

## **AMCHP 2007 ANNUAL CONFERENCE**

### **HEALTHY COMMUNITIES**

March 3rd to 7th, 2007

#### **Collaboration and Community Sustainability in Rural States**

SHARON NICHOLSON HARREL: Good morning. By complementary styles, what Debbie meant is that--one of the things she meant is that I like to stand right behind the podium. I don't move. I like to have some prepared notes, but my colleagues here are blessed with the ability to walk out to the audience and make comments without prepared notes. But even though they're very, every prepared on what they've done, let me get that straight.

DEBBIE GILMER: Boy.

SHARON NICHOLSON HARREL: So that's what she meant. I'd like to start off with talking about a program that I think epitomizes our title, which is Collaboration and Community Sustainability in Rural States.

Here is a picture of our dental care centers, and I'm going to talk a little bit about that, but Smart Start has been critical in our success at the dental care centers. And this is a beautiful North Carolina sunset, compliments of Phyllis, my colleague, but I'd like to talk a little bit about the history of Smart Start in our state as well as its mission in three core areas. So sort of set the background for what

we're going to talk about the rest of the morning.

And just what is Smart Start? Smart Start is our former Governor Hunt's statewide initiative--and you have some brochures on the Smart Start Program--and the mission of the program is to ensure that every child in North Carolina will arrive at school healthy and prepared for success, and it focuses on children age birth to five. It started in 1993, and it's a public/private partnership. North Carolina has 100 counties, and each of the counties has its own local partnership for children through Smart Start, which identifies its own specific needs.

The North Carolina partnership for children sort of does the technical assistance and the oversight component, and the budget is funded by the North Carolina General Assembly, and by businesses, private donors and foundations. And for this past year, the statewide budget for Smart Start was 200 million, and for our county, which is Moore County in North Carolina. For our local county, we had 1.5 million allotted.

There are three core areas of the Smart Start Program. Childcare is the first, and you'll see this in your brochure, health care is the second, and family support is the third. And I wanted to share just a couple of examples of the progress North Carolina has made since the program opened in 1993. Let me share two goals with you. There are several. But let me just share two with you. One of the goals was that every child enrolled in childcare would be on a four or five star-rated

program. And in 1993, North Carolina, I don't know if you know, but we had the worst child care standards in the nation. It's not something we're proud of, but in 2007 we've advanced in that. More than half of North Carolina children are in the highest quality programs. By that we mean four or five Start programs, about 56 percent of children.

The second goal I want to share is that every child will receive well child visits and timely immunizations. Again, in 1993, North Carolina had the lowest immunization record in the nation. I looked that up again and make sure it was right. Yes, North Carolina had the lowest immunization record in the nation in 1993. And in 2007, we're one of the top three states in terms of these two measures.

And I wanted to point out the two Smart Start brochures. David, they're right next to you. There the gray one, and then there is a more colorful one as well.

Now, I'm going to talk just a little bit about the impact of the Smart Start program locally, and I'm going to sort of skip around on this slide. Let me talk first about the unlikely partners' portion. As we mentioned before, as Phyllis mentioned, FirstHealth is a hospital system. We have three different—three separate hospitals. We have hospice, we have home health, and we—in North Carolina, dentistry is not often tied in with hospitals. Here and there, but you don't always think of those two together, particularly when you're looking at dental care for

underserved children. So, you might ask, well, how did your hospital system get involved in dental care, and that's where the unlikely partners' part comes in.

Over 10 years ago, our School Health Nurse Program which used to be housed under the Health Department became housed under FirstHealth, and Phyllis is the director of that program. And what the School Health Nurse is who are in the schools as you know on a daily basis brought our organizations attention that the number one unmet need in our rural county was dental care. And that's probably no surprise to you. I'm sure you find the same problem. Well, in the true unlikely partners fashion, our hospital administrators, their response to this when they first heard of the need was, "We don't do dental." But because—with lots of persistence from the stakeholders, which were the school health nurses, the local dentists, the health department, the school system, we established our first dental care center in 1998.

And before I talk about our local dental impact, I want to just draw your attention to just a few examples of the overall local impact to Smart Start. If you look in your brochure inside of it on the first page, it talks about the way Smart Start has helped in an area paying for child care. You'll see there's a child care scholarship program. There are more at four programs at the elementary schools. Phyllis will talk about the child health consultant portion. In addition for health care, there are the early intervention outreach services for Special Needs Children, and the Children's Fun Health Fair, their wide range of screenings, and then even

interpreter services. So I just wanted to share with you those are just a few of— that I've highlighted, but you can see there 17 different programs funded by Smart Start in our county.

And now I want to talk about—a little bit more about the local impact for dental. And we were established, as I said in my opening, to provide comprehensive dental care to low income children up to age 18. They have to be up to the 200 percent poverty level. And during the first weeks when we opened—we opened in October 1998—because there had not been much access in our area, we had so many children who came in with toothaches and pain and swollen faces. In fact, I think of Deamonte, the 12-year-old who recently died, because we had so many kids who had no access. And many of them were crying; they had been in pain for a while. And the staff kept saying to me, they said, “When is it ever gonna get better? Are they ever going to get better? When are the kids not going to cry?” And I said, “Eventually, once we work through all of these, this pint up demand, once we get through the emergencies, then we'll be able to do more preventive and routine care.” But one child in particular that our staff will always remember, he was about six years old and Hispanic male, and he walked to the front desk. His face was literally swollen out to about here. He had tears streaming down his face, and he just had such an innocent look about him. His name is Nicanor. And that's not hip because I just used the first name and you might—and I can say that I'm using a false name, Nicanor. And we saw him, put him on antibiotics, brought him back, remove the tooth, and we also kept

following up with him, provide a preventive and restored care. But what's so special about Nicanor is that years later, even now, he still comes in; he's all smiles now. But what I find so fascinating about him is that he's our biggest advocate. He has four and five-year-old cousins that come in. He will walk with them into the dental treatment room, pat them on the shoulder. "It's fine. They won't hurt you. This is fun." So, we'll always remember Nicanor. The point I want to make about Nicanor is that our community wanted to decrease the number of children coming into our office like Nicanor. And we thought one of the best ways for us to do that was to target kids early, birth to five, so we can prevent those problems early before they got six or seven like Nicanor was. And that's how the Smart Start component of our program, the zero-to-five focus, was born. And just to give you a testament to the program and to the preventive efforts, prior to the time we started with Smart Start—we started in 2001—about 30 percent of all entering kindergartens in our county had untreated decay. What that means is they had cavities that had not been filled at all. By 2004, that number had decreased to 27 percent, and just before I came up here on yesterday, our local executive director called me to tell me that that percentage now was 22 percent. He had just gotten the 2007 figure. So we've gone from 33 percent to 27 percent to 22 percent. So we're making progress in the right direction by targeting kids early.

