>> Jackie: Hi, welcome to the DBMD quarterly webinar. This is Jackie Gantt with DBMD policy, the Long Term Services and Supports unit for policy at HHSC. The first thing we want to go over is the agenda. We have a limited but rich agenda today. We will be talking about DBMD program updates and upcoming Electronic Visit Verification policy and information so that our DBMD providers can be ahead of the curve when that is implemented. We are also having a special section on trauma-informed care with an emphasis on the DBMD population and we have special guests to talk about that.

Nova Evans is a behavioral health specialist and David is a Transition Counselor/Specialist with the Texas School for the Blind and Visually Impaired. As you all know, David has a great deal to do with our DBMD program and staff training for working with individuals with deafblindness. And would I appreciate it if you guys would type your questions in and you can type them in as we are going along or if you have a story you want to tell, you know, an instance you would like to share about working with somebody who is deafblind, that is great. We will save all of that for the end. We have Camryn Burner from the CLASS program moderating the questions and we will save that for the end.

So our program updates, our critical incident reporting -- oh, sorry. So we have been talking about this quite a bit over the last few months and pretty soon we are hoping in the next week or so HHSC will issue an information letter for CLASS and DBMD providers on guidance as to how to submit critical incidents. There will also be information about ANE abuse, neglect and exploitation training that we will post on our HHSC website that will generate a completion certificate for staff who work in your programs to ensure that people that are working with CLASS and DBMD understand signs and symptoms of abuse, neglect and exploitation, how to report, how to follow-up with somebody, and to assure center for Medicaid and Medicare that Texas is in compliance with abuse, neglect and exploitation requirements and maintaining the health and safety of the individuals in our programs.

Stay tuned for that. Make sure you are signed up for the govdeliveries. And here is the link to the form. We are asking that people go ahead and start reporting those incidents effective December 1st. While the information letter has not come out yet, it will still be backdated to December 1st. Go ahead and submit your forms. Camryn and I are the ones who will be reviewing those reports and we may be contacting providers to ask about the follow-up, if the person is okay. Just go ahead and send them in. We have to report those to the center for Medicaid and Medicare so let us know if you have any questions or if you have any difficulty managing the form.

This is a form I know that it is very hard to see on this particular slide. But this is a form that came up in our last provider training. A provider who has been around for a while told me she never knew about the 3694 IPC cover sheet. And this is something you would send in for any type of renewal, enrollment, revision, revision in an emergency to make sure that you have all the correct forms with the submission and that will help you get things processed more timely when you are dealing with the remand process and that
kind of thing. This will really help you know which forms you need for adaptive aids, for minor home modifications, and so it is not a mandatory form but it will really help you if you are not sure about which forms to use when you are submitting a packet for any type of individual plan of care action. And then again just stay tuned to your DBMD update for rules update.

Our next webinar will be March 7th from 10:00 to 12:00. I will work on putting together a presentation on how to become an intervener. I keep hearing this question from providers and there is not one clear path to becoming an intervener. So I am gathering information from people in the community, the DBMD community and we just want to give you guys kind of some practical guidance on how to support someone or to help somebody develop those skills if they are interested in becoming an intervener. I was going to put together a presentation, hopefully from the utilization review department on the procedural guidance for minor home mods and adaptive aids. And then if you have any other topic requests, go ahead and send them to me at the DBMD policy mailbox. I do check those and will do my best to get a subject matter expert to help us with that particular presentation.

And so up next we have Julia Turnini. Did I say name your correctly? She will be sharing with us some information on electronic visit verification.

>> Julia: Okay. Hello everyone. Once again, my name is Julia Turnini. I am with the EVV operations. Today I’ve got Deja Hill here and she will be your EVV subject matter expert for DBMD.

And so any questions that you may have or inquiries, if you submit them to our EVV mailbox, you expect to receive a response from Deja. She will be your contact. Let's get started.

All right. So today, our agenda, we will talk about EVV implementation. Okay. Programs required to use EVV. What is EVV? How does it work? The three acceptable methods that HHSC has approved. GUI. What is an EVV transaction? What is next after I enter my visit data? Visit maintenance. Reason codes. We will talk about EVV compliance plan and the EVV state model.

Just to give you a little background on the EVV implementation, Texas Section 531.024172 code requires HHC to implement an EVV system to electronically verify personal care and attendant care services that are provided to immediate raid recipients, including managed care. In accordance with a prior authorization or a plan of care. It will replace paper-based attendant time sheets. The EVV visit records are used to match claims. EVV was implemented statewide in 2015 for certain Medicaid programs.

All right. What is EVV? EVV is a computer-based system that verifies visits occurred. It documents the date and time services begin and end. EVV electronically documents the member receiving the services, the attendant providing the services, the location of service delivery, and the date of service delivery, the time that the attendant begins and ends service delivery.

The programs that are currently required to use EVV is the CLASS program, CFC Pas/Hab model. Community first choice, CFC Pas/HAB. Family care, personal
care services, primary home care, PAS services are the ones required to use EVV. STAR health, the services is CFC PAS/HAB. Star Kids, formerly known as, in home respite, flexible family supports. STAR PLUS. CFC PAS/HAB protective supervision. I kind of want to mention right here in 2020, DBMD is required to use EVV and we will get you that information as -- of the services that are going to be implemented in 2020. We will get you that sent out. But I did want to let you know that DBMD is the -- is one of the programs that are required to use EVV. And the services in the DBMD required to use EVV are community first choice, CFC, personal attendant services, PAS/HAB. The provider agency and CVS will be required. In home respite, the model and CVS will be required to use efface well. Currently we are developing training, policy and procedures for DBMD to implement in 2020.

All right. Let's get into how does EVV work. When an attendant provides services to an individual member in the home or the community, the attendant must use one of the three approved EVV time recording methods to clock in and out. One is an EVV mobile method. Another one is EVV alternative device. And lastly is the member's home landline telephone. Home landline is a device used when an attendant provides authorized services to an individual/member in the home or community. The attendant has the option to use the individual/member's home landline telephone to clock in when services begin and when they end. The check in and checkout process for the home telephone -- home landline telephone, the attendant will call in and they will enter the client number and call in again for clocking out.

Alternative device, it is provided by the EVV vendor at no cost to the provider agency. The attendant will utilize the device to clock in and clock out. The check in and checkout process for the alternative device: When the attendant arrives, the alternative device will display a numeric number. They write down the numeric code, generated by the device. And then when they depart, because this device changes numeric numbers every 60 second, they will write down another numeric code. And then they call in the codes to the EVV system or relay the codes to the provider agency to enter into the EVV system manually.

The EVV mobile method: The EVV vendors may use an EVV mobile application for clocking in and clocking out. The EVV mobile application captures the geolocation coordinates, longitude and latitude of where the attendant clocks in and out. I just wanted to let you know that is the only time the attendant -- the GPS will locate the exact location is when the attendant clocks in and when they clock out. That is it. No protected health information is stored on the phone. All right. The check in process for the mobile method, the attendant logs into the application upon arrival. The attendant selection the client receiving the services. Clocks in and out by pushing the in and out button on the application.

