2011 AMCHP and Family Voices National Conference: Welcome Plenary and MacQueen Memorial Lecture

02/13/2011 Omni Shoreham, Washington, D.C.

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>> Steve goes to work at Aunt Martha's Healthy Start Project in Chicago Heights, Illinois. I'm coordinator for Perinatal Health Services.

>> Tell me about Aunt Martha's Healthy Start Project. We target high risk pregnant women and infants under two. We make sure they get health care and their children get immunized and screened for any developmental delays, and things of that nature.

>> What's rewarding about the work you do?

>> A lot of times, these women and children wouldn't get the services if we weren't there. We help make them aware of services that might be in their neighborhood, but never knew anything about them, so that's really rewarding. Also, just being an advocate for them. These young ladies need support systems. They may be new to the area, or don't have family support, or for some reason don't have it. We are ready to be there for them, so that is very rewarding.

>> Why do you think the work you do is important?

>> Again, without our programs and others like it, these women would be doing without adequate prenatal care. The outcome of their pregnancy might be compromised. Unhealthy babies, low birth weight babies, or possibly infant deaths.

>> I am Wandy Hernandez and I work for Health Connect One, which is based in Chicago, Illinois. My function there is as a senior trainer.

>> What do you find rewarding about working in the area of maternal and child health?

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>> What I find rewarding in maternal and child health is working with mommies and babies and making sure that they're healthy early on, prenataly, and postnataly, and just everything, the bond. It just really lights me up to see a mommy and baby together. That nourishing.

>> What's challenging about the work you do?

>> Lack of funds. In the social agency world, there is a lot of maternal and child health services that are being cut off. Everyone is having to face challenges in providing this service, especially the extended ones, to low income. Where we come from, there is a lot of poverty in different areas. We really need the funds. It's really lack of funds that really hinder our work. The reason that I love what I do is because I am actually a member of the community that I serve. I see the importance of health, and the lack of health that there is. It really drives me when I'm in front of people having chats or being in Laundromats or in churches talking about the importance of heath, and being that link to the health care system.

>> Great.

>> Hi, my name is Lori Hasket and I am the Director of Injury Prevention in the Kansas Department of Health and Environment.

>> In your work, what do you find gratifying?

>> The work that we do is so gratifying because we can see results related to preventing injuries with kids.

>> And what are the challenges in trying to do that work?

>> I think one of our program partners says it best when we talk about challenges related to our work. We have new parents that are born every day, so our jobs will never end. Parents have different kids, different ages, and injury

prevention effects kids at different ages in different ways. And so, our work will never end. We would love to see it end, though. All kids being safe in everything they do.

>> I'm Judy Theiry. I'm Maternal and Child Health Coordinator for the Indian Health Service. I work here at headquarters in Washington, D.C., Rockville, Maryland. I manage anyone from women in childbearing years to pediatrics to children, zero to eighteen, children with special health care needs, adolescent health.

>> The whole gamut. What's the greatest challenge in the work you do?

>> I think to communicate the needs from the field, and our constituents, as well as the providers, nurses, midwives to our health care system. To communicate those needs across agencies, the Federal Government, and across states.

>> What's most rewarding about the work you do?

>> Everything. I love my job.

{Video Ends}

PHYLLIS SLOYER: Good Afternoon. When I looked at that, and I saw those pictures, and I look at all of you, I celebrate you. What a phenomenal job each and every one of you do every day on behalf of women and children and families. So give yourself a hand. Now last year, I understand there was an imposter up here at the podium. I just want you to know that I am the real Phyllis Sloyer and I am president of AMCHP and extraordinarily pleased to welcome you to the 2011 conference. It is co-located with a dear friend of ours, Family Voices. This year’s meeting. This is sort of a bittersweet time for all of us. This year's meeting comes at very

important time for Title V. I think you all know we're facing some significant economic and financial challenges across this country and nation. We're going to face some reductions in our states and certainly it will impact a workforce that does so much for women and children. I know that all of you are here because you care. So I welcome you and hope that you will gain a lot from this particular conference. We're going to learn more this week about the Federal Budget as the President releases his budget on Monday. And it's true, we're facing difficult times, but you know, we've been there before over 75 years. We do what we do because we care so much for women and children. That's why it's important that you're here. Thank you for being a part of this tremendous event. I'm pleased to tell you that will our partner, Family Voices, we have more attendance at this conference than we've had since 2000. Welcome, all of you, for being here. Now, while I started with a little bit of somber note, I want to obviously encourage you to learn, to network, to have some really good times with your colleagues. For those of you who can, visit Capitol Hill and share your stories, share your successes with the policy makers who have an impact on what we do. Now this is a little trite, and I'm going to say it. When the going gets tough, the tough get going. Well, here we go, and our conference kicks this off. We have an opening session with some remarkable individuals who are going to share with you the Federal perspective from the Maternal and Child Health Bureau, the Centers for Disease Control, and the Administration for Children and Families, and then we're going to be entertained by a phenomenal group of American youth. They are here in DC. And finally we're going to end this session with a MacQueen lecturer, who I understand, is a truly barrier crossing individual and she is going to inspire and challenge us. So while we have some bittersweet things, we're also going to be challenged and inspired at this conference. And following that, we're going to try power

sessions. Those are short rapid session where you'll have the opportunity to learn a lot about what other people are doing in the maternal and child health world. That's are agenda for this afternoon. There is a lot to do, so we're going to get going. Our first presenter this afternoon is a very dear friend, Dr. Peter Van Dyck. For many years, Peter has been at the helm of the Maternal and Child Health Bureau, within the Health Resources and Services Administration. I think we know that Peter's biography and his commitment are long and strong, and his accomplishments are many. But what we see as so important is his unyielding support for Maternal and Child Health and for AMCHP. Peter is here to welcome us to Washington and to share some updates from the MCHB.

