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All parties, please stand by. Your conference will begin momentarily. Please stand by for respecting personal choices, engaging communities. Conference will begin momentarily.

Good afternoon and welcome to our conference today titled respecting personal choices, engaging communities. At this time all participants are in a listen only mode. Later we will conduct a question and answer session. Please note, this conference is being recorded.

Thank you so much Brandon. Thank you for joining this very important webinar today. I appreciate all of your participation we have great information and great speakers. I would like to introduce our first speaker. You may know her, Kate DeBartolo. She is the national the old manager for I H I. National Institute for home -- healthcare improvement. Currently the national field treat -- team at I H I and the conversation project. Work on the conversation project began in April 2013. We are fortunate to have her today to tell us about the conversation project community engagement that is happening. Thank you Kate.

Thank you so much joy for having me. It is great to chat with you all. I have been with IHI since 2007. Many of us may have worked together over various campaigns. My work now is transitioning to the initiative around end-of-life issues. We have taken a lot of what have learned at IHI and engagement to the conversation project. My hope is to share with you a bit of background about the initiative. Also, to let you know my contact information if you want to follow up for additional information. The first thing and want to share with you is what the conversation project is. It is a large public engagement campaign, dedicated to ensure that everybody and their life wishes are expressed and respected. I think there are input it is important how we engage the public. Will we have a conversation. Another that as health care, we respect and perceive what those wishes are. We know from our work, that there is a pretty big gap now. About nine out of 10 Americans agree that this is something that we need to talk about. Only 2 to 3% have. Our goal is to shrink that gap. One of the ways we've been trying to do that is to get feedback. With the feedback from healthcare system that we need help from the outside when you've been trying to move the needle on this within healthcare. It is moving so slowly. Meaning more families and peaches coming into the settings that have not had these conversations. We want to be clear that we have no position about where these wishes should be. Whether you want to receive measures and a lot of carrot the end of life. Would you rather be at home? We have plenty of care, but not much treatment. We think it is important for people to be having these conversations early and often, around the kitchen table before the crisis. We know it is a terrible time. Our emphasis here is really on understanding how people want to live at the end of their life. I include this image here because I think it is helpful for figuring out what it is we're talking about. Only talk about some is end-of-life wishes, it is important to talk about this with the but he is healthy, when they may be have been diagnosed with a chronic illness, and again, as they are approaching end-of-life. I think for now, if people have the conversation, they tend to do it only as they are approaching end-of-life. We know that is important to expand this. We would love to see more time spread across. In the orange you will see, what we think is important about expressing wishes. At the conversation project, we see far over to the left. How do you get people talking about and breaking the taboo, and getting it documented. Men working within the healthcare system. That is receive, record and respect with those wishes are. In a large continuum, we want to share today, is the expressed side you have a lot of information in our healthcare system also. It is what we do with that information and respond to it properly. As a mentioned, we have this idea of a double helix, if you will of the building and awareness within the healthcare system, so that we can come together. Many of you may have heard the timing of shifting away from what is the matter with you medicine, to what matters to you medicine. I think at is particularly important as we think about the end-of-life. For the conversation project, we have three goals. The first is to generally build awareness about the importance of -- importance of this initiative. Importance of having these conversations. We do that through our large media campaign PS A's, articles and all of the different websites that we have. Additionally, we build tolls to help people get started. We have a very popular conversation getting started guide. How to have a tourniquet, if you want to have the conversation, we have tools or make it easier for people to do. Also, to learn how to bring this to people, where they work, live and pray. We have seen amazing interest in different regions, who want to start introducing us to the community. That is what the third principle is. As I mentioned, building awareness. We have had some wonderful media opportunities. We have a lot of great videos on a website. The conversation project was cofounded Allan Goodman, who is an a pull it prize-winning author. It helps when the times are good house keeping helps us build awareness. I mentioned some the tools that we have. We have a conversation starting kit. We have in different linkage translations as well. We have a one-page summary that people use for the medical record. We have a how to talk to your doctor kit. One for parents of seriously ill children. It is when we created after getting feedback the folks who like a but that. As well as one that we are working on right now for patients with dementia and and Alzheimer's to give to family and caregivers to address end-of-life issues. All of these tools are freely available on a website. As I mentioned, reaching people in the community. This is a recent call that we had come up that I love of working with different community groups all over the country and internationally. And individuals that I want to bring this to Cincinnati, Ohio. I think I know who I should engage in the region. Which we different than people we engage in Dallas, or people we engage in Seattle. All different types of people and organizations, some are healthcare organizations, some are not, who have expressed an interest in translating into their local settings. We have been working with different companies actually, and there have been employers to a been introducing us to their staff. We have Goodyear, tire company company who gave out 25,000 kits to the employees. A lot of employers are realizing this is something that's important to their staff to give it to their caregivers when they come home. They hope that it will be comfortable hearing from their loved ones. Health systems are introducing us to their staff as well. We have been working with congregations and houses of worship around the country who are introducing this into the regions. You name it, we have people who are bringing it to local prisons and panels and to libraries. That has been so much excitement about the topic. It makes sense that it applies across many settings and it is just not a medical expense it is the human experience people assigned to pull that back. When we are doing this work in the community we are seeing local leaders start to get involved. They are hoping for the patients and the trainers and going to different assisted-living facilities. They are going to the chamber of commerce who want to introduce it. There are a lot of employers who are introducing its either as part of the HR on boarding process, or maybe doing brownbag lunches. It is definitely health systems where they want more people to be having the conversation