ARCHIVAL AUDIO (00:06):
"We are here today for George Floyd and so many others who have been killed by systemic racism."

Seán Collins (00:19):
The conjunction of the aftermath of George Floyd's murder and the rise of the Covid Pandemic provided for a unique moment of self-reflection for people working in healthcare.

ARCHIVAL AUDIO (00:32):
"And as we rise from this moment of silence, let's look inward at our own implicit biases and let's look outward at discriminatory policies and find a place that we can affect change."

Seán Collins (00:45):
Across the country. White Coats for Black Lives events; serious discussion of the role of implicit bias in healthcare; and a renewed commitment to diversity, equity, inclusion, and accessibility — they all went hand-in-hand with street protests and Zoom seminars. Racial disparities in both the rates of COVID-19 infection and deaths among blacks, non-white Hispanics, American Indians, and Alaskan natives, far outpaced white people at some times during the pandemic by three or four times when adjusted for percentage of the population. But that truth was first recognized only at the bedside because as then-Maryland Governor Larry Hogan said the data on race were not something that was being collected.

ARCHIVAL AUDIO (01:47):
"Well, first of all, this disparity among African-Americans is very disturbing. It's why I called for the study. Nobody was really tracking these things and it was difficult to do because none of the federal labs, the CDC, nobody was actually tracking these tests by race. And we went back and actually individually looked all this up."

Seán Collins (02:07):
On today's program: Race, Healthcare, and Equity — a report card in the last month of 2023 with an eye towards work still to be done. It's the Hear Me Now podcast. Stay with us.

(02:27):
I'm Sean Collins. Glad you're listening. Dr. Nwando, Anyaoku joins us now from Seattle. She's the Chief Health Equity and Clinical Innovation Officer for Providence. Dr. Anyaoku. Welcome.

Dr. Nwando Anyaoku (02:39):
Thank you. Thanks for having me.

Seán Collins (02:41):
Oh, it's great to have you here. I'd like to start with you telling us a story. I watched your TED talk that was at Bellarmine in Louisville back in February of '23. And in that you tell the story of a patient from Liberia who when you told her that you were relocating, said, "Who is going to understand me?" Now you go on to say that you were her doctor, but that you felt that what she was really getting at was something else. And I'm paraphrasing here, but apart from your training and your clinical expertise, what she was going to miss was you, your whole self, your experiences she was going to miss, having someone who looked like her, who sounded like her and had experiences like hers and who could use those experiences when taking care of her. Do I have that right?

Dr. Nwando Anyaoku (03:37):
It's absolutely right. It's one of those things that in the course of your career, a moment stands out for you, right? You understand things in principle, but this moment crystallizes it for you. And this was one of those moments for me. I'm a pediatrician and I was serving in a practice in New Jersey. This lady was mother of one of my

patients, and she was a refugee from Liberia during their civil war. And she came to the states from Liberia with a heavy Liberian accent. I'm originally from Nigeria, not Liberia, but as you can hear, I have my own accent.

(04:20):
But we are from a similar part of the world. And while I didn't speak her native language, I did understand her broken English. I could sit with her and understand what she was trying to communicate. And I remember that when she used to come to my clinic, the other staff who didn't necessarily have my background were like, oh Lord, it's always so hard. They loved her and they wanted to help, but they were struggling to communicate effectively with her. But I could listen to her, I could talk to her. And so she would come to me when her children were ill when they needed their well visits or even when they were having trouble in school because she knew that I would get her, which is all that any of us wants. Do you get me? Do you hear what I'm trying to say? Is what I'm trying to say important to you?

(05:06):
And with me. She felt all of those things. So when I told her that I was relocating, she paused. She looked down on the ground. I'll never forget it, it was like yesterday. She looked up at me and she said to me, "who is going to understand me now?" And the understand was what stood out to me because people would say, who's going to be my doctor? Who's going to treat me? Who's going to help? But she said, who will understand me? And that understand me question was what hit at my heart. In in the journey of life, we look for people who understand us. And so for those of us in healthcare, we are dealing with people at their most vulnerable moment and on a good day, we have trouble communicating in our vulnerable moment. If you're now in a place where no one looks like you, no one understands the context from which you are coming, then you're saying things and they're like, all right, she must mean this or she must mean that. And the healthcare team is not trying not to hear you. They just don't understand you. And so that leads to something that has been described as an empathy gap, where people who generally say the same things to one another, watch

the same TV shows attend the same sport, they get each other, but somebody who's different might have a harder time being understood and therefore have more difficulty accessing empathy in that system. And for healthcare system that is key.