PETER VAN DYCK: Good afternoon. Thanks Phyllis. It's great to be here and welcome you to almost sunny, warm Washington. First I'd like to introduce a few of my heroes. Employees of the Maternal and Child Health Bureau. Would you stand folks. Come on, stand. Seek them out during the meeting. Say Hi. Pat them on the shoulder. Tell them it will be alright. As a step in creating the history of the Title V legislation, in 1921 President Harding signed the first Federal law, the Maternal and Infant Care Act, better known as the Sheppard Towner Act, providing grants and aid to states for human services similar to existing grants and aid programs for agriculture and vocational training. Although the appropriation was small, five or ten thousand dollars per state, it established several precedents that carried forward into the Title V Social Security Act. It showed that not only could the national government fund local health services for mother and infants, but also that it was possible and practical to distribute money to all of the states. In other words, it established a national policy that people in the nation, through their Federal government, share with the states and end

localities the responsibility of helping to provide community services that children needed for a good start in life. Now, we're almost a hundred years later and the responsibilities of the legislation, that was the beginning of, now is responsible and remains the only federal program that focuses solely on improving the health of all mothers and children. It's a partnership with state MCH and Children with Special Healthcare Needs Program reaching across economic lines to support their core public health functions. Capacity and systems building, population based function, such as public information and education, knowledge development, outreach and program linkage and technical assistance to the communities as well as provider training. It makes a special effort to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. It supports programs, providing gap filling prenatal services to more than two and a half million pregnant women, and primary and preventive care to more than twenty nine million children. Including more than 1.8 million children with special health care needs and all four million infants. It conducts special projects to target the underserved urban and rural areas, with efforts at the community level that promote collaboration between public and private sector professionals, leaders, and health care providers. It provides for professional training for needed MCH specialty and sub-specialty areas such as adolescent medicine, neurodevelopment disorders, and developmental behavioral pediatrics. It supports a national Title V information system that provides, in evidence and formed results of MCH practice nationwide. And it provides leadership in MCH Epidemiology research data analysis and MCH evaluation strategies, as well as many more. So from humble beginnings, in 1921, that first grant and aid program has grown significantly and now serves so many women and children. But, despite these good deeds and programs, we're going

through tough times. For us in MCH leadership, and that's all of us in this room, we're all leaders of MCH and that's why you're here, it's a challenging time. We're all leaders, whether it's at the federal level, state level, city level, county level, or agency level and we need to admit to ourselves that we can make a difference. We all have the same problem. I go to a lot of meetings and small group discussions and I hear a lot of stories about tough times and budget cuts. Doing more with less. About reorganizing in states, cities, and counties. Reorganizing away from the centralized MCH model. Pulling match from MCH to shore up Medicaid. Consolidations and centralizations for a better effectiveness and efficiencies. Freezes on hiring, or delays, and the federal government doesn't escape this either. It's critical to recognize the importance of leadership, especially in these tough times. The MCH strategic plan, interestingly, has some cost cutting goals for leadership. One, to create a shared vision and goals for MCH. Two, to forge strong, collaborative, sustainable MCH partnerships, both within and beyond the health sector. Three, to strengthen the MCH knowledge base and support scholarship within the MCH community. Four, to promote family leadership and MCH service delivery evaluation and policy development. And five, to provide both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide. I've told this story before. I think it's been ten or twelve years now, but it's one I'll never forget. I was sitting in a bar after a meeting like this in Chicago with a few people and happened to hear some familiar voice from TV, from the table next to me. I looked over and there's Tiger Woods. And who's he with, Stevie Wonder the great blind singer. And they were on each other's case. It was interesting to overhear and listen a little bit, because Stevie was challenging Tiger, and saying I could beat you at 9 holes of golf anytime. And Tiger say, oh, come on, that's not possible.

I'm the greatest golfer there is, although he'd just lost the Dubai open this afternoon with a double bogey on hole 18. And Stevie said, come on, give me a chance, let me see what I can do. I'll need someone to help me, to go out, walk a hundred, hundred and fifty yards, and ring a bell. Simple things like that I can easily challenge you. Then they started talking about money and they had some sizeable bets on it. And then they started pulling out their calendars. Tiger agreed he'd go nine holes. So then they tried to match calendars. Tiger said I'm busy this week and I'm busy that week, and Stevie said I have a concert this week, and finally , they just wrung up their hands and Stevie says, come on, I'm available any night next week. Well, even as we go through lean times, and face unique challenges, I think MCH leaders have exhibited what I call attributes of good leadership, just like Stevie Wonder. Creativeness, innovation, confidence, sureness of conviction, strategic thinking, flexibility, wiseness, and what I call, don't get stuck, find a way to get it done. Together with our partners, all of us are making progress. Let us all embrace the attributes of good leadership in an environment of hope and lead this nation in our strong sense of mission to improve the physical and mental health, safety and well-being of the MCH population. Welcome to the meeting. Thank you.

PHYLLIS SLOYER: Thank you Peter. Those are very wise words to live by, and I think we all need to remember a couple of them, leadership, flexibility, innovation, and don't get stuck. And now, it's my pleasure to introduce another great partner of AMCHP, Dr. Wanda Barfield. Dr. Barfield is the Director of Reproductive Health within the National Center for Chronic Disease Prevention and Health Promotion, and I'm not going to give you the acronym, at the Centers for Disease Control in Atlanta. Dr. Barfield has a masters in public health administration. She is also a practicing

neonatologist and a fellow in the American Academy of Pediatrics. She was selected as the new director of the Division of Reproductive Health in June 2010. She has a phenomenal staff and she is responsible for promoting optimal reproductive maternal and infant health. She has an extraordinary in making sure that we are doing the right things for maternal and child health, including surveillance and research and adolescent health. Dr. Barfield is an accomplished researcher, she is a practicing neonatologist, and for a person that worked in the NICU, my hats off to you. And most importantly, a wonderful champion for MCH programs. Wanda, thank you for being here.

WANDA BARFIELD: Good afternoon everyone, and thank you Family Voices and AMCHP for the chance for me to welcome you today. I know that recent times have been tough, but I want to take things into context, particularly as a pediatrician and neonatologist working with families, working with sick infants. I think all the more we need to continue to work together to improve maternal and child health. I just want to shed some light on new directions and opportunities on how we can work together, and continue to serve the needs of women, infants, children, and families. For over 40 years, the Division of Reproductive Health had worked to provide evidence that would advance reproductive health with a special emphasis on improving the health of women and their infants. Currently, we continue our research and surveillance activities on topics related to women's health before, during, and after pregnancy. The Division of Reproductive Health is housed within the National Center for Chronic Disease Prevention and Health Promotion, and it's now taking active steps in both organization and function to reduce solid funding in chronic disease prevention. So that the integration of MCH, chronic disease, social determinants, and life course can now become a reality. So why is

this important? As researchers, such as Dr. David Barker, have shown, the fetal environment increases the risk for chronic disease in adulthood. This, coupled with social determinants, multiplies our risk for chronic disease, in reproductive age and throughout the life course. As an example here, the prevalence of obesity among women has been increasing over time, with increasing disparities for African-American and Latino females. But it starts early in childhood, with the top slide showing age 0-5 and the split starting at age 6. But chronic disease also drives the tragic event of pregnancy related death as a leading cause of mortality during a time that should be among the healthiest periods of life. This requires an important call for action. Our center's action area is built upon the same foundation of MCH, to build public health infrastructure, healthy communities, and health care environments in collaboration with those communities and other partners. Specifically, several funding opportunities exist that allow reproductive health, MCH, and chronic disease prevention integration to now occur. For example community transformation grants will provide opportunities for local programs to think about life course perspective to improve health. We are also working together with other federal agencies on an important area of life course, addressing the winnable battle of teen pregnancy prevention. By working together, with other HHS federal partners and in communities, we're striving to improve health for our nation's youth. So, in the spirit of this year's conference, let us all continue to work together and to keep it in context in order to understand the possible new ways that we can improve maternal and child health.

