

AMCHP Annual Conference, 2010

Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

**State Programs to Identify and Improve the Health of Children with Autism
Spectrum Disorders**

and Other Developmental Disabilities

March 6-10, 2010

BONNIE: ...early identification, we have issues around insurance and the adequacy of benefit programs, transition planning, if we think childhood is an issue, growing into adulthood and living as an adult is even more challenging, and then of course the whole issue of inter-agency coordination.

To address all of these issues, congress passed the Combating Autism Act, and essentially what that legislation did, was provide funds to NIH for research, CDC for surveillance and research, and to HRSA, to increase awareness, to promote evidence-based interventions, reduce barriers to screening, diagnosis, trained professionals, we didn't get most of them, but we certainly got a large part of the responsibility, and these are the areas that are so difficult to change. The change and the challenge that we heard in this morning's opening plenary. So we will try to do that rider in the elephant approach.

These are some of the things that we were told, challenged to do, with the Combating Autism Act, you're probably familiar with them. We have programs in four areas, and we're going to talk about all of them a little bit, but we're really going to put a lot of emphasis on the state infrastructure in today's session, but I just wanted to give you an idea of the bigger program as well.

Actually the vast amount of the money that HRSA got for the Combating Autism Act goes toward the training and research piece. In the training area, we are charged with educating interdisciplinary health professionals, providing continuing education and technical assistance, and we'll be hearing from George with more information around that, and contributing to building systems of care. Actually all of this effort is to build systems of care, whether it's training, research, or direct systems work, the end result has to be a better coordinated system of services for children, youth, and their families.

And here I've indicated some of the strategies that we are using, expansion of lens, expansion of developmental behavioral pediatrics training programs, and we have, as I mentioned and George will be talking more about, the national interdisciplinary training research center.

The second prong of the program is a research focus. We, here you see the purpose, I'm not going to read that to you, but as you can see, it's again, guided toward improving that system of care, utilizing this network of research programs, not starting a brand new one, but creating a platform of integrated coordinated research. Developing

evidence-based guidelines and disseminating information. To do that, we have two research components, one is focused on physical health and one is focused on behavioral health.

The third component is our state demonstration program. Interestingly enough, we got no specific funds through the Combating Autism Act to do this, but we knew that we couldn't implement that legislation without having an opportunity and a strategy for playing this out at the state level and you're going to hear a lot more about that from Travis and Jamal as they talk about the program in Alaska.

Here's the purpose, I'm not going to go into that, because I think you'll hear a lot more about it. And then finally, well, here are the states that have state programs. I don't know why I highlighted Rhode Island there, I meant to just highlight Alaska because they're the ones presenting today.

And then the last area, we have training, research, state demonstration, and we're not going to talk about this today, but you should know that we're involved in a very large and complex national evaluation of this program. With CDC integrating the training program, the research program, the demonstration program, and we will be preparing a report to congress to show how we're doing.

The last thing I want to mention is that we're, as many partners as we have at the federal level, at the national level, and at the state level, we are also partnering outside

of HRSA and the Title V community and very, very much with CDC and I just wanted to outline some of the partnerships that are going on between HRSA and CDC, that you don't always get an opportunity to see. We're working with them to identify multiple areas of collaboration, we've identified and we believe that we have a healthy people 2020 objective, very specific to ASD. We've worked together on the National Survey of Children with Special Healthcare Needs, and the National Survey of Children's Health. We collaborate around the summits that we're going to talk a little bit about later, and we've also collaborated on how to get the Learn The Signs Act Early Campaign into the programs, all state programs, whether they have a grant or not.

This is our website for autism, www.mchb.hrsa.gov/autism, and I hope you'll all take an opportunity to visit that site.

So now, with that context, I want to briefly introduce the remaining speakers. Grace Williams is going to give an overview of the AMCHP Coordinating Center and some of the work that AMCHP has been doing, but also, the important role of families in this whole endeavor. And Grace is going to be introducing the next section, but also talking a little bit with Alaska as they go through their presentation. Then Grace is going to turn it over to Jamal Lawson and Travis Hedwig to talk about the Alaska Program. Jamal leads that program and she currently serves as the Public Health Specialist for the State of Alaska's Combating Autism Act Demonstration Grant. Her work with local and state agencies to coordinate a managed care for Alaskan children and adults with special healthcare needs since 2003 has given her the opportunity to connect with families of

children with autism and with healthcare providers throughout the state and the nation. She's committed to further developing systems of care, to support children and adults with autism and other neurodevelopmental disorders within their home communities, and she's a very strong advocate for early identification and intervention. She works closely with families and multidisciplinary teams to address adulthood transition issues, including residential and employment opportunities. She looks forward to continuing state and national efforts to increase autism awareness and ensure people who experience autism have access to diagnostic services and ongoing support, as needed, to lead healthy and fulfilling lives.

And then Jamael and Travis will turn it over to George and I don't think anybody needs to introduce George Jesien, but just in case you do, you don't know George, he currently is a CEO, is that, of AUCD, I never know whether it's CEO or director or what it is, but anyway, George began his appointment as executive director of AUCD on July the 1st, 1999. His experience includes extensive administrative and supervisory responsibility, most recently as the executive director of the Joseph P. Kennedy, Jr. Foundation, since 1997. In this role, he directed and managed foundation activities, including national grants management, public policy fellowship program, the associate trustee program, and fiscal management of the foundation budget. Gee, George, I didn't even know that about you. He has served as principal investigator for a series of federal, state, and locally funded projects in personnel preparation research, materials development, outreach, direct services, and information dissemination.

So you've got a cast of extremely well prepared and knowledgeable presenters here and I welcome you to the session and know that you will enjoy it. I'm going to turn it over to Grace at this point. Don't forget to fill out your evaluation forms before you leave the session, I'm going to start them through as Grace begins to talk.

GRACE WILLIAMS: Thank you, Bonnie. Good morning. So the project that Bonnie talked about, the State Demonstration Grant, that is, AMCHP passed the cooperative agreement with Mental and Childhood Bureau, HRSA, the State Public Health Coordinating Center for Autism. It is to increase the capacity or improve, but some of the states, the nine states that Bonnie put up, we had six states for the second year, going on the second year, and the last three states, New Mexico, let me go back to the first states again, Alaska, Washington, Utah, Wisconsin, Missouri, and Illinois, they are on the second year of this grant, and New Mexico, New York, and Rhode Island are on the first year.

