[Please stand by for realtime captions] Please stand by. This conference will begin momentarily. Welcome to the end of life care and culture conference call. During this presentation of participants will be in a listen only mode. Afterwards we will conduct a question-and-answer session. If you have a question lease press the number one and the start button on your telephone. This conference is being recorded. I turn the conference over to Ava Richards .

Thank you and good afternoon everyone. I would like to welcome you all to this committee of practice call. My name is Ava Richards I am the education coordinator and I will be moderating today's call. I am sure you are familiar with our house keeping. We will move right into the agenda. To begin the call we will learn about why planning for end of life is important and that will move into and of life considerations for African-Americans there after that we will hear from you all the participants. We will then have a few brief announcements. Following the call please remember to complete our evaluation. At the end of the call we hope that everyone gains an understanding of the importance of end of life as mentioned. We also want to assess the told troll norms of end-of-life care for African-Americans. And the impactors that impact disparities at end-of-life care. I will introduce our first speaker Dr. Thomas Harter . LMSW, Educator, motivational speaker and author Heart Tones please refer to his biography to learn more about his past work.

Thank you there we have a lot to get through in a short amount of time. This will be a power packed presentation. Hopefully I can move my slide forward, here we go there the purpose of this particular presentation is to discuss advanced care planning but largely what we have been able to establish clear that big Henderson -- Gunderson health care. These first slides are background of relationship to dance care. I will be focusing on slides 14 through 22. With data that shows impact we have been able to have and then at the end I will come back and talk about how this model advanced care planning is able to meet the aim of health care to the Institute of health initiative. Let's get started.

The biggest outcome for just care planning that we have been able to develop is to understand, no, on or patient preference. We do that with a tool called the advanced directive to help with that. The advanced directive as a tool is not the goal. The goal is to come back and understand what patient preferences are further end-of-life care. And advanced directive in particular being a plan, it is the tool by which we communicate those lands for end-of-life. It can be expressed and if written it should be in accord with state statutes were simply documentation is currently in the patient's chart as well or both. We actually prefer both we prefer to have it in the electronic medical record and to have a written copy. Advanced care planning is the process at which we get to an advanced directive. It is the planning that we spend our time focusing on. We have three goals for planning in particular. We want to generate reflection on the lease goals and values. Understanding, of select possible future situations. Discussion, of what these preferences are and how we get to them. The relationship of advanced care planning to advance directives.

Our emphasis is on the advanced care planning and we recognize and advanced directive is only as good as the advanced care planning that went into it. There is a fair amount of data that shows advance directives aren't doing what they are intended to do their when we look at that data and we begin to see what becomes evident to us is that part of the problem is not the advanced active itself, but that the plan was not well understood or communicated. But in the standard approach here in the US? Providing information to adult inpatients about their legal rights there asking patients if they have in advance directive on admission is an increasing them to fill it out. Asked him questions like if your heart stops to be do CPR? We find that this standard does not often work. So advance directive awesome -- sometimes get a bad rap. Evidence that standard approach to advance directives consistently fails. Prevalence is about 20 to 30% in the general population and less than 50% for end stage illness. References are far too vague to be helpful.

We put a lot of thought and effort into this and the system that we have in place with respecting choices and what we have been able to find, is that there are five conditions that are needed to have solid advance care planning. One you must create a plan. It has to be specific enough to meet clinical situations work it must the an accurate reflection. It must be available to the decision-makers. If those people don't know what the plan is, then you really have no plan. Plans must be incorporated into decisions when needed. To follow and advance directives and advanced directive cannot cover all medical situations. What we are trying to accomplish is getting a sense of patient values and preferences so that when it comes time to make decisions that is what we are basing them on. Not what somebody said about a particular treatment that might not be applicable. When we take this to other places we often will focus on for design elements for this talk we'll just focus on the advanced care planning facilitation skills these are necessary elements for success we are looking at advanced care planning for the system of communication. We also feel that -- we do training here to help our facilitators learn how to have these conversations. The facilitation process we often look at with advanced care planning occurs in stages so attempting to plan for all possibilities in a single document is impossible and unnecessary. This slide they were currently looking at is what we have found to be how we set up our stages over a lifetime. The black line represents the average persons decline so to speak from when they are healthy to the end-of-life. With our first step what we are looking at is you have patients who are older and relatively healthy or have been nearly diagnosed with a condition. They are able to communicate with us and they are not suffering publications have any illnesses at this point.

