coordinated School Health Team, including but not limited to administrators, teachers, nurse, counselor, OT/PT, school staff members, targeted students' family, volunteers.

Key: *PA – physical activity; SSP – Strategic School Profile; physical fitness data – students meeting health-related physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance); BMI – body mass index; MVPA – moderate-to-vigorous physical activity; individual health-related physical fitness profile – physical fitness data including body composition and physical activity data; OT/PT – occupational therapist/therapy / physical therapist/therapy.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Assessments	Physical fitness assessment. Body composition indicators (multisite skinfold caliper testing [preferred for accuracy] or BMI data).	PA data (pedometer steps, student journals, PLPE [Perceived Levels of Physical Exertion] scale). Individual health-related physical fitness profile.	PA data (pedometers, student journals, PLPE [Perceived Levels of Physical Exertion] scale). Individual health-related physical fitness profile. OT/PT
Data analysis and decision making	SSP data re: school physical activity and physical education instruction time. Physical fitness data. PA data (using pedometers). Body composition indicators (multisite skinfold caliper testing [preferred for accuracy] or BMI data). Attendance data (school attendance, activity participation data). Behavioral referral data. Identify students in need of Tier 2	Physical fitness data. PA data (using pedometers). Body composition indicators (multisite skinfold caliper testing [preferred for accuracy] or BMI data). Attendance data (school attendance, activity participation data). Behavioral referral data. Identify students in need of Tier 3.	Identify need to refer for ongoing psychological or medical services, intensive counseling, OT/PT.

Key: *PA – physical activity; SSP – Strategic School Profile; physical fitness data – students meeting health-related physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance); BMI – body mass index; MVPA – moderate-to-vigorous physical activity; individual health-related physical fitness profile – physical fitness data including body composition and physical activity data; OT/PT – occupational therapist/therapy / physical therapist/therapy.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Family Engagement	Parent Education: School provides opportunities for families to become knowledgeable of the PA curriculum and ways to support PA at home. Communication: School conducts two-way communication with families about improving PA and incorporates families' cultures and perspectives in the PA program. Volunteering: School provides opportunities and support for families to contribute to the PA program at school. Home Learning: Families demonstrate interest in physical activity as models for children as well as engage with children in physical activities (house and yard chores, community volunteer work, exercise, recreation). Decision Making: Families are part of the school improvement and data teams making recommendations for the PA program. Collaborating with the Community: Students gain PA skills and experiences with community partners both in the school and in the community.	Family and community engagement activities planned to meet specific needs beyond Tier 1. For example, families assist and participate in students' special homework assignments/ challenges related to physical activity, such as ways to be more active outside school.	Family and community engagement activities planned to meet specific needs beyond Tier 2. Students and parents involved together in extensive training in relation to healthy levels of PA, and activities in which families can engage in PA together (active games and pursuits).

Key: *PA – physical activity; SSP – Strategic School Profile; physical fitness data – students meeting health-related physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance); BMI – body mass index; MVPA – moderate-to-vigorous physical activity; individual health-related physical fitness profile – physical fitness data including body composition and physical activity data; OT/PT – occupational therapist/therapy / physical therapist/therapy.*

* 2008 Physical Activity Guidelines for Americans, US Department of Health and Human Services: http://www.health.gov/Paguidelines/pdf/paguide.pdf

**State Board of Education Position Statement on Nutrition and Physical Activity, Guidelines for a Coordinated Approach to School Health, Action Guide for School Nutrition and Physical Activity Policies (2010)

EXAMPLE RELATED TO OUTCOME: Students will self-manage their asthma.