And all of these states had programs already in autism and developmental disabilities and this is to increase the capacity for their state programs demonstration, so all the other states could improve the services.

Most of the activities that we have are to have a virtual resource center, we call it SPHARK, and we have it, both the public site, and the private site, State Public Health Autism Resource Center. The public site, that's where we put all the resources, the information that we collect, so all the states can access, and then we have a private site

where all the grantees come together, use it as a working center while they are working on their challenges, their **** is there, activities to coordinate all of those.

And we, AMCHP, we provide the technical assistance for all their needs, coordinating the help that they need improving the services.

And this is the site that we have for the public, so please take a look at it. And here, too, the technical assistance that we will be providing is to provide a health, public health policy framework, so we could have an ideal, a model framework that all states could follow.

And also, one of the most important things that we are finding out is the peer to peer mentoring. Some states have been there, done that, and they have faced the challenges so the other states don't have to repeat it. They have had the successes, so that's what we do, that's this year, we'll be pairing the states to improve these services.

And like we talked about it this morning, the best practice, what works, so target on what works so it's much easier to do the change than to look at the problem. So we are big on collecting best practices and sharing the wealth among the states. And how we do this is we conduct topical calls with experts. We partner with all the national organizations on the needs that they have out there and conduct a technical assistance call every two months.

And some of the technical assistance needs that Bonnie has already put out what they had on the grant is almost, some states have focus on a few things, but these are the most important things that they're all working on, recruiting physicians, the family physicians in the rural areas, and also when it comes to transition, this has been a major issue for all states. To train the providers, it's a huge area, screening, the diagnosis, and as you all know, the pediatricians as well as family physicians, they did not have much in their medical school or in their training in the past, and so this is an area of interest to all the grantees.

And financing, without, it does take a lot more resources, financing, to serve the children with autism and developmental disabilities, so the states are looking, how do we fund this, how do we incentivize the providers? How do we provide the financial resources to improve the services? That's another area of interest.

And as you know, families, they have been the most resourceful partners for the children because when they were reaching out to their states, or their providers, or the agencies, or the educational system, they did not have the answers. So families have found ways to improve the services so the states would really like to, they work with the families as partners and as you know, we have lots of successful stories and that's another area we work, and care coordination. Children with autism and developmental disabilities, not just go to a pediatrician or a family physician, there are so many other specialists that they work with. So this is an area that we are working on, in fact we had a technical assistance call, how to coordinate the care, the state's benefited a lot, we

had a great discussion, and we had a lot of great feedback. So all of that is posted on the website, we record the calls and it's posted on the website.

And like Alaska, and so many other states, we have rural areas and cultural competency, reaching out to different population has been a very important topic for the states and we are able to provide the technical assistance in reaching out to rural areas, as well as the other cultural competencies. We work with the National Center for Cultural Competence to provide the technical assistance.

Transition issues with youth, my daughters are 18, so I'm going through that, I know how hard it is to find, transition them from the pediatric to adult healthcare. Our next call is going to be on that area and it's not an easy, even as we have so many partners around the nation, it's not easy to gather the experts, but we are trying because that is a huge need because our children were diagnosed long time, they are growing, they are reaching that age to transition, so it is a huge area that our team, when we did our environmental scan, this was one of the major issues that I brought up that they need help in this area.

And so that's what AMCHP is doing, ongoing technical assistance, we provide not only to our grantee states, but there are other states and other organizations reach out to us as they move forward in serving children with autism and developmental disabilities.

Thank you.

JAMAEEL LAWSON: Hello, I'm a little bit shorter. There we go, actually the perfect height. My name is Jamael Lawson and as Bonnie mentioned, I'm with the State of Alaska Division of Public Health. I'm with the section of women, children, and family health. I'm going to be presenting today, along with Travis Hedwig, who is one of our partners with the Family Voices Program in Alaska and he's going to be talking a little bit more about that as well.

Chris Green is a close co-worker of mine, she's unfortunately out of the state, she was planning to present today, so hopefully I can cover her information as well. If I don't get it right though, let me know if you have any questions and I'll try to answer the best I can.

Our objectives with this portion of the agenda are to highlight Alaska's response to autism spectrum disorder. We've been really focused on using the multidisciplinary approach and really developing those teams which would include local, state, and tribal health organizations, which our tribal health system in Alaska is very large and a very key player in this work.

I'd like to hopefully provide you with some useful examples of how we've developed those multidisciplinary teams and also work with culturally-sensitive perspective and I believe Travis will have a lot to say on that, too.

So we kind of used the pyramid model we were talking about this morning. At the top, of course, we have the parents and children that we're serving, which Grace is actually going to be speaking a little bit on as well, from that perspective, and then Travis again introducing the Family Voices and our Family to Family Health Information Network in Alaska and then I'll be talking more on our state level response to the need and then of course, George is going to wrap up with the federal initiatives with the AUCD.

So actually I'm going to turn it back over to Grace real quick here and she's going to give us kind of her experiences as a family member.

GRACE WILLIAMS: Thank you, Alaska, for making it Alaskan for a couple of minutes. What does a **** got to do with Alaska? A whole lot when it comes to autism and developmental disabilities. And the first and foremost, when we think of Alaska, we think it's a rural state. To start with, my pediatrician is in the rural areas. I live in this urban, I live in Washington suburbs, **** National sent to Children's Hospital, Johns Hopkins, Georgetown, University of Maryland, Kennedy Krieger, but still my pediatrician moved from my ten minutes drive to a half an hour to Annapolis, the capital. I followed him, then he did not, he had to set up his practice, Eastern Shore, over the Bay Bridge, that's really rural, an hour's drive, I still, I'm still following him, so I go over there to him, so that's the comment when I go out there, I feel the rural areas.

Yes, my daughters, they are 18 years old, they were, they're twins, they were born average weight, perfect health, full term, and developing typically until they were about

3, 3-1/2 years old, they were attending a Montessori magnet school where the older siblings were. They were regressing in their, they met all the developmental milestones, in fact, above intelligence and they spoke all the, met all the developments, when it comes to speech and physically, OT, everything was perfect until when they start regressing. So they were diagnosed around 3-1/2, to almost 4 years old, by the school system, because it was a county Montessori magnet school, so they were able to test them.

