- Hello, my name is Rachell Johnson and this is Taking the Myths out of AAC Evaluations and Treatment.
 And just going to say greetings to everyone from South Carolina.
 And just a little background on who I am.
 I am an assisted technology team lead with Florence One Schools in Florence, South Carolina, and I work for the Stepping Stones Group.
 I'm also an independent AT consultant with Minnesota Technology for Home Program.
 And my background is speech language pathology.
 I served on many interdisciplinary teams in the past, including being the program manager for the DC Maryland and Virginia chapter of the, or not the program manager of the chapter, but program manager for assistive technology for the DC, Maryland, and Virginia chapter of the ALS Association.
 I've worked with AAC from birth to geriatric and assistive technology, and so these experiences that I might share when it comes to a case example, I'll try and do a good job of giving you both adults and children.
 So in this webinar, we will examine research regarding AAC myths, we're gonna discuss AAC myths versus realities, we're gonna look at past myths, present myths, myths that just won't go away.
 We're gonna explore the effect of AAC myths on people with disabilities and even their families.
 We're gonna do that with an interview with a family member.
 And we'll also get to do that with some case studies as well, or case examples as well.
 And lastly, we are gonna talk about why I chose the galaxy theme for this presentation.
 What is that analogy about I am Groot, that Guardians of the Galaxy character? Why did I choose that for this topic? So we'll get into that.
 So the first thing we're gonna talk about is AAC myths and a glance at origins and history.
 So there is a research article that I wanted to share with you guys.
 And what I did was I put at the two links that I'm really gonna refer back to, but one is this article here, and it is an older article, but even though it's older, it has some really good topics in here.
 Some it delves into some myths.
 In fact, this article kind of looks at six common myths that you see in AAC and kind of dispels them with research.
 And also if you kind of read, you know, into the article, you'll find that some of the myths come from our own teachings

in our profession.
 So you'll find that something was believed and taught as this is the case with typical developing children, this is, and then later research, you know, kind of changed the thinking on that.
 But that's kind of where some of, you know, most of, or some of our myths have come from.
 Okay, and.
 I'm gonna move my tools to a different area.
 The other article that I wanted to share, or it's actually a resource, is from the Tobii Dynavox website.
 And again, a speaker disclosure, I'm by no means compensated by Tobii Dynavox and I do not work for them, but I love this site, this link.
 What is AAC, Busting AAC Myths.
 I think that it's a good resource for any family or AAC user to have or therapist, no matter what device you're working with or technology tool you're working with.
 And so I'll be referring to some of the article links today from this.
 Okay, so to get into some of those, like these are the most maybe common, and it's just an introduction and then we'll delve into ones that I see, you know, every day in practice.
 But here we go.
 So AAC is the last resort to intervention.
 And how often have we heard that? So with it being with people thinking that it's the last resort, it's almost like they're saying we have to try all these other things and if they don't work, then we'll try AAC.
 And we just know that that's, you know, that's not the case, right? So this article, it does, that I linked it to, it does take you to AAC can be provided too soon after a neurological event, which is, you know, also a myth, that's not true.
 But I took you to this article for that topic just because it had really good talking points.
 So, you know, the first part might be talking, you know, only about neurological events, but if you keep scrolling through the articles, you'll find some other topics within that or other talking points.
 Another way of saying the same myth that I just said is AAC is a bandage at best and a last resort at worst.
 And you know, there are naysayers that truly feel this way and it's really our job, you know, as therapists to educate everyone.
 And that it's not a bandage and you don't have to wait to use it.
 It's a tool that you can use, you know, right away.
 Another one, AAC stops natural speech development.

And, you know, we just, we know that that's not true.

It actually encourages natural speech.

Children must have a certain set of skills to use AAC and we know that that's not true.

If I go back to the, to this article, and I'm gonna, I have it here.

Myth three.

I just love how it kind of takes you into the past.

And, you know, there was a time in our profession that it was thought that because of the development of children in that maybe their sensory motor development or cognitive development, you know, that if they hadn't reached a certain point in their development, they weren't ready for AAC.

And we know that that essentially just isn't, it isn't true.

And I love the quote here from, from Tobii Dynavox, I'm not sure who came up with this quote, but I think it's here, you know, that the only, the truth is the only prerequisite is breathing.

And that's just a powerful statement and I love it.

You know, you try AAC, you don't just leave it on a shelf for the last resort or thinking that they have to, you know, it's not a baton that you pass is an illustration that I've used in the past.

You know, it's not a relay race that we only tag in, you know, AAC at a certain point.

And so another set over here on the left of myths that are commonly used and been proven false by research, AAC is only for children with intact, you know, cognition.

And I took you to the same link about the neurological event because it had more talking points, but again, no prerequisite.

So you meet them on the cognitive level that they're at.

