[MUSIC PLAYING]

ROLLIN WRIGHT: All right, I have no conflicts of interest to disclose, I paid to use this material.

[LAUGHTER]

All right. So, in this next exercise-- this is the eighth inning stretch-- I want everybody to stand up, everybody stand up, stretch, eighth inning, we're about done. We're about done. All right, now, everybody, turn to the person next to you. That is your partner, OK? For the rest of this 30 minute session, that person next to you is your partner. All right?

So, person on the left, introduce yoursel-- you have 15 seconds to do this-- you have 15 seconds to introduce yourself to your partner, and ask the person on the right these three questions. Go.

[LAUGHTER]

Animation is not working.

RACHEL: I gotcha. Oh, there we go.

ROLLIN WRIGHT: All right, so go forth and ask someone if-- what they [INAUDIBLE] to introduce one person, introduce their partner.

All right, OK, time's up, time's up. All right, Rachel is going to pick a lucky member of the audience, she's going to pick a lucky team, and she's going to ask you to introduce your partner, what you found out.

AUDIENCE: This is Amanda, her teacher was Mrs. Reed, she's an extrovert, and she leads with her head.

ROLLIN WRIGHT: All right, yay, everybody give Amanda a hand.

AMANDA: Thank you.

ROLLIN WRIGHT: All right, so what did you notice? You guys can sit down now, but stick with your partners, because you're going to need them again. All right, so what did you notice about those first two questions? Those first two-- which ones were easier, the first two or the last one?

AUDIENCE: The first one.

ROLLIN WRIGHT: The first-- somebody said the last one. That means that whoever said the last one has some serious emotional memory, and it took them no time to dial up their fifth grade teacher. And I'm not going to ask if that's a good or a bad emotional memory.

All right, but the point here is that we, doctors, we've been taught to answer open ended-- or to ask open ended questions of our patients all along. And this is a major communication snafu when it comes to the person with dementia. So let's see what we're talking about here.

So in the next, I guess, 27 minutes, we're going to go over the three elements of an effective conversation with a person with dementia. And this thing is acting wonky. So those three things, the three things that you need to know to have a good conversation, a meaningful conversation, not a disabling conversation with a person with dementia, is you need to have an agenda, and you need to know what to do with that agenda. We all have an agenda, but sometimes we don't do the right thing with our agenda.

You need to have a positive approach, and you need to connect, and build a relationship. And each one of us in this room is going to get to practice that. So the purpose of learning these skills is so that you will learn how to improve your care, as I have learned how to improve my care and support for people in families that are struggling with this disease.

So, we're going to talk about brain change, and how it's changed communication in people with dementia. We're going to learn a few-- and practice a few, in this room-- nonverbal communication skills to role model, for you to role model to families at the bedside. And we're going to teach you how to use this knowledge, and these skills, to help families connect meaningfully with their loved one with dementia, and get things done without all the challenge and the stress.

All right, so, why is this important? It's important because we PCPs, we often miss the diagnosis of dementia. How do we know that? Well, the data shows that in one out of three people in a chart review who had dementia, met criteria, only one out of three were actually identified in those charts as having dementia. PCPs, when they do see the disease, they often don't see it, or recognize it, until it's pretty late and [INAUDIBLE] so it's kind of obvious.

So we don't know it when we see it, and when we finally recognize it, the person is already probably well on their way to moderately advanced dementia. And so that means that we've missed, maybe a few opportunities to accomplish a few important things with our families, and people with-- in our patients with dementia. So one other statistic that's a little bit scary, is that in the other two of those one out of three people, so of all the people who were not documented as having dementia but did meet criteria, 20% were already advanced. Again, we don't know it when we see it sometimes.

So what's really happening in the brain with dementia? Dr. Rodriguez spoke earlier, and he gave this long slide that had all these different types of dementia. And then he said, it kind of really doesn't matter, because what it comes right down to it, demensia is really, just you know, another end organ disease. It's brain failure, the brain is dying. Just like in lung disease when the alveoli are dying, just like in renal disease when the nephrons are dying, just like in heart disease when the myocytes are dying, the neurons are dying.

So, next side. So just a couple of points that I want to make with this slide. And if you've been here before, and if you've listened to this talk before, then you've seen this PET scan. And what it really highlights is some of the major changes that happen that impact communication skills.

