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Health Access for Independent Living (HAIL). Presenters – Researchers: Jean Ann Summers, PhD, Dot Nary, PhD, and Aruna Subramaniam, MS. Participant in the research project: Mary Herrick. Scientific and Consumer Advisory Panel Member: Jamie Lloyd Simpson.

**Jean Ann Summers:** Thank you, everybody. Glad you are here, appreciate your coming. I wanted to just begin by saying a little bit about what Val and Martha were saying earlier. We moved from, in this grant, from exploration to intervention development in the mid-year of our five-year cycle, we finished our secondary analysis projects and then moved into intervention. I think, to me, this is the important part of it; I wanted to say this is where the rubber hits the road. This is where we start to answer the “So what?” question. What is it all about? What is it that we can do for people with disabilities and consumers who, that we're serving. So the intervention development process to me is very important because it involves taking your idea about what an intervention is and trying it out and then trying it out again and again and again until you get a product that you can really say, “This one works.” So I want to report today on one that has been through only its first iteration, so we are, we are in mid development, but I want to show you and talk about what that's about.

I want to first start, this is an evolution from the original project that was written by Amanda Reichard, who is here. And Megan O'Brien then became the next director of this project after Amanda took a job and New Hampshire stole her from us at KU. So we had that. And then, so Dot and I became co-investigators of this project and have been working on moving it from the evolution that was necessary due to some changes in the policy environment and the way that independent living centers function. So we had to really think about how to redefine this intervention to fit the current realities of the world.

So, I'm introducing Dot, who's been around awhile and I know many of you know her. And then we have also on our team Aruna Subramaniam; she is our project coordinator, and the person who works directly with our independent living team.

And Alice Zhang, back there, she's our queen of the database and she knows how to do all of that stuff that makes the content real.

So and then on our panel we have Mary Herrick, who is an independent living specialist from Three Rivers Independent Living Center at Wamego, Kansas. So she represents a rural center and one that was, we have partnered with in the past on other projects and really appreciated that they are willing to be our participant and co-developer of the project.

That's why we really always, and I really appreciate this format that Martha and Val put together, because they really are co-researchers in many ways because we really depend on them to say, "Okay here's what we sat back in our rocking chairs and drew up as a blueprint for this intervention. Now how does it work?" They get to tell us how it works and how it doesn't work.

Then we have Jamie Simpson, who is another member of our scientific consumer and advisory panel. Jamie has been with us for many years in different capacities and so I always appreciate her point of view. In particular, she has recently been working with this Kansas Department of Health. So you know she has a good perspective about health and health issues, so we wanted her to be on our panel.

**Dot Nary:** So, why do we need HAIL? I think we're all familiar in this room with why we need it, but let's review. People with disabilities face significant health disparities due to barriers. I would say barriers to health not just healthcare. We're not just looking at what happens in the doctor's office. We're looking at what happens in the community when people need to promote and preserve their health just like everybody else. We know that people with physical disabilities – and other disabilities but we're focusing on physical disabilities in this iteration – have secondary conditions that may limit their health. So, we're really looking at translating medical recommendations into practice in real-life settings. What happens when you leave the doctor's office? How do we move in the right direction – and I'll echo John Tschida in this – move in the right direction on the health and wellness continuum? I remember being in a session years ago when somebody said, "You know, anyone can improve their health. Anyone can move on that continuum." So somebody brought it up, "What about someone who is a really high quad, who can't move any of their limbs?" And she said, "Well, one of the things they can do is, when they're lying down, they can put some books on their chest and practice deep breathing." This could prevent pneumonia in a situation. Everyone can do something to improve their health. But, we've got to relay that not just to the medical community but to people with disabilities. You know, we go into settings and we deal with a doctor who says, "Well, what can you do for exercise if you're in a wheelchair?" That's got to change. But the person with a disability has to be the one to look around and find things that they can do and maybe educate their doctor. We have providers who really don't understand the transportation barriers that people face. "Oh, we've got an opening tomorrow, can you come in?" "I've got to set up transportation. I probably can't do that. Do you have something later in the week?"

So we have people who need to learn how to work the system to their benefit and how to learn to do that from a program like this that can help them deal with some of those issues. So, our goals, are both for the consumers and for the independent living staff. My background is in independent living and I was thrilled to find a research setting where I could come and start to generate knowledge to improve what people can do in independent living to help themselves and to help consumers.