Next step is for people who have been diagnosed with a chronic or terminal illness and they are beginning now to suffer publications. There planning to come a little bit more specific to specific kinds of medical enter vengeance. And last step focuses on what physicians project would be the last 12 months of a patient's life. The question is would you be surprised if this patient dies with the next 12 months. If the answer is no, I would not be surprised, then we begin to discuss the last steps planning. We don't call it last steps planning when we talk with the patient and family, for the sake of the model, that is just where it falls into.

Lets talk about the benefits of ACP facilitation. Standardized process of planning so effective, shared practice can be implemented across the organization or community here for better use of physician time. It does not require them to spend great amounts of time and conversations with these patients. We have facilitators who are trained to do that. It creates more patient and family

centered help system. You can read the rest of these bullet points but at the very end it's more probable for those who are close to the patient to both now and support the plan created. That is what we really want. We want patients to be able to tell us what they want everyone to be able to align our medical treatments and interventions with those preferences. Particularly when patients are no longer able to communicate with us.

This is some data that we've generated coming out of LADS . Two studies done between 1995 and 1996 and another study done in 2007 2008 you can see here that the number of advance directives, five years after we implemented the second choices program in lacrosse that 85% had -- this data also shows us that from a seven through 08 that although 90% had advance directives, the number with plans, that number rises up to 96%. Those importantly click enter most recent data. These are outstanding numbers by any comparison.

The question is does it work elsewhere. Is lacrosse unique? Now not really. We have been able to take this program to a wide write of different alters and communities and we have never had it not succeed. Has been a successful implementation everyplace we have taken it. This is data from 2010 from Australia. It is a randomized controlled trial looking at advanced care planning and end-of-life care in elderly patients. The participants were people who were competent with her mental faculties about them. English speaking patients who are 80 years or older and admitted to internal medicine, biology or pulmonary service. They were excluded if they were expected to die or be discharged within 24 hours. Or if they had it in advance directive onto family. The intervention group received the ACP model that we have here and the control patients received a local standard of care.

What we were able to determine if that the people who had the intervention, people who had advanced care planning based on the respective choices model, 93% were very satisfied levels and 5% of satisfied and 2% who are not satisfied. In the control group 6% were not satisfied, the number rose to 29%.

Be a strain study outcome when subjects died. If you look at the intervention group the number of patients with AD was 85%. As opposed to 30% of the control group who did not have the advanced care planning intervention and the impact on families with the intervention group is a case where the lower the number is a less negative affect the that had on the family. With the intervention group and advance care planning group you're looking at 5.5% and then in the control group you're looking at five through 21%. What that means is that in the control group, there was significantly more distressed about the decision-making process at the end-of-life.

Other populations where we have been able to tweak this model. We have been able to successfully implement this model everywhere we have taken it. Here are some examples. We've gone to Australia, Singapore, Vancouver, inner city hospitals in Milwaukee, we've implemented it successfully with adolescent HIV infected populations and we have taken it to Germany and Hawaii. The full model has sound success in other Outcomes in Australia.

We have taken it to the twin cities were major health systems have agreed to use the standardized material throughout the state of Wisconsin via the Wisconsin medical Society and in other places like Kaiser in Northern California.

This is a map of where we have had successful implementation of all the stages of our advanced care planning. You can see many different areas of the United States and different geographic and cultural diverse regions. Canada, Alaska, Hawaii and internationally because he again with Germany, Australia and Singapore being the most promising thus far, as getting data.

Outcomes and benefits of the respecting choices systematic approach. How we are able to retrieve this triple aim. Better patient care. How is this model able to improve patient care? Effective advanced care planning can better sure that patients receiving medical management that matches their identified gold leading to the highest level of functioning possible. Timely symptom management and timely use of treatment along with those and hospice care with no change in length of life. There is never been a place where the length of life has been shortened as a result of this.

We look here at improving population health. Patients and families show they are more satisfied with care. It lowers moral distress. Visit turns out as far as controlling cost of care, incidentally patients at the end-of-life don't want a lot of intervention. Our goal is to make sure that we identified this threshold of intervention and we do we can medically to match that. The slides are available to you if you want to look through them with any questions you can e-mail myself or Dr. Bud. [Indiscernible] I will not go over the DR data and outcome but I will leave you with this. Advance care planning is a means to a better and. One that is free from avoidable distress and suffering for patients families and caregivers in general accord with patients and families wishes and reasonably consistent with clinical cultural and ethical standards. This is the definition of a good death from the institution of medicine 2007. These are some of our resources. And I pass the baton to Gloria Thomas-Anderson .