Seán Collins (06:35):
In the TED Talk, you say that "systems default to uniformity and conformity," and that we have this mental model of what our team members are supposed to look like and sound like, and it's therefore harder for people who sound different or look different from the majority to feel like they're fitting in with that team. And that seems like it's at the absolute crux of healthcare's problem with this issue.

Dr. Nwando Anyaoku (07:03):
It is. The purpose of my TED Talk was to really encourage people from different backgrounds to come into this space to let healthcare know that there is unique value in having different perspectives represented on our teams, and recognize also that the lack of diversity in our teams is not because anyone has intentionally made the decision not to have it. Really, people get offended when you talk about it. They feel like you're accusing them, but really it's not their fault. They're just living in this space and everybody who they've ever seen, who's a doctor, looks like that. So when I show up as a doctor, they're like, are you sure the physicians of color who tell you that they saw a patient introduce themselves, have a big ID indicating physician on it? And that patient at the end of the day writes a review saying they were never seen by a doctor. It happens pretty much every day because that's in their head. A doctor doesn't look like that. A doctor doesn't sound like me, look like me because that's not what they've ever seen. And so even people who look like me then don't see themselves in that space. And so it sort of becomes a catch 22.

Seán Collins (08:25):
You said something really powerful. I think about this experience of say young caregivers earlier in their training when they're confronting this issue, you use the verb

to blunt that they blunt themselves in order to fit in. I think that's an incredibly powerful way of putting it.

Dr. Nwando Anyaoku (08:48):
And so sad, right?

(08:49):
Yeah, absolutely.

(08:50):
You come into this space and people are like, well, what's up with your hair and why do you look? Why does your hair look different from everybody? And why do you talk like that? And why don't you laugh at my jokes, right? They're talking about games that I've never watched and TV shows that I've never, well, I'm not laughing or I laugh at something else. And after a while, you keep hearing all these things that make you basically feel other because you are not like everyone else and everyone else doesn't understand your perspective. And so you get othered. And when you get othered, it can be very risky for your career, for your training, for just your general livelihood. If people don't relate to you, you run a risk of being ostracized. Some people have described it as being hyper visible and invisible at the same time because every error you make is amplified.

(09:45):
And when you have success is not celebrated. When there's opportunity for promotion, people don't think about you because you are other. And after a while you start to try. People talk about, well, you're here now. You should assimilate. You should behave like everyone else. Well, what does assimilation mean? It means that I have to take away my uniqueness so that I look like everybody else. So I sound like everybody else, and I laugh at everything else that everybody else. And so the unique things of me start to go away. And at the end of the day, that's a loss for us all because my unique value proposition is me. It's my background. It's what I've been through. And so when I met

that woman from Liberia, I understood her. She was a refugee from a war torn country. I was born in a war different country, but I get it. I know what she's facing. I can have a conversation with her in a different way. If I had gone in, a lot of people end up doing well, I better not share where I come from. I better not share my accent. I need to go get that to go away. Eventually, we all become too uniform to make an impact to a diverse world, and we are a diverse world. We must celebrate that.

Seán Collins (11:04):
Can I tell you a story? I had open heart surgery about 10 years ago, and I had this sternotomy down the middle of my chest and the radial graft was ripped from my arm up to take an artery out and spent a couple days in intensive care. I then got stepped down to a cardiac unit and I had a nurse on the weekend who was from Liberia, and she basically came in and said, "Mr. Collins, it's time for you to take a bath." I don't know if I was smelling bad or what, but she was like, the time has come. And she brought a tub of water and antibacterial soap and a million washcloths and taught me how to bathe myself sitting in a chair. And it was sunny. I remember this so clearly. It was a Sunday afternoon and sunlight was pouring into this hospital room, and she closed the door and she left and she said, just push the call button when you're done.