Three things I want you to pay attention to, look at the red zones, that's the most metabolically active area of the brain. And so you can see in the first column with the normal brain, that everything active. All of your brains, you've got a lot of red zones in there, a lot of red zones right now, because you are listening attentively, you're processing, and you're storing it in memory so that you can retrieve everything I say at a future date when it will be really, really useful. OK?

If you look at the second column, again looking for the red zones, you're seeing that even early in the disease, there's a lot of metabolic loss, a lot of tissue loss in the frontal cortex, prefrontal cortex where executive function takes place. If you take a quick look to the sides-- and be ready here-- when you take a look at the sides, you see the left temporal lobe is fading a little bit. And that's where language happens.

All right, so everybody hold up your hands. So right temporal lobe, just notice that it's kind of red. Right temporal lobe, red, left temporal lobe is dying. Left temporal lobe is the cognitive aspect of language. It's where you articulate your thoughts, what's going on in your internal environment. So left, language, lost. And what am I going to do here? Right, rhythm, retained.

[LAUGHTER]

Right, rhythm, retained. Right? So even late in life, swear words, poetry, music, it's still there*Alive Inside,* if you haven't seen it, go see it. It's a phenom-- if you only have two minutes, the good news is they have a two minute YouTube video with *Alive Inside,* and how this guy, Henry, who's in the sleeping lot in his nursing home, comes to life when they put music and fire up the right side of his brain. Because when the right side gets fired up, sometimes a little bit of the signal gets over to the left side, and you have a person that you can interact with for a few moments in time.

So we talked about what's been lost. Cognitive function, you can't see the memory part on this side. So if you're thinking these two little doohickeys here are memory, they're not, all right? Those little two doohickeys, they're amygdala, the [INAUDIBLE] part of the limbic system. It's your primitive brain, and yes, we all have one. It's the area of your brain that tells your body, hey, there is an imminent threat in my environment.

You're going to do what, you're going to do one of four things. You're going to fight it, you're going to be frightened, you're going to freeze, or you're going to-- I can't remember the fourth thing. Fight, fright, flight, and freeze. There we go, got it, four Fs, got it.

RACHEL: There's one more.

ROLLIN WRIGHT: Oh, and what's the other one?

RACHEL: Oh, that's the unmentionable.

ROLLIN WRIGHT: Oh, right. That's in the apathetic brain, that's also an F word. That's two words, the first one starts with an F.

All right, so the amygdala, when unrestrained by the frontal cortex, the amygdala sometimes get us in trouble. And they are-- and the amygdala's response-- well, it's hard to advance this slide, I'm having a hard time here. I can't even get to my advancer. There we go. All right, one more view of the brain. Intact side, language, memory, gone in the demented brain. Demented brain, 2/3 the original size of a normal brain. All right, so here we go. On this slide, not only do we have language and memory, but we also have auditory processing. So what do we do with language?

When we're on the receiving side, we bring it in, and then we process it, and figure out what we're supposed to do with it. A person with dementia does not have good auditory processing. But our language skills are really intact, so we're really good at talking up a blue streak, and they're really good at not catching any of it.

So one thing that's really important, a couple of things, really important to remember about auditory processing--because we as providers, we live in a linguistic world. We live with language, we live in the verbal, we live in the now. But the person with dementia has delayed processing. It takes about 20 seconds, and I don't know if we're going to get all 20 seconds in here, I'm going to just stop for 20 seconds.

Rachel, what did you have for breakfast today? Waiting, waiting, but we're all so impatient. Hey, Rachel, I was wondering what you had for breakfast today. Did you go out to Denny's? Did you have toast? So we as providers, sometimes layer on the statements, and they're still stuck on the first one. The other thing about auditory processing, is that they're losing every fourth word, and they're losing nouns. So Rachel, what did, breakfast? So it's really hard for the person with dementia to understand what you're saying.

Another thing to point out, while we're here, is that we as providers, we ask so many open ended questions. When I say, Rachel, what did you have for breakfast today? What would she say if she didn't have language? Well, same thing I always have for breakfast.

So how useful is this conversation in the doctor's office? So, are you having any pain today, where do you have pain? Are you feeling constipated? Are you having trouble with your bowel movements? What did you do last night? These are all really hard questions to answer, and we get a whole lot of garbage in response. So one thing that we can help in the medical interview, is we can provide close ended questions. Yes, that's right, close ended questions.