Now that we have a better understanding of the trends surrounding end-of-life care I want to introduce everybody to Ms. Gloria Thomas-Anderson . She is a motivational speaker LMSW, Educator, motivational speaker and author Heart Tones .

Today I will talk about several aspects of my end-of-life work that deal with healthcare disparities and some of the key factors that influence African American decision-making and treatment options in planning. More specifically at the end-of-life. As professional service providers and practitioners, this contextual perspective may also provide a foundational understanding about end-of-life care as it correlates to the specific needs and concerns of many African-Americans. Regardless of one's ethnic background or other factors that the state was us from each other, our lives are connected to the human experience. All people share the universal commonalities of life and loss. All people from all cultures look for meaning in the mid-of suffering. Culture is simply a shared way of life. Consists of a unified set of values, beliefs, standards and behaviors that are shared by a group of people there our varying cultures impacted and influence as to how we see things. What are some of the primary influences on end-of-life decision-making? Weld the literature reflects that racial and ethnic background, culture, values I believe, so feel economic status as Wells lived experience all have an impact on healthcare and End of Life Care and Culture . 8% of blacks utilized hospice care at the end of life as opposed to 83% of whites. For many within the minority population there is a resistance to advanced planning for death and dying and less likeliness to use hospice or care or donate organs after

dying or terminate life support. Some believe that Stephen talk about death may cause it to happen. Cultural differences doing so it's end-of-life planning and care get many people find it difficult to talk about end-of-life issues regardless of their education, religion, gender or so sue economic status in life. Most people want to experience meaning of life and did not welcome suffering or dying there African-Americans are now dying -- now different. Many people in a given culture share values and beliefs there no two people in the same culture think or behave exactly the same in any situation. Intergroup dynamic exists within all cultures and must be considered to avoid stereotyping. Be mindful that diversity is a broad on bravo. Regardless of the population are group all members of that group do not share the exact same view. Even if they share common beliefs or values. With that said I will talk about three key influences in African-American end-of-life decision-making. Their historical. Spiritual and cultural. Generational values. I will start with why the historical mistrust in healthcare.

When one of my relatives was rushed to the hospital ship in sick for a long time but had avoided going to the doctor for many years here for memory was fading and she was calling us other people's names. I did not understand at this time why she was so distant. I later learned that it was in part due to mistrust issues towards the medical profession. I will never forget how response to the nurse when if asked if she had an advance directive on file. My relatives became upset and shouted, what are you trying to do to me, ain't nobody going to put me in no nursing home care the nurse was perplexed as to why she acted that way. Healthcare providers are required to ask if you have a AD and if not they give you the option to complete one. My relative miss understood this and thought the nurse was trying to trick her so she could be placed into a nursing home. In my subsequent research I found that my relatives story was the same as many African-American families there I learned she avoid going to the doctors for years because of her fear and mistrust of the health care system. When this medical emergency happened she was not prepared. Fortunately she was able to get one of her children power of attorney for healthcare and financial decisions after that experience. The awareness of racial disparity with heightened when this signal is study was exposed. Most of you are aware of this experiment. This study was done in the early 1930s were poor black men who had syphilis, but were not told so, and even when penicillin became a standard chore for the disease in 1947, these men did not receive treatment because of the scientists desire to continue to study how the disease spreads and kills. Many African-Americans particularly older generations, are aware of the disparities in health care between blacks and nonblacks. And those disparities have led to mistrust. This seems to be a factor in the hesitance of making life decisions. I was bashed as was the case of my relative. Racial disparity in healthcare has caused many people of color not to trust doctors or propose treatment options. Many people of color receive less body healthcare. More African-Americans die in hospitals and all other activities. -- Ethnicities. This fact is pending knowledged towards people of color particularly towards those of the lower economic status or poor people. The research confirms that most studies are conducted by Caucasians and many blacks believe that they will be automatically placed low on the priority list for organ and tissue transplant. There is also data that shows less issues of cardiac procedures, fewer surgeries belong answers occur for people of color. African-Americans experience higher incident and mortality rates for many cancers that are amenable to early diagnosis and treatment. African-American adults with cancer are notably underrepresented in cancer trials and are much less likely to survive prostate cancer, breast cancer and lung cancer than their white counterparts. Leading causes of death or heart disease, cancer and stroke. According to several studies ever patient relationships and for help

desk health outcomes are not acknowledged -- it is heightened when Ms. Truss -- [Indiscernible] African-Americans have the highest death rate in the shortest survival of any racial and ethnic group in the US from most cancers. The causes of these and equalities are contributed mostly to economic disparities. This includes employment him a wealth, income, education, housing and an overall standard of living. Even barriers to hike quality cancer prevention and treatment services.