And lastly, I wanted to share that our Smart Start funding allows us to do some Smart Start Saturdays. Remember some patients have problems getting in

during the week due to their work schedule, so we have Smart Start Saturdays. We just see kids zero-to-five and we do everything that needs to be done for them. We also have some kids who unfortunately are past the preventive stage. The reality is that there are some where prevention won't work. And we have a contract with the wonderful pediatric dentist who takes, through Smart Start, who takes some of our kids to the operating room, put some under general anesthesia and provides care. So I want to show you a before and after picture. (Inaudible) not exactly. You can see this child has a lot of decayed front teeth and back teeth. He has what we call rapid decay, which means decay on almost every tooth, so he's beyond being able to prevent. We have to repair. And for this young man, we had to actually end up removing those front teeth. Sometimes you don't have any options but extraction. And this is another after picture. It's not the same child, but sometimes we all are able to do a smile makeover and restore those teeth and make them look nice.

UNKNOWN SPEAKER: It's the same kid.

SHARON NICHOLSON HARREL: Is not. I'm sorry. I'm sorry.

UNKNOWN SPEAKER: (Inaudible).

SHARON NICHOLSON HARREL: But in summary, I just want to share an example of how the Smart Start Program in our local community has reflected

collaboration and community sustainability. And I want to—as if you had any questions, and then after that we'll go to Phyllis who will share another component of Smart Start and its local impact. Okay. All right.

UNKNOWN SPEAKER: Any questions?

SAM COOPER: Yeah, I'm just curious. So, how does—does this connect this with the BSAT Program in North Carolina in some way, or how does that work?

SHARON NICHOLSON HARREL: Very good question. You're talking about the head-start program.

SAM COOPER: No, the—

SHARON NICHOLSON HARREL: I'm sorry.

SAM COOPER: --the early periodic (inaudible) or Medicaid eligible for (inaudible)?

SHARON NICHOLSON HARREL: Yes. Yes. And we do—some of it overlaps and some of it doesn't. Mm-hmm. So it allows us to have a broader scope. I don't call a duplication, because we're trying to get kids who are not already coming in through that particular screening process. So it gives us a broader range and

allows us to target even more kids, zero-to-five, than we would under that program. Mm-hmm.

UNKNOWN SPEAKER: Please go ahead. She's got some (inaudible).

UNKNOWN SPEAKER: The other question I have is, is it because of the referrals that the nurse made, because that seems to be the same thing in our community, and impacted them to actually implement dental program, 'cause it seems to happen in ours, too, if it comes from the program of the school (inaudible).

SHARON NICHOLSON HARREL: And that's exactly who brought that to our attention because before the School Nurse Program went under the umbrella FirstHealth, the hospital had no idea that this problem even existed because they didn't have their hands in the dental community. But you're absolutely right. The school health nurses were the (inaudible). Now, there was a lot of collaboration between the health department and the superintendents of the schools, as well as the local dentists. But the school health nurses were the (inaudible) behind making our—beginning the dental care centers, or they were the (inaudible) behind it.

UNKNOWN SPEAKER: (Inaudible) I want to reiterate is the parents collaborate because a lot of our parents have a tendency that they may have (inaudible) to

the elementary school and they have already worked with the nurse, that they have that confidence with the nurse so that a lot of them (inaudible) between the parent and the nurses. They get together and they have their eyes and their (inaudible) basically. It's almost like a position thing, and I'm just wondering because a lot of our children have that too. (Inaudible) between the parents and the nurses.

SHARON NICHOLSON HARREL: Right. And the nurses do collaborate with the North Carolina Public Health hygienist to do the dental screens when they do the other screens that you're talking about.

UNKNOWN SPEAKER: Mm hmm.

SHARON NICHOLSON HARREL: Thank you.

PHYLLIS MAGNUSON, RNC: I'm one of those people that don't stand behind the podium.

DEBBIE GILMER: Do you want help with your slides?

PHYLLIS MAGNUSON: Yeah. Well, I just—I'll walk over here.

DEBBIE GILMER: Okay. Okay.

PHYLLIS MAGNUSON: I tell everybody is because I was married to a Methodist preacher and I just can't stand behind the podium anymore. I have a lot in common with you all that are in here, because I feel like that I'm kindred to you because I work for the Department of Health and Human Services in North Carolina for seven years. And before that I was a public health nurse in the mountains of North Carolina and moved in Greensboro, and then went—well, Sharon and I, if you haven't noticed, are twin sisters. We work very closely together. We have to serve the needs of the children in our county, and I want to give you a little bit of background about us. If you saw our bio, the end of our—says MPH. Both of us have our master's degree in Public Health in the University of University of North Carolina at Chapel Hill. Thank you very much. But the one thing that that requires that Sharon and I will tell you if you graduate such a program in Chapel Hill is that you don't get a diploma. You go out there with the challenge to take care of the children in the state. And Sharon, as big a heart as she has in her brain, I wish you could see her in her dental clinics. You go in there and it is happy. The children are smiling. Nobody's unhappy. The colors are bright. And she started this from nothing, and you can, too. It takes a little bit of a vision, and it takes a lot of hope, and it takes looking and finding who your stakeholders are. Now, I moved away from that. I moved up to the state and looked at it from that point of view for a while, and I learned a lot working for the State of North Carolina. But what I found out was the action is local. Just like politics, the action is local. I thank God for the time that I had at the state. But if

you want to get something done, you got to build partnerships at the grassroots. You have to know your community. You have to know the movers and the shakers. And I want to give you a little thing about Smart Start that—I'm sure Sharon doesn't know.

Smart Start actually started in a project in Greensboro, North Carolina. When you think of North Carolina, what do you think about?

UNKNOWN SPEAKER: Country.

PHYLLIS MAGNUSON: Country. What else?

UNKNOWN SPEAKER: Fresh air.

PHYLLIS MAGNUSON: Fresh air.

UNKNOWN SPEAKER: Good food.

PHYLLIS MAGNUSON: Good food.

UNKNOWN SPEAKER: Golf.

UNKNOWN SPEAKER: Basketball.

PHYLLIS MAGNUSON: Golf. Our hospital sits right near the golf course,  
Pinehurst No. 2.

UNKNOWN SPEAKER: Furniture.

PHYLLIS MAGNUSON: Furniture, High Point. Right. Exactly.

UNKNOWN SPEAKER: Basketball.

PHYLLIS MAGNUSON: Basketball. Back in the six—

UNKNOWN SPEAKER: (Inaudible).

PHYLLIS MAGNUSON: Yes. Back in the '60s, we were known as the hotbed of civil rights activism. Do you remember that? (Inaudible). Well, that all happened in Greensboro and in a project area that I happen to be the public health nurse for a few years later. We're talking about people, 20 people crammed in a house, and the houses are dark and black, and you're scared to go in there because they've got the blinds and the blinds are drawn in there. You know what I'm talking about. You're talking about public health here, aren't we? And that's where we are that is so different. This isn't a medical model. We work under a medical model framework, but we're not a medical model. We're a public health

model, which is very different. So we have to really work to get our reports right to these people who don't really even understand what we do. But anyway, I happen to be the first project nurse for Smart Start, the program, the grant that initially came from Robin Britt in Greensboro, North Carolina, who ended up being the secretary of state when I worked for the state of North Carolina, with Dr. David (inaudible) who was our next secretary of state, and also the state school superintendent who came from Moore County. So, lots of politics. You stay in it long enough, it comes back around.