And this is how it's done. Rachel, are you a head first, or a heart first kind of person?

RACHEL: Oh, I'm a head first.

ROLLIN WRIGHT: Are you an introvert or an extrovert? You're a big E, you're a big fat E.

RACHEL: I'm an extrovert.

ROLLIN WRIGHT: Big fat extrovert, man.

RACHEL: I am.

ROLLIN WRIGHT: She is so extroverted. So are you an early riser or a late sleeper? And by doing that, by closing the question and giving multiple choice options, you give them the words that they can't find. Because with a question like, who's your fifth grade teacher, that information is stored somewhere way out in extended parking, and it takes a minute for you to dial it up, and drive it in, and call on it.

All right, so we ask people with dementia to do these things all the time. And we get very little useful information in the interview. So what have we learned so far? We have learned that we can recognize where they are in the disease, and we can actually explain to families where they are in the disease.

Families-- get this, when you talk about neuropathology, and you say, oh, that's because the hippocampus, it's atrophied, it's gone. It's because language is gone, it's because it takes 10 steps to brush your teeth, but they no longer have executive function to do task initiation, tasks sequencing and follow through, and task termination. They lost that ability. And we've also learned, yes, you heard me say it right, to ask close ended questions. OK.

So if they can't use language, if they can't understand language, then what are they using? Because they're still communicating. Well, they're using nonverbal communication skills, and you guys have heard me talk about this before. We appreciate these as neuropsychiatric symptoms, or dementia related behaviors, right? But what they really are, is really a clue to some kind of unmet need, using Jessica Cohen Mansfield's theory of unmet needs as what triggers dementia related behaviors.

So what are these unmet needs, what are these neuropsychiatric behaviors? They're the delusions, the paranoia, your, my husband's sleeping around, somebody stole my purse. Sleep disturbances, apathy, as Dr. Rodriguez talked about earlier. The agitation and restlessness, this energy that's in there somewhere, and they don't know how to expend it because they can't organize it and focus it on something. Wandering-- and just so you know, 60% to 96% of all people with dementia have some sort of neuropsychiatric behavior, which means that they're communicating, but sometimes we're not there to receive the information that they're giving us. And we're not figuring out how to explore what they're telling us.

So the incidence of neuropsychiatric behaviors is around the middle stages of dementia, but it can happen earlier in the disease, for sure. And these neuropsychiatric behaviors on the psychiatric index are the ones that are most distressful to caregivers. This is why people come to you and say, don't you have a drug so that they can sleep? Can't you help me with this restlessness? Like, you know, she's up all night pacing. The aggression, and then the hardest symptom to watch sometimes might be the depression.

So, again, these are challenging behaviors, but they're not just behaviors to be stamped out by an anti-psychotic, they're actually clues to a possible unmet need. All right, so here we go. Put your hands up. If you've seen this before, this is how you guys remember unmet needs. Five physical unmet needs on your left hand.

Number one, are they hungry or thirsty? Number two, are they overtired or energized, over energized, got that energy? Number three, elimination. This is where it happens folks, again, remember, they've lost the language to express their internal environment stressor.

Number four, discomfort. Anybody-- can anybody hold up their pinky finger higher, or their ring finger higher than me? It's really hard to do that, that's why it's discomfort. It's, I've got an itch but I can't reach it, I've been sitting in the broda chair for way too long and I've lost my sensory motor strip because my motor cortex wasn't spared in this disease, it's all going, and I can't move. It's too hot or too cold in here. This tag in the back of my neck is really itching me. And then the fifth one is pain, and pain trumps everything. They're not able to have language and words to describe what they're experiencing and going through.

All right, so right hand. Remember, right is emotional unmet needs, because right is where emotional memory is stored. That means that, that guy on the bus, when the bus driver drove away too fast and I couldn't get off at the right area, I got pissed off. And I'm still remembering that, because I've still got that feeling, and it's hanging on with me. And so, if you rub someone with dementia, if you start out the day bad, or if you have one bad encounter, that emotion it's going to stick with them.

All right, so number one, twiddling your thumbs, remember, this is bored, boredom. So boredom happens because the brain's looking for something to engage it, but it can't plan that. I don't have a pill for boredom. I'm sorry, I don't think that Mylan or Pfizer makes that drug. But yet, when somebody's wandering, and getting into stuff, because people with dementia are curious and they're trying to stimulate their brain, they get in trouble for being intrusive.