So for consumers, the goals are to learn to recognize and address secondary health conditions. To develop skills to learn to be empowered healthcare consumers, which I think is even more important for people with disabilities. And to set and achieve short-term health-related goals. Conversely, for staff at independent living centers, it is to assist consumers to be healthier by

addressing secondary conditions. To empower consumers to understand and exercise their rights to access healthcare facilities and services. And also to help consumers gain knowledge and take action to address their healthcare needs. And let's not pretend that there are not still significant barriers just in the medical setting, like when you go in to have a scan and the person doing it says, "You'll be able to get up on the table yourself, right?" How do I know? Is the table low enough? Will I be safe? I may need help." That still happens. I think we all can acknowledge that that happens regularly. It's got to change. For now, the consumer has to have the self-awareness and the assertiveness to say, "I don't know. You may need to get some help. How high is the table?" and put it back on the medical professional. But that can be hard to do when you're the patient.

Our goal has been to partner with independent living centers because IL philosophy supports building consumer self-direction in managing health as well as in many other areas, and also that consumers tend to trust CIL staff members to help them remain independent in the community. A couple years ago I read an article in the *New York Times* about community health workers. These were people of minority backgrounds working in the inner city who dealt with some of the same issues that the local people did. I can see CIL staff as community health workers who help people with disabilities negotiate the healthcare system. This ends when you leave the medical system and go out into the community to figure out "How am I going to stay healthy to promote my own health, to deal with barriers, to deal with the lack of awareness that people with disabilities can be healthy?" So I see this as that essential step in translating the medical information and recommendations into real life settings.

**Jean Ann:** I want to talk first about what the content of our intervention is and then what the process of it is. And beginning with thinking about what our secondary conditions and what will we address, when we began to reorganize this project after Amanda left and then Megan left we presented a plan for reorganization to Pimjai. And Pimjai in her wisdom suggested that we do a needs assessment first sort of like... so, we did. We put together a national needs assessment of centers for independent living. We wanted to find out what were their most frequently reported secondary conditions and what were their barriers to accessing healthcare needs.

We sent the survey out to more than a hundred centers and got back quite a few responses. The results were that our top three secondary conditions were chronic pain associated with disability, depression and fatigue. And coincidentally, Dr. Ravesloot, Craig back there, had recently also done a national survey where those came out to be the top three types of secondary conditions. So, we were all gratified and we had a big celebration in Houston around that idea that oh, it was kind of a relief to us, because here we were thinking we were going to have to create a database focused on tons of different secondary conditions or other chronic parallel conditions that we didn't, I mean it was going to take a hundred years to put just the data base together.

Now we had a blueprint and a way to go forward, so creating a database with information for consumers with physical disabilities about pain, depression and fatigue became our next step. And also on the issues of consumer skills that Dot was just talking about, we begin to look at things. Because the question here, in terms of the content, was about how do we distill down, because there's tons of information out there about different skills. For example, the Centers for

Disease Control website has a million different tips and things for consumers or patients to use in thinking about a checklist for how you put together questions for your doctor, a whole lot of really, really informative pieces of information. But our job was to distill that down and we began to find out as we looked across all those sources that there were commonalities in the recommendations.

So we began to put together a series of fact sheets about consumer skills that sort of synthesized all that information. So a lot of this is really about what we all need, but the point was tailoring it to people with physical disabilities. So, we have a lot of fact sheets that we created and it is also available on our website.

The steps in implementing HAIL – that is the content. We have the process that we need to do, which is the steps that the independent living specialist will use to translate that information or figure out what pieces of that information are relevant to his or her consumers. So we have -- we were trying to set out, I say we are trying, which means that we're still working on this, it's all a work in progress, to create the steps here. One is to begin thinking about how do we identify or prioritize what needs, what health needs the consumer wants to work on, and then move to finding the resources that can help inform the consumer and figure out what strategies or approaches they'd like to take to address those needs. And then to create and pursue some short-term goals.

**Dot:** I just wanted to add, too, this project started when Dr. Reichard co-authored a study in Kansas finding out that people in independent living centers were interested in assisting consumers to promote their health, but they really didn't have a way to do that. They didn't have the steps. Our needs assessment echoed that independent living center staff responded that, "Yeah, we know it's an issue we would like to help but we don't really have a way to do that." So our goal was to help find a way to do that.