and Memphis. When we start with 10,000 health employees in the city. We will introduce it to them in each of them can have the conversation continue to grow. Similarly, at this time of year, the work at Beth Israel Hospital in the Boston area, where they are doing a turkey campaign, for all of their employees before they head home for Thanksgiving. How can you get materials that you need to have to get health care proxy to start having the conversation? There are neat ways of engaging people within the employer world. We just finish last week a big conversation in the Boston area where there were more than 40 houses of worship that got together to teach, preach our reach as part of the conversation. It is really exciting to see different leaders sharing some -- sure sermons. That has been really exciting to see. I wanted to take a moment to share with you examples of what some of the materials are and what they have included in them, so you can become familiar with it if you want to seek it out. The first thing we do in our startup kit that people can fill out on their own, is to think open ended of what matters most to me of what's end-of-life is. Just make note, that we see all different types of responses on this. It can be everything, of wanting to meet in a hospital for nursing care. What do people like to do with their family, what is her favorite pet? It is not a medical question. It is about what matters most. A woman that I met in St. Louis last month said the most important thing she could think of right now is that she hates to have her feet tucked into the sheets. She thinks her loved ones that know all about her medical wishes, but she really she had never told them that. What ever it is the matters most, people can include that. They can go through a series of questions on a scale of 1 to 5. I think a lot of people who do not know what we mean when we say end-of-life planning or advance care planning -- we really have the questions that are not immediately medical or legal in nature. This is not about feeding tubes resuscitation. It is more on a scale of 1 to 5, are you more concerned that you're going to get too much care or too little care? Getting people to figure out where their values are, these are the conversations that are very helpful to have with your loved ones or your providers. There is no way you can possibly deliver every hypothetical scenario that you can think about. We can understand what your values are. That is what we try to get through. As well as to let people make plans for who it is they want to talk to, when they are going to do that come a get some icebreakers and to get people to introduce the topic to loved ones. We do all sorts of training for people. We do speaker training. We have another one coming up in January that is free. If you are interest in enjoining, about how to to do system people. I thought I would share a few tips that have, in the course of this. We really encourage people to tell more than one person what your wishes are. There was a woman I met in Florida that said she felt like she had spoken to her husband about this, but they had never told their stepchildren, and how difficult that would've been if they became upset when she was making decisions for their father, not realizing that was based on conversation they had had. Sometimes you may let people know who you have spoken to. Similarly, the importance of having to conversations. I had a conversation with my husband about what I want, but then I also follow up with him about what he wants. As a follow but my mother by what she wants. There are multiple conversations that can happen. I think to others that stood out to me -- one, is that many of you may have seen where people say they wish they want to die at home. That is not always feasible, either financially or physically. There are a variety of reasons for coming out be possible. We asked that they try to unpack that we want them to learn more about that. I know I was working with teens in New York City, where it is very difficult when summary has a floor with walk ups whether aging grandparents are living a home. Let's find out if that means you do not want to be hooked up at -- to a lot of machines. Do want to have music playing and have your pet with you. You need to understand what people mean by that. I wanted to share a couple of the tough questions that we get, in case they come up for you as well. If you get through this. One of them has been particular. I don't want addresses at the bottom. I just got off a phone call. For any of you personally with the term, this is around the idea of Medicare being with conversations for patients at the end of life that there is a lot of political brouhaha for a few years about that. Just a few week ago, Medicare has now passed the payment plan that they are going to reimburse for this. It will go into effect in January. We just started to have all of these calls about what this means for people. I think they're actually has been way less fear about these conversations. Understanding that if you are concerned that some the also going to make decisions on your behalf, it is all the more reasons to be having his conversations with loved ones. Similarly around the position of suicide, questions have been coming up exploring the legislation. Especially after the popularity of the viral story of Britney who moved up to Oregon. We do not have a position of what some days wishes should be. I think Alan did a nice job in a piece which was talking particularly about Britney Maynard. It is too bad that the conversation and that story became about the position of suicide, because there are so few people who meant up in that situation, what was amazing as there was a young woman who had had a conversation with her family and loved ones. They know exactly what was important to her and they were able to act on that. That is something that the 9 million people in the course of the story could take to heart and take home with them. We try to encourage those types of conversations. As they pass this off, I want to make sure that you are aware of what we have available. The first, is a IHI course for any providers who are interested in providing how they have the conversation with their patients. We have a course that we will be giving in January as well, especially with the new reimbursement structure that has come out. To help you understand how you can do that. We have a white paper that I will send out with the notes as well, about the role of health systems I'm been assured that we actively receive, record and respect the wishes. If I do my job, get everybody in the calm -- country having a conversation, weenie and need to figure out how we respect with the wishes are. We have been doing a lot of work in that area. I want to invite you to the website, where there are a lot of different tools and materials there and getting a community resource Center. If you are interest did in introducing this in your region, you do not have to start from scratch. We have a lot of examples from over the country in the last year so that you can build on the work of others. Similarly, to join us, we have monthly community calls from different regions that come together to share the work that they have been doing. You can ask questions. As we mentioned, we do a free training call. Our next one is in early January this is meant to be --. This is meant to be a teaser of everything were doing in the conversation project. We have a quarter million downloads of our starter kit. There's a lot of exciting energy happening. I would love to chart -- chat with any of you are interested in joining our community. There hundreds of pennies around the country. If you like to follow up. With bats, I want to turn it over to joy. I do not want to steal too much time from any other presenter. There any questions, I'm happy to answer them.