This whole Smart Start Project was built on the fact that if you give children, to healthy children a chance, if you give the parents a voice and designing that, if you give the children an opportunity to do it, then the project will work. And that's exactly what Smart Start is about. Now I probably—he's got signs that they're to tell me when to shut up. But you could tell I get pretty passionate about this. I want to be back up. There's Maine. The impact from my program with Smart Start was that--and let's back up what Smart Start is. The governor goes to the legislator, and he says, "We got poor kids out there. Their teeth are rotten out, with their poor health care, they don't have a dental--they don't have good daycare. They don't have this, they don't have that." They appropriate funds. The funds initially don't do really well because they keep going places that we're not sure they're going. And it gets a bad reputation in the state. And so now, Sharon and I have to jump through a gazillion hoops because we had to fill out this paper work to get these positions.

What happened in childcare was the University of North Carolina at Chapel Hill came down, and said, "Look, we've got the worst daycare situations in the state," and Moore County, there are 167 daycares. There are 111 people that keep children in their home that we don't even know about diapering. I just finished up a pertussis outbreak in Moore County. I mean, you talk about epidemiology and chaos, we better hope a pandemic doesn't come because it just about kill every resource we had for this whooping cough, small whooping cough outbreak, but diapering, sleeping positions. There was no regulation for that. So, Chapel Hill comes down and say, "Hey, we're going to give you a position. We'll give you 75,000 dollars and you do this, and you get this childcare consultant in place," and she's going to go around, and she's going to check these daycares if they let her in, because she has no authority. If they let her in, you can go in and see how she's there diapering, and you can offer help, and you can do these type of things, but you can't tell them what to do. You're not a regulatory kind of person. Well, that position lasted about two years and money ran out. And the people that was affected the most and helping the most were the Smart Start folks. But it was like in there Thomas Edison; all great ideas don't end up the way you think they're going to. And sometimes you have to let good ideas die. We had to let that die, because no one was going to pick it up at that time. So for three years we let it die, and FirstHealth stayed there, was very quiet. They said, "We'll partner with you but we're not taking it on," which is our boss's mantra. And then Smart Start, we had an open house at--the home health and the school health

moved into a new building, and we had an open house, and the Smart Start director walks in, and he says, "Phyllis, would you administer childcare consultant position?" And I said, "What's the possibility?" I said, "What are you thinking about?" This is how collaboration begins. It begins over dinner, over cocktails, over confessions, in church. Just wherever, somebody else, one other person has a like mind like you to sit down and create the vision and make it happen. And from that grew the childcare consultant position. We're just two people talking and then that took him to two more, and then we went to four more, and then we went to six more, and all of a sudden we have 110,000 dollars to the childcare consultant position. And she works with the daycares. I can't tell you, I think she made over 1,000 contacts last year in support of childcare, and raising that standard, raising the childcare consultant bar. And so it can work, and it does work. And we're going to go a little bit more detail about that, but I want to give you a little more history about Smart Start, because when you think about--it sounds like it's a cute little name but it was a really a hard--a lot of hard work that someone with a vision and a dream brought together to be able to bring this program back. Maine. Are you guys next?

UNKNOWN SPEAKER: We are.

UNKNOWN SPEAKER: Good.

UNKNOWN SPEAKER: I do.

UNKNOWN SPEAKER: Okay.

TONI WALL: I think when Sharon got up and Deb, and we talked about similarities, I think you'll find--Sharon and I have many similarities, because I'm going to stand up here, and I'm sure Deb will probably moving around the room. It was one of the things when we had dinner last night, we're like, "Oh, okay. We see why we were together." So, I just find it really interesting in talking with Sharon about our children, and she loves to get up early, and her husband and child stay in bed, I'm like, "Yeah, that's the same thing that happened to me."

DEBBIE GILMER: I think you're going to talk about your 10 year--what is it? Retirement--

TONI WALL: Oh, yeah. Our retirement plan. Sharon and I already have our retirement plan and when we are going to retire, and--

DEBBIE GILMER: Backwards please (inaudible) over the next 10 years. All the--

TONI WALL: It was very funny, wasn't it? Yeah. It was great. It was great. And we only just met last night, and I just feel like I know these two women for a long, long time.

So Maine, Maine is rural. I will not claim it to be the rural state like Alaska or Texas, but one of the things I'd love to tell you is Maine's land mass--we can throw in--you were talking about Montana and all the other states. We have Connecticut, Rhode Island, New Hampshire, Vermont can all fit--

DEBBIE GILMER: And Massachusetts.

TONI WALL: --and Massachusetts can all fit into the land mass of Maine. So we love to claim that, and we do have the longest coastline in the lower 48. We have over 3,000 miles of coastline. Just a little trivia.

DEBBIE GILMER: And I think, and I can't fathom how we could top Alaska on this one, but I just heard on public radio the other day, and I thought I'd heard--I knew this, but 90 percent of our state is forested.

TONI WALL: Yes, we had—yeah.

DEBBIE GILMER: And we're the highest state--the percentage of land mass that's forested. But I can't imagine how we could top Alaska, but that's what public radio said.

UNKNOWN SPEAKER: (Inaudible) most of our land is actually (inaudible).

DEBBIE GILMER: Oh, that's true.

TONI WALL: Oh, that's true.

DEBBIE GILMER: That's probably it. And this is sort of a snapshot. These are pictures of our state government's Web site where they have photo contest of the different seasons, and you can download the pictures. Our state director of Special Education Services, David Stockford, was hoping to join us, and he would have engaged us and added to the flavor of our team incredibly. But in honor of him I put a picture from Lubec. Anybody know where Lubec, Maine is? It's the easternmost community in the United States. It's where the sun rises first in the country. And David is a native Lubec, Mainer. And then up north are potato fields in Northern Aroostook County. Not tundra, but flat potato land. I'm in the corner, and then of course woodland and moose, which we find in the cities as much as we do, and really hilarious just like—yeah.

TONI WALL: Which probably happens (inaudible).

UNKNOWN SPEAKER: (Inaudible).

DEBBIE GILMER: Yeah. I know. Yeah. Yeah. I had a deer on my deck. I live right in Orono. My property abuts the University of Maine campus of Lubec. We have an overabundance of deer in our community. Yeah.

TONI WALL: Next. So, collaboration. It's the way we do business. And we're looking at it from a state perspective, and North Carolina is really looking at it from the community level. And what happens at a state? Well, for those of us who are in state government, and we know that governor's change, commissioners change, we love the word, let's reorganize the departments because we can do things more efficiently, more effective, and what's the other E--it doesn't matter. We're in that process now.

UNKNOWN SPEAKER: Economically.