Number two, I'm sad. Use your index fingers, I'm sad. I'm sad because I've lost a lot in this disease. There's a lot I can't control in my life anymore, I'm sad. Number three, lonely. Because I am now by myself in this disease. My family put me in this nursing home, my family is at work all day, I don't have any of my friends to connect to, I don't have my life partner anymore. I have to have people help me, but they're not my friends, and they don't connect with me. I'm lonely.

Number four, I'm scared. I'm scared because I don't recognize anything. This is not my home, this is not the place where I feel safe, this is not the place where I feel loved. I'm uncomfortable, I'm emotionally uncomfortable, and I'm scared. And then again, angry. Oops, OK.

So what we've learned now, is we've learned a little bit about the neuropathology behind the behaviors and the communication changes. And we've learned that we need to look to nonverbal communication skills, look to behaviors as nonverbal communication skills, that we need to decode an unmet need potentially. Because usually, you're going to find one. Sometimes you won't, but usually you will.

So next, we're going to move on. All right, so here's another interactive exercise. All right, everybody, grab your partner again. You guys made friends a few minutes ago, so grab your friend, all right? And between the two of you, you guys decide which one of you has dementia. [INAUDIBLE] are you the demented one, or are you the provider?

So you get to choose now, because in another 30 years you don't get to choose. Half of you will be demented and the other half will be taken care of you. All right.

[LAUGHTER]

All right, so we're going to learn-- we're going to learn about the relationship and how to connect. All right, so have you all decided? Everybody decided, all right, so here we go. Again, providers, I want you to raise your dominant hand.

Providers, who's a provider in the relationship? Providers, get your hands up. I want you to take a look at your hand. Tell me about this hand, this is your caring hand. Providers, caregivers, spouses, this is the hand that you give care with. You give care because that person needs your care, and you're the one who knows how to give care with your caring hand.

All right, now, flip your hand over providers, look at the back of it. On the back of it, that's your agenda. Now, you need to be doing this with your partner, OK? So you need to be looking at your agenda, providers, you providers, every single one of us goes into the exam room or to the bedside with an agenda. Because there's something that we gotta get done. We gotta get care done, we gotta do a rectal exam, we gotta do a blood pressure, we gotta to do orthostatics, we got an agenda.

Nurses, nurses have to give meds, nurses have to change people, nurses have to get trays set up. Nurses have a lot of stuff on their agenda. So we doctors, nurses, nurse practitioners, pharmacists, everybody's got an agenda, right? Sometimes that agenda comes between you and the patient, right?

[LAUGHTER]

Right? So, I'm so busy with my agenda that I don't have a relationship with my patient, because I've got to get stuff done, and I got to give you care, OK?

All right. People with dementia, take your dominant hand, place it on the provider's hand. OK, providers, ready? Actually, people with dementia, put you down for just a second. Providers, keep your hands up. Providers, keep your hands up. All right, take your caring hand and your agenda and shove it--

[LAUGHTER]

--and give your care to the person with dementia. You're going to do care to these people with dementia. All right All right, so this is where the people with dementia get to actually have fun with this disease, OK?

RACHEL: Rollin, I saw some people remove their glasses.

ROLLIN WRIGHT: Well, that's because we can be a little aggressive with our care sometimes. All right, people with dementia, all right. Providers, keep your hands there. People with dementia, put your hand down. People with d-- ready? Talk to the left, 'cause you ain't right. Say it with me. Talk to the left, 'cause you ain't right. One more time, I don't hear participation.

This is the one time you get to have fun in dementia, OK? Talk to the left, 'cause you ain't right. All right, good, good job, everybody. OK now, caregivers and people with dementia, people with dementia-- all right, caregivers, I want you to give care to the person with dementia. All right, give care, you're giving care.

People with dementia, I want you to say, no, and push back. I don't want it. No, I don't want it.

AUDIENCE: I don't want it.

ROLLIN WRIGHT: There you go, all right. Fair, fair. So that's kind of how we give care, that's how we go about with our agenda. So the point is, and the point is I'm totally distracted by this mouse without a mouse pad. I don't have a gripper over here. All right, there we go. All right.

The point is, is that when you're doing this, you're tangling. You providers, you guys have just planted yourself firmly in the negative emotional memory of the person with dementia. And you're going to have a bad day and a bad time with them, unless you fix it. So how do you fix this?

