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Thank you for holding. Your honoring choices engaging choices and advanced healthcare planning and respecting personal choices will begin shortly. You may have also seen it promoted as respecting personal choices, will begin shortly. Thank you for your patience.

Welcome to the honoring choices engaging providers in advanced care planning. You may have also seen it promoted as respecting personal choices. My new Ms. Richard and I am your operator today. At this time all participants are new listen only mode. Later there will be a question-and-answer session. Please note the conference is recorded. I will now turn it call over to just King. You may begin.

Hello. Welcome to our webinar today. We are excited to have Dr. Donn Dexter available to present on engaging providers in advance care planning. Dr. Donn Dexter is the chief medical officer of the Wisconsin Medical Society. He also practices part-time at the Mayo Clinic health care system. He's a board-certified neurologist and medicine specialist. He's a fellow of the American Academy of neurology and a fellow emeritus of the American Academy of medicine. Dr. Dexter received the medical degree from Mayo medical school in Rochester Minnesota and has been in practice for nearly 30 years. He is also a leader in honoring choices Wisconsin which is a major initiative whose mission is to promote the benefits of and improve practices for advanced care planning across the state and healthcare settings and in the community. With that I will hand it over to our speaker Dr. Donn Dexter.

Thank you, Jessica. This is Donn Dexter me to you live from Madison Wisconsin. Talking to you this afternoon about a topic that is near and dear to my heart. It's something that is important advanced care planning. We will have about an hour together today to talk about this. I hope to leave a lot of time for questions at the end. The objectives for today are to define advanced care planning. To make sure everyone has a good understanding of the process. To talk about how we are handling advanced care planning and Wisconsin through the medical society. Our program called honoring choices Wisconsin. And I discussed ways to integrate landing into patient care. Hopefully to engage physicians and other members of the care team and moving it forward. Advance care planning is a process. I think - - hopefully we will make that clear during the course of the discussion. It is a process. It's not a simple document. We want to move that discussion away from just a document. It's a process of understanding and reflecting and discussing choices about your future decisions. Including end-of-life preferences. It includes understanding healthcare treatment options. For those of us in healthcare, often we take this for granted. It is not always true for everybody. Laypeople often have a different understanding of treatment options. This is really well documented in an article called how physicians die. That highlighted the difference between doctors and laypeople at end-of-life. It's a process of clarifying healthcare goals. Reflecting on your personal values, beliefs, and how that translates into your healthcare goals. Weighing options about the types of care you would want, and perhaps more importantly the types of care you don't want. Particularly at end-of-life. Making decisions about whether, probably more importantly, who you will import as your health care agent. The healthcare agent is the person that you direct to be in charge of speaking for you when you can't speak for yourself. When I did my advanced directive and have the discussions at home. My first agent, my primary agent is my wife who knows my wishes and values pretty well. I think she would follow them. My secondary agent was one of my three children who I thought was the most levelheaded and the one that would most easily make tough decisions when they needed to be made. I gave a talk recently at a church on this topic someone in the audience said when my mom had her advanced directive done she didn't pick me or one of my two sisters because she was afraid of cause conflict so she picked a cousin. I thought that's very thoughtful. So lots of things have to go into making that decision of who your agent will be. I think the most important part is communicating your wishes and your values with your family, friends, and healthcare provider. And surprisingly, most importantly but with your agent. Often times I will discover that people have picked an agent and have not told the agent they were picked. That can lead to an awfully rude surprise when the agent is called upon to make decisions. It's important to have these discussions well in advance and make sure everyone is on the same page. Why is this important? This headline from The Onion a news source out of my hometown city of Madison showed that the death rate is holding steady at 100%. I think this is a funny way to look at. The fact is all of us will face this decision. As hard as it is to think about, we will all face mortality at one time. Being prepared for it I think is really important. The reason it's important, less humorously, is that if you have not had this discussion and prepared a document, the care you receive may not be what you wanted. This can lead to a fair bit of suffering at end-of-life. As a practicing neurologist, it is not uncommon for me to be called to intensive care where someone is struck down quite unexpectedly by an event whether it's a stroke or hemorrhage or trauma. Illness that leads to loss of the ability to share their wishes. There is no one to share those wishes with the care team. Healthcare providers won't know your preferences. Then the family is left wondering if they are making the right decision. This is a terrible position to put your family in. To make these life-and-death decisions, these heart wrenching decisions without any guidance. Often completing an advanced care document are having a discussion