Children have to be a certain age to benefit from AAC, you know, and I see that we kind of have that going on at the front end and the flip side of that.

And what I mean by that is we'll say, oh my goodness, they're too young.

But then if the child or young adult is older, at the other end, you're saying, oh, but they're too old to learn it now.

So you know, they're catching it on both sides.

And so we just really have to stop that type of thinking, it could be very detrimental to the potential communicator.

Children, and so this last one, there is a hierarchy of symbols from objects to words or that I have to use some type of low tech tool and excel at that before I can be introduced to something hi-tech.

So that type of thinking has been dispelled.

So one thing that I love about the articles that are linked on

that Tobii Dynavox site was just, I like the research that they state and then at the end, they do a nice summary of all the articles so that you can go and look at those and form your own opinions if you would like to look that up.

So I just think it's, they're nice summaries, you can use them as talking points, it's a good resource for your practice.

So moving on, I'm just closing out some of our tabs so we can keep going.

We're gonna talk about myths versus realities and AAC evaluations and experiences and case examples.

So hi-tech is the best tech.

I have seen this so many times and I am guilty of this one because we get so excited, don't we? We get so excited when there's a new technology or when a technology has worked so well for, you know, for these clients or these students or this person, and then so it must be the best thing for the next person and we can kind of get caught up in that but we have to be careful not to get caught up in that thinking.

The reality is that low tech solutions are also very successful and that you can recommend both at the same time and that we should be, right? Because a hi-tech solution isn't always gonna work a hundred percent of the time.

There's gonna be a times where it's off, where it is being updated, in for repair, where it may not work in a certain, you know, environment or lighting.

So you always do need a low tech and should be exploring both in your evaluation.

And I have talked about here, the SETT framework, SETT, and I think there's a link to it in your resource list, but if I didn't put the link, forgive me and please look it up if you're not familiar with SETT, but it's Joy Zalas was involved in that framework of creating it.

S-E-T-T stands for Student, Environment, Tools, and Tasks.

And so are we actually finding out what the AT or AAC user and their family would like to use? They're part of that S and that E, right? And so one example that kind of taught me this very, you know, early on, back in my days of working with ALS, we were working with a family and we did not ask maybe enough of the right questions to find out what really are they interested in using? And I think a lot of times, this is where device abandonment starts.

And when you're talking about device abandonment, a lot of times, we discuss it in the context of after the evaluation and after they've been provided the device.

And I wanna say that to challenge everyone, hey, device abandonment starts right here when we don't include and ask enough questions, you know, in the evaluation.

So this particular family had gotten their young son, young man, actually, adult, I think he was 25, out of bed and into his wheelchair for the evaluation.

And you know, ALS we're thinking Eye Gaze device.

The family thought it was so cool, he thought it was so cool.

So we tried out, he was very successful with the Eye Gaze device in the chair and then lo and behold, device abandonment started right away after getting the device and why, we didn't find out enough information about where he was during most of his day, which was in bed, and he had nystagmus and while he could use the device in an upright position, it was more difficult for him to use it lying supine in bed.

His, I'm sorry, it was difficult for him to use it in the chair upright.

His eyes kind of were more rest when he was relaxed and lying down.

So we ended up providing a low tech solution for him and blowing up a communication board and putting it on his ceiling because he would lie in bed, do the fatigue with ALS and talk to mom with the communication device on the ceiling and a laser pointer on his glasses.

And so, you know, again, if we involve the family and ask all the right questions about their day-to-day environment, that's gonna, you know, cut down on that.

There are prerequisites to using AAC.

So this one was mentioned earlier and it is a pet peeve of mine when I hear, you know, people say no for different reasons, and sometimes, it's just due to lack of education on the topic.

And so we can be that champion for the user or for the potential AAC user knowing that there's no disability disqualification meter when using AAC.

So there's no rule book out there saying you are not ready and you can't get one and you, so it's really, we have to try things, right? And there isn't gonna be a tool that works right off the bat for every single user, and sometimes, it's a long process and explaining that to a family, but when there are no opportunities given, sometimes that process becomes even longer for the family, right? And so how is that, how are our families feeling when they're faced with these challenges? They already have, you know, a challenge of maybe a medically complex family member and that they wanna communicate with.

And then, you know, with these myths, we might be presenting an additional challenge.

And so I would like to share with you this video and it's an interview with a parent.

Hi.

So we have been talking about misconceptions that therapists

can generally, or usually fall into that can really affect the outcome of using communication and trying new devices.
 And some of those misconceptions that we've been discussing are things like when therapists are afraid to try something new or we're going to try and master, quote unquote, master low tech before hi-tech, which we know is not a requirement, or even that when we have a vision difference or vision impairment.
 And so we're dismissing things like Eye Gaze or other hi-tech technologies because of that impairment.
 And so to do, to have this conversation, we have with us Erika Chapman and she is the parent liaison with Florence District One in Florence, South Carolina, Florence One Schools in Florence, South Carolina with me.
 And also she is the parent of a student who uses a hi-tech communication device.
 So I wanna get her perspective on their journey and what it took to overcome some of those misconceptions.
 So Erika, tell me more about you and Sui.