I went to my pediatrician, he did not believe me, this is what he told me, "Please don't listen to the psychologists, please don't believe the psychologists, there's nothing wrong with your girls, they are just twins." That's what I also thought because I had two typical children, talented and gifted, and I did not think anything else either. But then the struggle came, I asked him, please give me the benefit of the doubt, let me go to a, well, I had read every book in my library, researched everything, and said, "Oh, this is a neurological disorder, okay, let me find a neurologist." And when I contacted my insurance company, they said, "We don't cover autism." That's then. And my neurologist told me, "You have to call it congenital encephalopathy." Wow, I learned to spell it and pronounce it properly so every time I talked to the insurance company, that's when I was getting the appointments. So we have come a long way from those days.

And then of course, the services. We had to go to several specialists and my girls regressed really fast. They lost all their language, the words, at three-and-a-half, they knew every geometric shape, parallelogram, trapezium, they could tell all of that and

they regressed and one of them is completely non verbal, one has few words, and sibia complex behaviors to such an extent, so much of self-injurious behaviors, one of them, Joyce, has blinded her eye, and she's completely blind in one eye and she has very little vision in one eye, with bubble and a buckle holding, that solves sibia. So we have to deal with several specialists, behavioral supports, and things like that, but in Maryland, I'm able to stand here because of the Maryland Autism Waiver. If not for Autism Waiver, I would not be able to work or be the parent professional that I am. So we have one of the best services in the country and that qualified us for Medicaid, which covers a lot of services, like therapeutic behavioral service, EPS, PT service, that helps us to live in the community, but because of their complex, severe behaviors, they could not be included in our neighborhood school. I had all the fights like a lot of our parents had for inclusion in my neighborhood school, it did not work. So they are attending a private separate school because of not enough support system even with all the help that I could provide and we could not do that. So that's the part that I'm not pleased with, but that's what we have right now.

And I would like to talk about transition. Like that is the age that I'm in. It is scary, as the children are growing older, the guardianship, that's another issue that we have to deal with. The reason I don't practice what I preach, the transition, I can't practice it, that's why I'm going still to my pediatrician, I told him, I would be coming to you as long as my insurance would allow me to go to him and as long as he's able to see them.

So these are the challenges, even though we have come a long way, we have a long way to go in order for our children to be productive and with living in our community, functioning as much as they can, like typical children do.

So I'm so pleased when my children were diagnosed at 3-1/2, 4 years old, I remember walking to the Capital Hill going from every, there was nothing in our states, we need services, education, and healthcare services. So I'm so pleased that we have come a long way with Combating Autism Act Initiative, trying to improve the services in our states so the children who are being diagnosed, as you know, the numbers are high, and I'm so pleased to work with AMCHP as well as in this project, to come to a full circle to improve services. Thank you.

TRAVIS HEDWIG: Hi, I appreciate the opportunity to be here, I wanted to thank Jamal and the state for allowing me to be here. I don't work for the state, I work for a non-profit called Stone Soup Group, and I wanted to say I appreciate and respect our growing partnership, particularly around the Title V needs assessment that we've been working with together.

So as was pointed out before, I am the Family Voices Affiliate for Alaska and without kind of doubling up on some of the Family Voices information, there is a booth out there, you can kind of help yourself to some of the information, but I did want to point out that I really respect and appreciate the move toward family centeredness, both within Family Voices and within Maternal **** generally. I believe that families are the respective

experts on their journey, so one of my roles is to connect parents with parents and to kind of break down that siloed effect that I think we can all relate to, where in our own respective jobs, we tend to get rather myopic in our every day practices and activities. One of the values, I think, of Family Voices and the value of Connecting Parents, is to try to work to break down some of those barriers to truly build some family and professional partnerships, which is one of my primary grant objectives.

So again, I think some of the mission stuff here, I can let you all peruse the information at the Family Voices booth.

So I work for a non-profit called Stone Soup Group. We've been around since 1992, and I'm the project coordinator for the Family to Family Health Information Center. As I pointed out before, one of our primary grant objectives is to increase family and professional partnerships. We do that in a number of different ways, through some of the collaborations that we've been doing with Title V and the needs assessment, working with tribal health organizations, working with provider agencies, not only in Anchorage, but elsewhere in the state. There was a reference to rural before. Alaska is rural in a way that many people may not be familiar with. There's only 300 villages that are only accessible by airplane. I'll highlight a story from one of our families in a couple of moments related to that, but it creates several layers of challenges that I think are unique and one of the things we've been doing by building these partnerships is learning to not duplicate efforts and making sure that we can work together to really

bring the services to the families, rather than expect families to come to the services. That's also true for training opportunities and other educational opportunities.

So we kind of serve as a one-stop information clearing house to help families make informed healthcare choices. We have a strong parent navigator program, where we will connect families, connect parents with parents that are a little bit more seasoned in their journeys and we help build those networks in a number of different ways, I can talk to in a few minutes. Promote the delivery of culturally-responsive supports to families, we do that through a lot of the tribal health partnerships, and I think there may be a misperception in Alaska that there's this native/non-native thing. There certainly is that, but I want to also point out that in Anchorage, for example, there's over 92 languages spoken in the Anchorage school district. We have a growing Sudanese and other refugee populations growing, a number of different populations, and so for us, culturally-responsive is not just reaching out to the native communities, not just reaching out to tribal health organizations, although as Jamael pointed out, that really is a critical partnership because they're important resources for folks, especially in the rural areas, or I might say frontier areas.

Support youth to successfully transition to adult healthcare work and independence. We do that in a number of ways as well. We've got some youth leadership coalitions and we also have developed family stories curriculum where we pair families, parents, as well as children, with other parents and they spend some time working with one another to craft their story for a particular legislative audiences, kind of believing that the stories

are the kind of connective tissue that can service to break down some of these silos and also kind of articulate some of the different paramount needs in different areas of the state.

And then sustain the benefits to Family to Family Health Information Center. This is a challenge because the Family to Family Health Information Center funding is currently in jeopardy, wink, wink, maybe we can get some help from NCH and our state partners here, but we'll see how that pans out, we're actively working to see how we can sustain those efforts and keep our doors open beyond the end of this grant cycle.

So I wanted to really spend most of my time highlighting a story from one of our families in a community called Kotzebue. Kotzebue is only accessible by airplane, it's a small community, what is it, about 500 people, and that's actually a large community for that region, it's what's considered a hub community, so there would be several, probably roughly a dozen villages upriver from Kotzebue that would be anywhere from, you know, 50 to 150, 200 people. And one of the families that I've been working with, we've put together an Alaska Family Advisory Committee, as I was saying before, believing that parents are the experts in their respective journeys, we've built this coalition statewide, where we've got family representatives from different areas of the state and one of our families is from Kotzebue and he's been kind enough to allow me to share his story with you.