PHYLLIS SLOYER: Thank you so much. It's refreshing to hear that presentation Wanda. Our next presenter is Colleen Boyle, who I saw less than a month ago. She serves as acting director of the National Center on Birth Defects and

Developmental Disabilities at the Centers for Disease Control. Dr. Boyle joined the division of Birth Defects and Developmental Disabilities in 1988 and today she is division director. We're very pleased that you have that roll, Colleen. She is very active, in terms of promoting the birth defects registry and other actives around birth defects and developmental disabilities. We're very pleased to have her here. I have actually prodder her, in terms of birth defects, and I'm also pleased to acknowledge that her friend Julie Beckett is a part of the center's team and we're glad to have Julie here with us as well. Colleen.

COLLEEN BOYLE: Good afternoon and welcome to Washington. I'm delighted to be here. I wanted to express my sincere gratitude to AMCHP and Family Voices for inviting me and the Nation Center on Birth Defects and Developmental Disabilities to welcome you to this important conference. It's a critical time, as everyone before me has indicated, for all of us to work together on improving maternal and child health. Much is at stake and we need to all work together in terms of assuring that we don't lose ground in maternal and child health efforts. 2011 marks the tenth anniversary for the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention, and we are very grateful to our partners at AMCHP and Family Voices, who really have made the first 10 years of service so rich and meaningful, both to us, as well as all of those that we serve. I'd like to take a few minutes and reflect on those that we serve. And here, I'm going to provide for you some of the faces. I know you know these women, and I know you've met these children. It's the mother of the child with spinabifida who makes sure that her daughter dances from her chair. Or it's the child with special health care needs who plays in the playground. It's the young mom with a disability, who is trying to raise a family. Or the young child with hearing loss who

has benefited both from newborn screening for hearing loss as well as the new technologies that that affords him. And it's the mom with a child with autism who's become a champion for early identification in her community. Or my favorite, it's the Special Olympian who lost 150 pounds and brought home several gold medals from the Special Olympics. And actually, this young woman's life size photo is on my wall in my office. I get a lot strength and courage in the work I do by looking at her picture every day. And it's the new mom taking her infant to one of many well-child visits. And these are the millions of faces, and many more like them, across the country, that many of you touch and inspire each day through the work that you do. These are the faces that make our collective work matter so much. Now our center, which is the National Center on Birth Defects and Developmental Disabilities, obviously works to prevent both birth defects and developmental disabilities,

COLEEN BOYLE: (Technical Difficulties) ….but what the name doesn't reflect is the fact that we work with people with disabilities across the life span. That's children, youth and adults as well as people with blood disorders such as sickle cell disease to ensure they live as healthy a life as possible and our efforts impact millions of the nation's most vulnerable. And what we like to think of at CDC is that we are essentially the CDC for these most vulnerable populations. We have been doing work in terms of trying to focus our priorities and the work that we do on those things that will have the most health impact and this slide here highlights three of what we consider our most important priorities. I'm not going to go into detail but I want to highlight them for you. The first one is preventing major birth defects and other poor infant health outcomes attributable to maternal both medical factors such as obesity, diabetes and safe medications and pregnancy as

well as lifestyle factors. And that includes our continued work in terms of having pregnancies that are free of exposure due to alcohol and cigarette smoking. A second priority, again going in line with our focus on blood disorders, is to prevent death and disability associated with deep vein thrombosis and pulmonary emotionalism. Up to 600,000 people in the U.S. are impacted by those conditions and pregnant women are particularly vulnerable. Our third priority is reducing disparities in obesity and other health indicators in children, youth and adults with disabilities. Now I know you're all aware that the secretary and the first lady have made obesity one of our prime targets in public health but what you might not know is that children with special healthcare needs, children with disabilities have a higher prevalence of disability and also are much more likely to suffer the adverse consequences of obesity. So we're trying to essentially join the wave or ride the wave, I guess, in terms of making sure that children with special healthcare needs and children with disabilities are included within the concept of prevention. Now as I mentioned, we're celebrating our ten years of service with events happening across the country. And this slide shows you just some of them and also indicates some of our additional priorities beyond those that I listed in the previous slide. We like for all of you to join us in this work and join us in this celebration. And we look forward to the coming of all of these events over the year. So in closing, we couldn't have made the progress we've made over the past decade without folks here at AMCHP and Family Voices. We're really grateful for your committed work and we really look forward to the opportunity to work with you together over the next ten years. So please come join us at our exhibit here at the conference, or you can take a look at some of our activities planned for our anniversary on the website. Thanks a lot. [Applause]

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PYLISS SLOYER: Thank you for those touch points, Colleen. Those are very helpful as reminders for us and I was also very pleased to have participated in the early hearing detection program which was a true collaboration between the Maternal and Child Health Bureau and the centers for disease control and we in the states really appreciated that. Thank you so much. It is now my privilege to welcome Dr. George Askew. From the agency for -- the Administration for Children and Families. In Florida we have the same thing but we call it agency so pardon me. He is a board certified pediatrician and he is nationally recognized as a social entrepreneur and child advocate. He is the senior advisor at the Administration for Children and Families and prior to his appointment at that administration he was deputy CEO and I'll run through his list because it's impressive. At the national voices for American children here in D.C. And prior to that appointment, he served as president and CEO of jump start for young children, a Boston-based non-profit organization dedicated to assuring that all children enter school ready to succeed. The one that really touched my heart in 2003 he founded docks for tots. Encouraging more doctors to increase their role for infants, toddlers and preschoolers at the state and local level. Under his leadership as executive doctor for four years the organization developed a network of nearly 900 children's doctors who committed to increasing their civic engagement on behalf of young children. So it's with great pleasure that I welcome Dr. Askew. [Applause]