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Focus	General education core practices.	Supplement core practices with interventions for targeted students.	Supplement core practices and Tier 2 interventions with dedicated intensive interventions for targeted students.
Setting	Districtwide		
Curriculum and Instruction	Establish and support school asthma policy that addresses: • healthy school environment (school buildings and grounds smoke-free, maintain air quality, integrated pest management practices); • support for students and staff members with asthma; • education of all school staff members and students about asthma (needs of students with asthma; causes, triggers, how to avoid them; early warning signs; medication administration); • appropriate school health services, including education for students with asthma on increasing knowledge and strategies for self-management • establishment and encouragement of use of asthma action plan for asthma management and responding to emergencies; • positive relationships between school medical adviser, school nurse, and school-based health center; and • collaboration with parents, community and PTA. *Source: (Managing Asthma in Connecticut Schools, CDPH/CSDE Resource Guide, June 2002); Managing Asthma in Connecticut Childcare Facilities, nd)*	In addition to regularly scheduled physical education, implement specialized behavioral and educational program for teaching self-management skills (students learn to self-manage asthma for increased participation in context of physical education and other physically active components of school day). School staff members collaborate to integrate asthma awareness into curricula (especially health, science, physical education).	

KEY: *PA – physical activity; physical fitness data – students meeting health-related; physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance; peak flowmeter – hand-held device that measures how fast air moves out of the lungs in one breath, a standard indicator of air flow used for asthma.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Curriculum and Instruction cont'd	Implement best practices in regular physical education and physical activity settings, and encourage students with asthma to actively participate in physical education. Implement individual modifications as needed within regular physical education setting, such as providing physical activity options (short burst aerobic activities as an alternative to longer endurance-type activities; opportunities for frequent rest intervals in the form of static skill stations). School health/nursing services work with others in the school to coordinate information, recommendations, protocols and oversight of students with asthma. Physical activity program services.		

KEY: *PA – physical activity; physical fitness data – students meeting health-related; physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance; peak flowmeter – hand-held device that measures how fast air moves out of the lungs in one breath, a standard indicator of air flow used for asthma.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Interventions	Encourage students to be physically active and to apply asthma self-management skills during recess. Engage community partners (i.e. municipal departments, youth-oriented clubs and agencies) to implement asthma policies during before- and after-school physical activity programs.	Develop protocols for students to make up schoolwork due to absence from school. Work with school medical adviser and school nurse to plan school health programs on asthma. Use, as needed, accommodations and modifications, pupil services team, Section 504 plan. Enlist community partners (American Lung Association, physicians, PTA) in providing appropriate after-school facilities and programs. Small groups of students meet weekly or biweekly during school hours with physical educator and school nurse, as needed, for special program that includes information, self-management skill development, PA goal-setting and progress monitoring (Sample resources: *American Lung Association Asthma in Schools Initiative; Open Airways For Schools; Asthma Awareness Curriculum for the Elementary Classroom; Not-On-Tobacco).*	Refer student who exhibits signs of unmanaged asthma to primary care provider, school nurse or school-based health center for evaluation. Dedicated before- and after- school program to engage identified students in weekly asthma self-management skill-building program. Students and parents involved together, for example extensive training for students and parents in information and skill-building sessions, and development of individualized healthcare plan. Form asthma family support groups. Individual counseling
Interventionists	Coordinated School Health Team, including but not limited to administrators, teachers, nurse, food service staff, custodial staff, pupil study team, school transportation services personnel, paraprofessionals, health assistants.	Coordinated School Health Team, including but not limited to administrators, teachers, nurse, food service staff, custodial staff, school transportation services personnel, paraprofessionals, health assistants, respiratory therapist, targeted students' families.	Coordinated School Health Team, including but not limited to administrators, teachers, nurse, counselor, food service staff, custodial staff, school transportation services personnel, paraprofessionals, health assistants, respiratory therapist, targeted students' families.