I love this picture, by the way, this is Anthony and his son, Alika. He has spoken with me at length about some of the issues they face. Particularly he has described his efforts at securing services for his son as a fight. A constant fight at that. He is what I would consider to be a very seasoned parent. He has lived in several states, he knows how to navigate systems, he is the grant writer for a tribal health organization called **** and a couple of things he asked me in particular to share, one was his challenges getting extended school year services, where in previous states, he had an opportunity to at the beginning of the year, based on Alika's needs, negotiate extended school year services because he was able to demonstrate clearly that regression was occurring when he was not in school. That's been a fight and one of the reasons for that is because over 90% of the school teachers in this area are not from there. Actually, currently 100% of the school teachers are not from there and while they ordinarily have two flights in and out of Kotzebue a day, on the last day of school they have 6 flights and they call it white flight day, because that's the day that all the teachers leave. So extended school year services are challenging on multiple fronts and Anthony has really articulated that frustration to me.

Another thing that he talked about, as I eluded to before, is the challenge of getting services and education in training to the families. While it's great if we can offer stipends for families to fly into Anchorage and get the training, because the turnover rate is so high in some of these areas, there's no continuity. Families, or school teachers and other professionals will come down to Anchorage, get some training, go back to Kotzebue, and then within a year, they've quit. And there's no transfer of those skills, no

transfer of that training. So we're now exploring ways to pilot small projects, to bring those trainings out to those regions, rather than expect those families to come to the trainings, which for Anthony would be very difficult.

Am I done here? I guess I am done here and at this point wanted to turn it over to George. We could talk, we can continue to talk some more about this after, if you have questions, I'd be happy to talk to you, but Anthony's story, I think, is powerful, in a number of ways because it speaks to more broadly some of the concerns that people are experiencing out, in particular, the rural or frontier areas of Alaska. So again, I think that's a really unique aspect of our state and the Family to Family Health Information Center is critical in that regard, because we tried to break down some of those silos, we're trying to connect partnerships and connect families to professional organizations at a number of different levels, so it's my hope that Family to Family will get funded and we'll see if my program officer is actually here right now, so wink, wink, maybe we can get this going through here.

So thank you for your time and I'll now hand it over to George.

JAMAEL: Thank you, Travis, thank you so much. Yeah, I'm actually going to speak a few more minutes then. Based on our parent experiences in Alaska, you know, that's a rather typical story, the one just expressed by Travis on behalf of Anthony. These communities are so isolated that services there are even fewer and far, more far between than they are in areas that are considered to be well served, which we all

know, really can mean different things in different areas anyway. So we've really attempted with this state implementation grant to build the services and the systems of care in Alaska around families like Anthony and also not forgetting that a lot of our urban families are experiencing a real shortage of care as well.

So starting with the families in the center, we really focused on this family-centered care delivery model. Starting at the top, we're hoping ideally, that when a developmental concern is identified, the next step would be there to the right with screening and referral, and that's an area that we've really focused on with our grant work. That would carry through, then, to the diagnostic evaluation, with right now we have one main center in Alaska, based in Anchorage at our Providence Children Hospital, that is doing the comprehensive diagnostic work, and then of course, that hopefully leading back to coordinated treatment and intervention for that specific child.

We're very fortunate in Alaska, in 2006, and actually years leading up to that, our Governor's Council on Disabilities and Special Education had a very focused group working on an autism state plan for Alaska, had a very diverse group of stakeholders come together from around the state to talk about what services were needed, what was lacking, try to start identifying some of the goals that as a state we needed to work towards to really augment services and figure out what we're doing right and what really needed to happen.

From what I heard, it was very, very arduous work and they were finally able to kind of pair it down to these six main ideas, infrastructure building, universal screening, the diagnostic clinic expansion, resources, referral and training, workforce training, and time limited intensive early intervention, which is something I'll talk about in a little bit, that is kind of a term that nobody really knows what it means at this point.

We're again, very fortunate, following up that state plan developed by the Governor's Council, two years later came the opportunity for this Combating Autism State Implementation Grant, which we were very fortunate to be one of the first six states to have these grants.

Our goals for the grant work are very closely aligned with the goals that were just on the screen for the Governor's Council. First of all, to improve early screening and identification in rural Alaska. We do have a rural focus for this because we found that there is a real lag time in a lot of these rural communities, even more of a lag than in our urban settings, from two to three years longer for kids in our rural communities to be identified with autism spectrum disorder.

Our second goal was to increase the number of children that were connected with our part C program, and that's ages 0 to 3, and of course, through them, to connect with a medical home whenever possible.

Our third goal was to align all of these improvements with our existing plans within the state, which included the state plan we were just talking about, and also ECCS, which is Early Childhood Comprehensive Systems Plan.

So for sustainability purposes, we want to make sure that all these plans are working together. So the way we structured our staffing for this project was with our section of Women and Children and Family Health, which is our Title V program in the state, Stephanie Birch is our section chief, and I believe the president-elect of AMCHP, so she's very involved with this project. And Thalia Wood, our assistance section chief, and both great leaders in getting this program up and running. Our parent services manager, Chris Green, again, unfortunately couldn't be with us today, but has done an incredible amount of work and outreach in pulling together this team prior to me starting last year as the primary autism staff.

So this is just a really basic look at some of our really important partners in Alaska, Stone Soup Group, you'll see there, is Travis' organization, been very important in getting the family supports and that Family Voice included in what we're doing and all of the planning that we've done. **** up there on the right, also another very important statewide organization that houses our Alaska Autism Resource Center, which is a great resource for families and professionals in both learning about autism and in professional development. And then Center for Human Development, also working on a lot of workforce initiatives and of course, our tribal health organization up there in the corner, and then the families, always the families.

So working toward our first goal, to improve early identification, one of our first projects, activities, was environmental scan that we did last year. Started in the spring and actually kind of took a little bit longer than we thought because school was let out and we had to wait until fall to contact some of the providers, but the goal was to identify rapid responders in the community, which would be that first contact and the first people that were really able to identify any developmental delays in a child and hopefully then learn to refer and where to refer.