GEORGE ASKEW: Good afternoon, everyone. If I skip over some things you won't know it if I skip over, that's good. It truly is a pleasure to be here this afternoon and as testament to that I'm in a suit and tie. I have some disdain for suit and ties on Sundays unless I'm going to church, funeral, wedding or have special occasion. This is a very special occasion so I've suited and tied up

just for you. Welcome to Washington, D.C. I came to Washington with 11 years ago as a physician. I told my wife we'd be here for 10 months. 11 years later she's still smiling and married to me. She called it the big switch. I got Potomac fever as an advocate and for a short time was in the Head Start bureau as well. I'm the senior advisor in early childhood health and development in the Administration for Children and Families. But most importantly I think I am a practicing pediatrician. And I have a profound respect for the importance of how policy intersects with other childhood mental, physical and oral health and a tremendous feel of appreciation and inspiration from the work that you do. So I salute you and thank you because it's because of the work that you do I come to work in the morning at the Health and Human Services with a big smile on my face and ready to roll up my sleeves and do what I hope will be good and important and long lasting things for our country's children. I bring greetings from David Hansel, the assistant secretary at the Administration for Children and Families and Joe Lombardi, the Deputy Assistant secretary. I'm going to -- we struggle even those of us who work in this office, Deputy Assistant secretary. Interdepartmental liaison for early childhood development. It's a rather long title for the office but it is actually quite important and quite meaningful. I had the pleasure of working with Joan and Olivia golden as part of the transition team before the election and just after the election of the our task was to review the administration on children and families and one of the things that we found was that there was with *** the kind of communication across our agency with respect to early childhood health that we wanted to see. One of the tasks in coming in to this new administration was to have an office that is newly formed, which is this office, that really does look across the agency, across the department, and interdepartmentally to create linkages that are meaningful and make our work more efficient and effective. So

within our group we are striving to assure more children and families have access to high-quality early childhood development services. More importantly we're working to -- trying to do it by tearing down silos within our own groups, Head Start, early Head Start, Office of childcare and now home visiting which we co-administer with our colleagues at HRSA which I have greatly enjoyed as my primary activity coming into the administration. My main focus is health and Phyllis pointed out something interesting to me. She said I didn't know they were hiring pediatricians there and I said yeah, I'm the only one. And I said and I'm trying to remind HHS of that on a regular basis. We're a health agency. When you think about the long and storied tradition of health in our programs, particularly Head Start and I have to throw this in there for those of you involved with Head Start out there I'm a Head Start child. When I was here before it was from Head Start and back again, which is great when I worked with the Head Start bureau. But we really are striving to tear down the silos and work more horizontally to increase the effectiveness and efficiency of the work that we do for our youngest children. My main focus is, of course, health. We have some targeted areas that we're primarily interested in. It doesn't mean we aren't doing work in other areas but these are some of the things we're trying to raise the profile. Obesity prevention among our young children. You saw earlier is a very important and critical piece to later poor health outcomes if we don't address it early. Improving developmental and behavioral screening practices. Asthma prevention, particularly as it relates to second and third hand tobacco smoke. Injury prevention, of course including abuse and neglect. And health literacy which we feel like will be a tremendous aid in helping our parents become much more effective advocates for their children and we've seen in some programs you can drive down emergency room visits and have significant cost savings as

well as significant improvements in health for young children. If you're all like me, you get to the last speaker and want to get to the kids and hear them sing. I certainly do. I'm particularly interested in hearing what Kathryn has to say so I'll keep my remarks short and once again say thank you for the work that you do for our nation's children and families, they greatly benefit from all that you do and welcome you to Washington, D.C. and hope that you have a wonderful time here and a wonderful conference. Thank you. [Applause]

PHYLIS SLOYER: Well, I hope you all realize we had four wonderful appetizers of what is happening at the Federal level and how we can draw upon the expertise across agencies to help us do our work in states. Thank you all of the presenters on behalf of what you do and we look forward to working with all of you here at AMCHP and in the states. And now, it is my pleasure to transition to the MacQueen memorial lecture segment of our program and to help us make the transition, I'm pleased to welcome the American youth chorus. The American youth chorus was established in 2008 as an education outreach program of the Congressional core use. The American youth chorus achieved a remarkable account of artistic success in its inaugural season. The chorus, which has grown to more than 60 members, has performed at the dedication of the U.S. capitol visitors center, the children's inaugural ball in January 2009 for Secretary of State Hillary Rodham Clinton, at the U.S. Department of State and at the Smithsonian folk life festival with the Welsh national opera, and has been presenting concerts at the at last performing art centers including community outreach performances with the capital city symphony. The chorus collaborated with the Congressional chorus in a joint concert at the Kennedy center. A history of accomplishment on two short years. Founded on the premises that all children deserve a high-quality music

education, the chorus offers students a performance-based choral music theater program to develop their voices, create activity and self-esteem in a healthy, age appropriate manner through active participation in rehearsals and performances. What a delight to see these young people perform. So I welcome the chorus. [Applause]

Choir Conductor: Good afternoon. It's a pleasure for us to join you this afternoon as we're the American youth chorus. We have 65 children in the program ages 8-14. Broken into two divisions. 8 to 10 year Olds and 11 to 14 year old. We have part of our junior division day. Our 8 to 10-year-olds, most of the music they sing is two parts. We'll start and try to keep the music from all over American and throughout the world. We often sing in different languages. We'll begin with a song today called "Gloria," which is in Latin. [Choir singing "Gloria"] [Applause]

Choir Conductor: We'll liven it up with a piece which has a little Latin to it. [Choir singing] [Applause]

Choir Conductor: Next piece is another piece in Latin. It talks about the importance -- one of the things we tried to teach the children in addition to music is also being responsible and respecting people of all different cultures and races and creeds and traditions. And so this song is Latin. [Applause]

Choir Conductor: We want to thank you for having us with you today and we're going to end our program this afternoon with a song -- [Choir singing] [Applause]