So the first steps were to identify health needs. Does the consumer have a secondary condition he or she is concerned about? What skills would help them to be healthier long term? So, you know some of this is to work with a person to impress on them that you don't necessarily have to be unhealthy when you have a disability. No, you have a medical condition that can be treated and you deserve treatment for it. So it's looking at things through the lens of health promotion and the goal of being healthier. For some people it might be, I don't really feel I can communicate with my doctor well, my visits don't go well.

Or it might be, you know I'm taking a lot of different medications prescribed by a couple of different doctors through two different pharmacies. Polypharmacy is a huge issue for people, for many people with disabilities, so one of our skill fact sheets is on managing your medications. But maybe these concepts haven't been introduced before and they can really help people to start to get those issues under control. So again the first one is to identify health needs and skills that you might need.

The next one is to find resources. And as Jean Ann mentioned, we polled resources for – not just disability-specific resources, but general resources – that would be applicable and then we compiled them into a database. We looked for the most reliable and evidence-based, and we

came up with our website. So we looked for evidence-based resources that were consumer friendly and for what we felt were the most important topics and skills we compiled fact sheets. We probably will have more to come.

This is the opening website, the opening web page when a person goes to the site. We emphasize that we encourage consumers to do as much as they can but always with whatever support they need from the IL staff. So that's an important component. The goal is for the person at the end of at least one or two trials to be able to do this independently, but they will always have support should they need it. And then the next page is navigating the website. So it gives them instructions on how to use the website, how to find resources, entering a disability, identifying skills that the person might want to learn or a secondary condition that they are particularly concerned about. That will produce a set of resources.

So the short-term goals will help the person experience some success early on. So they're small goals but they can achieve something and feel "This system might really work for me." And maybe tracking is the hardest part and Mary might talk a little bit about that. But having people document things and keep a calendar of the success that they are having. But again, this is about moving from the idea stage to concrete steps. Some example goals that participants set were: outcome goals were to address pain, reduce the amount of pain medication they take, to lose weight, to increase mobility, and some of the process goals were maybe to exercise, to cut back on how much soda they drink, maybe to use a walker for more mobility. And again, CIL staff are likely to know "Where can I go in the community to exercise that might be accessible? Where can I find a walker? Where can I borrow one or get a loaner to try it out?" So again, CIL staff are integral in helping people achieve these steps and get started on them.

**Jean Ann:** Let me just say, I think one of the things that we want to continue to emphasize with this process is the idea of a short-term goal. So you may have a long-term goal to reduce pain and to get off of pain medication. But that's going to be something that will take many months to do. So what we wanted to do in the meantime is achieve short-term goals such as going to a yoga class, exercising, getting yourself able to stand, you know, those kind of things so that people start to feel good about themselves and feel like, "Oh boy!" and then can just continue to work on their goals. So, our next step is to revise this based on the results. We want to keep adding more resources and tools. And test with another CIL. And then repeat. So I'm figuring, in the coming year we will have at least opportunities to do this with at least two more CILs, centers for independent living, and move forward. So, now I'm going to ask Mary, who was one of our independent living research partners, to talk about what happened.

**Mary Herrick:** So, we had a meeting at Three Rivers, that's the company I work for. They basically gave us the same PowerPoint as what you guys just saw. Because I didn't know anything about this program. I was fairly new to Three Rivers because basically I'm a nurse and went into an ILS situation. And I didn't know a whole lot about computers, I knew a little bit because of my degree but I hate computers. Here they were, "Would you be willing to try to do this computer [program] with your consumer?" And I said, okay. I had just started working with my consumer. My consumer is a retired veteran. He had sustained traumatic brain injury and he also had broken his back when he was in Iraq, so he had lower back pain and was always missing

his appointments. So that's why he got involved with the Wounded Warrior Project. And we were working on goals. But his goals were more focused on his family. What can we do to make our family unit stronger? That sort of thing. And the program that they introduced to me was, what can he do to improve his life? Oh, this is a whole new thing, all right. So, I asked my consumer what do you think about this program? "Oh, whatever." Well, come on, we can at least set a goal. What would you like to see happen with your life? "Well, I take a lot of pain medications because the VA gives me a lot of pain medications for my lower back pain. But they are kind of weaning me off of it because I smoke marijuana at night because that works better."