is often called the best give - - gift you can give your family. When we talk to people, 60% of people do not want to be a burden. Unfortunately, 56% have not communicated their wishes. This is not at all surprising or uncommon I think. Most of us would reflect on that. So I did not have polling questions, but I do want to stop here and have you think about have you done your advanced directives. Have you thought about some of these tough questions, and share them with your family members? Is interesting how often even in medical - - medically astute families, this has not come up. When asked 70% of people want to die at home. Of course that was a couple of generations ago the norm. That is what I think most people aspire to. They want to die at home, peacefully, surrounded by family and friends pain-free. In fact 70% will die in an institution. A nursing home or a hospital. Most people, a vast majority in fact, like to talk to their doctor about end-of-life issues. I think doctors feel that they are prepared and interested in that as well. Unfortunately, only about 7% say they have talk to their doctor about end-of-life issues 82% say it's important but only about a quarter of them have completed an advanced directive. And three quarters of physicians did not know that one was done when they were done. We are falling far short of the mark when it comes to advanced directives. What does every adult need to plan for? You need to plan for that sudden accident or illness. The one that is the bolt out of the blue. The one none of us is aware that will come. This is sadly not uncommon. It can happen to anyone. One of my good friends, quite an athlete, was profoundly injured in a bicycle accident. Another had a complication after surgery and could not speak for a while for themselves. Even in people that you would not ever expect this to occur, it can. I think it's really appropriate for any adult. And then a change in circumstances. Those people with chronic illnesses that know they have an issue, but take a sudden turn. I think it's important to know what their wishes are. So honoring choices Wisconsin. This is our take on this. This is the way that medical Society of Wisconsin has decided to approach this and the mission is to promote the benefits and improved processes for advanced care planning across the state. It is a very formalized process. And initially, if you would look at the map of Wisconsin may be 10 years ago for sure five years ago probably, there would be one county in the state and that would be La Crosse in the southeast part where advanced care planning would be in the green. They were doing a great job. Over the cross - - course of the last four years it has spread. The counties are green are counties that have a robust Honoring Choices presents. The counties that are yellow have a system in place aligned with one of the other counties. If you mapped out the population centers you would see we would cover most of the big population areas in the state. The goal is to have the entire state of Wisconsin be green. We want to be as good as we are in the South West part of the state in La Crosse in that area. We will share a little bit about their success as we go on. That is the goal for our state. To this point we have trained over 300 facilitators. We have over 10,000 documented facilitated conversations so we have really started to make roads over the last three years. Our approach is a comprehensive one. It's based on a few key principles. First is for all adults. As we discussed, everyone deserve to have this conversation. It's also not a one-time event. We want to move away from the idea that this is a once in done thing. It's a process over a life course. It also changes over time. Because we change over time. There is a number of things that come up that would have us readdress the advanced care discussion. Such as, if there is a new diagnosis. If you have a diagnosis of a new illness. You should probably revisit your advanced care planning. If there's a death in the family. If there's a divorce, or a decline in your health and then once every decade. I can tell you that the difference between going from 40 to 50 is not insignificant. A lot of things change but often your approach to things change in that time. In the advanced care discussion it needs to be revisited. As I have said before and will probably say many times again, it is important if you come away with nothing else this is about the conversation. Legal documents are important, but they cannot take the place of a well-prepared healthcare agent. I know when my mom was in her midlife years, my brothers and I were young. She sat us around the kitchen table and had it - - the discussion with us. I don't know if she ever filled out a document, and I never found one. But when she got ill my brothers and I knew exactly what her wishes were. We did not need a document, but we supported her in her care choices. Her care at the end of her life was exactly what she wanted. It is a conversation that is important. Having documents is important as well. Then there has to be systems graded to be sure the conversations are routinely offered. They have to be scheduled so we have a way to promote them through a physician. They are scheduled through a standardized process. The conversations are had and documented in the medical records. Our program is based on a successful program out of La Crosse and Gundersen health system and program called respecting choices. It's a trademarked program that we used as our guide. And they have had an incredible success. The process includes a well-prepared healthcare agent. That means when you go to do your advance care planning you typically bring your agent with you. So they are as informed in the process as the person completing the advanced directive. Specific instructions are done, and then the plans are created and stored. Advance care planning over an individual's lifetime. If you plot out the average person's