KEY: *PA – physical activity; physical fitness data – students meeting health-related; physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance; peak flowmeter – handheld device that measures how fast air moves out of the lungs in one breath, a standard indicator of air flow used for asthma.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Assessments	Health services referrals (nurse's office). Attendance data. Physical education performance and anecdotal data. Physical fitness/aerobic capacity data. Anecdotal records of classroom teachers and other adults within the school. Connecticut Department of Public Health (CDPH)/ CSDE recommended assessments (Self-Medication Assessment, Individualized Health Care Plan, Asthma Action Plan, Parent and Child Questionnaires, Asthma Assessment Sheet, Students with Asthma Tracking Form).	Health services referrals (nurse's office). Attendance data. Physical education performance and anecdotal data. Student's self-assessment of goals and progress. Anecdotal records of classroom teachers and other adults within the school. PA data (pedometers, student journals, PLPE [Perceived Levels of Physical Exertion] scale). Peak flowmeter data. CDPH/CSDE recommended assessments (Self-Medication Assessment, Individualized Health Care Plan, Asthma Action Plan, Parent and Child Questionnaires, Asthma Assessment Sheet, Students with Asthma Tracking Form).	

KEY: *PA – physical activity; physical fitness data – students meeting health-related; physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance; peak flowmeter – hand-held device that measures how fast air moves out of the lungs in one breath, a standard indicator of air flow used for asthma.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Data analysis and decision making	Attendance data (school attendance, activity participation data). Physical fitness data (aerobic capacity).	Physical fitness data (aerobic capacity). PA data (using pedometers). Attendance data (school attendance, activity participation data).	Identify need to refer for ongoing psychological or medical services, intensive counseling.
Family Engagement	Parent Education: School provides opportunities for families to become knowledgeable of the school asthma policy, ways to support their child with asthma at home, and encourage active participation in physical education and physical activity. Communication: School conducts two-way communication with families about school health/nursing services to coordinate information, recommendations, protocols and oversight of students with asthma, and incorporating families' cultures and perspectives in school programs and services. Volunteering: School provides opportunities and support for families to contribute to the asthma management program at school. Home Learning: Families demonstrate interest in the asthma education and management program, and provide support and encouragement for students to apply asthma management skills at home. Decision Making: Families are part of the school improvement and data teams making recommendations for the asthma education and management program. Collaborating with the Community: Students gain self-management skills and experiences with community partners both in the school and in the community.	Schools provide opportunities for families to become aware of special programs for children with asthma. Assist children with making up schoolwork due to absence from school.	Schools provide families with support for and assistance with access to special programs. Schools provide opportunities for students and parents involved together in extensive training for students and parents in information and skill-building sessions, and development of an individualized healthcare plan. Schools offer opportunities for students and their families to participate in asthma support groups.

KEY: *PA – physical activity; physical fitness data – students meeting health-related; physical fitness standards for aerobic capacity, flexibility, muscular strength and endurance; peak flowmeter – handheld device that measures how fast air moves out of the lungs in one breath, a standard indicator of air flow used for asthma.*

Additional resources

CDPH/CSDE recommended assessments (Self-Medication Assessment, Individualized Health Care Plan, Asthma Action Plan, Parent and Child Questionnaires, Asthma Assessment Sheet, Students with Asthma Tracking Form):http://www.sde.ct.gov/sde/cwp/view.asp?a=2678&q=320768#Publications

Connecticut Department of Public Health Asthma Homepage: http://www.ct.gov/dph/cwp/view.asp?a=3137&q=387988

American Lung Association Asthma in Schools Initiative: http://www.lungusa.org/lung-disease/asthma/in-schools/

About Open Airways For Schools

The American Lung Association's Open Airways For Schools program educates and empowers children through a fun and interactive approach to asthma self-management. It teaches children with asthma ages 8-11 how to detect the warning signs of asthma, avoid their triggers and make decisions about their health. http://www.lungusa.org/lung-disease/asthma/in-schools/open-airways/open-airways-for-schools-1.html

Asthma Awareness Curriculum for the Elementary Classroom, 2002. National Asthma Education and Prevention Program, National Institutes of Health, US Department of Health and Human Services http://www.nhlbi.nih.gov/health/prof/lung/asthma/school/index.htm

Not-On-Tobacco; American Lung Association: http://www.notontobacco.com/

Managing Asthma in Connecticut Schools: http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/asthma_schl_manual_web.pdf

Managing Asthma in Connecticut Childcare Facilities: http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/day_care_fldr_web_final.pdf

EXAMPLE RELATED TO OUTCOME: Students will select and consume a nutritious, well-balanced diet daily.