Well, this is good goal. So what we did was, we got online and I had him go through it with me. So we got on the HAIL program, we did our finding our resources, and then we went under the physical disability and there were several listed under physical disability. There wasn't anything for lower back pain but we chose spinal cord injury. And then from there we went to our secondary, which was the pain. And from there, we found the physical therapy, exercise, meditation, and then right under there it said yoga. And he said, "I've always wanted to do that."

Great, let's see if we can contact Heather, his case worker for the Wounded Warrior project and see if they would help you get involved in these programs. Well we did, we did ask her and she thought that might be a good idea. So she was able to get him six months into this, with a gym membership and two days with a trainer. And I suggested, "Why don't you pay for a third day?" Because then that makes him responsible and accountable for that program. And then also we looked into a yoga class. There's different types of yoga -- you have your strengthening yoga, your power yoga. We needed to find a gentle yoga class that was more for people with knee injuries and knee surgery, hip surgery that sort of thing, so they're recovering, because that's what he needed to be in because his range of motion was very low. That being said, he was very skeptical. And I was like, "Come on, we can do this!" And he started out with his gym membership. We got online again because it said exercise and strength training. Well, it took us to another website, which Jean Ann had added links, and what they did was we found Web M.D. and it said strengthening for your back muscles.

So we printed off that page where it specifically targeted those back muscles and we took it to the trainer. And the trainer actually started working with Jonathan on strengthening his back. About three months after starting this regimen, Jonathan just happened to say to me, "You know, I notice that I'm walking straighter." Yes, because Jonathan was a little hunched over because of his back pain. And he said "Oh, by the way I haven't used marijuana in a couple months." What?! I mean, I see him every other day, now you are just telling me it's been a couple months and you are not using this.

Then he said "I have a VA appointment, I'd like for you to come with me." I said okay, because we also work on PTSD. So I went with him and he saw his primary care physician at the VA. The VA, as I mentioned, took him off of some of his pain medication because they are not going to give him that and allow him to use marijuana. And so they gave him a UA and it came back clean. He said, "Wow, great, we can give you more medications." And we both went "No no no!"

We don't want you to do that. We want to know what we can do more for him to be less medication and a stronger back.”

And so, we told the physician, what we were doing with the exercising and training and yoga and he said, “We're just starting classes on that right now.” Awesome. That's what we're doing already. And so, Jonathan, that's what I'm going to call him, he started doing the squatting with the muscles like this (*holds hands over shoulders as if pressing a weight bar*). When he first started, he was weightlifting about 125 pounds. That's not necessarily a lot for a guy. It is for me, because I – I can't imagine. But for a guy, that's what he started out doing. Because he was in his 30s he thought, “Oh I can start doing this.” Last week he told me that he's squatting 310 pounds. That's his lower back muscles have increased that much.

He used to be able to get in and out of my vehicle, and make that “Oh OW!” He just hops right out of the vehicle. He doesn't even make any sound at all. That's the change in what we saw. And I didn't even know about this project. I have another client, when the women asked me if we would do this, I hadn't started working with her yet. She had just gotten out of a nursing home, her daughter took her out of this nursing home and brought her home. She was attacked by her, ex-husband now, but it was her husband. He took a hammer and hit her in the back of the head about seven or eight times and left her for dead. Locked the door and walked out. When they found her, the hospital put her in an induced coma to let the brain swelling go down.

But during that healing process, she had received a stroke on her left side. So, when I met her, she was in a wheelchair, of course. And left-sided weakness. But she spoke very well. And I thought, oh my gosh, how am I going to help this woman? I'm fairly new to this. And asking her what her goals are, it almost made me feel, I don't know if we can even do this. So, imagine how she felt? So, I said, “I'm part of this program with this HAIL project.” I had my laptop and we plugged it in. And I showed her and I said, “Here's the spinal cord injuries, what do you think we could do to help you with your goals?” And she said, “Well, eventually, I'd like to take a few steps.” Okay. Well, let's see what we can do to make that happen. So, we did basically what I did with Jonathan, we went through the website, found the resources, spinal cord injury, exercises. “Oh, wait, this is physical therapy and exercises. Maybe we need to hook up with your physical therapist.”