Geographical user interface: This is when if attendant does not use the EVV system. Whether the reason is allowable or unallowable. The provider agency is going to build a pair for the visit. The agency must manually enter the visit pay hours into the EVV system. The visit method in and out is marked as what we call GUI which is geographical user interface. Entered visits -- the GUI entered visits should not be the norm but the exception. Payers will question an agency when they see frequent GUI visits.
What is an EVV transaction? An EVV visit transaction is a complete, verified, confirmed visit consisting of the date of service, the actual time service delivery begins and ends. It is all made up of required data elements that identify and link the individual member to the attendants and attendant to the provider agency and a provider agency to a payer. EVV visit transactions are matched to billed claims to verify authorized services occurred. Claims that are not supported by an EVV transaction may be denied or subject to recoupment.

What is next after all the visit data is entered into the EVV system? Auto verified visits that match the planned schedule and have no exceptions. Give me one second here. The next step is when your visit transaction is sent to the EVV system, the system will try to auto verify. So basically an auto verify visit is a visit that matched the plan schedule and have no exceptions. If the visit is not auto verified by the EVV system, the provider agency must complete visit maintenance to make necessary corrections to the visit. Once the corrections have been made, the EVV system will attempt to verify the visit. The definition for verified visit is the number of visits for which all exceptions have been resolved through visit maintenance in the EVV system.

What is visit maintenance? If the EVV system cannot automatically verify an attendant visit against the schedule in the system, the provider agency must accurately reflect the visit data through visit maintenance. Visit maintenance allows designated staff in a provider agency to edit records of EVV visits by reviewing, modifying and correcting certain data elements in the visit information. So basically visit maintenance is correcting a visit.

Providers must make adjustments and assign an HHSC established reason code and any required free text in the comment field to explain and clear the exceptions. Providers have 60 days from the date of the visit to perform visit maintenance in the vendor system.

What is a reason code? A reason code is a standardized HHSC approved three digit number and description used to explain the specific reason a change was made to an EVV visit transaction. When the EVV system identifies a difference between the planned schedule and what actually occurred, the system cannot auto verify the visit and generate exceptions. The provider agency must clear exceptions by adding the most appropriate reason code.

There will be an EVV compliance plan. The compliance plan will establish a standard percentage of the GUI which is the graphical user interface visits. A provider agency must maintain quarterly to ensure attendants use the EVV system appropriate. GUI is a manual entry of the visit pay hours into the EVV system. In 2020 when EVV is expected to be implement, this is what our state model will look like. The provider agency will maintain the identification data that will go into the EVV vendor system. The attendant will clock in and clock out. That information will go into the EVV vendor system. And then we are currently creating a EVV data aggregator which is basically a centralized place that will receive all visit data daily. It will reduce risk of data errors. Standardized validations and it will standardize claim matching. Once all that information is
input into our EVV system, all those visit transactions will be forwarded to our state data aggregator which are our centralized model. TMHP assisting with that model. Once a claim comes in through TMHP, it will locate the data aggregator data and match the claims. If you haven't already, we encourage you to me sign up for GovDelivery alerts. Here we will post alerts for the upcoming implementation for 2020, which includes DBMD once again. Be sure that you select the EVV subscription topic to the EVV alert and there you will find the link if needed.

>> Jackie: I think we have a couple of minutes where we can take to answer any EVV questions? Have any come in?

>> Camryn: I have got one.

>> Jackie: Okay. The question is, will intervener services be required to use EVV? And that is not one of the services that we are looking at for EVV. It is more about personal home -- in home assistance, personal care attendants.

>> Julia: That's correct. It is not included -- what service was it again?

>> Jackie: Intervener specific to DBMD and they are not personal care assistants.

>> Julia: That's correct.

>> Jackie: Thank you, Julia. That is great. Next we have Nova Evans who will begin the conversation and presentation on trauma informed care. Welcome, Nova. Here you go.

>> Nova: Thank you very much. Okay. Thank you, Jackie. So my name is Nova Evans and I am a senior behavior health policy analyst. And prior to my working at the office of mental health coordination, I have worked with, supported, and been in policy for about 20 years working with people with IDD and specifically behavioral health issues. And currently we are taking on a trauma informed care initiative and how very important this work that we are talking about. So I am very happy to be here and talk to you about this. My presentation is going to be a little bit more global in talking about trauma informed care overall for individuals with IDD and then David Wiley will come in after me and talk more specifically about issues around deafblindness. And so I am just going to start from there. And then we are happy to take questions and kind of talk through some more specific issues.

So kind of just to give a little bit of history, when I got into this field, like I said 20 years ago, we looked at behavior as a problem and we -- when we worked with people with IDD, the behavior management and we had behavior management plans but we really need to reframe that and we need to look at supporting people and recognizing that behavior is -- we all have behavior. We all behave and that we don't want to try the change people's behavior. We want to try to support them and understand what people are trying to communicate through their behavior. What we used to do is have these behavior plans and work on changing behavior. But we didn't really ever look to see what would make a person change their quality of life. So in some cases, we would change their behavior
and in a lot of cases we wouldn't. But that was really not, I think, successful in a lot of ways. So the new way we look at things is positive behavior support. We may have a positive behavior support plan or actually more recently I think we look at recovery plans. But that is really not kind of embraced completely but that is something that with people with -- who have experienced mental health issues, we are look at recovery plans too.

So people with IDD can have challenging behavior. We all have challenging behavior if you think about it. We see people with disabilities exhibiting behavior more because they may have more limited ability to express themselves verbally along with just quite a bit of other impulsivity or different things that they are dealing with and they don't express themselves in a way that makes sense to us.

So behavior management plans or another thing we used to think of as behavior management plans are for the person with IDD and you would hear things like, oh, that person is on a behavior management or BMP or they have a PMP. I like to think of support plans as a roadmap for the caregiver and support staff and it is not that the person is attached to that plan or that they have behaviors and that they need this plan but it is really about the person who is writing that plan is identifying what supports a person might need to get to what they are looking for and improve their quality of life and get the best support for them and giving that plan to the caregiver to help support the caregiver in that way.

Another thing we used to think about as behavior management plans can help the person change their behavior but we want to focus more on mental wellness and help the person again improve their quality of life, improve their mental wellness and gain skills to become more independent in their daily living and just have a good life. And then again the only -- we used to think that the only way to help a person with IDD who has challenging behavior is with a behavior plan or medication plan is not true. Anyone including people with IDD can participate in therapeutic and wellness activities just like everyone else to enhance their quality of life and a lot of times you don't need to be on a behavior plan or have medication and sometimes, you know, those things do help. But having wellness activities in your life is definitely going to enhance your quality of life. It is really about the individual and tailoring their needs to their plan and what they like.