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Focus	General education core practices. A coordinated approach to health with a foundation in school nutrition programs, nutrition education and comprehensive school nutrition programs.	Supplement core practices with interventions for targeted students.	Supplement core practices and Tier 2 interventions with dedicated intensive interventions for targeted students.
Setting	Districtwide; individual school		
Curriculum and Instruction	Implement the federally funded SBP and NSLP in district schools to provide age-appropriate, nutritionally balanced meals to students in accordance with USDA guidelines. Implement a planned, ongoing and comprehensive school-health-education program that includes nutrition education and specifically addresses the importance of all meals including breakfast. Implement district wellness policy requirements throughout the school setting, including school meals. Provide individual modifications of foods offered in the school nutrition programs to meet the specific medical requirements of students as documented by a medical doctor.	Implement an alternative meal delivery method to increase participation in the SBP (e.g., breakfast in the classroom, grab and go breakfast, breakfast after first period). Provide specific nutrition or ingredient information to students with identified medical needs. Implement process to address the needs of students who may suffer from food insecurity at their homes.	Provide specialized educational opportunities for students and families for students with specific nutritional needs (e.g., diabetes, obesity, eating disorders).

KEY: *USDA – United States Department of Agriculture; SBP – School Breakfast Program; NSLP – National School Lunch Program.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Interventions	Provide well-balanced, child-focused breakfast at school to all students following the USDA meal pattern guidelines for the SBP. Provide well-balanced, child-focused lunch at school to all students following the USDA meal pattern guidelines for the NSLP. Provide a clean, safe, and physically comfortable and attractive location for the service and consumption of breakfast and lunch meals. Offer a variety of choices within the USDA meal pattern requirements to encourage the consumption of a balanced meal in the SBP and NSLP. Encourage students to select a variety of foods from the breakfast and lunch selections available daily. Offer culturally appropriate food selections to students in all school nutrition programs. Promote the consumption of targeted foods containing nutrients of concern for the student age group being served (e.g., milk for calcium, fruits and veggies for vitamins and fiber). Provide nutritious food choices at *all* school events, functions and classroom activities to encourage healthy eating throughout the day.	Provide breakfast to students outside the traditional cafeteria setting. Develop nutrition resources to provide needed information to students with identified nutritional needs. Use, as needed, accommodations and modifications, pupil services team, Section 504 plan. School staff members collaborate to provide safe food environment throughout the school setting for students with special nutritional needs (e.g., allergies). Small groups of students meet, as needed, during school hours with food service director, dietitian or school nurse for special instruction on food selection and meal management. Provide resources for supplemental nutrition programs such as food stamps or local food bank.	Refer student who exhibits signs of exceptional nutritional needs to a dietitian, primary care provider, school nurse or school-based health center for evaluation. Offer a dedicated before- and after- school program to engage identified students in nutrition self-management program. Involve students and parents together, for example extensive training for students and parents in information and skill-building sessions, and development of individualized healthcare plan. Form appropriate family support groups. Arrange individual nutritional and/or psychological counseling.
Interventionists	Coordinated School Health Team, including but not limited to food service director, administrators, teachers, nurse, food service staff, certified and noncertified staff.	Coordinated School Health Team, including but not limited to food service director, administrators, teachers, nurse, food service staff, certified and noncertified staff, social worker, dietitian, targeted students' families.	

KEY: *USDA – United States Department of Agriculture; SBP – School Breakfast Program; NSLP – National School Lunch Program.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Assessments	Breakfast meal counts Lunch meal counts Production records (which record the specific foods selected by students in the school meal programs). Nurse visits Attendance data Behavioral referral data Anecdotal records of classroom teachers and other adults within the school.		Report from dietitian/counselor.
Data analysis and decision making	Identify students in need of Tier 2 Completed production records Meal participation rates Food waste studies Medical Statement for Children *with* Disabilities Medical Statement for Children *without* Disabilities	Identify students in need of Tier 3.	Identify need to refer for ongoing nutritional or psychological intensive counseling.