TONI WALL: Oh, yeah, economically. It's unbelievable. So, how do you sustain collaboration and partnerships when all this change is always happening? And I always say when they do all these changes at state government, I just go, "Okay, this will pass to—"

DEBBIE GILMER: This too shall pass.

TONI WALL: --"This too shall pass. We're going to go back to the same way of doing things," and it's just--I could tell you lots of stories about what's happening now. But anyway, so how do you maintain those collaborative efforts? Phyllis did a great intro where she said, "Well, you meet one person, and then you have another person, you had another person," and that's really how we do business

in Maine. And I'm going to refer back to you Deb now, and just to talk about more of the collaboration that we do at the state level and at--more of the community level too.

DEBBIE GILMER: We all come from different perspectives. Alaska has issues that we can't begin to understand, and while the issues in general may access rurality, transportation, those all--but how they play out either at the local level or the state levels are different. We don't have to deal with airplanes, and whatever. However, folks get around in Alaska, but we have no public transportation in Maine, to speak of. And so, the issues are just--at dinner last night, these guys are talking about what they call a rural community and mentioned that there are 12,000 students in the school district. We don't have a school district in the state that has that many. I mean, not even close. I think our largest school system is 2,700, 2,800 students. Our largest city is Portland, 63,000 people.

TONI WALL: And that's not the capital.

DEBBIE GILMER: And that's our largest city. So we have very, very small towns, and no school system, I mean, not even close to that size. We only have 180 students K12 in our state. We're a state of about a million people, a little over a million people, 1.1, 1.2 million. We're a state that's very, very poor, but with incredible wealth and pockets of wealth as well. We're a state that--there's (inaudible) get back to schools first, with 252 school districts in our state right

now. And I'll tell that—say that (inaudible). We have a school system as small as 60 students K12 with their entire--with their own administration out on one of our islands. We have three school systems that I'm very familiar with, with one project that we're doing. They have under 150 students K12, one school. And so we have 252 administrative structures, educational and administrative structures in our school.

TONI WALL: Can I just say, and one of the things that the governor is now looking at is to make--go from 250.

DEBBIE GILMER: Talking about reorganization.

TONI WALL: A reorganization down to--

DEBBIE GILMER: Twenty-six.

TONI WALL: Twenty-six.

DEBBIE GILMER: (Inaudible) got a proposal to.

TONI WALL: And one of the interesting things that she states at—is that if somebody 100 years ago came back and looked at the school system, that's in the present time, it would be exactly the same, exactly the same, so.

DEBBIE GILMER: And it is true. In our age of technology--I do a lot of work in schools, and we can step back 100 years. So somebody could--I'm going to wake up from 100-year nap, and our schools look exactly the same as they did 100 years ago, for the most part.

TONI WALL: Local control.

DEBBIE GILMER: Nothing else has changed much but our school still looked the same. So we need to change our schools whether or not we need to go from 252. Without any discussion, Maine is a local control state. We're very collaborative. Things are driven at the local level, and the Gov. proposes to fire 226 superintendents and have only 26 superintendents. So, that's caused some outrage in our state in the last couple of weeks.

But one of the things that's absolutely critical to the way we do business at a state level because we have--it's a small state with--although we're large geographically in our--not in the Midwest, not west of the Mississippi, we're a very small state, geographically. But in New England we're a large state and our population is very, very dispersed. I think probably 75 percent of our population is south of Augusta or Augusta south. So, the very tiny, tiny smallest part of the state is--so the issues of access are critical in the rest of the state. But as a whole we have the right commitments. We have the highest percentage per

capita contribution for the--in the country towards Medicaid expenses for folks with developmental disabilities in the long-term care system as adults. We spend more money on that system, which is completely community-based. We have no state institution. We have the right commitments. We have a governor who is committed to healthcare access and created the (inaudible) Health Program in trying to get insurance access for all uninsured Mainers. One of the highest high school graduation rates in the country, unfortunately, we have one of the lowest rates of participation in higher education. We have, I think, only 26 percent of our adults have bachelor's degrees. We have a very low percentage. So, our high school students, for the most part, are first generation, or would be first generation college goers. And so that's a problem. And it's all tied to economic development. We need to keep our young people, we need to have--build the capacity to keep folks. We have one of the highest in the top three states--if you can imagine Maine, don't people move south when they retire and get elderly? No, we have the third highest elder population or the oldest state in the country, and an incredibly large in migration of retirees, believe it or not. And so, it's straining, incredibly straining our public service system in ways that are just becoming more and more evident. We identify kids with disabilities in our public schools at a rate higher than most other states and almost double the rate of the national average. What does that mean? Does that mean we provide lots of services that kids may or may not need? I'm not sure, but we have a very high rate of identification of kids with disabilities.

With that, I share that sort of as context to then talk about, well, in a rural state, how do you get anything done? We don't have resources to throw at programs. We're a state that has long determined that we have to address issues systemically that we can't rely on grants; we can't rely on the legislature. So, we have to figure out what works and then how to make that sustainable. And it's a good a thing and it's a bad thing. We talk about Maine being very incestuous. Everybody knows everybody. Everybody's related to one another. That's a good thing and it's a bad thing. But the good thing is that we sit at one another's tables. We don't talk about the issues related to economic development, and keeping kids in Maine without talking about high school reform, and how we keep kids in school, how we support higher entertainment. We're all doing that together, and so we're sitting at the same table. We're tackling the problem. If David were here, he would talk about—back in the early '90s when the U.S. Department of Education was funding a whole lot of statewide systems change grants. There were systems change grants for inclusive education, systems change grants for supported employment, systems change grants for transition—then on a missing one. Anyway, there were a bunch of—and David put us all in a room and said, “We got to change the systems together,” because he didn't want all of these organizations changing a system without collaborating. So, we sit at one another's tables and we address issues systemically. Tony and I are going to talk about today about, sort of, our focus on transition, and what we've done around transition. But I just wanted to share one example of, sort of, what it all looks like ultimately, and then we'll talk about transition.

One of the hats that I wear—I had this wonderful job. I get to and have for since 1990 when I left public school teaching, had had positions where I have this autonomy to—that’s a good idea. Let’s write a grant. I’m a decent writer. I write grants. I write a lot of grants. And so, I’ve been able to bring—to come up with ideas and get them funded and stimulate change. I call it Introducing New Ideas and Emerging Best Practices, and then I get that going and I get to move on to something else. So, I’ve done some early childhood stuff, a lot of stuff in schools, employment stuff, and so a lot of different kinds of things. So, I’m sitting at lots of tables, because I have my finger in lots of different pots. But one of the hats that I’m wearing right now—how many people have ever heard of GEAR UP? Great. U.S. Department of Education and Office Postsecondary Education since 1999 has funded an incredible effort. If you look at the Federal budget, my guess is that there were a few programs in the Federal government with the exception of the defense department in this period of time whose budget has grown as much, would be my guess. GEAR UP was funded in 1999 as an initiative to address the postsecondary educational attainment of kids from low-income backgrounds. There are now, I think, 37 state grants, 237 partnership grants, and with the 330 million-dollar appropriation for that competition. We have an 18 million-dollar grant in Maine, our second GEAR UP, our second six-year GEAR UP grant. We’re working in 19-school districts and 47 schools. But what we’re doing in that is looking and how we create a college-going culture for all students. Not just low-income kids, not just kids with disabilities, but how do we create and sustain

as college-going culture for all kids? And we're doing it in lots of different ways, but one of the things that we're requiring our participating districts to do is to require that every single student complete a college application and a (inaudible) in their senior year, the financial aid application in their senior year as a requirement for graduation.