So that is going to kind of give the whole reframe to the rest of the presentation. So we talk about behavior, why do we behave? Behavior is a means of communication and when I say that, it is not necessarily something that someone is trying to communicate very specifically to us. They may not know what, you know, what that behavior means. But sometimes they do. Sometimes someone with IDD, like I said, may have limited communication or verbal communication. So if someone may be trying to communicate something specifically to us and we don't get it and so that comes across as different challenging or weird or odd behaviors. And you know, we attribute that to a person's disability which I will talk about in a minute as diagnostic overshadowing. But a lot of times it is something more subtle or something that is misunderstood like a medical condition or pain, someone is in pain. Again, you see that exhibited in challenging behavior like aggression because a person who is in pain is not going to
necessarily know how to deal with that if they didn't get rid of that pain. So they may, you know, hit their head or they may try to, you know, or they may punch a wall or something to exhibit, like I want to get rid of that pain and a lot of times in fact more often than not, someone who I out of nowhere who is exhibiting behavior that is not normal, the first thing you want to correspond is that they are in pain or something is going on medically.

Another thing that people have with IDD that is common, there are different genetic conditions and genetic phenotypes may have commonality or behaviors that are similar in conditions. Folks with IDD have more anxiety and impulsivity than in the general population which doesn't cause someone to have behavior but may increase the chances of or increase the likelihood of behavior happening if they are put under certain circumstances or there is a trauma history. And then mental health issues are more common in this population as well than in the general population. Antecedents are something that happens before a person and then consequences are something that happens after. If someone punches, you might react to that, that is an antecedent. If someone wants to get something or get out of something, get out of work, for instance, that is a consequence and that is another reason you might behave a certain away. A setting event is something happening generally that won't cause a behavior but increase the likelihood of someone behaving a certain way. A mental health condition like depression maybe a setting event and someone who is depressed may in the behave a certain way. May not act aggressively just because of their depression but you know, if you are depressed and then someone comes and the caregiver comes and wants to put demands on you and get you to come out of bed and go to work and you are not wanting to do that, you may hit them. So that is something you don't necessarily expect in someone that is depressed. But that is the setting event and then the antecedent was someone who, the caregiver coming across and asking that person to do an activity that was unwanted.

This is the way that someone is communicating, it is not very obvious. And then trauma which is the focus of this presentation. If someone has experienced trauma and they are reliving that trauma experience, they may behave in a way that, you know, is not necessarily something that you as a caregiver or a person that is trying to support the individual is going to understand or that the person is even going understand but it is a reaction to trauma and again, when we talk about communication, that is not something that they are necessarily communicate specifically but it is something that we want to try to understand to help support that person and their recovery. So behavior can be a lot of different things.

So a second ago I just talked about diagnostic overshadowing which is the tendency to attribute a challenging behavior or odd behavior to a person's disability. It is a very common thing we see for people with IDD, unfortunately. But a person with IDD, you know, a disability does not cause behavior in and of itself. So usually what you will see is that someone attributes a behavior to a person's IDD without really thinking about an underlying medical or physical or mental health condition to be the cause. So again, we want to always consider that there are other causes that are attributing to a person, the way a
person behaves and not just to the person's disability because we are overlooking what is happening and putting a person in a situation where we are not empowering them and not going to be helping to find a treatment for that person or supporting someone in recovery.

So again, just want to touch on the fact that people with IDD have a much higher, you know, rate of mental co-occurring mental health needs. Research has shown that about 30 to 35 or more recent actual research has shown 35 to 40 percent of all people with IDD have a co-occurring psychiatric disorder which I think is about 18 percent in the population of folks without IDD. And the highest psychiatric condition is anxiety and then depression. Although it could run the gamut of any psychiatric disorder. But you will see that a lot in this population. And that really is significant in how someone is going to react or behave or communicate and had you we need to again -- had you we need to again tailor or treatment plans and our thinking around setting up our environment and our responding and supporting those persons. And you know, and we will talk a little bit about how trauma also, having a lot of trauma in your life increases your risk of or probability of having a psychiatric disorder too. So there is a lot going on with a person who has been exposed to trauma.

So what is trauma? Trauma is an experience. Trauma is an experience that causes an emotional stress reaction which results in fear, threat to life or helplessness and it is a reaction to the experience that is the actual trauma. I am trying to read the definition that I have from SAMSA. But people experience different traumatic events differently. So something that happens to one person is going to maybe be realized by someone else differently. The stress reactions may have different effects on different people. Trauma has long lasting effects. And the people who experience trauma really feel threatened, emotionally harmed or physically harmed. And it impact the way people can -- I am sorry, impacts the way people respond to the environment and respond to others and have relationships and impacts their communication and behavior.

Trauma-informed care is a framework that guides principles in our day-to-day operations. Trauma informed care is an approach and it is really different from trauma informed therapeutic intervention. It is something that can be implemented anywhere and you don't need to be a therapist to implement trauma informed care. It has to do with recognizing the -- educating yourself at training on understanding the symptoms of trauma. And SAMSA the substance abuse mental health administration talks about trauma informed care is realizing the widespread impact of trauma, recognizing the signs and symptoms of trauma, responding by integrating that knowledge and then seeking to resist retraumatization. We can do that reeducating ourselves and setting up environments that really create safety and empowering individuals to recover from their traumatic experiences.

So encourage everyone that they can take part in creating a trauma informed atmosphere through the trauma informed care approach and framework.

What it does, it really shifts the focus from what is wrong with you to what happened to you. Instead of thinking when you working with someone and they are behaving in a certain way or acting strangely, what is wrong with that person? Really thinking about what happened to that
person and how can I help in taking that approach with not just a person that you
know has experienced with trauma but anyone. And changing that focus in general in the
environment and just how we think about our-- the people we work with and the places we
work in.

So we started really looking at trauma as a really big deal in the medical
community when there was a study done -- I am not sure, I think it was 2007, but I
don't remember when it came out. The adverse child experiences study was a study
done by Keyser to look at traumatic experiences in childhood and
long-term effects. What it found was significant findings on folks
who had four or more of these adverse child experiences (ACE) which included abuse,
neglect and partner violence, violence in the family, substance use or
misuse, mental illness, separation, divorce and incarceration. That there was
long-term, chronic physical health outcomes but also mental health outcomes,
increase in different types of activities like early sexual activities, substance
use, and increase of victimization. We started looking at trauma as a very
serious thing in the medical community and started looking at it in the mental
health community. And the reason we talk about this is -- well, the reason I am
talking about it here is because it really impacts, you know, so much of what
trauma informed care is about and it has guided that philosophy. But for people
with IDD who have experienced so much trauma in their history or in their lives,
the instance of these types of experiences really is magnified. What they didn't
look at in this is study are a lot of different things that happen all the time,
like disaster, witnessing violence, bullying, medical trauma, institutionalization,
mental illness of the person, being separated from loved ones and other things.
So they are still studying things like this but these are other things that people
well IDD go through commonly or kind of more on a routine basis.