Thank you so much Kate. That was thought-provoking. It opens up a lot of possibility for having good conversation. Does anybody have any questions? Brandon, would you like to give instructions?

We will begin the question answer session. If you have a question, please push star one We will begin the question answer session. If you have a question, please push star 100 telephone keypad. If you want to be removed from the queue, push the pound key. If you are on the handset, push star one.

I should mention, sometimes I do this presentation and six hours, where we go over all sorts of tools and resources. The wind blows people's hair back. I wanted to make sure people got a taste of it.

Looks like we have no questions at this time.

Kimi Q up -- can we Q up the first polling question? And your state do you have forms similar in your state? The time is up on the question we --. We are waiting for results. We have 54 yes, and 23 no. It looks like the majority is aware of this and has it in their state. That is good movement across our country. Is there any questions for Kate?

Nothing on the phone.

You did a fantastic job Kate.

Thank you for having me.

I would like to introduce our second speaker. Michelle Cantillo is the advanced air -- advance care planning. She is been there since 2011 she has oversight responsibility for the development of ACP at four different hospitals in Hawaii. She is responsible for teaching the facilitator training at all for facilities as well as community organization. Prior to her work as ACP Courtney and her, she practice and nursing primarily in the area of principal care. She began her career in Toronto, Canada and came to Hawaii to continue her experience at Straub Clinic & Hospital. She was there supervisor for 12 years before transferring to the patient and safety quality department. Quite a wealth of experience, and I appreciate having hurt here today. Michelle, I present to you.