DR. MICHAEL FRASER: Oh my gosh, that's a tough act to follow. [Applause] Thank you so much. I do a lot of speaking and never had to go something as great as that. Well, good afternoon. What a great group of young people. Are any parents in the audience of the American Youth Choir? Any parents in the back? What a great group. Welcome to AMCHP, everybody. I hope that

you are having a good morning and now afternoon. I'm so pleased that you're here and I'm so pleased to work on your behalf as are all our staff back at AMCHP headquarters. It is an honor to be doing this work with you and we are absolutely thrilled with our conference this year and being here in D.C. with our Family Voices partners has added to our numbers with probably close to record-breaking attendance and it just indicates how committed you are and how robust our program is. Thank you for coming. If you're speaking or participating in the program stand so we can acknowledge you if you're participating in our program. Please stand. Thank you all very much. [Applause]

DR. MICHAEL FRASER: Let's use the voices of those children to remind us why we do this work and how important this next week is going to be, because you have come to Washington at a very critical time for maternal and child health. On Wednesday, it feels like it's years ago. On Wednesday of last week we learned about house plans to cut funding for many Federal programs, that included a serious reduction to the Maternal and Child Health Block Grant of 32% or the $210 million reduction. Friday, is that yesterday? Two days ago. Feels like a year. We learned that that has been changed to a $50 million reduction as opposed to a $210 million reduction. But folks, let's not applaud that kind of change. It's still almost an 8% cut. Tomorrow the president will announce his budget for 2012. While we're dealing with the reality of a 2011 continuing resolution. And so it's all the more important that you are here. We need your help letting Congress know that cuts of any magnitude at this time now in the states are devastating to maternal and child health. It's going to impact health. It will impact jobs. And it is going to mean adding more challenges to an over-burdened system that cares for all children and families. All children and families, including children with special healthcare needs. It's no

coincidence that we meet this time of year in Washington This is when the annual appropriations cycle starts, this is when we get the president's budget, this is when we need to be working together. The 2011 cut is real. This cut of some magnitude is going to happen and we need to respond. That's why we're asking everybody who is able to visit your Congressional representative in the house or Senate. If you can't do it while you're here because you can't get over there, use the telephone. Please contact your representatives while you're in town this week before you leave. Between now and the end of this week, we are in a crucial days of decision making. Let Congress know what cuts will do to your program and the people you work with or the services that you receive. And if they don't hear from you, it's going to be a lot easier for them to make the wrong decision. We know we cannot balance the Federal budget on the backs of those who are most vulnerable. And we all know that we need fiscal restraint. But what we also know is that penny-wise savings today are pound foolish decisions for our country's great future. And so we must work together to share our stories and we must work together to get up on the Hill this week and let folks know about the impact of these cuts. AMCHP is working hard with you. Now, let me just say, please notice that I said with you. Not for you. We cannot do this work for you. We will do this work with you. With us, with you together. I can promise that together we are going to try to make a difference. The news of late this last week was encouraging but there is a lot more to do. And as all of our speakers said, now is the time for leadership. So please make sure that you are doing what you can to work with us over the next few days. Stay informed, share information and let us know how we can help. Leadership and innovation. I can think of no more fitting a way to respond to these kinds of challenges than with innovative, impactful solutions and options. And we have quite an innovator with us to receive our MacQueen award this afternoon. Today's

2011 AMCHP and Family Voices National Conference: Welcome Plenary and MacQueen Memorial Lecture

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MacQueen lecture is sponsored by an award winning company that believe that collaboration is key to our MCH work. Go beyond provides information technologies in the effort to improve birth outcomes, reduce infant mortality and improve the wellness of families. And I would like to ask my friend, Allen to stand and be recognized as CEO of go beyond in support of AMCHP and our work. [Applause] You probably noticed the buttons that many of us are wearing. I learned how to send tweets myself. This is a hash tag for our conference and we'll be sharing learning and innovation and information over the course of our days together via Twitter, Facebook and yes, even YouTube so thank you to go beyond, our sponsor of both today's event as well as our social media experiment. And now I would like to introduce two good friends of mine, Dr. Kimberly Wyche-Ethridge and Patrick Simpson. I would like to invite them to the stage to introduce our MacQueen award winner, Dr. Kim nominated Mrs. Kathryn ***. Mr. Simpson is a good friend of AMCHP formerly at CityMatCH and now as a program officer at the W.K. Kellogg Foundation. Please eat your cereal tomorrow morning. His portfolio includes improving birth outcomes. Kellogg is a supporter of programs like Kathryn's. Dr. Kim and Patrick. [Applause]

PATRICK SIMPSON: First of all, it's always my luck that I have to follow the young, cute, talented group. So thank you, Colleen, Wanda and George. Oh, and the choir. On behalf of the W.K. Kellogg Foundation, it really is an honor to introduce Kathryn Hall-Trujillo for the MacQueen lecture presentation. I bring her personal greetings and congratulations from our CEO, and our vice president. And I know they have a special place in their heart for you. They bring their congratulations. The W.K. Kellogg Foundation supports children, families and communities as they strengthen and create conditions that propel vulnerable children to achieve success as

individuals and contributors to the larger community and society. Our programming emphasis on education and learning, food, health and well-being and family economic security all play interconnected roles in creating an environment in which vulnerable children are protected, nurtured, equipped and stimulated to succeed. Kathryn's work in New Orleans has been one of our key strategies for improving birth outcomes after Hurricane Katrina. When Mr. Kellogg left his incredible gift, he gave very little direction other than to use the money to help vulnerable children and to invest in people. I know Mr. Kellogg would be happy and pleased with our investment in Kathryn's work. Kathryn's humble and unassuming demeanor hides a giant inside. Her tireless effort to help soon to be young mothers and fathers prepare to be effective and whole parents has transformed the lives of hundreds, if not thousands of babies around the world. And the way she's done this makes her accomplishment even more remarkable. She helps surround these young families with systems and expertise from elders and practitioners that wrap them in love and well-being. Birthing project babies come into the world the way nature intended, full of love, less stressed and with a strong support system. Kathryn is the founding director of the Birthing Project USA, The Underground Railroad for New Life. The mission of the international organization is to improve birth outcomes for women of color by providing technical assistance and support to communities and organizations to replicate and sustain the birthing project model of providing education, support and access to care and services to at-risk women. She has more than 15 years experience as an advocate in the public and private sectors. Her experience and understanding translating and bridging policy, administration, service delivery and client culture has earned her national and international recognition. The birthing project model has been replicated in almost 100 communities in the U.S., Canada,

Central America and Africa. And she in 2010 was named a CNN hero for her work. And my friend, Kim, will complete.