(12:09):
Take as long as you need. And Dr. Anyaoku, what was really happening is I was afraid to touch my body. I was afraid to touch those wounds. They were only six days old. I mean, they were still bloody and awful looking, and I was afraid of them. And I spent, I don't know, 40 minutes giving myself a bath and eventually called for her. And she came back and I thanked her and I said, "Thank you for making me do that." I said, "I was afraid to touch these wounds." And she looked at me and she said, "I know." And I immediately felt a degree of compassion and empathy, and I don't know what her story is, but I know enough about Liberia to know that she knew what I was talking about when I had these bloody wounds on my body that I was afraid to touch.

Dr. Nwando Anyaoku (13:07):

I love that story. "I know."

Seán Collins (13:09):
That's all she said

Dr. Nwando Anyaoku (13:11):
In those two words. It just encapsulated everything you were feeling in the moment, right? That's empathy. That's what we all seek.

Seán Collins (13:20):
And that's exactly what we want from our healthcare providers. We want, and not that we have to share our life stories with one another constantly, but we want a sense that this is a human being that cares about me beyond the numbers that are on the chart. We're more than lab values. We're human beings,

Dr. Nwando Anyaoku (13:40):
Let me tell you. But when you think about that, that is not the experience of a lot of people of color. It is not the experience of a lot of members of marginalized populations for whatever reason they're marginalized, whether for their sexual orientation and gender identity, whether they're rural versus urban. And so we have a healthcare system that has been designed to make people come to us, for example. And if you live 300 miles away or you're in rural us somewhere, you can't get to a doctor or without taking several trains, planes, and automobiles, well, your compliance as we think about it, might not be optimal. If you are a low-income patient in a city who has to take three buses, can't take the day off work without losing pay, then you might be seen in the healthcare system as being non-compliant because we haven't taken the time until now to understand the social drivers of health, how people are navigating their lives and what they have to deal with in order to show up at our doorstep.

(14:52):

And so you would find in the past, some of those patients are labeled as noncompliant and kicked out of the practice because the practice is thinking about it from their perspective. I reserve this time for you and you didn't show up and it's happened two or three times so you can no longer come here. Well, if they don't come here, where should they go? And so what the pandemic did was force all of us because as scary and as horrendous as that experience was, it had a few silver lining. It forced us to all sit and watch this thing unfold in front of us and see who was more disproportionately impacted by getting the disease. See who was dying disproportionately find out that it was those patients, those people that we described as essential workers who could not shut down their job and go work remotely on a computer.

(15:43):
They had to be in there every day interacting with everybody. They were also the ones who lived in multi-generational households. So they had grandma, great grandma, baby mama. Everybody lived in the same place and didn't have space to isolate. And so all the criteria we had and all the strategies we had for mitigating this were not available to these folks. And then when we got the vaccine, they couldn't take the day off to go look for where the vaccine was or take that day to come and get that because then they didn't get paid and then their children didn't eat. So that brought into stark relief the impact of how we live and work and how we worship, how all those things play into healthcare. We've known for years, there've been research and lots of articles that said, we've known about disparities. We have about 120 years worth of research on that.

(16:37):
We know that 80% of healthcare is determined ever before they walk through our door of the healthcare system. But that episode forced us to actually watch this play out. And I hate to say it's not because we became more altruistic. It's because we realized if we didn't figure this out, none of us was ever getting out of this thing. And so we had to understand that you have to be able to serve people in a way that's accessible to them and can make a difference in order for us all to be safe, in order for us all to

emerge from this nightmare that we found ourselves in. So that's what brought it into stock relief. I'm grateful that I work for an organization that watched this unfolding with the pandemic and all the revelations that I just shared, but also with the social uprising that showed up in the wake of the murder of George Floyd Breonna Taylor in the summer of 2020.

(17:37):
And Providence said, you know what? We know that these disparities exist, but this lives on our doorstep and we have a responsibility to act and made a commitment as an organization to address health equity. I'm incredibly grateful for the opportunity to be part of a team that thought about that in that forward thinking way. We don't have all the answers, but we are committing to ask the questions, to engage the voices, to partner with the community, to find solutions, to start to close those gaps. We use data and stories to understand who we serve in the different communities, where we live, who we serve, and how they experience, how they access and experience and have differential outcomes in the care that we show up every day with intention to provide excellent care, and yet different populations experience it differently. So how do we use our data and stories to figure out who those are, the drivers of those gaps and start to work to close those gaps? Yeah,

Seán Collins (18:41):
We're at the end of 2023, so three years from the beginning of the pandemic. I'm curious, what has Providence done? Well, if you were going to point to two or three things that really have made an impact in how you counter those drivers and many of which are the legacy of decades and decades of historic and cultural racism, you are not going to change everything in three years, but tell me where you have seen change.