Thank you Joy for inviting me to the presentation. Kate, thank you so much. I see my slides are up. I have a lot of years of experience. My role for the last five years is promoting advance care planning throughout Hawaii Pacific health. Hawaii Pacific health has for hospitals. Three and a Wahoo, Kapi'olani Medical Center for Women & Children , Pali Momi Medical Center, Straub Clinic & Hospital, and Wilcox Memorial Hospital inquiry. This is a quick general information about our facility sites. What I will go through is basically what we have done to implement advance care planning at our hospitals and how we have help -- helped spread it to the community. This is general specifics that I believe everybody know. 7 to 10 Americans die from chronic diseases. We know that 2% of Medicare is spent on patients with chronic disease. As Kate mentioned, where do people want to die? Many people want to die in their homes. Over 80% of the people die in our hospitals. Many of our patients do not have advance directive on their file, much less -- when I started in 2011, we had nine 9.minute in our system. This is specifically for the dark mouth 2010 data. F or the hospital as place of death, we ranked second worse, following New York. Compared to national average it is 25%. We have room to grow and work. For hospice utilization, we have work to do Inc. terms of our hospice referral. We have a sixth worst state. Compared to the national average of 47.5%. You talked ranking the worst of the top five. For us, our hospice referrals are done really late. Usually within a week of discharge, where are patients are getting hospice referrals. Within our program, we have looked at advance care planning. What we want to do, as Kate mentioned before, we want to make sure that the advance care planning conversation happens. We know that it is not a one-time discussion. It happens at ages. It needs to start in the home first. In public, before comes to the position. Then at they have spittle as they transition out to the continued to care. Weatherby hospice, long-term care or community service. We want to make sure that advance care planning is documented. That we can understand it. Documents are accessible, and honored. This is about respecting choices. We joined Blue Cross and Lutheran respected choices in 2011. What they have done is looked at the first steps, next steps and less steps. Life advanced care planning of a lifetime of adults. Here is a chronic trajectory of adults in and out of hospitalization. Our first steps are for us, adult to have no planning. We all need to start that. Next steps are for chronic patients with progressive, life limiting illness. The third one are the last steps, -- when we started in 2011, last stage Asians. -- Patients. At HPH this is where we put our efforts. Our goal is basically to communicate, provide a mechanism to the seriously ill patients for these end-of-life treatments across these care settings. To improve implementation of our ACP planning. It is very specific for these patients . This is about respecting choices. What they have encouraged us to do as an organization is making sure that we go through our's system of redesign. We make sure that we do education and facilitator training. Number three is community engagement. Number 4 is due measurement and the quality improvement. In terms of the system design, within your organization, you have to know what you want to implement within your system. For us at Hawaii Pacific health, we include side document that we have medical documents scanned. The medical directive, living will, and the health Cal -- healthcare power of attorney. Also, the HCPOA. Sometimes they do not know which is there advanced care health directive. We also scan the guardianship, Surrey get and the POLST. It is good to hear that many of you have the POLST in your state. Within a HPH, we work closely with our medical department. What we have done is to make sure that our documents were scanned after the storage. This does not help us after the patient is in hospital. We have to provide visible access. Are medical department agreed to scan all of the documents within 12 hours -- 24 hours within the patient arriving. They also agreed to have a standard fax number. I know the slide is not clear. There is a process in place where anybody can scan or fax to the number at all for site. Within the 24 hours, medical records will put it in our EMR. Here is an example of our access of advance care planning storage and retrieval. You can see in the upper right-hand corner, and a snapshot, all advance care planning documents are noted. With the blue links, we can easily pull the scanned documents. In the upper left-hand corner, under their name, if they have POLST on file, we have it . That alerts all clinicians as soon as the patient comes to the door, they need to open up the 1212 -- POLST and open the link. They have a copy of only the latest scanned documents. All of the documents live in the chart and media. There is a history of all documents. And the bottom left corner, is a problem list. That is where we encourage all facilitators, physicians, and nurse practitioners, two document advanced care planning. This happens over time. We can see the course of what happens during the conversations. Within your organization, know your team is. Who can refer? Who will be your champions? Who can do advance care planning? What are their roles and responsibility? What is their work floor? What other resources can you use? One example that we have done is making sure that for advance planning team -- this is an example of an advanced care planning order. When a physician goes in and says we have