So we surveyed these groups, which were three main groups, medical providers, education providers, and para-professionals and followed up then with qualitative focus group styles, data collection, which was a bit challenging and we didn't get as many focus groups as we would like, but we really wanted to look into each region and find out what the needs of those specific regions were. Alaska is huge, I think you know that, and it's been reiterated, but we have so many huge land areas with different cultures and each one, we really wanted to try to connect with each area and meet them where they were, instead of trying to impose another government program.

And so in conclusion of the environmental scan, we found that some of our original grant ideas were not yet appropriate. We had hoped to do some in-home video screening, where we would send out video cameras to some of these rural communities and ask some of the paraprofessionals to record the child in their natural setting and then those videos would be sent into professionals and specialists in the Anchorage

area. It proved to be a bit more challenging than we originally thought, HIPPA and some other issues kind of prevented us from going directly into that. We're still hoping to incorporate that in some of our plans, probably most likely with the public health nurses rather than those community health aids, which our tell you more about those.

Actually I'm going to go ahead and skip ahead, the Community Health Aid program is one that's very unique to Alaska and we have, as Travis was saying, we have 300-plus very rural communities. A lot of these have little to no healthcare access beyond the program that's been developed to take care of their needs, which at this point, there are 180 village clients and they are the first link to the Alaska tribal health system for about 60,000 Alaskan natives in these rural areas.

Now, these community health aides are often high school diploma equivalents, but have then received extensive training through the tribal health system to kind of, they're the eyes and ears for the entire community. They do everything from delivering babies, to assisting with geriatric care. Like they're the first responders, they're everything for those communities, so we really thought it was important to connect with them and try to educate them as much as they're able, they're already saturated, they already are doing 300,000 **** per year and of course have many children in their practice. Some of which these children will not see a pediatrician until there's a real need, if they're not going into any of the main regional hubs, stay in the village, this is really their primary care provider.

So just to give you kind of an idea of the layout of our state, I'll show you where the road system is real quick. About from here to here, to here to here, about everything beyond that is off the road system and you have to fly in, which means also that if there's a real serious medical need, the children have to fly into Anchorage, which is the very large hub there at the bottom.

These health aides are so important, we've been very lucky to have a great partner within the organization that coordinates the training for these providers and she's been extremely helpful in telling us how best to access their services and make these trainings really interesting for them. They would love to learn more, and we know that they would, we just are trying to figure out the best way how to get them that information in a way that they're going to be able to retain it.

Another goal of our collaboration with the tribal health system is to connect the siloed services, which will of course allow parents to better access services.

So kind of an outside the grant activity but closely related are these pediatric neurodevelopmental outreach clinics that have been going on for several years but are being greatly increased over the next year. There's been a great response from the communities we've been to in the past and this year, we're very excited to offer that to nine new communities around the state. And again, these are children who may have never seen a specialist before and we're actually bringing a specialist to them.

So some of our upcoming activities include public awareness campaign and we're really excited, hopefully we're going to have this public service announcement launch next month, it's actually going to feature Anthony and Alike, we're going out to Kotzebue to do recording of them in their community, to really reach out to those rural communities and make it applicable to their lives instead of, you know, showing them in an urban setting. So this is, we're going to be launching this for Autism Awareness Month, which is in April, hopefully everybody is going to celebrate, and in conjunction we're also going to have a website that will be launched at the same time, so the PSA will refer the viewers and listeners on the radio to visit our new website that is going to have expansive service and resources available throughout the state and nationally.

We're also working to adapt the CDC materials to meet the needs of the rural healthcare providers. We found that they don't necessarily want a lot of written materials, so we're figuring out the best way to reach them with maybe some more visual and hopefully the PSA will be a good way to start off with that, too. And CDC has been great, they've actually provided us with a Beta copy of one of their PSA's that we're going to try to break down and modify to make appropriate for our urban settings, too.

Training initiatives, we're working hard to design these trainings for the health aides specific to the regional needs, so that's been an ongoing effort. We actually have one coming up this month, there's a community that has invited us in and this is going to be kind of our launch for that training, very exciting. We've been working to distribute

screening tools, including the ASQ, the ages and stages questionnaire, which is kind of a basic tool for identifying very early delays, and working very closely with our **** program, too, to provide trainings for the rural healthcare providers as well.

So our second goal is again, to check children with the medical home. We've done some distribution of the AAP, the American Association of Pediatric Tool Kits, we've sent many of those out already, we're doing more this year. We're working very hard to include our Part C program in everything that we do, they have a very strong foundation and we want to help them build services that they're already doing, instead of again, duplicating, which tends to be awkward for everyone.

We want to also support our public health nurses and those first responders in each community with the materials that are appropriate for that area.

The Stone Soup Group and **** again, being very close partners, have been really wonderful over the past year and a half in collaborating with these trainings that we've been doing and word is starting to get out. We have specific audiences that are requesting information from us now, which is great. We've done a collaborative foster parent training in Anchorage and it's been requested by other groups as well, which is wonderful. We have a parent that comes with us and then our education specialist and then we're able to come on with them and kind of give the state perspective and really get feedback as well on how each community and each set of providers really wants to see the information presented. We have another one coming up with the home school

parents, which is kind of a unique population as well, got about a dozen kids with autism out in our Matsu Valley, which is north of Anchorage, who are really at a loss right now on how to work with their children in the home and provide education and support at the same time, so that will be very helpful and that was another one that's been requested.

Again, the website and then back to the training initiatives, and again with our third goal, just to kind of reiterate, we want to make sure that our implementation grant, the Governor's Council plan, and our ECCS plan are all combined for sustainability, make sure that the work that we're doing now endures and is actually embraced by the community and by the, you know, the agencies that will really be able to carry it forward.

I'll only be very brief on this, because I don't want to steal George's thunder, but last month we had a great experience in Seattle, and I see Katy in the audience, our very resilient facilitator for the Alaska team. We had the chance to get everybody together in Seattle for our region 10 meeting and it was extremely helpful in kind of refocusing and including even more stakeholders that we hadn't yet really connected with on this level and just gave us the opportunity to both continue and kind of take some new ideas home and we'll be following up with that and redesigning our state plan, actually is our goal from that.

Yeah, there's been a lot of work done on the workforce development piece, which is in one of those original slides talking about our goals. We have a BCBA program that has started in the past year in conjunction with our university. It's very exciting, we currently

only have one BCBA, that's board certified behavioral analyst. We have one in the state and she's retiring, so we really need more of that high level support for therapeutic interventions. We have some undergraduate tracks that are being developed and we're also working to do some online modules and bring in some nationally recognized speakers to do some skill based training with a variety of provider groups.