She hadn't gotten one yet because she was new to the area. So the physical therapist and I got together and with my client, we're going to start moving her legs a little bit more. “Can you move? Put your leg up?” Those types of exercises to strengthen your leg muscles and your arm muscles. So we started working out. She saw the therapist once a week, and I saw her twice a week. After... I was working with Aruna at the same time because she would call me and say, “How is your client doing? Have you set any goals?” I said “Well, she wants to take a few steps and this is what we're doing to get to that point.”

And I saw her on a Monday morning. And always my cheery little self, “Hey, how's it going? Have you done your exercises?” She said “Yes, you want to see what I'm doing?” Sure. She put her hands on her table and went like this (*stands up*). I went, “What?? Are you holding out on me?” She had been exercising so much, that she was able to strengthen her right leg muscle to

compensate for her left leg muscles. She was also working left leg muscles. She was actually able to get her leg muscles to start a little bit of that, you know momentum, even though she had the left-sided weakness. It was amazing.

That's what, so far that's what we've accomplished. And it's just two people. And the girls, after I finished with Aruna, she said, "Okay well we're now completing our -- what else would you suggest us to do?" Well, I think that because your program is so new and you're working with a generalized age group, what if, we're all getting older why don't you focus on an older age group, those of us who are going to be retiring in 20 years. Maybe do something for just the older people.

But I was talking to this lovely lady this morning and she said, "Well, how are we going to put this information out?" And I thought, wouldn't it be great if you could put yourself on Facebook and do some mainstream media? So, I thought, well, while I'm thinking about it I'll mention that, because I also have TBI, I've had it ever since I was a child. A very, very small child, so I don't ever have a memory, where I have short-term memory, I've never had it, I've had to over compensate and learn a different way. That's pretty much what's girls wanted me to mention. I thank you all for giving me this opportunity to be here. It's amazing.

[Applause]

**Jean Ann:** Let me introduce Jamie Simpson, who is our SCAP member. She will give us a more broad picture, ideas, thoughts, reactions.

**Jamie Simpson:** Sure. My first reaction is to Mary, her stories. Those two individuals who are now on this path to wellness and not just having something fixed where they might encounter that in a medical model home. Now they have the resources, the tools and this push start momentum to really take control of their own health and well-being. This would not have happened in the medical model in and of itself.

2007 through 2012 I worked at the Kansas Department of Health and Environment and Centers for Disease Control and Prevention. One of their recommendations to work with states was to go to the medical model and to educate about, you know, people with disabilities can be healthy – health and disability are not mutually exclusive, etc. And we were lucky that we, in working with partners who also got to work with doctors and nurses and things like that, I was able to work, to teach a class at KU Med Center with some nurses and what I learned from them is that given their limitations in the medical model, they may get all of this and believe it, but it's that time and given the resources, particularly in someone's community, how to do it. The next steps. And so, I think that reacting to this from Mary's perspective it's just how much more can this do if we roll this out to centers and get people where they need to go for the wellness path, that they are not getting in their medical homes.

And another thing that I'm reminded of is just how broad scale the barriers are for people with disabilities. I know in Kansas back in 2009, Dr. Amanda Reichard helped craft some questions for the Kansas Behavioral Risk Factor Surveillance System and we asked "What barriers are you facing to the medical field and/or healthcare access?" And one of the most surprising things to

me was that 10 percent of Kansans with disabilities said that they've experienced barriers to healthcare. But out of those, 30 percent said that they were being discriminated against because of a disability. So there is this recognition that there's a misunderstanding with doctors and other healthcare professionals about what is a disability and how it impacts their health and well-being in life.

I think this intervention has a lot of potential to really work with both the medical field and the community to figure out how to get that individual the care that they are not able to get on their own in the community. And that they are not getting understanding from their medical field. The only real concern I have, and I would like to ask you, Mary, as far as from your perspective, is that the time commitment from the staff and maybe administrators, thinking about sustainability of this, how do you see that impacting your CIL over the long-term if you were to take this on in a grander way?

**Mary:** Well, first of all, from my experience with my clients, I had to give them homework. And the homework was either, you know, can you stand for two minutes, mark it on the calendar and maybe, next week, try three or four. That gives them the opportunity to take control of their own life and responsibility for what they're doing. Because eventually, the Three Rivers, my supervisor is going to be going to a military school and she's going to be gone for nine months. She's going to start weaning everybody off of her list and giving everybody more of her clients. So eventually I'm going to have several, therefore I won't have as much time to work with my wounded warrior or my female, I'll have about six or seven. And to answer your question, I'm going to have to give them homework and then check up on them. That's the only other answer I can give you. But they are going to have to keep track of it.