life course, you have this great time that extends sometimes people last a long long time where they have good health and don't climb more than is expected for age. Then things started changing you have illnesses and eventually you decline to death. The first steps, the Honoring Choices program is the first steps. It's creating an advanced directive that identifies the agent and goals of care in case something happens that was unexpected. This is for healthy adults, or for anyone who has not yet planned for an advanced directive. When we institute this in northwest Wisconsin at my institution, we aimed our process that adults over 55 having a physical. Who were in good health. That was our target population will we did our pilot. I think that's a very appropriate place to start. And then our intention is to strut it - - spread it to everyone. As most of our lives progress, you pick up an illness, a chronic illness, and there are times where you have a decline for instance maybe you are diabetic or you have an infection or your lung disease has an exacerbation and you end up in the hospital. You recover but maybe not all the way to where you were before. Now you are starting to pick up more and more morbidity. This is next step discussion. This is where you identify goals of care if illness complications start to result in a worsening. What do I do if my heart failure worsens? What are my plans if my lung disease worsens? Then last steps is identifying goals of care when you are in the stage of your life or you wouldn't be surprised where your doctor wouldn't be surprised if you passed away in the next 12 months. This is where you start to have serious discussions about what would the end-of-life look like for you. This is the time and I think the only time, where the POLST is important. That's the physicians order for laced attaining treatment. That's - - sometimes advance care planning gets caught up in the very end-of-life planning. Which is completely different than sharing your values and wishes and how you want things done if you cannot speak for yourself. I think this is where death panels came from. I think it's an unfortunate place to be. That is way different than advanced care planning for people who are healthy and are looking at values and things and generality. What we have learned is that just completing a statutory advanced directive does not work. When I find these in the hospital chart or in the patient's medical chart, they are often not helpful. They are vague, they will say things like no heroic measures, I'm not sure what that means. I know what it means for me, but I'm uncomfortable about what it means for the patient. Or sometimes it says do everything. I'm not sure what that means either. Do everything when care is futile and all he would do is promote suffering? I don't think anyone would want that. Often they are too vague. But that's often if they are even done. The prevalence is so low, that the form itself is just not done. In the general population's we discussed before it's only about a quarter of the people have them done. Even in people with end-stage illness it's less than half. Even when they are done, we often can't find them. What do people do with important documents? They put them in their safe-deposit box. They put them in a file at home where they know where it is but maybe no one else can find it. I think we are doing a better job of that nowadays. 11 states actually have an advanced directive Registry. Wisconsin is not one of them. We are working on it. 11 states do. If you are in one of those 11 states, you can contact the place at the state where the registry is held and get the advanced directive. But more often the course is that they are not done, they are unavailable or they are ambiguous. Than if they were not shared, loved ones, families, they will often be in disagreement about what it meant. More than once I have had family members torn apart by differing interpretations of a loved one swish at end-of-life. It is really quite devastating. I would be very happy if that would never happen again. So for an advanced care plan to be successful they must be created. We need to make sure that this work is successful. That we get the majority people having an advanced directive done or the discussion held at least. Specific enough for the clinical situation, or enough direction to the agent so the agent knows the person's wishes and can follow them. That they accurately reflect the individual's preferences, that they are understandable and that they are quite clear, that they are available, and that they are incorporated into decisions. We will see how this can work only come to an example of a community where it works well. How do we move from documents to conversations? It requires a culture change is relatively straightforward to get a piece of paper. We can direct people to have them done, but that really isn't the ultimate goal. The goal is to have the conversation, so the documents, when done, are accurately reflecting the issue - - the wishes, and desires of the person. It requires an organization and community effort. It takes time, patience, and hard work. It needs multiple professionals involved. I think starting with the patient but then led by the physician and the remaining care team. And a commitment to learning the new skills and practices to make this happen. Let me just say about the new skills and practices. This will vary from place to place. How we do this in northwest Wisconsin will be different from how they do it in Green Bay or Duluth Minnesota, or Seattle Washington. It may be different in rural areas and inter-cities. - - Inner cities. But the ability to get that to the community and get it implemented is critically important. So what will be the outcome if we do this? There is a huge increase in individual and family satisfaction. There is a piece to knowing your plans are made and you are confident your wishes will be followed. I cannot under emphasize