I think I already spoke to this. Oh, our lend program, that's another thing that we're really hoping to do over the next year, is increase our partnership with the Washington Lend Program. They offer a great deal of support that we are just learning how to really access, so that will be hopefully a very beneficial partnership over the next year and a half for us.

So continued efforts, again, we, through our Title V program and this grant, we want to continue to support the other plans, including the ECCS plan, to improve and increase early universal screening, that, of course, is I'm sure a common goal of most states, but we're really trying to focus on that and use all available partners to make that happen.

We're also looking into surveillance opportunities, the CDC has some funding and some structure available that we're hoping to access. You know, there's only about 14 states right now that have surveillance programs for autism and, I don't know, maybe we'll be joining that number soon, we'll see.

We also support university research initiatives. There's been a real interest in finding out how these red flags or early signs translate across cultures and to see if some of our native communities, not only the native communities, as Travis was saying, we have a huge diversity in Anchorage especially, and to see if we can figure out, you know, if those red flags apply from one culture to the other. And then our telehealth system, which is going to be a great resource once we get it up and running. Those rural areas are going to be much more accessible.

And just to wrap up, of course our transitions, being a huge, huge theme throughout, all of the sessions I've been to so far and really very related to our children with autism. We want to make sure that, you know, parents and families moving from rural to urban areas are properly supported if they choose to do that and if they choose to stay in their home community, making sure they have the best supports available there.

Bring the kids home initiative, happy to talk about that more later, looks like we're running out of time, and then of course lifespan issues, just really trying, we're going to be focusing on that, especially with our university partner, to really work on those transitional issues and see if we can kind of smooth out our system and eligibility requirements to make that an easier process for families, because, of course, when a child is home, whether it's in rural Alaska or in urban, home is the best place for everybody. So thank you very much.

GEORGE JESIEN: Good morning, my name is George Jesien, I'm going to take the last 15 minutes or so and leave some time for, I feel like that cigarette on that presentation. Well, I don't know, how's this. There we go. Good.

To shrink the elephant a little bit for you, this session is really a combination of two proposed sessions that we're going to be looking at, sort of the statewide efforts around the country toward early identification. I want to point out, there's a little footnote here in the original presentation, Georgina Peacock, who is staff at the National Center on Birth Defects and Developmental Disabilities, was going to join us and we sort of combined presentations, so I have plagiarized, I mean borrowed, she has shared some of her slides about the Act Early Campaign. And I also just want to acknowledge Jennifer Bogan, if she would raise her hand, and Katy Beggs, in the audience, who have been working on these summits as we've doing them across the state.

The shrinking the elephant part of the speech is really, I think as Grace so ably presented, autism is complicated, it's lifelong, it cuts across all kinds of agencies and disciplines and family concerns and service systems and at the same time, because it is so complex, it really does afford us all an opportunity to look at the way identification procedures, services, supports to families are planned, organized, coordinated, and delivered. And if we can learn to sort of work together in the area of autism, that same system, I think in a way can be used for all families that have children with developmental disabilities. And you'll here through this presentation, sort of an emphasis on autism, but it's meant to really say, autism and other related

developmental disabilities. Looking at each child has his or her own specific needs, autism does provide some particular specific challenges, but in fact, the systems we develop should be addressing the needs of all children.

Let me first start out with our work with CDC. They have three major goals in this area, one is surveillance and monitoring. The second is epidemiological research, examining risk, and protective factors. And the aspect that I'm going to be talking about more is the Learn The Signs Act Early, it'd be interesting to hear the speaker this morning react to that basic message. Is it concrete enough, is it directional enough, and does it provide enough information? But Learn the Signs Act Early is meant to be a public awareness campaign. Let me just, for kicks, those of you who are non-Feds, how many of you have heard of the Learn the Signs Act Early campaign in the States? All right. A good percentage, but certainly not everybody.

Learn The Signs Act Early is a communication campaign and sort of CDC's role of public education and public awareness that is meant to build capacity across the country in the early screening identification, assessment, and diagnosis, which would lead ultimately to services for children with autism and other developmental disabilities. It is meant to engage partners across professional and parent groups and there's a large evaluation component to it, to measure its impact to it and it's success.

The objectives of the campaign are to raise awareness, increase knowledge, increase parent provider dialogue and to increase early action. Those of us who've been in the

business for a while, and it goes to Grace's comments again, how long have we heard these stories of parents having an initial issue, worry, concern, and the service system not immediately responding to it. Having a, well, let's see and wait, let's see if the child grows out of this, you're too concerned, too anxious about development versus attending to those kinds of signals. And in many cases, that mother and mother and dad's initial indication being the correct one, that that gut feeling of there's something going on, something that ultimately does prove to be right.

And the second, I think, element here that combines or binds with the research, the very clear message, not only in autism, but in other developmental disabilities, the greatest bang for the buck for intervention is to catch it as early as possible, the **** to neighborhoods research showing the greatest plasticity as early as possible in terms of interventions and that the intensity of interventions needs to increase as the child gets older and the easiest time to intervene is early on.

The targets for the campaign – healthcare professionals, meaning pediatricians, family physicians, physician assistants, etc., parents of young children, especially those ages four and younger. If you look at some of the data recently, we still have the age of initial diagnosis in this country for autism. Around four and a half, four years, eight months, somewhere in that category, the capacity of our folks is to diagnosis at two and a half, and some are pushing the envelope to two, 24 months and below. So we have at least—

UNIDENTIFIED SPEAKER: ****

GEORGE JESIEN: I'm sorry?

UNIDENTIFIED SPEAKER: 16 months.

GEORGE JESIEN: Six to eight months there are some initial indication—

UNIDENTIFIED SPEAKER: 16.

UNIDENTIFIED SPEAKER: Yes.

GEORGE JESIEN: 16, around the time when language gets formed, certainly some research pointing in that direction, but in terms of sort of general practice, we're still probably at that 24 months. And that clearly will get pushed. So we have at least a two year gap when we could be catching so many more other children.

These are the materials that CDC has produced. If you haven't used them, they're free, they're available, they can get shipped out to your states. They're also downloadable from the website at CDC and even more so, they have a firm that will actually work with a state or a particular group to adapt those materials to local needs, so that they may make sense more in a state like Alaska or Florida or California. So, a resource that certainly could be used.