Dr. Nwando Anyaoku (19:18):
I'll say that the biggest change we've seen is in the conversation. It's educating people that this is real. This is not nice to have or a suggestion. It is. Like I said, we have lots of data, but how do we begin to share, and we've done this across Providence,

disaggregate our data, which healthcare systems have to collect and submit data for all sorts of reasons, for regulatory reasons, for payer reasons. Look at that data. Don't even collect anything new. Look at what you're already collecting, desegregate it so that you look at it by race, ethnicity and language. Look at it by sexual orientation and gender identity. So you see who you're serving instead of just looking at our performance across the board where you won't see differences for smaller populations. When you disaggregate the data, you can look at the same metric, but for different populations.

(20:11):
When you do that, you start to see where you have opportunities to close gaps. That's one thing that I will say that we have done well. There is more to go, but it is certainly significantly moved from where we were three years ago. And so people can see it because when you talk to healthcare providers who come every day with their whole heart to do their work, and you tell them that you're not serving some people, well, the first thing you get is, what do you mean? I do my best for everyone? But when they see the data, they can see, oh, I'm doing my best for everyone. But there are factors that make it look different for different people. So I'll say that's the one thing, that first thing we've done pretty well, but we've also got our teams to understand that this is what it means because some of these words start being bounced around and people have all kinds of thoughts of what does health equity mean does, what does this work mean? We have been very careful about sharing that across our teams and our communities. And then communities is the last one I want to mention is we've built partnerships with organizations and companies in all our communities to say, we need to work together to co-create solutions so that we're not coming in and saying, we found this gap here, and thou shalt no. We are coming in and saying, here's what we found. What can we do together to address these disparities?

Seán Collins (21:38):

That's got to be gratifying to start to build those community relationships in a new way that feels like it has the ability to actually make change in the community beyond the walls of the hospital.

Dr. Nwando Anyaoku (21:51):
It absolutely is, because you create opportunity for win-win, right? Is I tell people that health equity is a challenge because society is not equitable. So health is not equitable, but it also means that we all have agency. We all can do something about it because the factors exist all across society. And so some of these community organizations and companies are like, yes, what can we do to help? And so they feel like we all feel empowered to start to drive whatever change we have in whatever area of influence they have. So whether it's going upstream to build a pipeline of diverse medical students, healthcare workers, all sorts, they can do that. Oh, let's partner on that, whether it's pharmacists saying, we can reach out for patients in this demographic that you've seen a gap in, and we will be your partners in the community to make sure they get their medications refilled and things like that.

(22:53):
Great. Whether it's one of these ride apps saying, we will offer our services to you so that we can bring people who have difficulty with transportation for their appointment. Great. So there are all sorts of different things, food banks who've been looking for how to reach out to the people who that's their mission. And now we're working closely together to say, I have this patient who has food insecurity in their family. Food bank has food to share. We bring these two together, win-win. So really building those partnerships across the community offers the best opportunity for sustainable impact in this space.

Seán Collins (23:34):
Maybe it's worth talking about the difference between equality and equity.

Dr. Nwando Anyaoku (23:40):

Thank you for asking that. I think one of the things I talk about is that we think that justice is equality is giving everybody the exact same thing. We think that's what that is. That's what society has sold. And really in healthcare when we've been advancing quality care, quality means reducing variation. And so people interpret that to be equal. Equity says that everybody is coming to you with a different need, and therefore you need to engage with them based on their particular need. So it doesn't mean that you create all new medication policies and pathways, but it means you need to understand what this particular patient needs from you in order for you to optimize their care. So if you are treating hypertension in your clinic and you find by reviewing your data that you have lower performance in the African-American population, in your head, you're like, well, I see them.

(24:42):
I give them their prescription. I do everyone. So I'm giving equal care. But equitable care requires you to ask, well, why aren't they having the same performance? And then you look behind and see that, oh, a lot of them can't meet their follow-up appointment, and therefore they're not filling their medication prescriptions on time, and therefore they're not as controlled as you want them to be and they don't have, do you see? So when you understand the context of the person that you're serving, you're able to deliver more equitable care because the care that you give addresses that patient's unique needs.