that this will also reduce pain and suffering at end-of-life at least in my experience in people that have not had this done I have been often quite distraught at how people have needless suffering. We really want to see the planning numbers go up. The percentage of plans at time of death. Increase the number of hospice admissions were people would have a more peaceful and pain-free death at home. A reduction in family stress, anxiety, and depression. That is really clear. When a good advanced directive is done and is followed, there is less grief for the family members. There is less bereavement. There is less depression. It's much better on families. We want to reduce the number of in-hospital deaths. I've come a couple of times to how this can, well. This is data from La Crosse County. There are two different studies one in 15/96 and the other in 2007, 2008. This is work that had been in progress. They did not start in 95/96 with numbers is great. That 85% of people had an advanced directive. That took years to get there. They did not stop at what I would consider outstanding numbers. They kept working. Now if you are in La Crosse County, if you die in hospital, there's a 90% chance that you will have your advanced directive done. Not only that, if it's done, they will find it. Almost 100% of the time. Even closer to 100% of the time the decisions for treatment at end-of-life will be followed almost 100% of the time. Those are incredible numbers. It is completely doable. I think they are to be congratulated. That is not just my opinion. A major news network came to Wisconsin and did a report called the best lace in America to die and they highlighted the work done there. And the work of respecting choices. Last summer there was a consortium of people from 10 different countries that came to Wisconsin to learn about advanced care planning and how to make this happen. We are showing the whole world a way forward in this effort. I think it's incredibly exciting. Of course it's part of the [Indiscernible] improving care. This is from the Institute for healthcare improvement. They understand the importance of this they have their own program as well is called consider the conversation. We are not the only people doing it. It is very important for the triple aim. Improving patient care. In system providing care and treatment. Who would not want care and treatment consistent with the person's goals? That just makes sense. Like I already talked about it increases individual and family satisfaction. It increases the prevalence of planning. Particularly in areas where we are underserved. We want to make sure this is culturally diverse. Improves population health by spreading this through the community increasing hospice use and then it really has been shown to be very effective in coordinating care. Maybe it should not have been a revelation to me, but it was a bit when I learned that people that go into hospice care actually live longer than people who don't. I think part of his because of the referrals for other needed services and care coordination with hospice. It's a little bit off-topic of advance care planning, but when you have your wishes known it eases the transition. So cost, this is not an area I like to focus on but the data is clear. If we reduce unwanted care and treatment you will save money. There is dramatic improvement in the cost of care in the last two years of life and reducing hospital deaths is also a favorable thing for a number of reasons. We had a patient recently in our intensive care for a very long period of time who would never leave the hospital. They had not had an advanced directive done in the family was being torn apart. The other issue was the hospital was on bypass we could not put a patient in the bed that really needed it. There are other major costs besides dollar cost. If you compare Gundersen were this is probably the most advanced place in the country, the cost is significantly less than the national average. If you compare them to centers like the Mayo Clinic is pretty dramatic. I think people say it's hard to compare Gundersen which is then La Crosse, Wisconsin. Although it's cutting edge compared to Mayo Clinic or UCLA, maybe you might have a point but my argument would be look at the national average peer we are significantly better than that. More important than the dollar is patient satisfaction and family. So how do you get started? I would encourage you to do what Honoring Choices does and that is starting small and thinking big. Start with a trial implementation. Pick a target population and design your workflows and processes. It's simple to say we will just do it this way. And what I have learned the hard way is that you can have the best ideas in the world but if you have a process to implement it, you will be in big trouble. Starting small and refining your process is a way to go. I think it's a way to give you the best chance for success. In my clinic we started with three primary care doctors, to family care doctors, and an internist. We started with patients 55 and over coming in for a physical. We learned a lot. We learned a lot about how to design workflows and all the ways they can go wrong. But we are doing well now in starting to grow. Test new workflows and processes. That is important so you can see how they work. You don't have to do it like we did. Some places have started in oncology unit or in a community center. However you do it, you want to start relatively small with a relatively fixed pilot. Test workflows and processes. You have your facilitators who do the discussions. Give them the opportunity to practice their skill and refined -- refine their skills and their practices and processes. And then learn lessons for broader implementation. How do you spread that program? So the key is designing a system you have to train your facilitators and continuously work on your quality improvement. And engaged community. Those are the four key elements. Then for wider