- So Sui is 11 now and she started in preschool at Florence One when she was about four and a half and she is considered nonverbal.
 She has cerebral palsy and she has cortical visual impairments.
 She has limited use of her hands but good head control.
 And so we, she has pretty fair receptive language but not expressive.
 She struggles and she can only say a few words but we cannot, we've always been able to tell she had a lot more she wanted to share, a lot more she wanted to express, and so she's had great private speech therapy and speech therapy at school, but we never could seem to come up with a plan or opportunity or options for her other than just trying to improve speaking, trying to speak more.
 And so I would research and I would ask questions and I mean, I knew that there were Eye Gaze devices and different programs but I was always told that because of her visual impairment that that wasn't an option or because she still seemed to have such limited language that that probably wasn't, she wasn't ready for it.
 And it was frustrating because I would see videos of other kids utilizing some of this amazing equipment and just wish that for her she had that opportunity.
 So you know, it was at least five years of us kind of pushing and searching and being very faithful in therapy.
 And then finally, we had the opportunity to trial the Eye Gaze, and I was kinda skeptical, but basically the first time she

tried it, she showed that she could at least utilize it and it was an option for her and it has just opened up a world for her and for our family.
 And so it's amazing to see her growing and like learning a new language and us as a family basically learning a new language.
 So it's definitely taking time and investment, but the reward in seeing her do independent work, independent, even just independent entertainment, she can choose what she wants, tell us and express what she wants, has been incredible.
 And you know, it does take commitment as a family to keep it in front of her and to make it a priority and to train the people that come into her life how to use it and why it's there.
 But it's just made a tremendous impact for our whole family.
 It's made a big difference.

- That's so great to hear and and I'm personally happy to hear you say those things because I am still involved so I have enjoyed working with her as well and you as a family as well.
 What would you say to a therapist who thinking, you know, we can't try anything new or the vision impairment is automatically going to impede now knowing what you know, what would you say?

- I would beg them to become educated and informed that I think for so many of our kids, this is the way the future is going and that to never, to always assume competence and capability and not to assume that they're, that the limitation is too great and that there is, the worst thing you can do is just not give them a chance.
 And that you do feel like, of course everybody has different things they're better at, but as a therapist, if you have students that are primarily non-verbal, especially to learn how to give them this option because it really is, it's life changing for these kids and for their families and that they don't have to be at a certain place in a skill level to learn, you know.
 They can be way down at hardly any intentional communication that you can tell verbally and they can still make great gains and it opens up a whole new world to them.
 So just give it a try and always assume competence.

- Yeah.
 So I'm gonna stop it there.
 We definitely always wanna assume competence.
 I love that she said that.
 And the other thing that I noted that she says and throughout

the interview is that, that she was just looking for an opportunity.

And so, you know, as we are, you know, in my galaxy analogy here, providing opportunities, you know, that, you know, if we're wearing a superhero cape, so to speak, or my Guardians of the Galaxy analogy there, that you know, that's what our cape maybe says, you know, that we're opportunity providers.

And so that we're not perpetuating waiting the idea of someone is not ready and that, you know, we're always assuming competence.

So AAC is only for persons who are non-verbal.

That's a, you know, a myth that I have heard repeatedly and in that interview, I didn't get to show you the whole thing, but she and I talk more about that.

But we know the reality is that even persons with limited or some verbal skills can still benefit from AAC.

You know, and it doesn't stop them from being verbal.

And how do we document this is a question that a a lot of therapists may have because they're thinking, you know, as they should be about funding and what do I write in a funding report if I have someone who's verbal? And we're not talking about a funding if they're unintelligible, 'cause obviously they're verbal and they're just not intelligible.

So of course that's a different, a way to get a device.

But if you're, if you just have limited verbal skills, and maybe I can speak a few words or even a few sentences, but that's all I can say, you have to think how do I document this? So you're thinking about functional communication.

Are those few words functional, you know, are they able to meet all the communication functions, communicative functions? And there's a big list of those that we're gonna look at later with the words that I can say and if not, document that.

Are they able to do more with the device verbally than their verbal speech? And document that, have a comparison in that funding report.

So my case example, and I'll try and give two really quickly, I was working with a very young person, I think four years old, and this child had, was diagnosed with autism and apraxia of speech and only had less than five intelligible words and then was very limited verbally, probably, you know, due to the autism.

So once we got his device, and a year later, he was doing eight word sentences on his device and four words verbally.

So it really was improving his verbal skills and he, you know, he was more advanced with what he could say with the device, but the verbal was still being improved.