And so what they -- what they did find was that the more issues you have, the
more chances are of having these long-term chronic disease. Even with people with
I think six or more ACEs, it increases your chances of dying 20 years earlier. Those with
four or more ACEs, have three times the chances of having lung disease, 14 more chances
of suicide attempts, five more chances of likelihood of developing depression. Let's see.
Three times more chances of developing anxiety disorders. And on and on. But those are
some of the things that I wanted to point out about ACEs. So I think it is important when
we talk about people with IDD that there is a lot of things that are more specific than
just the general population even for them.

So again, prevalence of abuse and victimization in the IDD population. Some
studies say it is up to 90 percent of people who have experienced trauma. There
was a study done, the disability abuse study put out its findings in 2012. They
had put out a survey to over 7,000 participants, including people with
disabilities, their caregivers, advocates, to look at their experiences with abuse
and neglect and also their experiences with reporting that and to authorities
and what the outcomes were. If you look to the right here in this graph, I have
just put the results and I compared them to child specifics from CPS from the same
time frame. You can see, within those child abuse statistics how much more common
it was reported for people with IDD or people with disabilities, their rates of
sexual and verbal and emotional abuse in this comparison, neglect was higher in
child abuse.
But it is very significant as you can see. The other thing they found was that it is very under reported because people did not feel that they could go to the authorities. When they went to the authorities it was often not -- they weren't found credible. They found that the abuse was -- the types of abuses and neglect were not done in isolation and that it was very ongoing. So it wasn't done in isolation.

People with IDD are also more subject to violent victimization and children specifically with language and disorders are more likely to be subject to victimization as well as neglect.

There is also an inherent imbalance of power because people with IDD are relying on their caregivers which are often the abusers in these cases. So there is that ongoing relationship dynamic. And when you are supporting someone, there is also that imbalance of power so that is something to remember when you are providing the trauma informed care, when you are providing the support to them, that is something that is ongoing as well. I think that is all I want to say about that.

So there are things called little t and big T traumas. Big T are obvious trauma. The abuse, neglect instances, there is car accidents, there is war, there is terrorism, things like that, shooting. The little t traumas are more obvious. Ongoing social violence, family violence, bullying, there are things that fly under the radar but they happen a lot and ongoing. And foster care placements or a lack of stability and these are things that happen to people with IDD on a fairly daily or ongoing basis. And I am kind of generalizing here. But you know, I think it is -- it happens at a large enough extent that we want to just be mindful of that -- that it is pretty pervasive and that people at the very least feel excluded from social situations and bullying.

The other thing that happens is that what might not be considered traumatic for you or the people without disabilities is has a long -- may have a long lasting reaction for people with disabilities, things like being placed in a different home that they are used to. Having their support staff and their friends or being, if a support staff leaves and they have a relationship with that person and they don't see them again and don't have really an experience with that person. You know, we may not consider that very traumatic but that can be a traumatic loss for a person with IDD.

So these are things to remember as well. People with IDD are more often exposed to conditions that are known to contribute to the development of PTSD. Having a lower IQ is also known to contribute to the development of posttraumatic stress as well. So the posttraumatic stress symptoms are more likely to occur to an event as well.

And so people can be more easily hurt in these events as well.

So what is a trigger? A trigger is something that triggers a past traumatic event, can be a sound, sight, smell or touch or anything that reminds a person of a trauma. When they have a trigger, that triggers that experience, they are
actually brought back into that traumatic state or they are reliving that trauma. It is not just remembering of the trauma but reliving that trauma so they feel that they are in danger again or another person they are with is in danger. This is a time where someone may behave in a way that is strange or challenging or aggressive or odd or that you as a support provider doesn't -- don't really understand because it might have to come out of nowhere.

The person may not understand it because they are not in the same place that they were before the trigger. So it is not really a teachable moment because if you try to just tell the person to calm down or they are not going to get to -- they don't stop that behavior, they will not get to do the thing that you were about to do or go to the movies or get their soda or things that we, again, done in behavior plans in the past. They will not learn from that and they are not going -- that plan is not going to work. What really needs to happen is to get them back into the present and then help to figure out what the right thing to do is.

So coping strategies, getting them back into the present. Dealing with those teachable moments later. I don't know if I am going to talk about this later in the slides but another thing that really I like to stress is when in those situations and in trauma informed care in general when we talk about the key elements of safety and relationships and empowerment, those are the things that, you know, are really going to help a person to recover from their experiences and so the worst things you can do if at all possible is restraints. Because those restraints are going to retraumatize the person most likely and ruin that relationship and safety feeling are very necessary. In a situation where a person is reliving an experience and not only is it not a teachable moment but the last thing that you want to do even if the person is acting aggressively or some other way is to restrain that person if at all possible. You don't want to be involved in that.

So trauma response, when a person is in that moment and they are reliving that experience, you know, you go into that fight, flight or freeze experience. And so what does that look like? Well, it looks like, especially for someone who is not going to necessarily tell you, it looks like these behaviors and behavior support plan, it looks like running away. It looks like regression. It looks like self-injurious behavior. Someone who is retreating might have selective mutism. I put these in parenthesis because I don't like these.

But noncompliance. A person who is in that stage is not going to listen to you. Telling you what to do. It might looks like false allegations because someone who has for instance been sexually abused in the past may make allegations and this is something I have seen a lot where someone is labeled as making false allegations because they say that a staff member has abused them. And it is not -- when you look into it, it is that a staff member has abused them in the past and that it is not a false allegation. Now, it is not happening now necessarily. And the time frame is not right but they have experienced that and that is their way of telling what has happened and no one has believed them and so what the outcome of that is that they are not -- they have been labeled, they have not been believed and disempowered. We have not helped then when we are doing that. In fact in a lot of ways if we put them on a behavior plan and take things away from them or we
are setting them up for not recovering. Being manipulative is another behavior that people are labeled with or attention seeking. Someone might have ritualistic behavior. These are labels that I don't like people to get and that is why they are kind of in parenthesis. These are also things that the tough ones especially are the way people may express themselves. So we don’t want to-we want to try to help support them. What they are doing is responding to their experience.

There are grounding strategies and what you can do to help someone who is reliving that trauma. Or being aware of triggers. Not or not even reliving but experienced trauma but may relive I if you know that person is experienced a trauma and you know what the triggers are, being aware that those are there and try to mitigate that by changing their environment to support them and being trauma informed. Listening to their feelings and empathizing with them and acknowledging their fear. Being present with them and not scared. Being patient and undemanding. This is really important. It is not engaging in power struggles. Not taking it personally. Even if someone -- if you feel like it is personal. If you are a trigger, maybe still not taking it personally and swapping out. And offering alternative situations, deep breathing, calming strategies, music that a person likes, going to a sensory room may help. And so many having -- getting the person back to you, being present in staying in reality and just being present with them.