implementation use the lessons learned in trial implementation train more facilitators, and then have your training instructors trained more facilitators. Physicians role in this and other providers are the leaders of this. Because they are the ones that need to engage the patients. They have long-standing relationships they understand their values, and they have established trust. And no one can replace the physician and providers in the role of this. Others can help. The way we do it, is we have our providers ask the question of patients, do you have an advanced care plan? Have you ever considered it? I often tell my patients is something and I have done and I encourage it for everyone of my patients. If they are interested we make arrangements for discussion with the facilitator. There recently was a ruling that doctors can get paid for doing advance care planning for patients. That is great if doctors want to spend some time at the initial part of this having the discussion. When we do it with an agent and the patient and a facilitator, these typically run about an hour to an hour and a half to sometimes two hours. Sometimes in one visit, sometimes into, rarely and three. This is an important conversation. This is not something you want to rush through in a 10 minute office visit. It often takes time and facilitators are well-trained to have these discussions. What can physicians and other plug riders do? - - Other providers do? We provide physicians with information about advanced care planning to share. We can encourage the completion of an advanced directive. We used the standard form, the Honoring Choices standard form that includes a power of attorney. We encourage people to get that done, but most important lead to have a discussion. And then normalize it by making it part of routine care. I rule - - routinely it prompts me when I look at the electronic record there's a place for advance care planning. I asked plan - - patients about it. Even if they say it's done, I will often say have you discussed this with your family? To you think they really know what your wishes are? Often that will generate some thoughtful discussion. Then I asked physicians to engage in advance care planning for themselves. This was meaningful for me when I did this formally again. I had done it when I first moved to [Indiscernible] 23 years ago. When I did it again my children were older and so was I. It was a very worthwhile experience. Generally physicians do not have the time for extended conversations. I like to take my time with patients, but I don't have an hour, and Howard half or two hours to spend discussing this. But our physicians dosed our facilitators do. We are used to physicians and providers referring to other people to help us with dietary counseling or my diabetes education which is done by a diabetes educator. My blood thinning monitoring is done by the anticoagulation team. I have no problem with having not done by a trained facilitator. Why would I for advance care planning? The facilitators also acquire needed skills. They get better with more conversation. We have had very positive feedback from our patients. What can physicians say? Advance care planning helps make sure we know what your wishes are. I think this isn't about pulling the plug. It's something the patient say well you have to get someone to pull the plug. No. We want to know what your wishes are. We want to demystify this for patients. Like I said this is what I tell my patients. I have completed mine and I think every adult should. I often tell them I think it's the best gift that I could ever give my family. That they know what I want. I recommend it for all of my patients. I often say this as well because they truly believe it. It's very important. And then, when people are interested we talk about the process of a trained facilitator to meet with them. The importance of picking a health care agent, and then we schedule a time. We make sure that the discussion is held, the advanced directive documented, and then incorporated in the medical record. Another thing I want to mention is that when you are in a state like Wisconsin where we don't have a registry, part of our advance care directive has a place in the back where there's a wallet card where you put your information, it identifies you as having an advance directive and it allows you to state where it is stored your agent or primary agent is and who your physician is. You keep it in your wallet as another aide. I think that is pretty helpful. Coming back to the importance of it's about the conversation. These are some quotes from patients that are in a video we have produced about Honoring Choices. This is what patient said. It was interesting. What patients thought of what they wanted. There are many people that said they did not want to be a burden. Often people would have stories about times where it did not go well. I bet if you reflect back you will have experiences if not in your family probably and families of friends where things did not go well. The importance of reflecting on values. I think it's really the most important part of the conversation. That helps to direct the course of care for most of us. It's really interesting when people say when they reflect on what's important, that often is helpful in defining choices at end-of-life. So if you want to learn more about that part there is a couple of different options for videos. If you go to www. www.Tran18 - -. HonoringChoicesWI.org. There are three different versions. There's a 10 minute version, a three minute version, and one with Spanish subtitles. I wanted to end and make sure you had my contact information. So if there are questions you don't feel comfortable sharing life, you can certainly contact me, and I would be happy to answer them or put you in touch with one of our experts and advanced care planning. I think we will open it up for questions now, and Jessica will help me through that part if there are any questions.