Although healthcare institutions and workers are often targeted source for patient care healthcare has a documented to impact another historical point and that is the social and economic factor. I had years ago the opportunity to meet Dr. Hood who was the president of the medical Association. You noticed twice in history when health reform improved African American health outcome. The first time within the post-Civil War Reconstruction period when the -- this is when blacks left plantations and pursued independence. They started black institutions such as medical golden hospitals. The death rate was reduced are not time. The second time was during the second civil right act in 1965 to 1975. When this outlawed racial discrimination in government help programs like Medicare and Medicaid and integrated hospitals. There was an improved health outcome for African-Americans during that season as well. Segregation was to go less than half a century ago. And many older African-Americans remember this not only in healthcare but in every phase of daily life. The issue of social and economic justice has and still affect many African-American people and cannot be ignored in treatment planning and end-of-life care. African-Americans account for 13% of the total US population approximately 41,000,000 in numbers and make up the second largest minority group in the US air 5% of African-Americans live below the federal poverty threshold as compared with 90% of whites. 19% are uninsured versus 11% of white lot health insurance. An individual with no health insurance are more likely to be diagnosed with against cancers. Research shows that there is a definite association between socioeconomic status and health. Persons with lower SES have higher death rates regardless of race or activity. -- Ethnicity. They have fewer opportunities for physical activity and less access to healthy foods like fruits and vegetables according to the national class standards, health inadequacies are related to current discrimination and social injustice. Health disparities adversely affect neighborhoods immunities of the broader society. Thus making the issue not only an individual concern but also a public health concern. In the United States it has been estimated that the combined cost of subsequent death due to inadequate or poor care is one point $1.24 trillion.

I would like to talk briefly about some of the cultural influences regarding spirituality and religion. Religion and spirituality are key factors that influence health care decision making and end of life. Then spiritualists of many African-Americans come out of west African heritage and was present before slavery. Not all African-Americans hold true religious or spiritual beliefs and some do not identify with her 12 the organization as all. However, researchers have found that blacks consistently report higher level of religious and spiritual leaf and involvement than all other ethnic groups there but the literature suggests that religion and spirituality a major influences on the lives of African-Americans. Pure research centers state that 50% of African Americans described themselves as born-again or evangelical Protestants as compared with 20% of whites. The lives of those who do consider themselves written, the African-American church has a key presence. Many households are frequent attendees were actively involved with the

church there any African-Americans resort back to their religious and cultural beliefs at the end of life to get meaning and guidance in treatment decision making.

Recurring themes in African-American spiritual beliefs. Spirituality and religion are often viewed as a source of comfort, coping and support. And effective way to influence healing group prayer or singing or worship. God is responsible for physical and spiritual healing ear the doctor is God's instrument.

I was share a quick story, three sisters shared their different reactions to the recent death of their mother. Illustrating how individual responses can be to medical treatment options and even to the loss of a loved one. The first sister believes that her mother would be miraculously healed through her faith and continued prayer. After the mother died she was distraught and very angry at God and her two sisters for being so accepting of their mother's death. The second sister felt that it was God's will and except that it as a source of comfort to cope with her loss saying, there has gone to a better place and she won't have to suffer and be in pain. She is with the Lord for eternity. The third sister's reaction was different from both. She thought the doctor did not do all that he could do and that if he had taken a different treatment approach her mother would still be alive. She did not express any faith belief. The medical model focuses on the physical and mental aspect that has traditionally not included Orndorff rated the spiritual mechanism that can be the actual driver of some patient's behavior and responses to medical treatment. For example, take the case where Dr. Tobin African American Christian patient you have lung cancer and have only six months to live. The doctor is doing what he is trained to do but the patient was guided by spirituality while most likely not accept that drug doses. In fact he may often declare that God is the decider of life and death not the disease of the doctor. Others may refuse any matters getting it to God's hands. Others may want everything offered to medical treatment. I was asked once, if a person is relying on their pagan God to heal them, why do so many African-Americans want all possible medical measures to be administered in life threatening situations? My response is that some people feel that God is the decider of life and death not the disease or the honest. They may decide against any life extending measures leaving everything in God's hands while others will accept all measures available in the belief and refused medical aid to play God. Some do not trust health professionals because they think they promote secular values that counter religious beliefs