Let me move on to what I think is in some ways a very innovative, if not unique, organizational structure. AUCD, which is basically an Association of University Centers and Programs that have as their mission interdisciplinary training, research, the demonstration of evidence-based exemplary practices, and the dissemination of those practices out to families and professionals alike. Have partnered under two cooperative agreements, one with HRSA and the Bureau, the MCH Bureau, the other CDC and their National Center on Birth Defects and Developmental Disabilities, to bring the overlap in some of the mission of all three of us to address this problem of early identification and screening. And what we've done are, and I'll try to describe these very briefly for you, our series of Act Early summits, which are then followed by small Act Early mini grants, and then also had a number of current and future ideas for some research projects that may build on some of those efforts that I'll talk about at the end.

So the overall idea here is that public awareness is critical and important, but not sufficient to get change to happen. And the basic premise here is that pediatricians will not refer and identify autism and other disabilities when that's in question, if they don't know what's going to happen after that referral. It's difficult for a pediatrician to say, "Here's a problem, but I don't know what you're going to do with it." Pediatricians are doctors who are asked questions, who are there to resolve a problem and so the idea of having an entire system from that early point of doubt and concern to the actual incorporation of assessment and diagnostic information into coordinated services, makes that early referral that much more likely. And so the idea behind these Act Early

summits was to bring people together across different sectors, if you will, that deal with children. So to spread the awareness, but I think in some ways much more importantly, to develop a common understanding among stakeholders of the opportunities, the challenges, and the barriers to developing a system, sometimes I think of the way, it's a pathway, a template, a set of sign posts on that journey for families from their initial concern to appropriate and sufficient services.

And then lastly, you know, those of us who work here in Washington think we, in a sense, solve problems. The reality of it is, we provide forums and venues for the states and communities across the country to solve the problem. I'm an educational psychologist, I haven't had my hand on a child, probably close to 13 years now, but I do still remember from my days of working out in the schools, that's where the actual supports and services, and it's in the states and the folks that work directly with families, and those of you in the audience that really can use some of these pathways in your work.

So we've held a series of regional summits that have brought together state teams into one locale to address this problem of early identification. The last one in 2010 was in Seattle and that's where Alaska participated. We have two more to sort of finish off all 50 states and we'll have one in Philadelphia and in Providence, Rhode Island for regions 3 and regions 1 in the coming couple months.

I think the innovative part of these summits is, very often when you look at early identification, you'll have something done in education, you'll have something done in the health and medical side of things, and you may have a third thing done in the social services and mental health child care side of things. We really tried to bring together folks that included families, advocates, service providers, both private and public, as well as health education and to the degree that we could, social services, including Title V programs and children with special healthcare needs.

I do have to say, I think this is much less true now in our third year, and our first year when we called a couple Title V directors, we were told, "Sorry, we don't do autism, it's not sure what we would have to contribute." I think the demonstration grants have gone a long way to show, now, this is really an issue for all of us, that we're going to have to work together to figure out. So these are some of the stakeholders that have been invited to these summits.

The outcome of these summits is an individualized state plan that each state will have to work on, not to come up with a set goal that we've put in from Washington, but rather to identify what their next step is toward a more comprehensive, complete and coordinated system. So they identify gaps in challenges and I think those of you from different states, you may have others, but these are some of the very common challenges, trained professionals, disparities among various population groups, lack of funding, and lack of services to certain under-served populations. These were some of the, as we abstract from the states, some of the overall kinds of outcomes that people

were looking at, seamless transition from service systems, especially when you have your part C or early intervention program different from your three to five year old program, and then this idea of addressing disparities in under-served population. If you look at some of the prevalence data, there's some very wide discrepancies across different ethnic and racial groups. High priority activities, work key state holders, disseminate information, and create a statewide system of technical assistance. One of the states, Kansas, where diagnosis was seen as their problem of lacking sufficiently trained personnel. Their solution was the development of five state teams that would be placed in different areas of the state, trained and supported from their university interdisciplinary hospital folks as a means of expanding their diagnostic capabilities throughout the state.

The mini grants, very small in amounts, \$3,000, but a way for the teams to keep meeting and dialoguing after the actual summits and to develop some of their activities. State teams have continued to meet by and large, I don't mean to present this as a total success across all states. In any group thing you're going to do, some states are going to be more effective than others. Some states have really taken off to the point where their team, because of the presence of a state legislator, who then became a champion for autism and developmental disabilities, actually got legislation passed to better coordination and greater focus on underserved population.

Let me just finish with talking about some of the research that these projects have spawned. One is to look at the possibility of using parent detailers. This is a model

taken out of drug companies who send drug detailers into pediatric practices to talk about a particular drug. These would be parent detailers who would go in and talk about the importance of early screening and identification, and then projects for reaching particular populations that have been hard to reach.

Things that we would like to do in the future is to work much more closely with the state demonstrations. If you will, let me just throw this idea out, the demonstration projects are covering a bigger area on a much more intensive manner. There really is almost an opportunity here to study different methodologies of producing state change. Something that may reach all 50 states, but at a much less intense level versus something that has considerably more funding at a more intense level and sustained over a number of years. To look at what the respective payoffs, in terms of change **** might be a real interesting question. We look to have some additional targeted funding for further summits and states and the idea of trying to capture the lessons learned and the nuggets of practice, if you will, from these states is something that we would like to do in the coming year in cooperation with MCH and CDC to see if those lessons learned couldn't then be promoted and disseminated to other states.

And then the last, I think, would be the idea of trying to identify some benchmarks that we could use to assess where states are, not in their process, but in their outcomes of full and total screening of all children for developmental disabilities, including autism as part of what the state assesses.

So thank you very, very much for your time. I'd like to stop now so we have some time for questions to anybody in the audience, I think including Grace and Bonnie. So thank you very much.

BONNIE: That was great! I didn't have to stop anybody, you are new, intuitively. I want to make one announcement and then I think we have about 10 minutes for questions because the ballroom is right in back of us, I think, just go through the door, but I'm asked to announce that the lunch is going to start promptly at 11:45. So we're asking you to go directly to the Cherry Blossom Ballroom and get seated when we leave here rather than hanging out in the hallway.

How about any questions for the panel? While you're thinking, I want to ask one of Jamal and that is, the Bring The Kids Home program. I was just intrigued by that and I know you were feeling a little pressed for time, but I would love to hear a little bit more about that.