Now, adopting a single, simple requirement such as that creates or goes a long way to sustaining a college-going culture. So, overtime, we're getting schools to adopt practices such as that that live on and are sustainable well beyond the funding of the period of the grant. How do we take and change the way we do business, changing our practices? What we can afford and what made us learn, and probably lots of places, is it's wonderful to get grant money to introduce and support new ideas and projects. We can't survive on grant-funded programs. And so, when we know and when we learn what works well, we have to look at sustainable practices. And so, we take these efforts and then we try to work with schools, with communities, to adopt practices that live on beyond the grant. So that's what we're going to talk about in transition. But in our GEAR UP grant, creating sustainable college-going cultures, and Lubec is one of our schools, the easternmost community in the state in the country, and their K-12 school, there are about 150 students in that school. Ten students a year graduate from—or there are 10 seniors, approximately 10 seniors in the senior class, if you can imagine. And last year all 10 students went to college. Now that's a school that's very poor. They have no ability to provide AP courses. When you think of the

breadth and scope of the courses that we need to support kids to take in college, to get to college, what does Lubec, Maine do? Well, they've partnered with other schools in Washington County in that region to offer courses using our distance technology, to offer AP course via distance technology, and they probably have one of the coolest courses. They do an aqua culture course with two other schools using distance technology, and Lubec has—and it's the community that has been supportive. But the school has a hydroponic nursery. They grow their own vegetables for the cafeteria. But the water supports—the water is filtered back into the nursery from an aqua culture lab that they're growing some kind of fish—I can't remember what fish it is—that they're doing advanced placement biology and chemistry with, and supporting all of this, and students come from other schools via distance technology. It's the only aqua culture course in the state. So, those are the kinds of things that we have to—and my guess is that Alaska uses a fair amount of technology in that way to get a breadth and scope of any kind of diversity of courses out to students. So, it's just how do we build and sustain good practice? We have to change the way we do business at the state, and then adopting those practices locally.

TONI WALL: We have to go. It's 9:00. Time for the next piece.

DEBBIE GILMER: Okay. Well, I could go on forever.

TONI WALL: Yeah, we had to cut her off, 'cause—

DEBBIE GILMER: They did cut me off.

TONI WALL: Yeah. I don't have the sign to hold up and go, but it's—if we keep to the agenda, we can get everything in and—but I think we'll be talking about the Healthy & Ready to Work phase one, phase two (inaudible) project and the resource center as we go ahead. But I think its Debbie and Phyllis who were talking about the mapping systems that are—

PHYLLIS MAGNUSON: Well, I can—we do our collaboration to them. But I'm going to stop a minute. Well, don't need a microphone. They keep recording us. They're recording us and I have to do a reality check. Of the things that you've heard so far, what kind of questions do you have about collaboration? Why are you here and what is it that you want out of this? We heard what you said earlier, is what we're saying and going in the direction, 'cause I can change what in the direction of what you wanted to hear for your particular situation. Do you know how to build collaborative partnerships? Are you interested in how you make these connections? Are you looking at it from a state level or from a local level? Tell me. What's Alaska doing?

UNKNOWN SPEAKER: Well, we do have a lot of good collaborations, I think, going on. Actually my boss is the section chief—help start the All Alaska Pediatric Partnership, which prides to bring players in from various hospitals in

the state, pediatricians and various interested folks and sort of figure it how that serve the needs of the children of the state, and I think it's been a great collaborative effort of—I'm not sure we're making a lot, however we really need subspecialty pediatric physicians in Alaska desperately. As you can imagine, the rural areas don't even have pediatricians and most of them don't even have family practice doctors, depending on how far out you go. But they have developed a community health aid system in Alaska where every village pretty much has a health clinic run by health aids. They're trained at the Alaska Native Medical Center.

PHYLLIS MAGNUSON: Is that an Office of Rural Health or are they community health centers?

UNKNOWN SPEAKER: No, we haven't definitely but we had, I think, it's FHAQs and certainly—

UNKNOWN SPEAKER: Yeah.

UNKNOWN SPEAKER: --whatever they are. Yeah, we have (inaudible) as well, but these are different. These are all run by the (inaudible) Health Service through the (inaudible).

PHYLLIS MAGNUSON: Okay. And so it's a federal money. (Inaudible) Health Service.

UNKNOWN SPEAKER: Right. And then we have just started a collaborative thinking of (inaudible). I went to a collaborative meeting last Friday, trying to bring together clearance to deal with—we're talking about dental health. We had a meeting on dental care for Children with Special Health Care Needs, because it's a huge issue. A lot of dentists don't know how to deal with Children with Special Health Care Needs or how to even treat them, because they don't spit or don't swallow—either they don't spit and swallow. Everything they put in their mouth is (inaudible). You can't use fluoride. And are those different kinds of issues that—and they don't swallow it all or they have trouble swallowing. I mean, we had parents coming in and it really was an eye opener as to what they have to deal with when they can't get it done.

PHYLLIS MAGNUSON: Mm-hmm. Do you have the Special Children's--?

SHARON NICHOLSON HARREL: (Inaudible) we're fortunate that we're able to refer those patients. We target—no, we don't.

UNKNOWN SPEAKER: No.

SHARON NICHOLSON HARREL: We don't.

PHYLLIS MAGNUSON: We do have—am I correct that we have resources at with the University of North Carolina at Chapel Hill? Can you refer up there for Special Needs Children?

SHARON NICHOLSON HARREL: We refer some to Chapel Hill but we also refer to the same pediatric dentist who contracts with us to do our OR cases. So, yes—no, we don't treat them in our office, but we are able to get them treated.

UNKNOWN SPEAKER: Let's get it down. That's the growing need in Alaska, and that's what we were trying to address as to how to best serve the needs of those children as well. Because yeah, some of those kids have never seen a dentist and so that's the parents were saying because they go to the—or either that they have to make an appointment three months in advance, and of course that day the kids have the seizures or having a really bad day so they have to cancel the appointment—

PHYLLIS MAGNUSON: Mm-hmm.

UNKNOWN SPEAKER: --and so there's lots of issues.