I also want to talk about some of the African-American traditional southern-based values. These are just a few of the traditional values and there are many more. For the sake of time I'm discussing if you. These values have been fractured do to drugs, poverty and other social economic factors. Often medical institutions and social service organizations require considerable amount of personal information and for many African-Americans that is not easily or willingly shared. Sometimes those are asking for this information may view patients the lack of responsiveness as noncompliant. The generational value of keeping family business private may be a part of the rationale for this unwillingness to tell the system personal information. This notion may have its roots in the history of slavery were blacks were valued only of property and living and dying often hinged on knowing when to talk and one not to talk. This belief still exists within the culture. One of the most important generational values in the African-American community is that of family. Family does not necessarily fit the Western concept of family that usually reflects the process of a father and a mother and the children model. But the family unit

may be much broader to include relatives and next of kin. This is just a turn that describes our relationship outside of blood can. Many African-Americans are considered collectivist and view life from an interdependent perspective which is inclusive of the extended family concept. Which may include family members not living in the household, friends, church members. These are all integral part of the family structure support system. End-of-life concerns are often a family concern. Which differs from those who view life as an individualistic effective. Family has a broader context and main group close friends relatives church members and pastors as decisions are being made regarding certain patients who share that collectivist you. The matriarchal presence is usually visible in families where African-American mothers and grandmothers are the head of household. Passing down stories, lessons, songs and other traditions worthy of mentioning. Believes such as getting private business trip it. Taking care of your own. These are understood within the culture for many. Other traditions may include old wives tales and Bible stories. It is also important to respect and show respect especially with the elderly. One way to do this is to use formal names when addressing them. For example, I reminded of a situation where a male nurse in the ER went into the room up an elderly black patients who were not on a hospital gown. He said, sweetie you need to change your clothes so Dr. can come in to see you. He meant well but it was offensive to her. Her response was not so sweet. Heidi then perhaps of this cultural consideration and adjuster as this is meant or Mrs. Jones, using her formal name, her parents went up and comment instead of heightened. Family corrective care is another area. And is required the sacrifice of one owns needs. Somebody might say I'll keep mom this week and someone will keep her next week and a sister can keep her next week. It's a sharing of the responsibility of care. This is not only seen in African-American cultures but other cultures as well. I would like to continue for focusing on life rather than death. They were the patient whose brother became brain-dead. This was a time when the family should have been sharing and supporting and become close. But there was decisiveness and discord because of that interview that I expect earlier about how people should leave here.

I will talk about two of these barriers. We talked about one and two. So I will focus the remainder of our session over number three and four. This communication and cultural competency missteps.

For my research I am convinced that part of the challenge in communication comes from where we see ourselves. The question is then, am I inclined more to be an individualistic or collectivist in my way of thinking. The Western European culture can be described as individualistic because the belief that people are independent of each other, the question is what is in the best interest of myself. Eastern cultures like China and Asia can be described as collectivist because it is believed that people are interdependent members of a social or cultural group emphasis is on what is in the best interest of well-being of the group not just the self. The question is then how will my decision upset the group. Most minority groups including Asians Pacific island and African-Americans associate with the collective disposition which may offer some insight as to why healthcare and end of life decision-making involves others outside of the patient such as families friends church and can. [Indiscernible]

The question I want you to ponder is what does this mean to you when a person does not make direct eye contact when talking to someone? What does the violence represent to you? Some think the patient's action of not looking directly to the doctors I've been talking is a sign that he is