advance care planning videos -- I apologize the flight is not clear. A physician can say I need this patient to look at this advance care video. Once it is order, -- ordered, it goes to a consult. That consult goes to the social worker. They are all facilitators, and they do an excellent job. Are nursing staff also gets the order for the advance care planning video education. They can get the ball rolling. I will continue on. The advance care planning team consists of chaplains, social workers, physicians, nurse practitioners and anybody who has a passion or end-of-life discussions. We know that not everybody is comfortable doing this. We want to make sure that we do a full on education. We have a full eight hour course. You can see on the purple bar, that we have 100 certified facilitators. This is a free event. We have invited the community, long-term care because we recognize advance care planning does not stop in our doors. We need to educate our colleagues in the community as well. Community engagement is important. We have done advance care planning workshops in our organization. We have attended senior fares. Recently we went to the AARP. We have Dennis senior fares. At our community, I go to the networks all around the neighborhood. HPH is a huge community service. For events a month. They have about 800 people attend. Last Saturday we had women's week of health. One of our discussions was serious illness. Educating the staff about advance directive is very important. Working closely with our long-term care, nursing homes assisted living, hospice services etc. Jeanette will talk later about Kokua Mau. We are leading the way in terms of making sure education is done throughout the state . The videos I mentioned before -- we use advanced planning decision videos. We are starting to use the conversation project. I use it in some of my closet -- classes that I do with new graduates. Community engagement, I worked closely with Jeanette, in terms of doing the Kokua Mau tools. It is available to the public for free . At HPH, we've done a video with advance care planning. It is on our website. It is trying to start the conversation. Getting the conversation is important. Within -- all of our patients have access on their TV to the education library. The advance care planning videos are loaded on their. They patients can pull up the advance care planning and see the videos. We have -- we have started to use the go wish cards. Especially at Children's Hospital, they can use the go wish in terms of end-of-life videos. They next goal for continuous quality improvement is making sure your organization is succeeding. Make sure who could do the data collection and analysis. Reviewing implementation workflows and processes and making sure we are honoring the healthcare decisions for our patients. Most of all, leadership involvement is crucial from the beginning. Care are -- since we started the program in 2011. This is raw data in the amount of POLST that we have an organization at HPH. You can see it has grown specifically within the last year . With insurance plans, they are encouraging our PCP to do advance care planning for 65 and older population. On the clinic side, more ACP discussions and implementation is happening . You can see the drastic growth since 2014. This is an example at Kapi'olani Medical Center for Women & Children. It is not only adult an aging population. It is the kids who are going home with tube feeding. This is the POLST of how many kids are exiting with POLST. This is mostly done by the palliative care team. More importantly, are we honoring POLST wishes honored. We started in 2013. We started gathering data in 2014. We want to make sure that you are looking at all POLST for all patients that I mentioned that come through the door within 12 hours of arrival. We are above 90%. Our goal is 100%. The little bar in the corner is our best practice alert in our system. It is for the physicians. With a patient comes in with a POLST. You need to open up the POLST and review it with your patient . If they cannot speak with their patients within 12 hours. I mentioned earlier, last stages patient are a specific set of patients that we look at, at HPH. We have been following them over the last five years. We have a registry for them. They are the patients who have limited resuscitative orders, such as DNR. Or elderly patients over 85 years old, admitted twice over the last year. All patients who are discharged to hospice. Our goal is to make sure that they have some type of advance care document when they leave the hospital, as well as more specifically, POLST. As you can see, within the last 4 years, we are at about 85%, where they are getting some type of documentation on their file. More specifically, across the system, about half of them have POLST in their charts. They bottom numbers in 2015 -- I also look at those patients who have died. Of all of those patients who have died, 60% have had advanced directive or POLST at time of death. Many people say the family always changes, the POLST at time of death, or even before. I look at that data for 2015, and noted, only 4.5% of our families are changing the designated directive. Of those, only 7% changed their own directives on admission to the hospital. This slide is thanks to Hawaii information, who provided this data from 2007 two 2014. As a state, we're moving in the right direction. Percentage of date occurring within the hospital is decreasing 221 -- 28%. As a state, we are making a movement for end-of-life care. That is it. I am on the top left-hand corner. This is one of our ACP training. There is my information, you can email me or call me at my number.