So I said before, the necessary ingredients to recovery for posttraumatic stress are really keeping -- making sure the person feels safe both emotionally and physically. So their environment really needs to be safe for them as well as their emotional state. And empowering the person to make real choices for themselves in their life and the connection that you have with them and remembering that, you do have an imbalance of power with them and if they have been abused in the past that there was an imbalance of power there too but also just not your relationship and connection with them but they need to connect with others in the community and have friendships in a meaningful way. So building connections and building empowering them to build their own connections is really important just for wellness in anyone, but especially in someone recovering from posttraumatic stress.

So I think I talked about most of this. It is essential that you build trust and how you do that is you be genuine with them and honest. Make sure you get to know the person, talk about their interests. Recognizing your role in the relationship. And also recognizing that they may have a level of anxiety and establishing physical safety and making sure their environment is physically safe. Someone in a situation where they have been abused in a certain situation say in a bathroom, which is pretty common I think, if someone has been sexually abused in the bathroom they may not want to go into the bathroom and take a shower at night so that is something you really need to think about. What are their situation and what makes them feel physically safe and emotionally safe as well and so you might have to work around that. You know, the reality too is if someone has been traumatized, they may need trauma informed interventions as well. You can set up the environment on your own as well.

Establishing connection, again, that is with you but also making sure that
they are empowered to establish their own connections and within their -- with you, within their friendship circle, within the community, and doing things that they enjoy, finding what they are good at and giving them meaningful choices and providing opportunities that are meaningful for them.

And empowerment, helping people to learn about themselves and identify their strengths and developing a sense of positive identity. What that means is really making them have real choices.

So just to talk about positive identity development, this is something Karen Harvey talks about a lot is folks with IDD who often really don't have a sense of identify in general so they don't feel -- they don't really know what they are good at. So helping people just identify what they are good at, who they are, what they do well, who their friends are, knowing what their preferences are and what makes them proud, we do a lot for people or tell them who they are. If you ask them one real common like how was your day or what did you do today? And real common response is, I did good today or I was good or I didn't have a bad behavior. That really doesn't tell a lot about a person but that is what they have heard a lot. So instead of focusing on behavior, identifying those things that are good about them so that they can really start to enjoy themselves and have a better life and a quality of life is really important.

So kind of in summary when you are working with someone, people are really complex. Make sure, you know, they are focusing on the whole person. Always take a trauma informed approach no matter what, whether you know someone has been experience -- experienced a trauma or not. Just kind of a safe bet. We all have complex lives, complex histories, and it is a good way to approach people in their lives. People can and do recover. You don't need to be a therapist to have a trauma informed care approach. There are a lot of wellness active these people can benefit from. There is exercise, yoga, music, there are therapies that people do adapt for trauma so consider if you do know someone has a traumatic history or has experienced traumatic stress reaction, talk to the team, if you have an interdisciplinary team, think about sending them to a -- some people don't think people can recover or can benefit from therapy. So I like to just mention that. When I talk about this. Also always reason why is this person acting that way? What can I support them and what can I learn from what they are trying to communicate? And focus on those relationships. And try to figure out what they are trying to communicate to you.

Recognize that there may be impact to mental illness, impact of trauma. Focus on the wellness activities and don't give up on that person. We didn't talk about this but focus on yourself and recognize when to step back. It is difficult working with folks, I know. And especially people who have a lot of trauma or have a lot of behavioral issues and not understanding that. And this is tough work. So you know, take care of yourself. Use the same approach with yourself and your staff and your coworkers. It is not just limited to the people you are supporting. Make sure you are doing self-care as well.

I wanted to put some resources up here to get more information, education and just awareness. The first one is mental health wellness for individuals with IDD.
It is a web-based training. One of them is a trauma informed care model and others are similar, about mental health and positive behavior support. Medical and genetic conditions and things like that. But they are free of charge. And available to anyone who would like to learn more. And as of September 17th there are CEs associated with them. Some of the other things up here as well are informational documents or other training and then the last one, at the bottom, is disaster resources that are real specific to trauma. So it is kind of more specific thing. But you know, there has been a lot of those needs, it is a TEA website but it is kind of local level. But you know, we have had a lot of disasters. So I wanted to put those up because they are really kind of targeted but really kind of necessary as we are in this place. So that is my presentation. I appreciate being able to talk about that. And I am going to hand it over to David Wiley to talk more specifically about how trauma effects people with deafblindness. So thank you.

>> Jackie: Thank you so much.

>> Hey, everybody this is David Wiley and I work over at the Texas school for the Blind and Visually Impaired in a program called the Texas DeafBlind Project to provide training experiences for people working with young people with deafblindness and their families. And Nova gave a really I think powerful and comprehensive look at trauma informed care and there is not a lot that I can add but what I wanted to bring to the table is thinking about some specifics about deafblindness and the individuals being served in the DBMD waiver and how they experience the world through their senses maybe different than the way that we do and how that in and of itself can change their outlook on things and the experiences that they have in ways that might affect their emotional well-being and their sense of security.

And when I think about deafblindness, one of the places I often like to start is going back to what I think is the most famous person with deafblindness. The most famous person with deafblindness that most people have heard of and that is Helen Keller. Now, Helen Keller was an extremely accomplished person. She was the first person who was deafblind, to graduate from college in this country. She obtained employment with the American Foundation for the Blind. She worked with that organization for 40 years. She was a prolific author and lecturer and has a huge paper trail which enables me to be able to go back and pick some things out that I am going to --that she wanted to tell us.

And then you know, she met world leaders. A very accomplished and brilliant person. When she was in college, she wrote a book called The Story of My Life. That was published in 1902. It was premature for someone in their early 20s to write a book called the story of my life, considering she lived another good 60 years after that. But what was I think important about that is she still had I think fresh memories of her childhood experiences. Especially those -- she is able to recount those experiences that she had before she developed language and became more connected to people as she eventually did. So I want to talk about a few passages that she wrote in her book, the story of my life.

Let me just say this, Helen Keller was consistently optimistic. She was not a
complainer and she was someone who was positive, had a positive outlook on life. It was hard to find passages where she was able to reveal some of the experiences that she had as a child that she felt had an emotional impact on her. But there are a few that I picked out.

In chapter two I found this paragraph. I do not remember when I first realized that I was different from other people; but I knew it before my teacher came to me. I had noticed that my mother and my friends did not use signs as I did when they wanted anything done, but talked with their mouths. Sometimes I stood between two persons who were conversing and touched their lips. I could not understand, and was vexed. I moved my lips gesticulated frantically until I was exhausted. I will come back and talk about that for a moment.