Seán Collins (25:19):
Can we talk for a moment about concordance, racial concordance or cultural concordance? What do we need to know about patient outcomes when there's racial or cultural concordance with the caregiver and what happens when there isn't that concordance?

Dr. Nwando Anyaoku (25:41):
The first thing I want to say is that it's going to take a very long time to get a hundred percent concordance right across between patients and providers because the gaps

are just so great. African-American physicians, for example, only make up 5% of the physician population. Therefore, that's not going to, that's a longer term goal. However, there's a lot of literature that shows that concordance between patient and physician or clinician improves outcomes. And that comes back a lot to that conversation we had earlier about empathy, about understanding context because a patient provider duo or diet that has similar background and lived experience can actually have conversation in a way that gives them more ability to connect. So I would think about my late father who used to go to his doctor and dad, what did he say? Well, I'm not sure. And then one day he went to the, don't even get me started, and then one day he went to the doctor and he had a new physician who had gone to his high school, clearly several generations later, but he looked like him.

(27:06):
He sounded like him, and they had that in common. When he came back, he was like a parrot, and the doctor said this and he said, we should do this. I said, wait, are you the same person? What happened? It turns out that he felt heard. He understood what the doctor was saying, and he felt the doctor understood him. It's not because he thought the other doctor didn't care about him. It just was like, okay. He'd nod his head and then he'd bring me the paper to read it and translate what the physician had said. But that's just an anecdote that's unique to my family that I'm sharing from my family, but it's not unique to my family. There was a study a couple of years ago that said newborns, black infants who had black pediatricians had a much higher survival rate than black infants who had white physicians. And you're like, how is this possible? Even at that level, the infant is not talking to the physician, and yet that concordance made a difference, right? Well, their parents are. So there's a lot of literature that suggests that concordance is really valuable, and what can we do except to continue to build the pipeline of diverse physicians to serve a diverse community?

Seán Collins (28:20):
And that starts in middle school and high school and college and long before medical school, I am guessing,

Dr. Nwando Anyaoku (28:27):
Oh, long before that's a whole other conversation because a lot of the pipeline is so narrow and leaky for diverse candidates from kindergarten almost, or middle school at least, they start feeling othered. You have, I think there was a documentary I saw on NPRA few years ago called Mind the Gap that talked about the low expectations for minority children. And so right from early school, they start being weeded out of STEM classes or not encouraged in those fields, and they get the line gets thinner and thinner, and then by the time they get to medical school and residency, they have all that othering that I was talking about earlier where they're in the space and people don't think they belong. So they keep othering them and making it more and more difficult by the time they make it through that really thin and leaky pipeline.

(29:32):
Last June of 2022, there was a series by stat publication. It was funded by the Commonwealth Fund that said that black residents were kicked out of their residency program at a much higher rate than their white counterparts. And when you start to review the reasons why, it was like really? Is that what's happening? Why would you expel somebody from training that has already cost them so much in time and effort to get through because of some things that seem really frivolous? They smile too much. They don't smile enough, is all the feedback the person has got, and next thing, they start to experience these challenges in their residency. And next thing you know, they're out of it. So it's challenging to build concordance between physician providers and their patients and the communities they serve, but it really does make a difference. I just want to add one point. Even if you don't have one-to-one matches by diversifying the pool, their non-diverse colleagues start to understand the perspective of others because they have colleagues who represent other populations. So when they talk to their patients, you know what? My colleague has mentioned? Something like that. So that empathy is built across the whole team because you've started to diversify it. So even if you don't have a one-to-one concordant match, you have a more robust connection because the whole team is more diverse.

Seán Collins (31:13):
One of the terms of art that I started hearing during the pandemic was cultural humility, which I think speaks to this issue that colleagues start to learn from one another in a new way, which is really kind of remarkable. And we heard this before several months ago, we did a podcast about the doula program that was going on at Swedish and seeing black doulas working with black pregnant women delivering babies in a completely different way, and then watching white OBGYNs learn from those doulas.

Dr. Nwando Anyaoku (31:57):
So important.

Seán Collins (31:58):
I'm going to ask you a sort of contrarian question that gets at some of these issues from a radically different way. If there was a white supremacist racist patient who didn't want to be seen by a black doctor and only wanted to be seen by a white doctor, that request, I'm assuming, is not going to be honored in most hospitals -- that that's seen to be a request that's beyond the pale.