And another example I had is a teenager, this is recently, you

know, is a recent user of AAC, had never had a device before, but can sometimes say five word sentences, just he doesn't do it every day and he doesn't do it often and he has autism.
 And so with the device though, he was doing, you know, seven, eight word sentences and putting contractions on things that he could demonstrate even with literacy that he couldn't do verbally.
 So, you know, there are ways of documenting exactly how the AAC is benefiting the person.
 All right, another myth, communication starts with yes and no.
 This I hear a lot and it's really sad that sometimes it comes down to, well they can't answer a yes and no question properly.
 Well, yes and no questions or sometimes even opinion questions, even when you think you are phrasing a yes no question in a way that it's not about an opinion, but it is.
 You know, so again, there's no prerequisites to using AAC.
 Mastery of yes no questions is not expected before moving onto other types of communication and typical development of language.
 So I, when I'm confronted with this, I turn it right back on, you know, the person and say, you know, think about your children and your typically developing child, you know, were you only confronting them with yes no questions at the beginning of their language development? And the answer's always gonna be, no, that's not what you were doing.
 So definitely take a look and think about that.
 This particular picture here represents, it's a veteran that I worked with and he was actually turned away from two, not one, but two clinics because he could not answer yes and no questions after having a brain injury.
 And so two clinics, and one of those was a VA hospital, turned him away from getting an AAC device for that reason.
 And we got him in our program and discovered that he just wanted to talk about what music he wanted to listen to and the food he wanted to eat and the games he wanted to play.
 And so he could use an Eye Gaze device just fine, and you know, did his yes no improve? Maybe, but that shouldn't have held him back from getting or obtaining a device.
 Communication only occurs in the clinic.
 Another myth, and you know, what I'd like to say about this is it happens everywhere.
 Communication happens everywhere.
 So are we really focusing on the E in that SETT framework and thinking about all of the person's environments? This next video is just a quick example from a client that I've worked with in the past, and this is from the Minnesota Technology for Home program and I think actually had this video up but I might have

closed it.
 So we'll start it.
 Let you guys meet Emily.
 Get this queued up.
 Here we go.

- Emily is a beautiful 16 year old girl.
 She's in the high school.
 She is in 10th grade Before Technology for Home, There was no
communication with Emily.
 As a mother, it's very painful not being able to know what your
child wants or needs or, it's just very painful not to ever hear
I love you or goodbye or hello.
 Always been told that Emily would never be able to communicate.
 She's at her baseline.
 She was not gonna make any more progress.
 The speech therapists have always shot my ideas down when I
come back from an assistive technology conference all excited
going to the school, talk to the therapists and they've always
said, no, it's not gonna happen.
 She won't be able to use this technology.

- When I learned about the Technology for Home program, I
started thinking about the people on my caseload and who might
be able to benefit from right away.
 Megan is a good mom and a strong advocate for her daughter.
 And communication has been a struggle for her life.
 Just because Emily hasn't been able to, you know, use words to
communicate, it doesn't mean that she doesn't have the thoughts
and feelings and emotions that she would like to share with her
family.
 And not being an an expert in assistive technology myself, it's
hard to keep up on the advancements.
 The opportunity to bring a consultant into her home who does
know what the current state of assistive technology is to be
able to work with her and see what her needs are and make
recommendations that I was hopeful for them that they would be
able to make a connection and something might work out.

- The day that Emily was able to communicate, I was visiting her
at school.
 I didn't know what I was gonna expect and quite frankly,
neither did the staff or her mom.
 We're all holding out hope.

We set up a communication device for her that uses her eyes to operate it.
And so it's a technology called Eye Gaze.
And on the screen, there was a whiteboard and on the bottom, all the colors, very tiny colors to get to.
And we hadn't calibrated her to the device.
And that means the device wasn't really paired or hadn't learned enough about Emily's eyes for it to be perfect, yet she was able to get every single one of those colors.
And she was determined and she did it.
And so we're having natural conversation with her and that was wonderful.

- I went into the room right at an amazing time.
So they had put up a program, it was a paint program, and they told Emily to choose a color and she chose it and she colored with it.
Everyone in the room was tearing up, goosebumps, because Emily, for the first time in her life, communicated.
She was able to communicate in a way that wasn't crying, body language.
She was communicating with her eyes.
It was phenomenal.
It was an absolutely amazing experience.

- So after Emily showed us everything she could do, the fun didn't stop there.
The teachers ran down the hall, they got her favorite things, they ran back, and we quickly took a picture of all her favorite things and put them on the screen.
Then, using that same technology, she was able to choose her next activity with her eyes and didn't do so just one time or in a sequential row of activities.
She chose everything she wanted.
It was her time, her desire, and it was communication.
It was beautiful.