KIMBERLY WYCHE-ETHRIDGE: It is such an honor to have shared a stage with two of my favorite guys up here but it is just as much an honor to be able to continue this introduction to Kathryn, who with after this will be known to you as mama CASS. She provides technical assistant to government, private and community agencies regarding project development, community education and identification of resources. Honored as woman of the year by the California state legislature. I hero in healthcare by the coalition for excellence in healthcare, and child abuse prevention professional of the year by the California statewide child abuse consortium. She is the recipient of the essence national community service award. The United States Public Health Services woman's health leadership award and the California state Maternal and Child Health certificate of excellence. Kathryn received her B.A. and masters of public health at the University of California-L.A. and was inducted into *** as a global entrepreneur in 2008. More importantly than all of these accolades, though, is that Kathryn is a mother, a grandmother, a god mom, auntie, mentor and sister/friend. An inspiration around the world. One of the first things I learned from Kathryn when I met her many years ago was a song which I won't sing, because I can't sing, but I'll teach you guys the words. So I want you to turn to somebody who is sitting beside you. Move. [Laughter] And then you are going to repeat after me to that person who now you are looking at. And the first line says, how can anyone ever tell you that you're anything less than beautiful. How can anyone ever tell you that you're less than whole. How can anyone fail to notice that your living is a miracle. And how deeply your connection to my soul. Thank you. Now that is the spirit of the birthing project. [Applause] It's a song we

sing at each meeting to our young moms because for them, it may be the first time that they've ever heard that. And so it is with great honor that, as you've heard the words that describe Kathryn, that I am up here as one of my favorite people in the world to bring her to the stage and introduce to you mama KAT, Kathryn Hall-Trujillo. [[inaudible] [Video being shown]

KATHRYN HALL-TRUJILLO: Ladies and gentlemen, please welcome Ms. Hall-Trujillo to the stage and please join me in congratulating Kathryn on the award this year's MacQueen lecture award. The only award I know of that comes with a lecture as well as a trophy. [Laughter] This is presented on behalf of all of our membership with special thanks from our board of directors and partners for innovation in the field of maternal and child health. Congratulations and welcome to AMCHP. Thank you so much. [Applause]

And thank you. Thank you, Family Voices, thank you, AMCHP, thank you for the sponsors of this great event. And I want to thank Mr. MacQueen for leaving such a wonderful legacy. A legacy that reminds us we have to continue to make room to think about what we're doing, to visualize an ever-expanding future and to also allow room for innovation to keep up with the thinking, the visualization and the ability of our hearts to accomplish more and more people in our dreaming, our vision and our future. I would like to just give a shout-out to Maribeth, who I am particularly missing at this moment because she was one of the people who was my champion and who gave me an opportunity to be a part of the bigger government system but not having to be in the government system. [Laughter] So the birthing project is a rogue healthy start, a virtual healthy start and I would like to say hi to my daughter Natalie who came as a gift when I married her wonderful father and she's here with me to provide me the family support. Thank you, Natalie, for being here. [Applause] I

consider today my report back to you, as my professional colleagues, on what I've learned during the last 30 years and what I want to offer to you as my contribution to the field. You can see from the video kind of an outrageous public health program. But this is what we're trying to get to. This is what all the meetings and all of the thinking and all of the policies and procedures and protocol and whatever is trying to get to something that we can see in the community that is seamless, but the target population is taking advantage of all the information and all the resources that we've come up with to minimize their suffering and maximize their well-being. This is, to me, an ideal public health program. And I'm just going to back up a minute and tell you how I started the project and why I call you my colleagues. A million years ago I did work for the California State Department of Health services as a health program advisor. I am feeling really old and this report back is taking on new dimensions as I'm thinking about where I am in my career and life. I'm feeling old because governor Brown, who was just reelected to the governorship of California was my first employer. I was brought in when Governor Brown was the governor in California the first time and he instituted a think-tank on how to deal with the problems that California was facing. And he brought in Beverly Meyers as our first female director of health. And I came into the department looking at managed care and what California would do with implementing managed care for our Medicaid recipients. And I stayed on and continued to work in innovative programs in California that we considered to be merging issues and to figure out exactly what the challenges were and where those programs should be placed in state government. My last assignment was working with Dr. Peter Abbott and his group was called Peter's ANGELS. And our job was the look at the emerging health issues and to really figure out what we were going to do with them and one of the things that we were looking at was the concept at

that time was something called drug babies. And we knew that the fiscal impact on California was that in order to take care of a baby during the first 90 days of its life that was born would really impacted by substance abuse was $300,000 and that was just the beginning. And so we with understood also from a public health perspective that you can't put money in public health if all the money is going into the pot to take care of the bleeding bodies because that's what's in your face. And so we were looking at that time at all of these babies that were being born that had to be taken care of and the dwindling public health that we had. We were looking at the number of public health nurses that one day we looked up and they weren't there. One day we looked up and 28% of our public health nurses were gone. They had always been the foot soldiers in the community. The ones who knew what was going on and could connect people to the resources that public health had to offer. And so I'm ashamed to admit this but I really started the birthing project to try to do something about the fiscal problems that California was having as a result of all these babies being born. I would like to say that I started the birthing project because I was mother Theresa and I was just out gathering the sick and bringing them into shelter or whatever. I was really looking at what we were going to do to reduce the impact of so many babies born that needed so much expensive medical attention. And what I decided to do was to actually use community volunteers as foot soldiers to our public health officials so that we would have people who were available to pretty much make sure the high risk and high-cost women would be connected to whatever resources the State of California had to offer. And because Peter's shop was the kind of shop where we could really go out and do what we thought needed to be done and he would back us up, it had to be something that was realistic because he was going to back us up, I didn't want to just go to him with words and say I think I have a good idea. I

actually put together ten women, including myself, matched us up with 10 high risk pregnant women and went about the business of trying to walk them through their pregnancies. Those of you who know my story know the woman I was matched up with, her baby actually died 10 days after he was born. But in his birth and his dying, he changed my life. His mother was actually discharged from care because she missed three prenatal visits in a row. And once I had my own clinic, I understood that your insurance will just eat you up if you have women who miss consecutive appointments. And so I began to see the other side of it. But in the beginning I did not understand why a doctor would say to a high-risk pregnant woman you can't come back to my office because you have missed three consecutive appointments. And at the point that she missed the appointments, public health nurse called me and said I wonder if you would accept her into your program. And so I took her as my own little sister in the project. And my job was to get her reconnected back to care and when I did and the ultrasound was done it was at that point we realized her baby was really in distress. When baby was born, the baby had massive brain damage, which we later realized on the autopsy was because her diabetic medicine was having a negative interaction with the psychotropic drugs she was taking for something else. And so that was something that really could have been avoided. But it was not avoided because she didn't understand her medical history and her medical records well enough to explain that to the doctor who asked her what drugs she was taking. But the part that was most impactful for me was during the 10 days that the baby lived, he was on life support. And every day I went to look at him and just to be with him. And to be with the nurses and the doctors who were taking care of him. And what I realized was that there was a really big gap between the doctors and nurses who took care of him and their feelings about the fact that he was even born to a mother who