Dr. Nwando Anyaoku (32:28):
Oh, that's a request that happens more frequently than we want to believe. And for the most part, it's not honored just because you really can't. But I don't know. It represents a challenge for the healthcare system who's thinking about, well, you want to meet the patient where they are, but at the same time, you don't want to have your physician in a bad position. You don't want them to be, that relationship is a relationship of trust. And so if they're already telling you they're not going to trust the person, how do you manage that? So I don't know that there's one rule about how you do it. If for instance, the physician of color is the only one there, well, this is who we have. This is our team, and this is how we do our best to serve you. And so what can we do?

(33:28):

If you don't want to be seen by us, then we can't force you to stay. But so each healthcare institution based on their particular policies, handles that differently. But if you're a minority physician in a place where you're really the minority and you hear that day after day, that really does start to mess with your head, even if you're able to override it and see the patient. But you're thinking, okay, well, do they trust me? I mean, can we build a trust relationship? How do we make this work? Each of those encounters is a divine encounter. It requires trust from the patient to you. So how do you manage it? So I don't prescribe a particular way of handling it. Each organization will do what they do, but you must think about how you protect your team, protect their mental health, protect their ability to do their work, while also taking care of the patients and giving them their best care. But it is a struggle,

Seán Collins (34:35):
We're coming to the end of our time together, but I want you to tell me about a South African friend of yours taught you a Zulu word. Tell us that story.

Dr. Nwando Anyaoku (34:51):
So I was thinking about how important it is to bring your whole self into your workplace and not to blunt aspects of yourself because you want to fit in understanding that your whole self is your value proposition. And I was having this conversation with a South African friend and he said, oh, in my language, that's ukuzilanda. I'm like, oh, that sounds really nice and rhythmic. What does it mean? He said, it means to go fetch yourself, fetch all the aspects of yourself from the past, and use that knowledge, meaning everything that you are to inform what you do in the present and the future. And I thought that was so powerful. Now, I don't speak his language, and so I am going with the interpretation he gave me, and none of my South African friends have corrected me thus far. But I love it because it really reflects what I think is so important.

(35:49):
So if you have someone who, who's gay and feels that they're not going to be accepted in the workplace, and so they spend all their time figuring out how to hide

who they are and what's important to them, you can imagine that that's a lot of energy. And yet, if they're able to bring their whole self, they can serve fully as themselves, but they can also be a uniquely valuable person for someone else who shares that background to be part of their care team. And so Lander represented to me, how do I get people to see that we need your whole self present? Don't blunt it. Don't change your hair, don't change your laugh. Everything about you is what's valuable in this space.

Seán Collins (36:32):
Yeah, the thing I love about that word and the idea of the word is the understanding that this stuff is at arm's reach. It's close by. You're bringing it with you, but maybe you're leaving it at the door and go fetch it. Bring it into this clinic because we need it.

Dr. Nwando Anyaoku (36:55):
I love it. I love that way of seeing it. I'm going to use that.

Seán Collins (36:59):
Dr. Anyaoku, thank you so much for taking the time to chat with me. I really appreciate it.

Dr. Nwando Anyaoku (37:06):
Thank you, Sean. This was fun.

Seán Collins (37:10):
Dr. Nwando Anyaoku is the Chief Health Equity and Clinical Innovation Officer for Providence. We reached her in Seattle. If you'd like to watch her TED Talk, visit our website for a link. Our web address is HearMeMowPodcast.org

(37:27):
The Hear Me Now Podcast is a production of the Providence Health System and its family of organizations. Subscribe at HearMeMowPodcast.org

(37:37):
The program is produced by Scott Acord and Melody Fawcett. We have research help from medical library staff Basia Delawska-Elliot, Carrie Grinstead, Sarah Viscusso, and Heather Martin. Our theme music was written by Roger Neill. The executive producer is Michael Drummond.

(37:55):
Join us in two weeks when we'll be exploring the breakthroughs of the past year in Alzheimer's research. Might we be at the place where we can say that a means to prevent Alzheimer's disease is now nearly within our grasp? A conversation with leading researchers on our next program.

(38:16):
I'm Sean Collins. Thanks for listening today. Be well.