I found another one that I found in chapter three. She said this, meanwhile the desire to express myself grew. And the few signs that I had became -- that I used became less and less adequate. And my failures to make myself understood were invariably followed by outbursts of passion. I felt as if invisible hands were holding me and I made frantic efforts to free myself. I generally broke down in tears and physical exhaustion. My mother happened to be near, I crept into her arms, too miserable to even remember the cause of the tempest. After awhile, the need of some means of communication became so urgent that these outbursts occurred daily, sometimes hourly. So those first two statements there, I feel like she was describing the deafblind experience, especially that experience of people who are not strong language users as is the case with many, probably most of the consumers in the DBMD program. And she is able to, I think, express something that these individuals probably wish they could express so eloquently as Helen was able to but probably are feeling and experiencing.

The next one is from chapter 22 and she is speaking to herself more contemporaneously of herself as a young adult. And she said this, sometimes it is true a sense of isolation enfolds me like a cold mist as I sit alone and wait at life’s shut gate. Beyond there is light, music and sweet companionship but I may not enter. Fate, silent, pityless, bars the way. Silence sits immense on my soul. Then comes hope with a smile and whispers, there is joy in self forgiveness so I try to make the light in others eyes my sun, the music in other's ears my symphony and the smile on others lips my happiness. She deals with emotional ramifications of her sensory disconnected from the world but she does mention that there is a sensory disconnect and that it gives her a tremendous sense of isolation and this is something that I think she was relating that she experienced throughout her life is this isolation even when she is in a room full of people.

Now, when we think about the story of Helen Keller, there was a play written about it called the miracle worker, made into a couple of movies. And I think that the narrative that we get from popular culture. I am an older gentleman, so I have a memory of this. And but I found the exact sentiment right in Wikipedia and what more global resource is there than that? And it says that in describing the plot of the miracle worker, it says that they are in Alabama, an illness renders infant Helen Keller blind, deaf and mute. Pitied and badly spoiled by her parents, Helen is taught no discipline and by age of 6 grows into a wild, angry, tantrum-throwing child in control of the household. That was sort of the thing on the Helen Keller story that I remember when I was a kid. That she was
essentially naughty. That she was undisciplined and that she was sort of willful. But I don't think Helen described herself that way at all. When she described her experiences, she described it this way. In the first passage she said she wasn't able to understand. She didn't know what was going on. She was unable to tell what was happening in the environment. She was unable to tell what other people were doing or what they were communicating. And as a result, she says she was vexed. That is a nice, old fashioned word in a book in 1902. Frustrated and worried are amongst those definitions that we find for that term. She was frustrated and worried and fearful about things because she was unable to gather information easily.

In the second passage, she talked about her frustration at being unable to express herself and an inability to be understood. There were certain things that she wanted to say about what she needed. There were certain things that she wanted to say about how she felt. There were certain things she would like to share to form relationships with people and she was unable to do that. And this caused her to also feel this tremendous amount of disconnect and anxiety about what was happening. And then in the final passage, she really talked about feelings of isolation. And how she felt socially disconnected from the other people in the world. And all of these things, I think we could describe as adversity. These are adverse childhood experiences. And they aren't among the list that Keyser permanente that put in their story.

But they are very strong elements of what a person feels and -- and their emotional brain and so I think we can really talk about these as trauma, as adversity, or however you frame that.

When we think about the functions of behavior and Helen describing herself as dropping to her knees and screaming and lashing out and aggression towards self, others and property, if we think about those experiences that she was having, where would put those in our functional behavior analysis? And I think one of the issues when we do functional behavior analysis of individuals is a lot of times we have a tendency to think of the behaviors that the person doing as being somehow calculated, like it says to reject something or to get something. It is as if the person is saying, how can I get that? Well, let me think about this, I could probably scream or bite myself or strike somebody or something. Helen doesn't really describe it that way at all. But she says is she had these feelings and it made her act this way. And so one of the things that I think we don't see in these lists of functions of behaviors that probably we need to are things like I am in distress or I am having a panic. Or I am subject to some sort of toxic stress. And toxic stress is something that a lot of researchers are talking about and the way I describe this and I am no neurobiologist so this is a total lay person's understanding of this. When the researchers talk about toxic stress, one of things they talk about is how our brain is constantly building itself, it is making neural connections and your brain is pruning away neural connection that is aren't used. The experiences you have, those stronger connections and experiences you don't have tend to get pushed into the background.

And so if we are until constant stress all the time, and other stressful
experience, another stressful experience, our connections in dealing with stress become the most common function of our brain. And we start to view everything as stress. What am I doing? Coping with stress. I start doing every event as a stressful event. This is something that happens for a lot of individuals who are having experiences that they can't fully understand that are highly -- that cause anxiety for them, that cause emotional disruption, that cause them to be feel frustrated and they start viewing all situations like that. And I think this is common for individuals who are deafblind.

So here are some things that I wrote down that I think are common to the experience of individuals who are deafblind. I will leave Helen Keller behind. The last thing I will say about her is that Helen Keller was not getting information through her vision and hearing. And the consumers in the program who are labeled as deafblind may use their vision and hearing in different ways. Some may be getting no information through their vision and hearing. Some may be getting information through their vision and hearing but one of the things that is true for all of them is that the information they are getting is either absent or incomplete or distorted or fragmented. And all of these things affect the way a person experiences and how connected they feel with the environment around them and the people that are around them. And so there are certain things that we can look at in individuals who are deafblind and attribute something is a fairly common experience for the consumers in this program. The first one being barriers to gathering information about the events, actions, the environment and other people. Helen Keller, I said I would leave her behind but they are things they talked about. Things are happening around me but I don't know what they are.

This leads to the second bullet point here which is that barriers to being able to anticipate upcoming events. When you don't know what is happening, you have a harder time figuring out what to expect and so your life experiences start becoming a series of surprises because you are not getting cues from the environment of what is happening and likely to happen. If you think about a stressful event, we don't have a lot of surprises in our lives. Occasionally you might have had the experience at some point in your life, at least I have seen it depicted in a movie. You walk in the door and a bunch of people may stand up and shout surprise. People saw that coming or someone tipped me off. If you didn't, then there is sort of this I hold my chest kind of feeling because surprises give us stress. And I think that is a common experience for people with deafblindness because they can't see or detect information about what is coming their way.

The third bullet point there is that people with deafblindness have barriers to recognizing others and forming relationships. They have this sense of isolation that I think is a common experience for them because a lot of times the people who come into their lives, particularly caregivers sort of reach in and what they are for the individuals is another pair of hands which seem disconnected from other people and a lot of times when I see caregivers working with individuals with deafblindness, I don't see a lot of introductions. I don't see a lot of here, let me share sometime with you before we get around to doing whatever care giving activity with doing to do. Let's first like sit down and just share time with one another and get to know one another. And so there is this lack of actually recognizing the person sometimes. But even when you do, not having
formed a relationship with them.

The next one is there are barriers to communicating about your interest and needs. The individuals have thoughts and ideas. We like to share our thoughts and ideas with others but they may find it difficult. They may not have the language for it. They may have things they need to a practical level like I am thirsty or need for emotional support or any of the various and sundry needs that we all have but they might have a more difficult time asking for those.