was developmentally disabled and on welfare, the mother who had the baby who had been raised in foster care and all she wanted was something of her own to love. And I saw myself in the middle understanding both sides because I think people who work in neonatal are ANGELS that come down from heaven. That's one of the most special places in the world and where we have our best and most highly-qualified personnel in health, I think, working to take care of these little babies. And they really value life and they understand life and many of them have postponed having their own children until they could complete their education and get themselves settled in their careers or whatever, so no, they don't understand having a baby that she could not take care of. My job was basically to help them understand that all she wanted was someone to love. And someone to love her back. And she didn't have the same expectations that they had about what a baby's life should be like. And that's when I began to really understand the possibility of the birthing project as a place where healing could take place not just for the baby who was sick who at this point was not going to live, but the healing between the people who take care of children and the people who have children. Deandre was scheduled to go before the ethics Committee on the 10th day of his life. And at that point the ethics committee was going to decide whether or not D'Andre could consider to receive this high-level and expensive amount of medical care. At that point all I could think about was Carolyn was on life support forever as far as I could understand and here was a little baby who was 10 days off who would be taken off life support because he didn't have any of the social and economic supports that we look at when we decide who should stay on life support and who should not. Fortunately, Dee -- Deandre died the morning of the ethics committee so the committee didn't have to hear the case and I didn't have to go berserk because I couldn't bring all this together in my mind in terms of how it was work with and

what seemed to be the injustice of it all. And when Deandre did die, as his mother's sister friend in the project, my job was to show her how to say goodbye to her baby, how to say goodbye to her baby. And so I had to hold the baby first and then give the baby to her so that she could know that she could also hold her baby and say goodbye. But in the moment that I held Deandre, that was the moment that I realized what infant mortality really is. I had used the word infant mortality every day of my working career. But until I held his little dead body, I did not realize that infant mortality means counting dead babies. So those of you who aren't as old as I am, you may remember that our last Federal commission report on infant mortality opened with a statement that said, at the rate that we're losing babies, by the end of this century, which would have been 1999/2000, we will have lost more babies that took their first breath and died before they were one year old than all the soldiers that we lost in combat in world war I, world war II, Korea and Vietnam. Until I held Deandre's body, I did not realize what that meant. But that meant that if you looked at all the soldiers that had died in all those veteran cemeteries and you saw the crosses that are there that mark their graves, and you looked at all the babies that had died and you looked at the crosses that marked their graves, there are more babies than there are soldiers. There are more little baby soldiers than there are big soldiers. So Deandre changed my life and at that point the birthing project was no longer an intention to save the State of California money, it was a mission to reduce the number of babies that are born in the United States that die before they're one year old. At that point I also left the Department of Health. I just walked off my job and never looked back again. So I've been unemployed for the last 20 years. [Laughter] I could thank Deandre for that as well. But what Deandre also reminded me of as I was holding him was who I am. Because I did not start off my life with a master's degree

and a MasterCard and accolades and recognitions. I started off my adult life living in the bus station in Oakland with two children. I left that bus station and I moved on campus to UCLA as probably the first student that was allowed to live in their student housing who was not married. And so again that's why I say, this is a report back to you on what I've done with the opportunities that have been given to me. Because that was an opportunity and I did take advantage of every opportunity that was out there, which is why it is so important for us to stand up and fight for funding to be put into programs. Because of all the programs that I took advantage of did not exist, I would probably still be in the bus station in Oakland with my children. But because I was able to move onto campus and to get an education, which was made very clear to me at the time that I was selected into the program, I was part of the very first class educational opportunities program at UCLA. And at that time UCLA was under sanctions of not having enough students of color. They were getting ready to lose their Federal funding because of that. So they scoured the community and came up with my class, which I call the original bad news bears. None of us had our A-F requirements and I was probably one of the stars of the class because even though I dropped out of high school, got married, had a baby, I also was always interested in education. When you see a person, sometimes you cannot see beyond their circumstances who they really are. That's another reason I chose to begin this work. Because when you see a woman in the bus station, you don't know what her potential is. So when you give her a hand out and a leg up, she may be able to stand on her feet one day and report back what she's done with that opportunity like I'm doing today. So Deandre reminded me that there was a bridge between my background and my experience, my education and my career. And I really did not belong in the California State Department of Health. I really belonged back there with those women in the

community who were either in the bus station or there helping to get women out of the bus station so that we could take advantage of all the work that was being done in the halls of administration, all the work that was being done to make things better. But to bridge that gap between the two. So that was my aha moment in terms of how to bring things together. The birthing project, this picture you're looking at right now is our national conference two years ago. Where the women who attended the conference went to baby land which is in Memphis, Tennessee. Are any of you from Memphis here? Okay, no one in the house from Memphis. Someone? One. Okay. So you know about babyland. And babyland has over 17,000 poor babies who are buried there and babyland, you can see where the little markers are in the circle, but that whole area is covered with bad babies and the babies who are buried there are poor so the parents don't have markers and each little grave site is just acknowledged by a little silver disk and over time the disks slip, they fall on top of each other, they've been grown over by grass or whatever and when I saw babyland the first time it remind me of how we do infant mortality in our country. That we have kind of buried it. We talk about it but we don't actually claim it and hold it. Because if we claimed it and held it, then we'd be more serious about it than what we really are. So at this conference the women were there had to go to babyland, get down on their hands and knees and dig up those little graves that were buried in the grass, clean them up and I think we did 156 of them. Every woman walked away from that experience with something in their hearts that said we're doing this work because it's real. Because these babies -- we want to prevent more and more of our babies from being buried anywhere. Once you've actually touched that, it has become very, very real for you. The women who are part of the birthing project run the gambit from being healthcare professionals to being beauticians, being grandmothers,