PHYLLIS MAGNUSON: And Sam, you were asking the question about EPSDT Medicaid and dental. It does overlap because Sharon sees Medicaid—and she

sees what we call (inaudible) Chip Program in North Carolina. It's called Health Choice, and supposedly you've got Medicaid that covers them to this level and Health Choice takes them to this level. Well, the level at from 75 to 100, it's getting bigger and bigger. And Sharon and I have worked together collaboratively to come up with a funding process. We also go out and raise money to meet the needs, medical and health and dental needs of those children that neither Medicaid or Health Choice, and don't have insurance, which is a huge gap. But did that answer your question? She bills for services.

SAM COOPER: Oh, okay. Okay. I guess part of what I would like to know more about is—so (inaudible) we have a few collaborative efforts. We have quite a few in Texas, but I think the our challenge is always going to be how we measure some of the successes out of those specific targeted activities or programs. And I'd be curious to hear like about the (inaudible) the child health care consultant piece or probably the transition planning piece. I mean, as far as how you're marketing that, we invest at this from the public or private perspective, and this is what we're seeing.

PHYLLIS MAGNUSON: Okay.

SAM COOPER: There are things that I think are really important for us to be able to carry back to some of our collaborative groups.

PHYLLIS MAGNUSON: Do we want to talk about that now or—

SAM COOPER: Yeah, we can do it.

PHYLLIS MAGNUSON: Well—

UNKNOWN SPEAKER: And so, it's a fabulous question, and it's not one that, sort of, I didn't think about in terms of comparing for this. But I think one of the things that we have to be careful about and funding funders are sometimes greedy in this regard. We can't always, in a two-year or a one-year or a three-year funded effort, be able to provide outcome information. That's not a good research design. And so, in our work, we're really looking at tracking that graduation rate, tracking the rate at which kids participate in higher ed. We can't attribute that GEAR UP created that change. We can say that we think, "Here's what happened in the meantime. Here are the kinds of interventions that we did." This is the sort of before and after, but we can attribute that it—and so funders don't always like that. But we have to look at—we talked about sort of big picture in detail. We have to look at some of those big pictures. Some things you can tell—I mean, you have to be careful about what it is you're seeking to measure. You've added dental services, and I mean, some things are very measureable and discreet. But some of the broad transition—was it the transition planning that you did age 14 or was it the fact that Medicaid all of a sudden started funding, or

Medicaid regulations changed in—so it's very, very hard to attribute change. And I'm not answering your question, but just wanted to put that in—

SAM COOPER: No, I appreciate that. I mean, cause and effect, I know, is something that is a huge challenge for us in what we do and what we try to see at the end as far as the outcomes for our families and for our children (inaudible). I guess my concern is that we're like probably all are. We're often committed a position and really try to justify why we're continuing (inaudible).

UNKNOWN SPEAKER: Absolutely.

PHYLLIS MAGNUSON: Absolutely.

SAM COOPER: And even small things, I think, we need to start using the market, so—

PHYLLIS MAGNUSON: Right.

SAM COOPER: --I mean, the idea that, I believe its Maine is requiring for the college application be completely for graduation.

PHYLLIS MAGNUSON: That's measurable.

SAM COOPER: And measuring how many are going on. Those are some things that, I think, that kind of thing can help us in trying to reassess how we can put that (inaudible).

PHYLLIS MAGNUSON: What is your specialty area, Sam? Tell me, is it development disabilities?

SAM COOPER: Well, no. My background is actually in social work and I work with Children with Special Health Care Needs programs in the state for many years. But now, I'm actually (inaudible) block grant. I'm supposed to be (inaudible).

PHYLLIS MAGNUSON: You're watching out for that.

SAM COOPER: For the maternal child health issues as well as CSHCNPs.

PHYLLIS MAGNUSON: Well, and I'm going to say something there. I said earlier that everybody in this room knows it is—you cannot put--and Sharon and I work under a medical model, and we have to show our CEO the same—they want to know—he wants to see reports, like, you can give them in a hospital like Falls. (Inaudible) goes into Falls right now, and patient identification for drug safety and pain management measurement. How much they're paying if (inaudible) into that right now, on a scale of one to 10. But Sharon and I can't do that. And we tell him

right upfront, “We are not a medical model. We can’t measure like that.” But however, I can measure some things. For example, also I did the school nurse program and I have two school-based health centers in a rural county and two middle schools, which are apples and oranges. We found out that our children were getting glasses. I mean, we’re being screened. We were screening our children for vision at 100 percent, but only when we went back and check, only 29 percent of them had glasses on the face. So, this is collaboration. So we set back and we said, “What’s going on here? Why aren’t those children?” The reason Sharon does really well, you got, well, flagging me, the reason Sharon does so well in her dental clinics, and one reason dentist’s don’t like Medicaid is the missed appointments. It’s not that they don’t get the kids in or—we all have—everybody in here’s got travel problems. We’ll just put that on the table. If you’re rural you’re going to have transportation problems. So, the reason Sharon’s program works well is because she works with my school nurses and the social workers, and makes sure that little bottom’s in the sea, and she gets them in them in the dentist chair. Is that right, Sharon? You want to talk a little bit more about that?

SHARON NICHOLSON HARREL: I just want to make one other comment regarding the measure and outcomes, and certainly, we are required to be a cannibal in that aspect. But one of the things I’m seeing that more and more grantors are asking for as well as our local Smart Start Program, are sharing the stories, and I know that’s not measures or outcomes, but I keep seeing that more

and more sharing the different individual stories about Nicanor. I'm sure all of you have certain stories of individual cases, and legislators love to hear that. They like to hear about the outcome but if you can put a picture on it, sometimes a picture speaks a thousand words or hundred words, whatever the quote is.

TONI WALL: I just want to say something, too, about measures because it has been at the state level. You have to show that your initiatives work and how you measure that, I think, is different. You can come up with numbers; you can come up with stories. But one of the things that we've looked at, and it goes back to the Healthy & Ready to Work when we started that in '96, I think, was to get youth involvement, and it's progressed over the years. Maine was one of the first ones that had a youth advisory committee to the CSHN Program. I have to say, I attribute that to Kentucky's efforts with the Commission on Children with Special Health Needs. They did a tremendous amount of work, and it was that spread meeting Eric and Cathy Bloomquist that really inspired us to move ahead. The governor—no, was it the governor who created the youth legislative task force—can I measure that with numbers? No, but I can say, "Hmm, did we have an effort or an effect?" I think we probably did to—

DEBBIE GILMER: There was (inaudible) an advisory committee in our state that I can think of that addresses issues related to kids with disability to special health care needs that now doesn't and have—

TONI WALL: Youth.

DEBBIE GILMER: --at least one kid on it that—and so, it certainly changed the way we've done business. We model doing something in 2000 that we can't talk about kids and what they need without kids, and we have a youth legislative advisory council, and so the legislature now with representatives from all the counties in the state. But so, can we directly attribute that? No, but those systemic changes that just the way we do business. At some point, but you do—most of it's by telling stories.

UNKNOWN SPEAKER: (Inaudible) when they're sitting there (inaudible)?