being evasive or even dishonest. But from a collectivist position he may be showing respect for the doctor. Too often healthcare professionals do not understand these types of subtle trolled defenses that can lead to misunderstandings that can affect equitable care. Medication can be hampered when there is a lack of understanding of cultural differences. Service delivery may be misdirected or misdiagnosed when cross cultures -- facial expressions and gestures communicate a message to others work verbal and nonverbal communication contributes to the message we are conveying when conversing with each other. Some of the attitudes and beliefs that contribute to health care disparities and -- healthcare providers with -- -- researchers note that communication problems are directly related to racial disparities and health outcomes within the healthcare system. These communication missteps can lead to lack of access and a lack of participation in the healthcare decision-making process. As professional -- we can increase our effectiveness in communicating with others by having more aware of our own prejudice sees and biases. Some suggested ways to increase medication effectiveness are. Be mindful that the cultural beliefs and values influence responses. Be considerate of cultural mitigation files. Formal birth of non-fertile. Avoid pet names. Ask questions to clarify responses. Is okay not to know that it's not okay to make assumptions. What really matters of the end-of-life? At the beginning of this presentation a talked about some of the commonalities that all people seem to share that inept us as human beings regarding our the city and background. The quality of life is just as important in the dying process. Having been meaning for being, a purpose as well as sharing and connecting with those you care about most. Confident and supportive. At the end-of-life the closing were and the things you have don't seem to matter too much anymore. In the final stage of life there is a review process. What it comes important are the little things like building memories and leaving a legacy. Most people regardless of their skin color or cultural influences, look back and assess what is happened in their lives. Dying with dignity is an inherent right. This is something to keep in the forefront of your individual reactions with others. I hope this overview will be helpful to you in your own work and communication efforts with this population. Feel free to visit my website. My time is about up. Think you so much for your time today on your participation on the call.

Thank you Mrs. Anderson for that inspirational talk about some of the specifics in the African-American community. I want to open up the line for questions.

If you would like to ask a question please press the number one and then the number four.

We have a question in the chat for Thomas Harter . What the results of advanced care planning are also seen in disparity population ring is the primary language.

Great questions. But we have found is that most people want to have some control over what happens to them in a medical facility. Keeping that principle in mind, we must be mindful of the language. And even people were English is perhaps the first language, like the native Americans high -- tribe just north of lacrosse. We were nervous that this wouldn't work. He was nervous because of this together tribe, they have a stigma against referring to themselves in the first person. Which is very hard to do when you are trying to ask people what do you want. What type of medical care do you want and what are your values and preferences without being able to refer to yourself. We had a few facilitators for the group who came down and got trained in this they took it back up and within six months they said things have gone really well. When the

question was posed to them how to do do it. They said that was easy we just taught them to talk about medical care in the third person. So that the question was not what you want, but if there was somebody like this what do you think they would want. They would say if this person was sick with this they could save this is what they would want. I think we remained convinced until we saw data otherwise, as long as they can get the language worked out we will be successful. We have also brought this locally. This includes all of the data. We have a large mound population -- Moung population. Our documents have been translated into their language as well as Spanish and we have been able to have wide success with that.

Are there any questions in the queue?

No questions at this time.

How often do patients or families refuse or get offended by being offered advanced care planning?

That is an interesting question. The reason I say that is because our process is that every person who is over the age of 55, when they come into our health environment they get asked whether or not they have an advanced directive or do they want to complete one. We do have is on record so when people bring them in we are able to pull them up. If our providers and see that they have one they will look at the date that this was entered. If it is over five years they will say would you like to review it. And of the specific question is how often do they get annoyed by being asked of this. Not really. They recognize it as part of our culture. When they come into any these institutions here the La Crosse area, they know they will be asked about that. It's such a low prevalence of people who have advanced directives that there is not enough of a number of people who do not have them for us to collect data on, how annoyed they get.

Thank you again. We also have a question for this Anderson. How can providers be more culturally competent and be more aware of the cultural factors that they should used to delineate how they render care to patients.

I would say always assess what is going on in your own head. I don't think it's possible to know every culture or every particular ethnic group and different intergroup dynamics. I believe that if you are genuine in who you are. We are individuals in have to be true to ourselves. Something as simple as that you just be true to ourselves and in terms of knowing what makes you tick will help you adjust and go with people who are different than you are. Things like if you don't understand something ask a question. Don't take things for granted that people think the same way you do or have the same values as you do. Medication comes from the heart and you express authentication and that makes a difference to any person regardless of who they are.

Thank you to both of our speakers once again for joining us today. We will move into a few brief announcements. Our first announcement is the data affinity group they will be hosting a meeting this Thursday, May 15 at 2 PM. We will recap Dr. Jeffries talk during the April conference.

No office hours this month.

Our CoP topic for next month will be understanding disparities among dual eligibles with mental health conditions.

Remembered to join the DNCC community. So you can stay updated to all the things we are doing. If you have any interesting stories or videos to share please send them to my attention and will be more than happy to post them on this site. Please remember to complete the evaluation and thank you again for joining the call today. We hope to see you virtually again next month.

That is include the call for today thank you for your participation you may now disconnect.

[Event concluded]