housewives. All of those things. When I'm talking about community, I'm not talking about a specific community. I'm talking about the concept of creating community. The concept of creating kinship, creating relationship. Because if we're really going to deal with infant mortality, it is really not even about counting dead bodies, it's about getting to the heart of the matter. It's about getting to the heart of the matter that determines whether people choose to live or they choose to die. It's about asking women what does this baby mean to you? We don't often have a place to do that on our government forms. But that's the place we have to get to if we want women to make better decisions about when they're going to have a baby, who they are going to have that baby with, and how they dream for that baby and what is that baby's future? And so the heart of the birthing project is finding women in our community across the spectrum and it's women and men, by the way, who are willing to go to that hard spot. You know, to sit with the woman and say -- and ask the question, what does this baby mean to you? What does your own wife mean to you? What does it mean to have a reflection of yourself that you can hold in your arms? And we do teach the women the song, how can anyone ever tell you that you're anything less than beautiful, how could anyone ever tell you that you're less than whole. We want them to first sing it to themselves and then sing it to their babies. We want them to have a deep, deep investment in their own lives and a deep, deep investment in the lives of their children. We want them to be able to feel that they are deserving of a good life. That they have to really be all they can be to give their children the life that they think their children deserve to have. And the women who come to help the women in the birthing project also benefit because what we know is that in the African-American community, our infant mortality rate does not adjust by age, education or income. And so usually we aim our programs at the 14-year-old who you think is on crack

and not married but the truth of the ever that the masters degree 37-year-old woman who is married have the same proportion of birth outcomes as their white counterparts. Why is that? It's because the things that we don't talk about when we're talking about the factors, we don't talk about racism and the impact of racism. We don't talk about the social and economic inequalities that you can't get to because they are so engrained that sometimes it's like the elephant who has been in the circus who has been chained down for so long that when you take the chain off the elephant, the elephant still thinks that he or she is in chains. And so what we have to do is create a space where people can really not only think, but to feel. Not only think, but to feel. When people tell me that things have changed and we don't have to talk about those things anymore, that we don't have to deal with those things anymore, oftentimes I don't say anything but I remember, I've spent my 10th grade in pine bluff, Arkansas, because I dared to drink out of a white woman's -- the white water fountain at the five and dime store. I used the white lady's bathroom at the shell gas station. I went in to order a hamburger at McDonalds the day that it opened in my community. And I dared to want to go to the white high school in my community that I walked by every day as I went to the Black high school in pine bluff, Arkansas. That is in my lifetime. And so, of course, I carried that with me and it's tempered by all the other things that I've learned. It is a part of who I am. But it is not all of who I am. But if I don't have the ability to deal with all of who I am, then I can't make the choices for myself, for my family and for my future. And so a part of reducing infant mortality, a part of creating a better system for maternal and child health in our country is being able to get to the real heart of the matter and to deal with the real heart of the matter as if it really matters. I would like to close by talking a little bit about what the birthing project does that's a little bit different. Because we are a community-based

organization, we can look for a different group of stakeholders. We can actually ask who is it that cares about our problems and who is it that cares about our solutions? I have found that the corporate world knows the same thing that my government colleagues know, that it does $300,000 to save a life of a baby. Even though we know it, sometimes it's hard in the government sector to turn the curve and do something about it. But the corporate sector is very, very much want *** to turn that curve because they don't want to keep putting money into solving a problem and not solve the problem. So we have an opportunity to look at other stakeholders in terms of saying do you want to help us solve the problem. When you look at the amount of money in both the national economy and the global economy that is spent solving the problems of black women, women of African descent, whether you're talking Africa, you're talking Latin America, you're talking the United States or Canada. Wherever we are, we're spending money because our sons are the ones who are incarcerated. I think the second largest industry in California is the prison industry. And the vast majority of men who drive the prison industries are our sons. When you look at the education industry and you look at all the money that we spend trying to fix our education system, we're talking about kids of color. When you look at how we invest that money and who is actually getting that money, people of color in the United States get less than 10%. I think it's only 7% of the funding actually goes into people of color-led organizations. So people outside of that community and those communities get the bulk of the funding and the bulk of the responsibility to solve the problem which they cannot solve by themselves. That's why my challenge to you, and I think my contributions to the field, is for us to figure out how we can integrate our communities into our bigger system. And by that I don't mean hiring outreach workers. I don't mean figuring out more ways to have us to go in and do what we think needs to be done.

But I mean to really see our communities as a source of healing. Not the only source, but as a source of healing. A piece of the puzzle. An essential part that needs to be there. Because it is about the babies, it's about the mommies, it's about putting families back together, it's about the community, it's about bringing in new investors, new stakeholders. It's about learning from other places. I cannot leave without saying Cuba is the best place in the whole world for black babies to be born. Cuba is the best place in the whole world for black babies to be born. When you think that Cuba is an island that is 66% African descent with an overall infant mortality rate less than the United States, it's phenomenal. But because of the politics of it all, we in the United States are not allowed to even go and ask the question, what are you doing that you have a place where a black baby is more likely to be born and live than any other country in the world? But I do want to applaud us for taking advantage of the scholarships that Cuba gave the United States for 500 students to get a free medical education in Cuba if they agreed to come back and serve in underserved areas. This is Honduras, and New Orleans, have to give a shout out to New Orleans because the people have resilience. This is Malawi, it helps us understand our motto is evidence-based, can be replicated and innovative. And finally, I leave you with a quote -- not a quote but -- we're called The Underground Railroad for New Life. And Harriet had a theory. Her theory was that everyone had to be involved to get from slavery to freedom. And she realized that some people could take a whole group of people from Tennessee to Canada. And some people could only take the message from one plantation to the next. And some people could only be asked to keep quiet and don't say nothing. But the point was, that everybody knew that they had a role to play. And at the end they could feel like I did something to help us get to freedom. What I'm challenging you to do, because you really are the powerful ones,

the ones that have the ability to write on the board and say this is what's real. I'm challenging you to include the community, to let the community do the part that they do so that they can feel not defeated, not that they have nothing to offer, that they -- that we have been given an opportunity and can report back that they've done good. Thank you. [Applause]

SPEAKER: And I thought the choir was a tough act to follow. Kathryn, thank you on behalf of all of us and for reminding us what we're here to do. To learn, to lead, to innovate and to be conductors in our own places, in our own ways. Thank you for your leadership. And now, the conference begins. We have power sessions this afternoon and we have a wonderful reception in our exhibit hall this evening. Don't stay up too late because we have a treat tomorrow morning at 7:15. Our knowledge cafe and we hope to see everybody there as well. Enjoy it, welcome, learn lots, and thank you all for being with us. [Applause]