KEY: *USDA – United States Department of Agriculture; SBP – School Breakfast Program; NSLP – National School Lunch Program.*

Features	Tier 1: Universal	Tier 2: Targeted (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Family Engagement	Parent Education: School provides opportunities for families to become familiar with the school nutrition programs, ways to support their children with healthy meals at home, and ideas to encourage healthy eating throughout the day. Communication: School encourages two-way communication with families regarding the various nutrition programs and policies in the school, and contact information to obtain further information and clarification on nutrition related issues. School provides nutrition information to families on a regular basis (e.g., with school meal menus) to encourage healthy eating at home as well as school. Volunteering: School provides opportunities and support for families to contribute nutritious food selections to various events that include a food component either during the school day or after school hours. Home Learning: Families demonstrate interest in good nutrition and provide nutritious food choices for students at home. Decision Making: Families are part of the school improvement and data teams making recommendations for school nutrition programs. Collaborating with the Community: Community partners both in the school and in the community reinforce the good nutrition message through all activities conducted with students.	Schools provide opportunities for families to become aware of special programs for children with specialized nutritional needs. Assist family with selection of appropriate foods from the regularly stocked foods served in the school nutrition programs. Provide opportunities and support for families to contribute appropriate nutritious food selections meeting the specialized needs of their student to various events that include a food component either during the school day or after school hours. Assist family with identification of community resources available to help with the acquisition of healthy foods for the household.	Schools provide families with support for and assistance with access to special programs. Schools provide opportunities for students and parents involved together in extensive training for students and parents in information and skill-building sessions, and development of an individualized healthcare plan. Schools offer opportunities for students and their families to participate in appropriate support groups.

KEY: *USDA – United States Department of Agriculture; SBP – School Breakfast Program; NSLP – National School Lunch Program.*

EXAMPLE RELATED TO OUTCOME: Students will demonstrate prosocial behaviors.

Features	Tier 1: Universal	Tier 2: Supplemental (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Focus	General education core practices supporting prosocial behaviors. Core general education classes prekindergarten to 12.	Supplement Tier1 core practices supporting student prosocial behaviors with interventions with small groups of targeted students	Supplement core practices supporting student prosocial behaviors and Tier 2 interventions with individualized and more intensive interventions with targeted students.
Setting	Districtwide Schoolwide General education classroom	General education classroom or non-classroom setting (if appropriate)	Nonclassroom setting
Curriculum and Instruction	Implement research-based and culturally competent/responsive curriculums supporting student engagement and prosocial behaviors (e.g., planned, ongoing systematic). Provide a code of conduct that is clear, concise and consistently enforced. Provide a district mission statement clarifying the overarching goals and objectives for meeting the needs of students. Provide a discipline policy that addresses the school's practices and procedures for prevention and intervention regarding student behavior. Provide activities that support behavioral and social development (i.e., self-awareness, self-regulation, decision-making, respect for self and others co-taught with school psychologist, school social worker, school counselor, school nurse, and others as deemed appropriate). Provide activities that support a positive school climate and a safe and supportive learning environment) (e.g., classroom morning meetings, greetings by staff, and student recognition programs).	Implement small-group instruction focused on social and emotional learning (SEL) curriculum activities (i.e., establishing relationships and positive peer interactions, recognizing and managing feelings and emotions, etc.) that support behavioral and social development. Use relevant curricula activities that are aligned with Connecticut's frameworks (e.g., Comprehensive School Counseling Curriculum- *Personal/Social Content, Healthy and Balanced Living Curriculum Framework, CT Preschool Assessment Framework, and CT Preschool Curriculum Framework*).	Implement small group instruction focused on SEL curriculum activities (i.e., positive peer and teacher engagement, recognizing feelings and emotions, etc.) that support behavioral and social development. Use relevant curricula activities that are aligned with Connecticut's frameworks (e.g., Comprehensive School Counseling Curriculum- *Personal/Social Content, Healthy and Balanced Living Curriculum Framework, CT Preschool Assessment Framework, and CT Preschool Curriculum Framework*).