- Emily is lucky to have people like Technology for Home that realize her need and do what they can to meet that need for her to go above and beyond to get her this Eye Gaze computer so she can learn communication.
As she gets older, people are telling us, well this isn't a reality, you know, she's not gonna communicate beyond this.
And Technology for Home came in and said, we're gonna make this

happen.
 She can communicate.

- So I'm gonna stop that video there, you know, and we don't all
have the opportunity, you know, to go into the home like that
particular program was able to go into her home.
 But I wanted to share this with you because if you're really
looking at, you know, the E in that SETT, the environment,
you're going to ask all of the right questions maybe to get that
information.
 And you know, we commonly, this particular myth, I'm referring
to the comments that we get.
 Sometimes you're on a team and you know, one person,
particularly the family or the parent may say, well they're
doing this but no one else on the team, you know, has seen it.
 So encourage that parent, you know, recognize that it doesn't
always happen in your clinic, in your therapy room.
 So you know, ask the parent, are you comfortable sending in a
video? Can you explain more about, you know, what's happening
during those times of communication and then moving on from
there, start where the person is.
 So communication devices can only be activated with the hands
is another myth.
 Some alternate access methods are, you know, switch scanning.
 And remember a switch does not need to be operated with your
hands.
 Think about the whole body as placement for that switch.
 Head tracking, Eye Gaze with a switch, or just Eye Gaze.
 EMG signal, partner assisted scanning, that's very low tech
even.
 You can use it with hi-tech or low tech.
 But partner assisted scanning, that's really starting at a
level where they are for someone who's medically complex.
 Keep that in mind.
 If a person is mobile, they do not qualify for an AAC device.
 This is another myth, believe it or not, that I would hear all
the time.
 But mobility, the reality is mobility has no impact on the need
to use an AAC device.
 And the decision to fund an AAC device is made on a person's
inability to be understood and their communication level, not
their mobility level.
 So what does mobility actually affect? It directly affects how
a person will transport their device.
 So it has a direct correlation to the accessories that they
will need when you're writing up your evaluation funding report.

So will they need a mount or a carrying case or a key guard? But it doesn't impact the need to use a device.
 If a person can use their hands, they only qualify for a touch device.
 And that's a myth.
 The reality is that the AAC evaluation is a snapshot in time.
 And so you have to ask yourself about the functional use of their hands, okay? How functional is it for all day everyday use? There shouldn't be a time when you're doing an evaluation that you're considering that they're gonna shut their voice off because you and I don't put our voices away, right? So if that person experiences extreme fatigue or a muscle changes throughout the, you know, the day of their function level, you know, if they can't coordinate their movement, then they may not have functional use for the purpose of a communication device through touch.
 And some, I've listed here some disorders that may, you know, kind of fall in line with this example.
 CP, spinal muscular atrophy, ALS, MS.
 You know, I've actually had quite a few patients even with ALS that were turned away from clinics with no device and you know, being told no because you know, you're not ready for a certain type of device because you can still use your hands.
 But what they weren't considering is the functional use.
 When you're writing an AAC report, you cannot write about progression as far as you can't comment that the person can, you know, touch now, but we know they're gonna lose their ability to touch in the near future.
 And so they deserve this type of device.
 So that you can't do, you can't write that in a funding report.
 But what you can document is, and you can only do this if you've asked all the right questions about their daily function, you can write about whether or not that the use of their hands is functional, and if you, you know, can determine that they don't have functional use of their hands every day, maybe mornings are best, but by the afternoon they don't, then getting them a touch device would be a disservice to them.
 It's kind of like you telling them, you have to put your voice on the shelf.
 So that's just something to remember when we're doing evaluations.
 So another myth, an literate adult cannot use an AAC device.
 And I put adult in here because when we are working with children, a lot of times, they are not literate yet, but we get them devices, right? So why would that be any different for an adult? And believe you, believe it or not, I have worked with adults who were turned away from assistive technology clinics

without a device because they were illiterate, or away from a therapist.
 And the reality is that literacy has no effect on a person's ability to use low-tech or a hi-tech device.
 And what you have to do is find a simple system that the AAC user is comfortable with and that's what's key when you're working with someone who's literate.
 So a case example, I was working with an adult with ALS who was illiterate and had been told that he could not get an AAC evaluation and we through the ALS association was able to give him a a loaner device and he was so happy and he just needed photographic symbols.
 And photographic symbols are just photos, right? And so he was able to communicate with those and right away communicate with his nurse and his caregiver about the things that he needed in the home.
 And that was wonderful.
 Another example, I was working with a business tycoon.
 I mean he was a CEO of a company and no one, maybe some of his own family members didn't know that he was illiterate.
 And so he also had been turned away from a clinic with no device and pictographic symbols happened to work for him.
 But try different things.
 Visual scene displays may actually help a person who's illiterate as well.
 Okay, so we're gonna get into myths versus realities in AAC treatment experiences and case examples.
 I'll try and leave enough time for questions 'cause I see we do have some.
 All right, getting an AAC device will solve all communication breakdowns.
 We know that that's not true.
 And I have linked another article from Tobii Dynavox that I like that nicely kind of gives you some talking points on that.
 But the bottom line is the reality is it's not gonna solve every communication breakdown.
 And that's why you should have multi modes of communicating and be working on conversation repair strategies with those who can and do that.
 Or if they, you know, have a lower cognition and where they're not at the cognitive level of working on a conversational repair strategy, then you're working with the team of people who are their communication partners and you're working with them on their ability to circumvent these conversational breakdowns, whether that be a mixture of low tech and hi-tech or other tools, but that's what you do.
 So another myth is only the AAC user needs device training and