DEBBIE GILMER: No, we can attribute the fact that there's a youth advisory committee to the legislature because of the work we did on transition back in the '90s. And so, we can't say as a result of this grant, this was the outcome. We can say that these were some of the things that we did. But we can't say that now Maine is doing business differently as a result of that grant. There's no direct cause and effect.

UNKNOWN SPEAKER: And they don't think that the reason would be they actually did. They try to do, but they don't. It's like we took the (inaudible), they gave you the money, (inaudible), but they don't actually care to see which (inaudible)—

DEBBIE GILMER: It's not that they don't care, 'cause--yeah. Yeah.

UNKNOWN SPEAKER: I'm not (inaudible), but it's just because they spend the money and we're trying to get it together, 'cause when you're talking money and grants is that—and so, I knew that is our future, and they are the ones that basically lets you know what's going on and how it would actually do to yourself.

DEBBIE GILMER: And at a policy level, we're now not talking about—one of the coolest things we're doing right now was staffing our governor's taskforce to engage Maine's youth. Kids in juvenile justice, foster care, homeless kids, how do we make sure that those—we've got, I don't know, eight or ten kids on that—taskforce that who are living those issues--

UNKNOWN SPEAKER: Exactly.

DEBBIE GILMER: --sitting on a governor's taskforce. So, it's just the way we do business, engaging those—can we attribute it to—

TONI WALL: And maybe we can, because 10 years ago it would be the adults who are developing policy for the youth.

DEBBIE GILMER: Mm-hmm.

TONI WALL: Now, you go there and people are asking, “Where’s the youth?”

UNKNOWN SPEAKER: Exactly.

TONI WALL: We’re developing policy; let’s have the youth here.

UNKNOWN SPEAKER: Or the diversity.

TONI WALL: Exactly.

UNKNOWN SPEAKER: Absolutely. Absolutely.

TONI WALL: So, I love to pat myself on the back and say, “Yeah, it was us.”

(Inaudible) but yeah, I truly think it—I can’t measure it, but I have to say I think it was probably our efforts way back in '96 that really changed Maine’s view on youth and to include youth, and it’s still happening in many states. Kentucky is doing great things with youth—going around the table. Other states and we routinely advised other states on how to get youth involvement and youth advisory councils going, so it’s—yeah, I guess I tend to attribute to all our work back in '96.

UNKNOWN SPEAKER: (Inaudible) involved in all aspects, because they're the ones that are changing policy, more on policy change. They're the ones that's speaking up with voices, because they feel the parents aren't doing the job (inaudible) legislative offices aren't hearing their need. And it's really surprising because they start (inaudible) about nutrition.

TONI WALL: Mm.

UNKNOWN SPEAKER: And that's a real key factor, because you got some of these children (inaudible) adults, they're going to high school and onto college, then there are (inaudible), but they're weary to get diabetes and different things or granting off from that. So we had to ask also to create a taskforce for the youth because they are the future. And when you get older you get into our (inaudible) that will need that sustainability and starting out with them, and hopefully in the future you could stay.

TONI WALL: And you're right. And one of the things leading onto that is talking about EPSDT. We have just had a huge meeting on EPSDT and Medicaid loves to tell us that their numbers are really high for usage at the lower level. I think it's the zero-to-five kids. Well, of course it is, 'cause those kids have to go in for periodicity checks and you're sure you're going to have 95 percent usage rate. But by the time you get up to teens, it drops way off. And the Medicaid representative was saying, "We really need to figure out why youth don't use

EPSDT, why they don't come in." Well, I raised my hand and I said, "I have a 16-year-old, and I can tell you right now he doesn't want to go to the doctor if he's well." So, let's ask the youth to come in and tell us why they're not using the system. Well, we know why. I mean, he doesn't want to go there. I'm telling him what the doctor is going to do, and he's like, "Mom, I don't think so. I'm not going in there." And so, he hasn't been to the doctors in a couple of years. His immunizations are all up-to-date, but he doesn't want to go. I know he should go for a yearly check up but he doesn't want to go. But we need to have the youth's help, the policymakers, its okay that we're not going. We'll still feel okay. But Donnie it's very hard to infiltrate the Medicaid system because they're so bound by these regulations that, my gosh, it's only 65 percent. We'd better raise it up to 85. Well, maybe 65 percent is okay.

PHYLLIS MAGNUSON: I just want to bounce a minute off which—I'm going to drift a little bit away from childcare just as—I was telling you that we have—we're talking about adolescent health issues which are extremely important. I have two school-based health centers in Montgomery County, North Carolina. That's a very rural poor country, has the highest teen pregnancy rate in the state. Last year we had three 11-year-old girls that got pregnant in a system that's 6,300 kids an entire system. We collaborated with the Office of Rural Health for money, and then Duke Endowment, and then Kellogg, to initiate grants to put in school-based health centers and these two middle schools and these two rural counties. And you were talking about teens not going to the doctor; a big reason is access

to care. And the other reason is doctors don't want to mess with them. They're difficult to handle and they're not going to tell you the truth unless you sit down in front of them and you become a part of their culture. So, when you put a doctor's office like we'd done at FirstHealth, two doctors' offices in the middle schools, and we make them accessible to any child in the county because we have cars, any child enrolled in the school system at Montgomery County can come to the school-based health center and see a mid-level provider and get comprehensive services, including mental health, nutrition services, physical assessments and a complete--nothing that they would get in a doctor's office. The actual exam goes over a period of two days where we sort of take them in and out of class so they don't miss class time. They're also there for sick and—we do well-child checks, we build for services, we have a Medicaid exemption. We're treated like a health department in that we don't have to notify the provider. And so, the children walk out to class, and they got a sore throat, the nurse practitioner does a strep test, has strep—according to school policy they got to go home because they got to be on antibiotics for 24 hours, but just as often we turn them right around and put them back in the seat. So, we measure, we can measure absentee rates, and we can measure in-seat time, and that's what we call it. But you have to know the audience that you're talking to. If you're talking to educators you got to talk education. You got to talk 504 plan, accommodation plan, individual-education plans, you got to talk education. But when you talk into medical people, you have to talk the medical talk. We had to talk in terms of—all right, I did this last week. The superintendent calls me up and she says, "Tell me why I'm writing a check to