Thank you Michelle. That was really great. Good examples of how moving the community and the right direction, and what happens when they actually end up in the hospital, so that we can honor their choices. Excellent. Do we have any questions?

Once again, if you have a question, please push star one on your telephone keypad.

Also, if you have any comments about what is happening in your community -- are you experiencing similar situations as Hawaii? Maybe you have some it examples to share to -- too.

We have Judy McGee

That was excellent. I was wondering if Michelle would be willing to share her sides? There were some in the introductory that had the three levels. The well people, compared with the people that might be expected to have problems within 12 months. I think that would be very helpful.

Most definitely I believe the slides are already shared.

There is a part on web acts where you can get the slides. Otherwise, your representative will make sure that you get them.

If you do have a question, please push star one.

Thank you so much Michelle. We really appreciate all the information. Everything that you do in Hawaii. Single-handedly, Michelle has gone out there into the community and help stimulate people having these conversations. We really appreciate you. We have a polling question. Regarding your advance care plan. Do you have one? If you are willing to share. If you don't -- if you have one that is great. That is what you are such a do. If you do not, if you are like many people who do not, what are the reasons why you have not completed this yet? You can take a look at that polling question. I believe the time is ticking. Go ahead and put in your response. The polling is closed. I am anxiously awaiting -- people have not done there yet. They say that healthcare professionals are the worst. We make the worst patients, and we do not do our planning very well. It looks like the majority of us do not. Those that answered -- we have 51 people that do not have a plan, and 35 that do. The most popular answer is I just not have gotten around to it. Typical human behavior response. I am meaning to do it and I know it is important, but I just not have gotten around to it. Some people did respond that I am too young. I do not need it right now. That is fine, but now you have the information and know where to go to start having those kinds of conversations. In my opinion, you're never too young to start talking about what is important to you in life. Great response, I appreciate it. If there are any other comments or questions about any of the presentations, I will make sure that they get to the right person. Now we have Jeannette Koijane . Jeanette is the executive director of Kokua Mau - Hawai'i Hospice and Palliative Care Organization - www.kokuamau.org. She is working with organization for over 14 years . Beginning while she worked as the executive office on aging. She received her graduate degree in public health from the University of whole IE and her undergrad degree from Cornell. She has been involved in the field of hospice and palliative care for over 24 years. I guess she was 10 when she started. Beginning in the field of HIV and AIDS, working with the AIDS Memorial quilt as the director of international program, and then in a variety of research and educational position. Jeanette has worked with the US the -- affiliated Pacific islands helping to develop palliative programs there a collaborative with the you each cancer and school of medicine. Is my great pleasure to introduce you to Jeannette Koijane.