that's just not true.
 Everyone on the support team for the student or persons needs training.
 So once that device comes back, what I like to do is I like to start training the parents or the family or the caregiver right alongside that person.
 And so even those who are tech savvy need training.
 And I'll say the flip side of that, even those who aren't tech savvy, they definitely need the training.
 So definitely keep going with that because that's gonna help you avoid device abandonment as well.
 Labeling equals communication.
 This is a pet peeve of mine and it's so easy to fall into as a therapist because we are used to what? Taking data, right? But when you ask find the, show me the, look, look at the, touch the, those are labeling, right? That's a task for testing.
 It's not communication.
 And the communication communicative functions.
 And I love this partner strategies booklet, it's from a clinic in Canada, but I just like some of the things that they had in their booklet here, and I put the link for you guys.
 But here are, you know, those communicative functions, and this is what we should be working on in modeling, right? And instead of testing, you model the language and you use it in real time in a real activity.
 And that's how an AAC, you know, user learns.
 Okay, so another one, a myth is communication is stationary.
 So a lot of times, we might fall into the habit of having our communicator only be communicating while at the therapy table or at a desk or while seated.
 And for those kiddos and clients who are mobile, sometimes it's best to get them up and out of the table and doing something if you can.
 When you're working with children, play during therapy is great.
 If you are working with a multidisciplinary team, if you can piggy back into OT or into physical therapy, you're gonna get a lot more communication or a different types of communication out of that child than in your therapy room alone.
 So think about how much communication happens when a typically developing child is on the move and on the go and start there if you're not as successful while seated, you know, at the therapy table.
 The client has to be a hundred percent accurate at using the trial device before submitting for funding or while using the device in treatment.
 This myth comes from that data, data, data, data, data that we

all have had driven into our heads.
 The reality is the act of communicating, it's not something
that you need to be collecting right versus wrong.
 You need to be taking data on whether they are reaching those
communicative functions, not, so if you have communication
screen up and let's say you have an art page on your device and
the child chooses paints but you are coloring, you know, and you
wanna say, okay, do you want more crayons? And you are hoping
that they choose more crayons or you've modeled more crayons,
and they choose paints.
 Sometimes with this myth, the inclination is to say, no, you're
wrong, that's not the word we're looking for.
 But that's not what you do in that moment.
 You just keep it going naturally and model naturally what you
want them to say or do and you respond naturally.
 So they chose paint.
 So you say, oh, but we're not painting right now, but I do have
crayons.
 And then maybe you touch crayons to give them that model.
 So here is a question I want you to think about.
 You know, what type of data do you collect? Think about how
you've written your goals or that treatment plan and what am I
really trying to gain improvement with the communicative
functions or am I gaining right versus wrong labeling task or
cognitive cognition type of task, because that's not
communication.
 Here is a quick example of this, and this is from Tobii
Dynavox.
 So thank you for the video.
 We'll just play a little bit of it.

- [Narrator] We need to stir it.

- You're right, go ahead and stir it.

- Would you sit down and do that?

- Yeah.

- Go ahead.
 Use your spoon.
 Good Easter.
 Here you go.

Can I help you? Can I help you?

- Yeah.

- [Cameraman] Now it smells good.

- Yeah.

- [Cameraman] I can hear the sizzle.

- Okay, put your hand up.
 Here you go.

- [Cameraman] Nice.
 You're doing it.

- Good job, Will.
 Is that good?

- Pizza.

- Maybe pizza on Sunday?

- Part of this?

- Yeah.
 So we'll, I mean I think the theme would be just setting this
up as you're doing something with him and just-

- [Cameraman] You wanna taste it already.

- Yeah.

- I know what you mean.
 When you're so hungry.
 But I think it's probably not gonna taste very good when it's
frozen.

- Taste it.
 We gotta wait until it's cooked, buddy.
 Yeah?

- Yeah.

- [Narrator] This is hard.

- [Cameraman] Waiting is hard.

- Waiting is always hard.
 It's hard for me.