FirstHealth for 200,000 dollars. And I said, "It's for school-based health centers." "But tell me what that means." So, we bring in the superintendent, we also bring in the school nurses who aren't my employees, and we bring in the school-based health centers, we bring in the political people, the two people we knew on the school board that were 100 percent supportive of school-based health centers, and the county commissioner that was very, very supportive. So, while we're sitting around the room and she goes, "Tell me why we're doing this." Well, I thought, you know, "I got some data. I got a little bit of data. I know exactly how many visits were made to the school-based health centers. I got it broken down by—I know how—their insurance source, I know what percentages Medicaid, what is Health Choice, what is private pay, and what is unpaid, uninsurable. I know the ethnicity of my students. I know that I have in one school I've got 85 percent Hispanic population that has very little insurance." And that's where she's going to say, "Where is that 200,000 dollars going to?" So, being FirstHealth, I called for the finance office, and I say, "Well, how much does emergency room visit cost, for an average emergency room visit cost for a child?" And they said 357 dollars. So, I knew how many ER visits we had averted because I make my staff keep that statistic when they see them come in. And we had averted almost 800 emergency room, unnecessary emergency room visits, so I'd multiply that out. And now we're talking at 600,000 dollars that this school-based health centers saving the community. Then the other stat we keep is hours worked. How many hours did we save the parents by treating them at school? And I have my staff keep those stats. And then I call up the Chamber of Commerce, and I

say, "What's the average hourly wage in Montgomery County?" It's \$10.13 in Montgomery County, the average hourly wage. But the staff at the school-based health center had saved in numbers of hours 18,000 hours of parental work time by putting that child right back in school and treating them on campus. So, you talk about marketing. You have to know your audience. You have to know who it is. If you're talking to the Chamber of Commerce, they want to hear the money, not much more. And if I want to hear a story or two, which we can tell you a lot, but if you're talking educators, they want to hear education. And what is it that you're doing that's keeping that child in the seat so that they can learn? And if you're talking to medicine, you got to talk in terms of outcomes, performance measures.

SAM COOPER: Sure.

PHYLLIS MAGNUSON: And so you have to know your audience. You have to know who you're marketing to, and you got to keep a little bit ahead of them because they're going to ask you these kinds of questions. Does that help a little bit (inaudible)?

SAM COOPER: Sure. Sure. I mean, let me ask you this; a follow-up to your vision story.

PHYLLIS MAGNUSON: Mm-hmm.

SAM COOPER: Hundred percent vision screens, 89 percent have glasses now. I'm assuming that's 25 percent that actually needed the glasses.

PHYLLIS MAGNUSON: Right.

SAM COOPER: How did you all address the gap? What was it that you did collaboratively that has put more glasses on faces?

PHYLLIS MAGNUSON: Okay. This is exactly what we did. We brought the school nurses in first, and I said, "Why is this number so low?" And they say, "Well, for one thing we can't get to our Latino population because they don't understand English." So, we converted our forms that we sent home into Spanish. Then, I got a grant in that particular area of the country, long-term I got a grant through the Department of Health and Human Services, and I specifically wrote that job description for a Spanish-speaking nurse. I didn't want one that could not speak Spanish because she's getting home. So, we got that part done. The biggest thing we did—well, Sharon and I, I guess it's our baby—is what we call in Kids in Crisis. We took the stories to the community and we started talking to church groups about these gaps in services, about children who—I'll give you a perfect example. This is one of the stories Sharon's heard me tell before. You go over for, you get yourself in public, and you talk to community groups, church groups, anybody to listen, and guess what? If one hears you, the ball will start

rolling. With Sharon, for two years we've done this. And together we could probably raise maybe close to half a million dollars together?

UNKNOWN SPEAKER: Close to.

PHYLLIS MAGNUSON: Close a half a million dollars, Sharon and I've raised, fund raised for—just health needs for children. Well, but what we said these were the stories that we told. I have a 16-year-old who's 27 weeks pregnant, and this is the truth. And she presents to the emergency room at 27 weeks with a urinary track infection. Because her mom's kicked her out and she's 17 and she's not going to have that piece of trash at home with her, she's living on the streets. But when she goes in the emergency room, the doctor prescribes an eight-dollar gentamicin prescription. Now, she does not get the eight-dollar gentamicin prescription fill because she does not have eight dollars to get the gentamicin prescription fill. So, in two weeks she presents back in the emergency room and delivers a baby at 29 weeks, who was immediately taken up to our intensive care unit and runs up a hospital bill of 367,000 dollars. Now you tell me, for the rest of that child's life, what we're doing—when I first went into nursing, abortion was legal at 25. Now we're saving them, but we're not saving them without is called disable longevity. We see them in the schools, we do trakes in the schools, we do tube feedings in the schools, we're doing medicine in the schools. These children, if we had paid for that eight-dollar gentamicin prescription look what economically that would save, because that child now has cerebral palsy, and it's

going to be a ward to the state, the rest of her life is going to be on social services, some kind of work, the rest of their days, over an eight-dollar gentamicin prescription. Does that make sense?

Those are the stories you have to get out. And you have to tell the truth to anybody, they'll listen. And when you can do that and you prove that economic outcomes, then the money comes in. Doesn't it, Sharon? And we have very little bureaucracy. The school nurses call me, they say, "I think Suzie's arm is infected and, well, she needs to go to the doctor." And she goes to the doctor and we agreed with them. They bill me the Medicaid rate. We pay them. We save them a day at school. We save the whole Medicaid, the Medicare, the whole hospital system a lot of money. And people have responded. People that you wouldn't even think would respond. They open their wallets and they give you money. And that's collaboration.

UNKNOWN SPEAKER: It's really weird because in Connecticut, we have already two clinics, full-blown clinics that are operating, at least I know in (inaudible) is other areas that have it. But the reason why I really wanted to come here, and I'm glad that you guys are innovating, what happens to the rural part in Connecticut. And exactly what you're saying, exactly what the parents were saying and the children were saying, as far as the collaboration, and I feel that I got really a lot out of this (inaudible), is to collaborate together so that we can go to the legislative office. I might be a little bit—to fight a lot more for what is

needed as a whole person like you said, and not just because we live in the city. Because even with the inner city we have a lot what you guys are still fighting for now. It's utilized, but not as much as it should be. So we go back now into the community and reiterate what they (inaudible) school-based health, what they can get out of it, what we're fighting for, talking about that you're saying (inaudible). We're fighting for to make sure we get (inaudible) outreach worker--

PHYLLIS MAGNUSON: Oh, yeah.

UNKNOWN SPEAKER: --through Medicare.

PHYLLIS MAGNUSON: Oh.

UNKNOWN SPEAKER: So, you did (inaudible)—

PHYLLIS MAGNUSON: You fight for that, 'cause—mm-hmm.

UNKNOWN SPEAKER: (Inaudible) first and put in place, so that when you come to go for a medication or you come for an insurance, she's actually on site. So I think I would say--

PHYLLIS MAGNUSON: Exactly.

UNKNOWN SPEAKER: --we think we got it bad with these guys. These people, they have 100 percent and still worth it.

PHYLLIS MAGNUSON: Right. That's right. All right. I'm going to shut up.

SHARON NICHOLSON HARREL: I would like to say that Phyllis is being very modest. You talked about raising (inaudible). She's been very modest. I just tag along. She raises about 90 percent of that, so I just tag along and give a few words, but you can see her compassion. I think right now, well, I'd like to ask, would you like to take a break now? Well, we're going to take one at 9:45 and this seems to be a good stopping point if you'd like to take a break now. And then we'll come back and do the mapping tools.

UNKNOWN SPEAKER: Yeah.

SHARON NICHOLSON HARREL: Okay. We'll take a 15-minute break.

UNKNOWN SPEAKER: Yep. Yep.

SHARON NICHOLSON HARREL: Okay.