Finally, feelings of isolation and loneliness which I think is a common experience for people that are deafblind. People that are deafblind and able to express it, often tell me about that. So I think that we can see that adverse experiences are sort of built into the framework of being -- having a sensory disconnect from the information that other people ordinarily expect to get.

One basic premise of how we start the feel connected with the world is what some researchers at Harvard have started to call serve and return. I put the link there at the bottom of the slide here to that Harvard center on the developing child. And that research team is really delving hard into this idea of how trauma and adversity effects people through their lives. And one of the notions that they have studied and labeled as serve and return is how people start to form relationships and how they start to form neural pathways to build their understanding of the world.

And the serve and return is basically this: If we respond to a person’s initiative, it builds brain architecture of new neuron connections. And by initiatives, I mean something simple. If we talk about a young child -- typically developing young children, one of things that would happen is that the child will gaze at something. They are looking at the light. And what typically happens as caregivers, parents, caregivers notice what they are doing and say, oh, you are looking at the light. That is the light. Oh, and they turn and they look at it too. What happens is that is a serve and a return. Like the child has made an initiative and it is responded to in some way by a caregiver. And that start to form the basis of our social connection.

And it is the basis for all of our learning that goes forward. And one of the things that is true about individuals with deafblindness is this serve and return function becomes much more difficult. Because the way it starts with most people who use their vision and hearing is this way, I am looking at something or I am pointing at something or I am reaching out to somebody and those are the things that for a person who is not getting sensory information, they have no motivation to do. I am not getting information about that. I don't know it is out there. I don't point at it. I don't really see where the other people are. I have a difficult time making eye contact or engaging what their facial expressions are and imitating them and all the things we do to form these early connections with the people in our environment.

And as a result, this serve and return function is often absent. And this is sort of the basis of how we build our way of interacting with the world. It is something that we have to keep in mind when we are working with individuals with deafblindness is that they need this kind of connection. And so there is one of
the things, a lot of this -- when we looked at serve and return and as described for typically developing individuals, a lot of it has to do with where a person's gaze is.

And one of the things that we talk about if somebody is experiencing the world tactiley, where is their gaze? And they do. There are certain things they are noticing but they do it tactiley. And we don't as a culture recognize this tactile sense as something we pay attention to too much. So if the person is fiddling with the button on their shirt, that is the same as pointing at the lightbulb. And one of the things that we need to do is to say, oh, I see you have got a button there. And I am noticing what you are doing and I am trying to connect with you. And this is something that can go all through a person's life is I think this is one of the problems with this sense of isolation that is prevalent for people with deafblindness is the person not being aware that other people are paying attention to them because they have a difficult time just making that connection.

If the person does something that is either noteworthy for being excellent or being funny or whatever, other people around them may smile or laugh but the individual may not even know it. And so all of that will feeds into this sort of since of disconnect that they get with other people. And lack of social relates ships and lack of social ability that they have. And that is something that we have to consciously think to ourselves how will I make this persona ware that I notice them and how will I make them aware how I feel about it and how will I show them a accepts of connection? This is something if we are doing we have to be thinking about.

One of the things that is true about many of the consumers being served in the DBMD program is that they are not strong language users. And that could be a variety of different reasons. But a lot of them have either emerging or somewhat not very abstract communication or very concrete communication.

And so I think a lot of times they might have difficulty expressing abstract thoughts or thoughts about their emotions. So I put these down as things a person who is being served in the program might want to say if they had the language and the verbal ability to do it.

One of the consumers might want to say is I woke up this morning and I didn't know what was going to happen today and I didn't know how to find out. And I think if that is the experience that the person is having, that is a stressful experience. And that is an experience of adversity. Or we might say it is a little t trauma.

The person might want to say, I was that room and I felt alone. Even though three other people were in the room were in the room, I didn't know they were there. This again I think is an experience that a lot of these consumers have. It is this sense of isolation even when they are in a room full of people because of the fact that individuals aren't making an effort to connect with them and the person can't casually connect with them because they are not getting as much information from the environment.
The next thing I put is there is something that helps me feel calm but when I try to get it, it isn't there or at least I can't find it.

And that is one of things that I think is also a common experience for a lot of individuals with deafblindness and additional disabilities is this sense of I have developed some coping mechanisms. There are some things I can do or I can interact with that make me -- that help me feel grounded and calm but I don't even know how to go about initiating that. I don't know how to go about telling anybody about it. I don't even know how to locate it. And this is a stressful way to experience life.

The fourth one I put there that a person might want to say is there is something that is important to me but I don't know how to let anyone know. When I try, they usually fail to understand -- or fail to respond or totally misunderstand. This is another experience that people have is the communication that the person maybe using maybe subtle. People don't know exactly what it means and even though they are well meaning, they don't respond as the person hoped that they would. And they view that as sort of a failure. And that they view it as why should I try to communicate usually ends up with frustration. So these are all I think experience that is the individuals being served in the program may be experiencing and may explain some of the ways that they behave and some of the ways that they interact with other people.

Some solutions for stress that we can use in our service strategies. I put a couple of them here. Many of these are very similar to the ones that Nova just covered so I will go through them quickly. But I think to recognize that the consumers have stress and develop support strategies accordingly. As Nova said, I often hear caregivers refer to the consumers are stubborn or manipulative or something like that when in fact I think if we examine their life experiences we may find they are coping with stress and anxiety. And so I think we need to recognize that. And bring that information to everyone who is involved with these individuals so there is a consciousness of it and a sensitivity to it.

I think if we could -- I think if we could help individuals to establish relationships and the model we have in the intervening program, there is a sense that that individual is a consistent figure in the person's life as opposed to just another staff, tomorrow it will be somebody different. Because individuals with deafblindness have a hard time forming relationships because they are getting less information about the people around them and having a stable and caring person in their life can help them work their way through the results of trauma and adversity that they have had in their lives.

Another one that I see sometimes mentioned is finding out what normal is. I think in the literature when people talk about finding out what normal is, a lot of times they are talking about normal is not being beat up by somebody. Normal is not being bullied. And a lot of times people have a skewed view of what their expectation should be because they are just going on their past experiences. So I want to take it away from that kind of sort of more explicit kinds of trauma and adverse experiences and just talk about everyday life for an individual. Finding out what normal is, I think is about this, that there are activities in your life that are meaningful to
you, that you recognize. I think a lot of people who are deafblind with additional disabilities wake up in the morning, wondering what is going to happen, not knowing everything that happens to them is a surprise and that is a stressful way to live. And a more normal way to live is to have recognizable routines of things that you do on a regular basis and you know in the morning this will happen because this happens on every Tuesday morning.

That is the way I live. And having recognizable routines and schedules and meaningful recognizable activities and the ability to participate in those things, I think is helping a person understand what a normal life is. And it may be something that they have never experienced.