We will now begin the question-and-answer session. If you have a question star please press than 100 touchtone phone. If you wish to be removed please press the pound sign or the hash key. Standing by for questions.

Again as a reminder that is star and then one.

This is Jess King I also want to remind you that we also have chat available if you prefer to type in your question.

At this time I see no questions and queue.

This is Donn Dexter. I just saw someone put on chat that Honoring Choices offers training sessions. They highly recommend it. It is - - I think it's intense, but the training is I think excellent. I have sat in on it and I was impressed about how robust the training is, and what it takes, what they ask you going to when you train. I would agree.

Dr. Dexter could you speak more about how nursing homes can support the advanced care planning process.

Sure. I think - - I'm sort of a believer of top-down. At a nursing home I would say the leadership at the nursing home probably should model this by doing an advanced directive themselves. So having the facilitated discussion themselves. And then what we have used a fair bit is faith ambassadors. People who are trained as facilitators but they can go out into church groups and talk or to nursing homes and talk. I think going into nursing homes and maybe having a program and sharing with families and patients about advance care planning. I think it demystifies things a little bit. When I first came home from the service, I worked for an ambulance company. We did a lot of runs and nursing homes. It was eye-opening to me. There was a sense sometimes that patients felt a little bit abandoned and alone. I think - - some places were just outstanding, but I think bringing the sin as a program - - bringing this in as a program would be very appropriate.

Thank you. I did notice we actually do have a number of questions and comments and chat.

I saw one about the registry and what can we do to make it happen. I will expand on that. When I found out that other states had registries that thought why doesn't Wisconsin? I was particularly - - there are 11 states that have it. I was thought we are a leader when we have it. Louisiana had it and I subsequently learned that they develop the registry after Hurricane Katrina. They found it was an important emergency response item. That they were having people that were profoundly injured and sick and be moved from hospitals. And they did not know what their end-of-life wishes were. They sought as an emergency measure. What did we do, we passed a resolution at the house of delegates in 2014. Then we shared that with one of our legislators. He has had a bill drafted and so I am learning about patients in the slope process of law. The bill is drafted. It is out for cosponsors. I'm hoping it will get a hearing soon. It is not as quick as I would like. I would love to see - - I don't pick it will happen in 2015 but I would love to see in 2016 that it will become law. Well 2016 is an election year so that may slow things down. It may be smarter for me hope for 2017. But I'm an optimist I will hope for 2015.

Another question I see as our facilitators volunteers or grip - - or paid staff. They are both. At least where I work. Some facilitators are social workers, nurses, and some are chaplains who are paid staff. But several are volunteers. That will probably be important in reimbursement. Paid staff if you are a nurse or a social worker and your facilitation is being provided incident to a doctor's order, that sounds like for my understanding of the payment information that that will be a covered benefit. But you will not get paid if you're a volunteer. Now if I was a big organization, I guess I wouldn't care so much about my volunteers not being reimbursed. In any case I wouldn't care because I think it's an important value for the community. Yes we have both paid staff and volunteers.

Dr. Dexter we have a question and chat who says that a social worker was [Indiscernible]' appreciate having the discussion because it can be too easy to get wrapped up in physical paperwork. As an organization how can we become involved with your program?

Great question. You could contact me just you mean email and my contact information. I will put you in contact with air in August in. - - Erin augison I think you are right. We sometimes do get too wrapped up in paperwork. That would be okay I guess if the paperwork was really valuable. What I often see is it's just not helpful. That's what I like about our advanced directive. It's longer and it takes more time to go through, but it will be hard to come out of that without having a understanding of your values. And making a much more informed decision about the plan.

I see there's a question about changes to the registry. I don't know. We don't have a registry. The way - - we have a registry in Wisconsin for organ donation. The question is how often is it updated and what if you change your mind? If you change your mind you contact them and say rescind my decision. For dance directive registry would be similar to a well is my understanding. Is that the newest document supersedes the older one. If you change your mind, you send in the newer one. Each state takes a little different tack on this. Another thing I've learned about drafting legislation is it is not done until it's done. Even then implementation can change the nature of it based on how it's implemented. I would hope that we would not ask whoever is holding the registry to be responsible for it. That includes whether or not it's a valid legal document. There are rules about having to witnesses sign it, the witnesses cannot be related or employees of the hospital peer we cannot ask the person responsible for the registry to check the validity. The person doing the advanced directive has to be of sound mind. They have to be competent. All the registry is a repository. We don't want to make it out as too much of a institutional thing. It's a repository. The changes would have to be made by the individual. They still own the document.

Any more questions, Jess?

I do not see them. I do not see any more questions.

I thank you all for your attention. I strongly encourage you to give this some thought yourselves, individually. Maybe discuss it with your family. Thanksgiving was a great opportunity. We did not do that I was on vacation and I did not want to bring it up. I encourage you to talk about it at the table. It's often a very interesting discussion. It gets kids off the cell phones.

Thank you very much for spending some time telling us about Honoring Choices we appreciate it. We do encourage everyone to fill out the evaluation before you log off.

Thank you, ladies and gentlemen. That concludes today's conference. Thank you for your participation. You may now disconnect.

[Event Concluded]