- So I'm gonna stop it there.
 I love it.
 What they did, when he was stirring the food, he said the word
pizza, but he's not, they're not cooking at pizza right now,
right? And so naturally, they said, oh, we're gonna have pizza
on this day.
 And so they were just responding naturally and then when it
came to the device, he did the same thing.
 They just put it on the stove, it's still sort of frozen in the
pot and he says, taste it.
 And then, you know, and so naturally, they just, you know,
talked to him about waiting and I loved how she modeled.
 It's so hard to wait, isn't it? So that's exactly what we have
to do instead of focusing on labeling and getting nouns and
things a hundred percent correct.
 We really have to, I feel, shift the focus there and think
about the type of data we're collecting.
 All right, so here's my analogy about I am Groot.
 So Guardians of the Galaxy, if you're not a superhero fan, I'm
sorry, but Groot is a lovable character, especially the baby
Groot in that video or movie series.
 And he can only say three words, his "I am Groot".
 And so they're always trying to figure out what he's saying.
 And so what's the comparison with AAC use? Sometimes, we can
get stuck in I am Groot behavior, and I'm gonna give one quick
example.
 Sometimes, or two different examples of this.
 Sometimes, we can get stuck with our routine of therapy and
maybe you, working with children of different levels in a group

and you, you know, let's say you're gonna do a welcome and everyone does a greeting as they're coming to the therapy session, and one student can already greet.

So, but everyone else may be still working on pushing the greeting, hello.

And this student is still expected to push hello, but they've already mastered that.

So think about something else to expand their language.

What's the next possible step in their greeting while maybe greeting someone by name or their group members by name.

Another example I can give is not accepting all modes of communication.

So if a child has a gesture, let's say they have a gesture for more and you, on the device, have more and some snack options, and so they say, they sign more and then you say, oh, but say it on a here, say it on your device.

Well that is very frustrating, you know? That's, the child's gonna feel like Groot.

I am Groot, I am Groot, I am Groot, over and over again.

More, I've already said it, you know? So what can you do instead? Model.

So accept what they said.

They signed more and you say with the the device, oh, you told me more.

Great! More what? Hmm, more drink? You know? And so, and just keep modeling and keep expanding on their ability, accept all modes of communication.

So ways to avoid I am Groot behavior, progress them on to next steps, expand that language.

Acknowledge when AAC is used no matter what modality.

Expand on what they say.

If they say one word, you model two.

If they say three words, you model four on the device.

Praising the AAC user appropriately.

And so our last myth, any potential AAC user can get the AAC resources they need whenever they see a school-based therapist or go to an outpatient clinic.

Unfortunately, that's a myth.

AAC myths that we've discussed today, the sad reality is that they directly correlate persons with limited to no communication today in 2021 still not getting the appropriate help that they need when they need it when it comes to AAC.

And another reason why that's a sad reality is cultural bias and discrimination still in 2021 still affects a person's ability to gain the appropriate help with AAC when they need it.

And so what can we do about it? Well we can dispel, start by dispelling myths in her own practice.

You know, think, you know, am I caught in this rut? And snap out of it.
Speak up and educate others.
And if you haven't checked out That's Unheard Of by ASHA, please do.
It's a good website, great resource.
This "Culture Covers More Than You Think" actually links to one resource on that website.
And I just wanna read from these fact cards that, you know, cultural competence encompasses knowledge and understanding of any number of dimensions of diversity.
And what's one of those things? Disability.
And our AAC users and potential users are often misunderstood and some of these myths might be holding them back.
So that is it.
Those are some resources for you guys from this presentation and I thank you for joining and here is my contact information and I'm going to now take a look at the questions and see what was there.
Okay, so someone asked me if they, they have had the struggle with vision therapist, do you have any articles that have been successful in communicating this vision therapist? So I must say, even the family that I interviewed, the mother that I interviewed, CVI is a big misconception that they cannot use devices and that's just one vision disorder, but it just stuck out in my mind.
And so a lot of times what I do is I will work with the vision therapist.
I will, actually, when, if it's an Eye Gaze student, I will do something like gaze viewer and record and heat map their gaze and play it back for the vision therapist and really try and get them on my team by working with them in a partnership.
So I hope that kind of answers.
Renee, please email me and I can see if I can share any other article with you.
Okay, Tori said she's a school-based therapist, often sees PEX used in the classroom.
Assuming PEX versus AAC devices are considered due to cost and funding of an AAC device, how do you determine through evaluations if a PEX or an AAC device is the most appropriate means of functional communication for a student in the schools? So for one thing Tony, and I might have said your name, that's Tony, for one thing, Tony, I do go ahead and check, well our district, we do some funding reports for AAC devices in our district.
So we're always looking at both of those options.
So not all districts have someone in the district who is