The next one is ways to express your stressors, needs and interests. Putting together communication strategies or communication materials that enable the person to express themselves. That can be increasing their sign language vocabulary or it can be something like having object symbols that they have access to so that if they are hungry, they can show you their spoon or when they are thirsty, show you the cup or when they would like to get some exercise, show you the handle bar grip from the tandem bike that they ride or their exercise bicycle or whatever. Any level of ways to allow the person to express themselves or inform you about the things that they are thinking about and the things that they need, I think, can really help with these situations for them.

I put nutrition and exercise there because it is in the all the literature. I want the mention it for those that are deafblind. Because in our common childhood experiences, one of the first things that kids do is have an urge to exercise and initiate it. They look out the back door when mom gives them to go ahead, they take off running across the yard. It is a common experience. Something that individuals with blindness have difficulty with though because they have less motivation to move about because they don't have verbal cues -- I mean visual cues from the environment about what is out there or what they might be curious about or what they might be interested in because they just don't get information about it.

Or they might find it difficult. Like this whole idea of running across the yard seems dangerous and fraught with any manner of trouble if you can't see your path. And so exercise becomes something that doesn't come second nature to an individual with deafblindness and it is something we need to think about how are they going to do it and things like Nova said like yoga classes are a good way to do something in a structured way that the person can more easily understand.

And then the final thing I put there is, you know, the big one. We need to reduce the adversity that the people are feeling. And so that means if adverse that they are feeling is that they are having an information deficit because they have barriers to easily gathering information, we need to find ways to give them more information. Or consciously give them more information. Either using communicated form or allowing them to explore things. As simple as when you go into a room, let's take a swing around it tactiley before we do anything in it because that is information and the more information a person has, the more comfortable they feel.
Developing communication methods for them. Developing communication materials for them. Either low tech or high tech. So they can express themselves. Helping them form relationships. Self-determination and sense of control and being able to have skills to use that they feel both proud that they can do them but also gives them that measure of control. All of these things help reduce adversity or the a person who is deafblind and helps us kind of tone down this toxic stress and help them be able to start viewing the world not as something they need to worry about or that is threatening but as something that they feel comfortable in.

The last thing I put up here has to do with the circle of courage. I see I didn't put the link up there. There is a gentleman named Larry Brendtro and martin brokenleg. They are in South Dakota. And I wish I remembered the college. They are at a college in South Dakota. Boy, that is a terrible omission. But one of things they talk about is they look at some of the traditions in native American culture and one of them was how do we help people become a part of our village? How do we help people become part of our group? And it mentions four things that help a person feel attached if they are disconnected and that is the attachment through belongingness and feeling like they are belonging and having relationships, feeling the sense of achievement or having skills, knowing how to do things, having the sense that they have the power to accomplish things. Autonomy or that is giving a person a sense of control, choices in their lives, ability to express their preferences. And finally, altruism which is we also say is generosity. One of the things that really helps us feel connected to other people is when we can do things for them. It is something that a lot of times we don't think about for the consumers that we are providing care to but we really should is finding opportunities for them to feel connected by doing things for other people. I started mentioning this when I talk about this because I was talking to some caregivers and case managers for a gentleman who was getting on up there in years and had some things, some belongings that they needed to prune down his belongings and they were talking about how should we get these things out of here? Well, he can donate them. Does he under how to give a gift? And one of the things that people said was, I am not sure that he has ever given anybody a gift. I thought, that is unfortunate. All of these things are things to think about in helping a person feel connected and less isolated in the world. So those are my thoughts on how this trauma informed care relates specifically to deafblindness or how deafblindness relates specifically toll trauma informed care. But I am going to turn now to see if there is any questions that people have.

I did -- I did get the info that the folks with the circle of courage, Larry Brendtro are at Augusta university in Sioux falls, Minnesota. That is where you can find them.

>> Jackie: Thank you so much, David. We did have a question come in but I wanted to share something that I have been thinking about ever since you guys have started talking. Last year I had the opportunity to meet some people who live in residential settings in DBMD and I happen to begin my interviews with these folks about two weeks before Christmas. And I realized that Christmas is a really stressful time for people who are wondering if their family is going to come, what are the plans for the holidays. And one of the instances I met a woman and she figured out that I could communicate with her to a certain degree and she kept
talking about Christmas over and over and mama. Mama. Mama. Mama. When is mama coming? And the staff said, oh, she asks every day and we are not sure yet but we think blah, blah, blah. So there happened to be a big tactile calendar with the Velcro numbers way up high on a shelf in the room where we were. And I grabbed the calendar and as I was showing it to her, the staff were saying, no, no, no, don’t give her the calendar. She will get upset.

And she did. She started bawling and she was so relieved and we talked about when is Christmas? And I couldn’t really explain much more than it is over here and this is today and this is when mama is coming. I think that calmed her heart so much and a recent example that I met with machine some DBMD. Don’t be afraid to try to tell somebody what is going on. I know it seems overwhelming if somebody doesn't have sign language or the ability to really -- they know more than you think. Give them the opportunity.

But the question we got, can a positive support behavior plan be under behavioral support? In the past yes needed to have a date when the behavior was expected to end. Many individuals have behaviors that are not expected to end but need to support. What would I say behavioral support in DBMD used to be known as behavior communication and, yes, you can develop a behavioral support plan that has measurable goals but a behavior would maybe change or evolve or something different would happen. I wouldn't say that will framing it around a behavior ending is necessarily what we are looking for. Because there is a reason that somebody is doing something, with health or communication and the behavior support specialist should be able to help develop that plan.

The team should get together, talk with the family. I don’t know if anybody else in the room has any suggestions for that particular question. And if it is an actual individual circumstance, feel free to send it to the DBMD mailbox and we can look at it a little more closely.

Anybody? Yeah? Okay. Do we have any other questions?

>> We have a few comments. Yeah. Sounds like serve and return is important for those with autism too, especially David as point about the need to recognize their gaze and tactile or even though effected by brain injury or stroke/TIAs through tactile.

>> Jackie: Yeah, good comment.

>> That's it.

>> Jackie: We will put you on mute for a couple of minutes and see if anything else comes in. We might end up ending a couple of minutes early but we will try mute for a minute and get back with you in a second.

[Silence.]

>> We just had a question about implementation of EVV. There is a testing or soft roll out in 2020. And then it is supposed to be implemented for real
sometime in 2021. But stay tuned to your GovDelivery for updates on that. And also, you know, if you are interested in participating in a pilot and kind of getting some experience before it is actually mandatory, let me know. Because I think there is still room for people to participate as a pilot program. Okay. Thank you so much for participating. We haven't had anymore questions. But if you think of something, you know, later in the day and you want to ask, please send it to the DBMD mailbox and I will try to get it to whoever should answer that question. And we hope that you have a wonderful holiday season and stay tuned. We will have another webinar in March. Thanks, bye.

[End of webinar.]