I am so sorry I made you feel angry. Wait a minute, wait a minute, wait-- I didn't hear anything.

[LAUGHTER]

Put your hands up. Put your agenda in front of the patient, take your left hand, and move your agenda to the side, then go into hand under hand. And say it with me, say it with me-- stay connected. Get connected over there. Nobody gave you a free pass.

[LAUGHTER]

Say it with me, I am so sorry I made you angry.

AUDIENCE: I am so sorry I made you angry.

ROLLIN WRIGHT: I am so sorry, I didn't mean to embarrass you. Do you guys not know how to do your I'm sorrys?

[LAUGHTER]

I am so sorry that you people aren't listening. I am so sorry this is hard. So, person with dementia, how did that feel? Does it feel a little bit better?

AUDIENCE: Yes.

ROLLIN WRIGHT: Providers, doctors, providers, what did you notice about your connection? Did the tension in the hand under hand seem to dissipate when you said, I am so sorry? So this is really important, it's the relationship that matters, not the outcome of the encounter. You need to get them to go to the bathroom, they need to go to the bathroom, you need to do the MoCA on them because that's what you're tasked with, you've got to do the MoCA.

But in order to get your work done, you have to set up a relationship first. Because these guys amygdala respond to the stress that you have created, unless you learn how to approach correctly. So let's go into the approach if I can advance the slide. Just taking up time here.

So who causes behaviors? We do. So what do you do with your agenda, because you still got to get things done. So you know your agenda, you don't show your agenda, and you put it in your back pocket. All right, know your agenda, don't show your agenda.

All right, getting on the positive physical approach. So how do you change the encounter, how do you develop a relationship, how do you connect with someone? First, you do have to connect in order to form a relationship. When you're connecting and communicating with a person with dementia who has lost language, you use visual, verbal-- but limited verbal-- and touch cuing, to show them what to do, to show them what you're trying to tell them, OK?

So you gotta do this, you gotta get a relationship, you gotta use a positive physical approach before you go and give care. And a relationship has many dimensions. It's visual, it's a verbal, it's physical, it's emotional, and so on. And so, when you're doing the positive physical approach, just be aware that there are three zones of human awareness.

There is public space, which is six or more feet away. Now, what do you do in public space? In public space, you're getting their attention, you're drawing the visual. Hi, Rachel. Can't have a conversation in public space. Then there's personal space, which is an arm's length away. So it's less than six feet, an arm's length away. Then there's-- and that's where conversations-- comfortable conversations-- happen, in personal space.

But we providers, we work really well, we work best in intimate space. And intimate space is for intimate things.

[LAUGHTER]

Only the kind of intimate things that we do is getting people undressed, touching them in very exposed and intimate places. So if you want to get to that intimate space without triggering the amygdala and getting hit, then you need to have that relationship and trust built between your first.

So there are six-- there are several steps to the positive physical approach, I'm going to skip the video. And so you're going to pause at the edge of public space, use visual-verbal touch. You're going to offer your hand, and it takes-- remember, their processing is a little delayed, so you don't move in until they've seen you, and until they've accepted your hand, OK? Because it takes them a while to figure out what's going on and where to look. And then you're going to move to the dominant side.

Take my mic with me. Hi, Rachel, hi. Move to the dominant side, hand under hand, get down low. And then you can start-- if she's accepted and she's still connected-- then you can start working toward whatever your agenda item is, because she's going to let you. And we're almost done.

So when you get connected, there's a little step here in getting connected. It's not like you can just do the physical part of it, you kind of have to engage them a little bit verbally. You can connect and start a relationship in less than 30 seconds and with just a few words. Ready?

Hi, I'm Rollin, and you are?

RACHEL: Rachel.

ROLLIN WRIGHT: Rachel, orange is my favorite color and it looks fantastic on you, you look fantastic.

RACHEL: Thank you.

ROLLIN WRIGHT: Rachel, I get a little nervous before I get up and have to get on stage. Little nervous before I have to get on stage. Rachel, did you happen to notice all these people out here? There's a lot of people. Rachel, right before you get on stage, are you one of those people who takes a deep breath, or runs to the bathroom?

RACHEL: I run to the bathroom.