actually writing funding reports and seeking devices that way.
 So that does make a, you know, a difference.
 What I say is if a child is really, really successful,
sometimes success equals that they're ready for the next level
of communication.
 And we know that PEX is a great tool, great low tech tool, but
it doesn't allow them to say everything they wanna say when they
wanna say it.
 And that should be the measure of looking at functional
communication devices.
 So I hope that that sort of answers your question.
 Heather, and Tony, if it didn't answer it enough, please email
me.
 Heather Hart, we've been able to get a device for a autistic
student.
 He's telling me things like food and his, in your opinion, he
should be offered a snack but the teacher will state he isn't
hungry.
 He pushed it three times before lunch and I feel we give him
what he requests the teacher if feels he is task avoiding.
 As an OTSA, we give him what he asks for.
 Am I wrong? He's still learning to use this device.
 So two quick thoughts on that and then Heather, please do email
me if I don't cover it all.
 But I would say that if you can, with an autistic student, so
when they're asking for something, it doesn't mean that, you
know, they need to get a big meal.
 So if it is allowable to give him a, you know, some snack,
maybe two or three little pieces, then that's okay to
incorporate.
 But if it isn't allowable and it really is not, it's
instruction time and not snack time, then you might also, with
the device, wanna build on a routine, a behavior support within
the device if that's helpful.
 And depending on the type of device that you're using, there
might even be built in behavioral supports.
 So it's okay to also teach them at the same time that what they
ask for isn't available, you know, and going back to their
visual schedule and looking at, well, answering the question of
when they are going to be able to have, you know, that time to
eat.
 So it's a very thin line, I think, of a balance of when to do
which, but I would maybe even try both ways of approaching it
and see which one gets you the desired behavior.
 Hopefully that answered your question.
 Okay.
 And I don't know how long I'm able to go with these, but we've

gotten two more, and Heather, I will respond.

Oh, thank you Heather.

Okay Sarah, I have students that transitioned out from the adult living skills program and they have to return the district owned device when they age out.

We've attempted to have the regional center to conduct evaluations when they transition out, but lately, the comments from the regional center will say, "Won't pictures suffice" to avoid assessment.

Oh, that's so sad.

But these students have devices for all their other, their school careers.

Any suggestions? So I would say, I would answer to them, no, pictures don't suffice.

I would give them reasons why low tech tools don't allow them to say everything that they wanna say when they wanna say it.

You know, in this case, for loan term device users, pictures are a backup method but not the method, and that funding report you have to kind of state when you're going for a hi-tech device, in the funding report, you state why low tech devices don't work.

I would feed that information to them.

I would also, I was, I kinda lost my train of thought there, there was another point I was gonna make, Sarah, but please email me for more comments on that, 'cause I think I do have more ideas, but I think maybe even getting VOC involved, VOC rehab involved if that's possible.

Usually around transition age, teenage age, you have to check with your state's VOC rehab program to determine at what age they can start but it's well before they graduate and they can perhaps even get equipment that way, or looking at providing the parents and families with other resources to get equipment maybe going through your, take a look at getting some education through the state program for the regional center.

That might help.

So those are just a few ideas, hopefully that was helpful.

Thank you all for coming.

Please, please do email me if you have any more questions.

- [Moderator] Rachell, we do have one question in the chat.

They're asking if you have any favorite Eye Gaze activities.

- Oh yes, I have lots of favorite Eye Gaze activities, but if you are looking for free ones, check out, Tobii Dynavox actually has a free part of their website called Eye Gaze Games where

they have links to other games, and one link is the Chrome Music Lab.
 And so that could be a fun, engaging way to work with Eye Gaze.
 I also love books.
 A lot of students just love to read.
 So some programs.
 So Tar Hill Reader, again, free access to books that they can turn the page themselves with their eyes.
 So that's fun.
 But cost programs, I do a lot with Sensory Guru, IFX, also Magic Eye, and Look to Read.
 So Smart Box has some programs out there, Look to read, Look to Learn are some programs.
 And then Board Makers, Tobii Dynavox Boardmaker Reading Avenue and some of their virtual field trips or book expeditions, or education expeditions are fun if you have a Board Maker account.
 So all of those things are Eye Gaze accessible.
 and Ginger Tiger is, you can Google that company, it's a subscription based, but they have a Eye Gaze button that you push and it just, it will take out every activity that isn't Eye Gaze accessible and only have the Eye Gaze ones.
 You can use Ginger Tiger with switch.
 Kids who are operating a computer with a switch, Eye Gaze, or by touch.
 So that's a good subscription to have 'cause it's probably gonna meet the needs of most of your users.
 Oh yes, Help Kids Learn.
 I love Help Kids Learn.
 Yes, thank you Lori for mentioning that.

- [Moderator] All right, that looks like about it.
 Thank you so much Rachell for all of the wonderful information and I hope everyone has enjoyed the presentation.
 That'll be the end of the presentation for today.
 Thank you.

- Thank you.