**Dot:** You also worked on a skill.

**Mary:** We had – they had to practice something and that was their homework, and then I checked up on them. But they were able -- both of them, which was amazing because I didn't mention it to them, she had, my female had her daughter put on the calendar what she did or the therapist at the time, that she did it. And who I'm going to call Jonathan, he had a calendar and when he would not, when he didn't smoke marijuana, when he did, he'd put an X. I went and I looked at his calendar there was a lot of empty spaces there for a while. That's a way for him to keep track of what he was or wasn't doing. And not just an X. He had how long he stayed at the gym. That was for him to see his progress. They have to have an ability to see what their little short-term goals are.

**Jean Ann:** Let me say that when we first started the training for this and we had this fancy idea to do goal attainment scaling and we trained, put the training through and showed people how to do the goal attainment scaling. Well they hated it. It's too fancy. Too detailed. It's too much thinking involved and not enough doing. So we now are looking at figuring out, how do we simplify? Because in spite of everything, I think a critical piece, even if we hate it, is – to be able to achieve a goal, you have to be able to look back and say whether you actually did those things or not.

So there has to be some way to track it. But we need easy ways to track it. We need ways, we all know when we have a New Year's resolution to lose weight and then we are just kind of floating along and we don't have records or any kind of diet logs or anything else like that, we fall very quickly off our resolution. So the idea is now, and that would be something we would try to do in the next round, is figure out better ways to track the goals. And that's another thing. We do have outcome goals, which, of course, with four consumers and two independent living specialists we don't have any data to share with you, but Aruna you asked people to do two pre-/post-tests around – what were those?

**Aruna Subramaniam [off camera]:** When we did the training, we gave a pre- and post-training test for the ILS just to see where they stood in terms of their line of thinking and the HAIL philosophy. Once the training was done then we gave a pre- and post-test for the consumers before they started the program.

Mainly to see their own attitudes towards health and how well they feel in charge of their own health. And we gave them the pre- and post. So it was a combination of the BHAPD, barriers to health promotion activities among people with disabilities. And then, a very short, a shorter version of the Stanford test, which was another, it's called the Self-Efficacy for Managing Chronic Disability.

So we gave that to them before and after it was done we gave that to them again. In addition, we also gave them exit satisfaction surveys to see how well they were satisfied with the program. And we also, and during the whole course we had conversations both with the ILS and consumers A, to see how it was going, B, to see if they needed any doubts clarified and C, just to see how our HAIL was playing out. So even though we had an N of four, our intention was to collect qualitative data so that we could tweak it for the next round. We did see some improvement and as Jean Ann said, the N is too small to make it even significant.

**Jean Ann:** I want to add that we did learn a lot from this process and the idea of having this goal setting and stuff, we know now that we have to work on it. The other thing I want to point out, our thinking and having Aruna call and do telephone interviews to administer the measures was an attempt to make, as least amount of demand on the independent living specialist as possible. We wanted to be non-intrusive and let you do the work with the consumer, but not do the research and so, we tried to separate that out.

I think that that's an issue that we need to think about in the future is where you either have to pay the independent living center enough to do some of the measurement, or you have to do the measurement for everybody and have the idea of what's the intervention and what's the measurement for the research completely separate.

**Jerry Schultz (off camera):** Do you see this tool as something that would allow for kind of getting a sense of what is missing? As you go through the checklist for example, are the, do you run into, this will be great to have, but we don't have this service, or yoga might not always be available, for example. Do you see this as a potential tool for doing a gap analysis for missing services, things of that sort?

**Jean Ann:** I could see a lot of ways that it could be used maybe beyond independent living centers, or pieces of it could be used. At heart it's a basic problem-solving steps you know. There are a lot of programs out there. Craig's housing usability thing is at heart a problem-solving steps around things. There's common themes. I think that once we get it set up, it is like guiding people to think through what is the problem? And then what are my resources and then what is my solution going to be? And that is like a universal skill. I think that we need to train or teach people to use it in thinking through how to solve problems.

**END**