Features	Tier 1: Universal	Tier 2: Supplemental (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Curriculum and Instruction, cont'd	Use relevant curricula activities that are aligned with Connecticut's frameworks such as: • Comprehensive School Counseling Curriculum - Personal/Social Content (CSDE Guidance) • Healthy and Balanced Living Curriculum Framework. • CT Preschool Assessment Framework and CT Preschool Curriculum Framework. Culturally Responsive- using information regarding the cultural practices, experiences and performance styles of diverse students to aid in the promotion of knowledge, skills and prosocial behaviors. Examples include: • employing multiple pedagogical strategies; and • using information about the influence of culture on student behaviors such as eye contact, response time, attention and cognitive style, mental processing style (polychromic or monochromic), interpersonal style (individualistic or collectivistic), learning style (field dependent or independent), etc., to inform disciplinary decisions and intervention strategies.		

Features	Tier 1: Universal	Tier 2: Supplemental (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Interventions	Create school and classroom social contracts that are clear, concise and consistently enforced. Delineate behavior/social standards and expectations that are clear, concise and consistently enforced in the school and classroom environment. Behavioral standards are explicitly displayed and modeled by the teacher and students. Employ differentiated instruction methods to facilitate student engagement and prosocial skill development. Implement research-based interventions and culturally competent school wide and classroom interventions supporting student engagement.	Implement research-based programs that support student engagement and prosocial behaviors. When students are unresponsive to school and classroom interventions (Tier 1), implement a behavior management program that addresses targeted behavioral needs. Develop behavioral contracts to support improved student functioning. Implement appropriate short term interventions (approximately eight to 20 weeks) to meet students' behavioral needs (e.g., behavior contracts, cueing, small group social skills instruction, check-in, check-out activities, contingency contracting, increased parent contact, etc.). Implement interventions to small groups that are well matched to the student's/group's specific behavioral needs (e.g., students who engage in bullying behavior are taught skills that promote positive self-control and peer interactions). Interventions addressing prosocial behavior development are delivered to small, targeted groups.	Develop a behavior intervention plan to specifically address targeted behaviors. Develop behavioral contracts to address specific behaviors and to support improved student functioning. Collaborate with community providers (i.e., DCF, juvenile probation, etc.) to meet the specific needs of the student. Make referral for evaluations when appropriate. Implement appropriate individual or small group (as appropriate) short term interventions (approximately eight to 20 weeks) to meet the behavioral and social needs of the student (e.g., 1 to 1 or group counseling, increased and consistent home-school collaboration). Use, when appropriate, the Connecticut Youth Services Association's list of Connecticut Youth Service Bureaus (http://www.ctyouthservices.org/ysblist.php) for resources to consider in addressing specific student needs.
Interventionists	General education teachers with collaboration and consultation from student support services personnel and other school/program staff qualified and able to implement the interventions effectively and with fidelity. Culturally Responsive- (see "Curriculum and Instruction", Tier1 for information on this topic.)	General education teachers School psychologists, social workers, school counselors, administrators and other support services specialists trained for Tier 2 interventions/services. Interventionists are qualified and able to implement the interventions effectively and with fidelity.[1, 2]	School psychologists, social workers, school counselors, administrators, and other support service specialists trained for Tier 3 interventions/services (including general educators or other school/ district/ community interventionists with appropriate training). Interventionists are qualified and able to implement the interventions effectively and with fidelity. [1, 2]