ROLLIN WRIGHT: So, in that 30 seconds, we formed a relationship, and it had nothing to do with my agenda. But now that I've connected with her, and she has a positive feeling about our interaction, then I'm going to be able to move on with my agenda. So let's see it in action. And this-- I want you guys to notice all the steps of the positive physical approach, and what happens in this encounter.

PEG: Hi [AUDIO OUT].

MARY: Hello.

PEG: My name is [AUDIO OUT].

MARY: I had you one day, yesterday.

PEG: Probably at St. Francis, when you were the 11:00 to 7:00 supervisor.

MARY: Right.

PEG: Mary?

MARY: Yes?

PEG: Will you come with me?

MARY: When?

PEG: Now.

MARY: Why?

PEG: Take a walk.

MARY: No, I'd better not.

PEG: No?

MARY: No, I'd better not.

PEG: You don't feel like talking a walk with me today?

MARY: No, tomorrow I'll [INAUDIBLE].

PEG: OK. OK.

MARY: I'd better get it clean, huh?

PEG: Nice talking to you.

MARY: I just could--

ROLLIN WRIGHT: That could have gone very differently if it was a caregiver who insisted, Mary needed to go to the bathroom, she needed to be taken to the bathroom. And what Peg knows about Mary, and what I know about Mary, is that she's had two hip fractures, and every time she does sit to stand, it's excruciating. Mary's not going to go anywhere fast.

And if you told her that you had to take her to the bathroom, she's definitely not going to go. The nice thing about this encounter, this moment, is that Peg went in slowly-- she's the PPA. She established a connection and she finished the encounter with what? A kiss and a thank you. So even if you don't get the outcome, thank the person, because that's going to be the thing that continues a relationship.

Why? Because Peg has to come back in a few minutes and get her to the bathroom. And it's not going to happen if she's at all pushing her agenda on Mary. So let's see what happened later.

MARY: And we're going to go there?

PEG: Yeah, stand up.

MARY: Let's go, let's go up where Ian is.

PEG: OK, stand up. Can you stand up?

ROLLIN WRIGHT: So she's using visual, verbal, and touch cuing.

MARY: Wait.

PEG: I'm with you, one, two, three, stand up.

ROLLIN WRIGHT: And touch cuing is-- with her hand on her hand as a supportive hand to help Mary stand up.

MARY: All right, wait, so I get there.

PEG: OK, [INTERPOSING VOICES] you got it.

ROLLIN WRIGHT: [INTERPOSING VOICES] a lot of help sit to stand.

PEG: OK, there you go Mar.

MARY: Yeah.

PEG: There you go, take a moment.

ROLLIN WRIGHT: At this [INTERPOSING VOICES], I would have done anything Peg would have asked me.

PEG: Yeah, take a moment, and I got you.

MARY: I got you both, too.

ROLLIN WRIGHT: Same thing goes, you can do a MoCA the same way.

PEG: Come with me.

MARY: [INAUDIBLE] got you, ha ha ha. We got you.

ROLLIN WRIGHT: So what's really important, is we need to put the drugs away, and not have them out first to stamp out these behaviors. Non pharmacologic strategies can work, but not unless you apply what you know about-- help me out, you were paying attention, right? Brain change.

Recognizing behaviors as nonverbal communications about--

RACHEL: Unmet needs.

ROLLIN WRIGHT: Unmet needs. Using your own non-verbal communication skills, and putting your agenda?

AUDIENCE: In your back pocket.

ROLLIN WRIGHT: In your back pocket. Making a connection and establishing a relationship, OK? So, in summary, challenging dementia behavior is usually a nonverbal communication about unmet physical or emotional need. And we as providers can demonstrate, in the room, techniques to help families work better with their loved ones, and not feel so stressed out about it. They honestly don't know all this neuropathology.

But they can learn really quickly, you just explain. It's just like lung failure and heart failure, only it's brain failure. They have a right to know what's happening to them.

All right, just want to acknowledge Teepa Snow, a lot of the material is from her, you can see her material at her website. I also wanted to say-- to pull one plug for the Dementia Action Alliance, because the positive approach isn't just about getting stuff done. It's really, really, really about trying to help people with dementia live a life fully and with dignity. And we can do that, we can do that. But right now, we're so focused on the negative. And lastly, the Alzheimer's Association, I think I go to this site at least once a week, and refer people once a week to this site, because it is so incredibly resourceful. Thank you for your time.

[APPLAUSE]