JAMAEL LAWSON: Sure. Can you hear me? Is that working? All right. I just have a soft voice, I can't even hear myself. The Bring The Kids Home initiative is actually an effort that began with our behavioral health program in the state. We found that we had a number of children that had such a high level of need that as a deinstitutionalized state, we simply weren't able to meet the needs of these kids and they were being sent out of state for treatment and residential facilities, here in the lower 48.

So when the numbers started getting high enough, people really started paying attention and we really, you know, able to identify, some of the systems gaps were also realizing that while we did need to give that option as a state, it really shouldn't have been the first resort. So the Bring The Kids Home initiative has been a wonderful, and multidisciplinary effort as well to figure out, you know, where are the kids that have these especially high needs, where we're really lacking in services, and how we can get them back into their home communities and adequately support them. So that's been a major initiative throughout the state for the past several years. The numbers were really on the decline for some time, but unfortunately I just heard that they're starting to go back up. So yeah, we still have a lot of work to do in that regard. But that really related to our autism work, though, because it's believed that about a third of those kids are on the spectrum and that probably more than behavioral help, they need, you know, greater support to meet their developmental delays in their home communities.

BONNIE: Thank you.

TRAVIS HEDWIG: Can I add something to that? Bring The Kids Home is actually losing its funding. I work on that actively, a lot of the families I work with have expressed concern that their kids have been in and out of state. At various points, there are as many as 400-500 kids that are shipped out of state, which is kind of ironic, considering Alaska hailed victory after claiming itself to be institution free, now they're just sending a lot of kids out of state. Fortunately, well, one of the positives of Bring the Kids Home is that it's raised awareness of that problem, which Jamal has just pointed

out, but it's going to be losing its funding this year and there's a lot of concern about what that's going to mean for families and their kids that are currently out of state.

BONNIE: Deb, and then a question back here, and then we're going to adjourn.

UNIDENTIFIED SPEAKER: Just quickly, the extent in which the state demonstrations, and I'm not sure to whom this goes, the state demonstrations are working with the D70 grant. It seems like sometimes where it's stuck building systems, working on systems building, and then we have categorical kinds of efforts going on and they're a lot of integrated system work going on in 30-some-odd states. I'm just wondering to what extent the, I don't know, autism grants are partnering or working with the D70.

TRAVIS: I can maybe just say briefly that I think there still is a lot of the silo effect in Alaska. While I think there is a big push toward integrated systems and increased partnership, like for example, we weren't invited to the regional summit, for example, and that Family Voice, while it's becoming increasingly valued, there still are a large number of context in which, you know, we don't really even get invited to the table.

BONNIE: Deidre, did you want to respond to that and then—

UNIDENTIFIED SPEAKER: Yeah, I just wanted to make a comment about it ****

UNIDENTIFIED SPEAKER: I'm wondering if you can comment on the thinking around expanding support surveillance efforts, I think, Chris here eluded to the **** to be included in the **** network, but it appeared that in fact, the support to that was actually decreasing **** so, you know, I think, we have a huge challenge in dealing with administrative data as it relates to prevalence, so we get our data from the school systems, special ed school systems, but it's not true population prevalence. I think it's played out Minnesota in regard to **** disparity from population because of, you know, the participation rate in special education programs. So I just think it's a real challenge and I'm wondering if the discussions and thoughts are about that?

UNIDENTIFIED SPEAKER: From the federal level or in Alaska? Let's start with Alaska.

JAMAEEL LAWSON: No, that's a really great question, it's something that we've been struggling with and as far as monitoring our own effectiveness with some of these programs, it's really hard to say because we don't necessarily have that base line data, of, you know, who's already been identified. So we, yeah, we don't yet have the surveillance system in place. Our university programmer, along with our Title V Director, are kind of looking into it with the CDC to see if it's something that we could do. I think in the past it's thought to be, you know, there could be initial funding to kind of get the groundwork laid, but then there's the issue of sustainability. And if you want to continue monitoring, it's really important that that be in place before you really start and I think that's been the state's approach thus far.

We do, you know, we get some of our information from the school system, I believe there's a little over 600 kids that are in our state school system right now that have been identified, but there's also discrepancies on, you know, what the diagnosis actually is to be counted in that, if it's, you know, PDD NOS, it might not be included, if it's Asperger's, you know, I think they're looking at just the actual autism diagnosis for those numbers.

UNIDENTIFIED SPEAKER: In fact in Minnesota, it's, I was just going to say, in Minnesota, because the state is quite generous in terms of criteria for access to special education, you know, our autism rate based on administrative data, are quite high and, you know, our **** is particularly concerned, because they see the participation rates, that data is indicating that, you know, their rates are way higher than other populations. We're looking at that, so, you think, you know, there's definitely something going on there, but, you know, again, if you have to do with true population prevalence ****

TRAVIS: Actually I think that that speaks really powerfully to the cultural piece at work here, especially in Minnesota where you have a strong **** population, we actually have a growing population there in Alaska as well, but it speaks to the differential rates through which families might be willing to subject themselves to those surveillance modalities and I think that can actually skew a lot of data.

But I was just corrected, we were invited to that regional 10 summit, I did not know.

BONNIE: And George's last comment, don't forget to fill out your evaluation forms and leave them, at the back.

GEORGE JESIEN: I just wanted to add, the whole issue of collecting good surveillance data is a real challenge in this country and in some ways we shoot ourselves in the foot. We have legislation that makes it very, very difficult for health and education to work together. There's a thing called FERPA around educational data, really I think in some ways, we need to address so that one agency can talk to another agency to say, "What's the best way for us to look at this data?" Rather than trying to find individual workarounds. The Adam sites right now, some of them have access to education data, others do not, it's no way to run a candy store or to collect data on kids on topics as important as this.

So I hope that we can work this out and it is going to take some, probably some legislative and some fairly high level federal cooperation, but I would certainly hope we are moving in that direction.

UNIDENTIFIED SPEAKER: ****

BONNIE: Yeah, totally agree. Well, I think that's one of the things that we can all, that's another thing we can add to that lost, as the working more on collaborative surveillance, that's useful.

Well, we'd love to thank all of you for coming, please join me in giving this wonderful panel another round of applause. I'm sure they'll all be around if you want to catch them in hallway, after lunch. But right now, everybody should head to the ballroom for lunch. Thank you again.