Features	Tier 1: Universal	Tier 2: Supplemental (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Assessments	Engage in research-based culturally competent/ responsive assessment practices when using the following assessment measures, techniques, and information. Such measures may include: • School climate questionnaire • Universal screening, e.g., schoolwide or classroom rating scales or checklist or other data as appropriate • Work completion • Classroom observations • Benchmark assessments • Assessment of the function of behavior	Frequent progress monitoring Additional assessments (beyond Tier1) may include: • Pre- and post-measures (e.g., behavior checklists addressing student's behavioral and social functioning, etc.) • Permanent products (e.g., discipline referrals, attendance records, suspension/expulsion records, etc.) • Discipline referrals • Student support service referrals • Student self-assessment of goals and progress • Information from behavior contracts/plans • Classroom observations • Anecdotal records of classroom teachers • Work completion • Parent interview	Identify and implement a schedule for more frequent progress monitoring. Additional assessments (beyond Tiers1 and 2) may include: • Use of a diagnostic assessment (i.e., rating scale) • A team approach that includes who is involved with children and youth (e.g., counselor from a youth service bureau, caseworker from the State Court Support Services Division, etc.) • Functional behavioral analysis. • Consideration of additional and more specific assessments • Intervention plan data

Features	Tier 1: Universal	Tier 2: Supplemental (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Data analysis and decision making	Data teams Attendance Universal screening Benchmark assessment data Discipline referrals Grades CMT scores Report cards Common formative assessments Progress notes	Assessment of student goals (e.g., positive peer and teacher relationships, etc.). Frequent progress monitoring Pre- and post-measures (e.g., behavior checklist results addressing social skills development such as understanding the feelings of self and others, and responding appropriately to teasing, etc.). Discipline referrals Student support service referrals Work completion data Identify students not responding to Tier1 interventions. Selecting appropriate progress monitoring tools.	Conduct extensive analysis of data collected (e.g., functional behavior assessment data). Modify or substitute interventions as needed. Identify students not responding to Tier 2 intervention. Review of ongoing and more specific assessment information.

Features	Tier 1: Universal	Tier 2: Supplemental (+ Tier 1)	Tier 3: Intensive (+ Tier 1 and 2)
Family Engagement	Parent Education: School provides opportunities for families to become knowledgeable of the school's policies, practices and resources that support and teach prosocial behavior development. Communication: School encourages two-way communication with families to support and maintain prosocial behavior (i.e., development of a home-school compact addressing the expectations of the school, parents and students regarding prosocial behavior, and provide awareness of opportunities for students and parents to engage the school staff.) Schools will incorporate knowledge and information regarding families' cultures and perspectives in the development of social and behavioral programs and services. Volunteering: School provides an environment that welcomes and supports opportunities for families to contribute to the development and maintenance of prosocial behaviors (i.e., parent and teacher meetings to discuss school climate initiatives, development of school behavioral policies, etc.). Home Learning: School facilitates families' interest in the activities that promote students' prosocial behavior and provide support and encouragement for students to apply these skills in the home environment. Decision Making: School facilitates families involvement in the decision-making process that informs schoolwide behavior policies and practices and makes recommendations to school committees (positive behavioral supports, SRBI, data teams, etc.) addressing prosocial behavioral development. Collaborating with the Community: School facilitates families in supporting student experiences with community partners both in the school and in the community.	Families become engaged in more targeted activities addressing small group needs. Schools engage in increased home-school collaborative activities. Schools provide opportunities for parents to engage in enrichment opportunities/activities that support prosocial behavior. Schools provide opportunities for families to become aware of more targeted interventions, programs, activities, etc. that address and support prosocial behavior.	Schools will assist families in accessing community and school resources (e.g., family support groups) to address more targeted and specific behaviors. Schools will engage in more intensive home-school collaboration. Schools will assist students and parents in accessing training to support information and skill building regarding prosocial behavior development in more targeted and specific areas. Schools provide families with support for and assistance with access to special programs and support groups. Schools provide opportunities for students and parents involved together in extensive training in information and skill building sessions, and development of an individualized plan.

1. Systems are in place to ensure that interventions are being implemented with fidelity.

2. School Specialists include School Psychologists, School Social Workers, School Counselors and other qualified interventionists.

* Adapted from Connecticut State Department of Education. (2008). *Using Scientific Research-Based Interventions: Improving Education for All Students: Connecticut's Framework for RTI*. Hartford, CT.