Loja everybody. Thank you very much for the imitation. It is an honor to be sharing the stage with Michelle -- virtual stage with Michelle and Kate enjoy I am very glad that I get to briefly talk to you about what we are doing. Thank you Joy. Kokua Mau - Hawai'i Hospice and Palliative Care Organization - www.kokuamau.org is our state hospice and value care organization. It is unique in the country because it is quite a bit more than hospice and palliative care. We are a community benefit organization. We are nonprofit and we work around the state. Are members are not only the hospice, health plan and has puddles, but anybody who is interested in caring for people with serious illness. We have people involved with long-term care, people involved with spiritual care, American Cancer Society mediation center and quite a number of people who are involved with caring for seriously ill people. For us, it is important that people with serious illness and their loved ones understand what decisions they need to make. Also to figure out where the resources and information are in our community. That is the first thing we do I wanted to say that it is so interesting to look at statistics and try to figure out what is really going on. Certainly, some of our statistics in Hawaii are bad. Some of the other ones are good. You saw from Michelle, the increased in POLST usage. One of the things we see in Hawaii is that our hospice utilization is the third highest increase in the country for the last 2 years. We really are seen that there is an increase in hospice usage. That data is from the Medicare beneficiaries, who are the people most using POLST . This all ties together. We are happy to see that. We try to figure out from the data, what is aqueous going on. I did want to say that we can see there is a large increase in hospice use in Hawaii. One of the things that Kokua Mau - Hawai'i Hospice and Palliative Care Organization - www.kokuamau.org tries to do is provide information for free to anybody that would like to use it. We have a website that has lots of information. We have a website that has lots of information. We have a free D newsletter letter. You are welcome to sign up for it. We try to talk about the resources that are available in the state, as well as events that are happening. We have national resources. We are all about getting the word out in not reinventing the wheel. We have a speakers bureau. We go out and talk to churches and retired teachers. We of the Rotary club. We are in the process of expanding the speakers Bureau. We are getting more requests. I show that we are at a tipping point. A lot of things have been going on for quite a number of years, including the fabulous work that Michelle and HPH is doing, as well as other parts of Kokua Mau - Hawai'i Hospice and Palliative Care Organization - www.kokuamau.org . Certainly enjoys organization at Mountain Pacific. We are seeing an increase. As a mentioned, we have materials that are available for free. All of the POLST material is on our website and we are the keepers of POLST in Hawaii. People can download the information there. We have a free advanced directive that a lot of people use. In keeping with Hawaii law, that is available information. We just started a project to translate our materials into 10 different languages. Hawaii is a multicultural place. As we try to help people with limited English proficiency understand these discussions, we have moved forward with the support of our health plan, as well as some of the state hospitals, to make those translations happen. They will be available for free at our website. Finally, we have been partnering with Kate and the conversation project. Michelle also mentioned the starter kit. What a great thing for the holidays. We are promoting the conversation project is something you can start upstream, rather than starting with the POLST . You can start with conversations about decisions, and what you want. In addition to helping people with serious Ole Miss, -- illness, we really try to help professionals do their job better. We have a diffusion method, rather than creating an organization that is going to do all of this. We want professionals to do this. We have monthly meetings with speakers, where we share information about what is going on. We have a by monthly clinical case discussion which is called Palliative Pupus. That is actually a well attended event, not only for the networking but also for the education. We try to do joint responsive training and workshop in our community. We really try to help people recognize what resources are out there. Finally, the third thing we are trying to do is change the system. We do not do lots of legislation, but we do look at things that will impact everyone. POLST is a good example. Last year we spearheaded the coalition to get POLST expanded to include advanced practice registered nurses as signers on the POLST . We used to be a physician order, now we are provider order. We are looking currently at how can we help people find the POLST when it is needed? We are looking at the idea of technology and POLST . Can we complete POLST online? Can we create a repository for POLST ? That is a big job, but it is something that we are working on now. I am more than happy to answer questions. I was trying to move quickly. We have lots of things that are going on. We do not control what is going on, rather make people aware of what is out there. Who else is doing things. Do not reinvent the wheel. Invite people in. We see that our community -- when people look for information in different places, find trusted speakers in different places, we try to pull together people. I am more than happy to answer questions. I encourage people to come to our website, or sign up for the newsletter. Let us know how we can help you. I do want to say that most other states do not have something like Kapi'olani Medical Center for Women & Children that brings people together to one table. That may be because other states are much bigger. We recognize the value of having the whole continuum of care represented in one organization. I know and others dates there are a bunch of people doing really great work as well.

Thank you so much Jeanette. That is just a snapshot of all of the work that Kokua Mau - Hawai'i Hospice and Palliative Care Organization - www.kokuamau.org does and that Jeanette does . There are many opportunities to work with our local Blue Cross Blue Shield affiliate, HS a. It has been a long road, but I think we're getting to a point of critical mass, where the healthcare community recognizes that this is important work. We are spending a lot of money at end of life.

If it is useful, that is great. If it is not what people want, and we need to correct that. Thank you so much for your presentation. Are there any questions on the line?

Once again if you have a question, please press star one at this time.

I also encourage you to reach out to what ever organizations are in your state. Even if they are not as comprehensive as what we have here, maybe you can get something started. You could start small in your community with the residents, patients and community members that you touch.

Joy, the California coalition for compassionate care are our model. They have tons of information, webinars and things like that. There are POLST organizations and that state. There is a national POLST organization. There are those good resources out there.

Great, thank you.

Looks like we have no questions at this time.

I think we are at the top of the hour. In the chat locks, I did put my email contact information. If you need anything, please feel free. Also, your QIU representative will have the information. I thank you all very much. Please enjoy the rest of your day. Happy Thanksgiving. Aloha From Hawaii.

Ladies and gentlemen, this concludes today's conference. You may disconnect. [Event Concluded]