



National Plan for Health Workforce Well-Being Public Launch Transcript

Mobilizing Evidence for a National Movement on Health Worker Well-Being

Chris Cassel, Vivek Murthy, Darrell Kirch

CHRIS CASSEL: Christine Sinsky, our moderator, is joining us remotely today. I will dive in and tell you a little bit about the history of this and Victor mentioned for six years we have been working on this. There is Chris. First slide please and who is managing the slides? There we go. This is the title of the national Academy of medicine consensus report taking action against burnout and professional well-being and I had the honor to cochair this effort starting in 2017. We did an extensive evidence based study. And we did this with this charge. I want to emphasize what all of our elected representatives that we have just heard from mentioned, which is that this issue has been with us for a long time. That is what prompted the national Academy to take on this consensus study and look at the evidence to examine the evidence regarding the causes of clinician burnout and the consequences for both clinicians and patients. Secondly, to look at the components of the training environment and the workplace. There are some different issues in those two environments that both of them have places where burnout is stimulated and can be addressed. And third to identify systems interventions, tools and approaches to support clinician well-being. Finally, to promote and propose a research agenda to improve the knowledge base. It was for this reason that I was pleased to invite Pascal to be my cochair and he is a systems engineer who understands these broader environmental and complex drivers for workplace health. This really is the heart of our report and it is a conceptual framework that we developed with experts from systems engineering and human factors, Occupational Health & Safety as well as the healthcare system. I just want to point out that it does describe a very complex world. That little white oval in the middle is individual mediating factors having to do with resilience and stress management, having to do with taking good care of ourselves and as healthcare workers. But those mediating factors are not enough to address the whole complex world of drivers that actually creates the need for this effort to be so multi-disciplinary and broad-based. Very quickly, the internal circle is the microsystem and the clinical workplace and your ICU an emergency department and clinical setting, your hospital. That is where the innovation can happen at the local level to really identify barriers and efficient workflow and ways that people can come together as teams to support each other. The in between circle is our healthcare organizations and healthcare delivery systems, hospitals, hospital systems, et cetera. These are the places that make decisions about staffing levels, investing in different technologies, about how they respond to different compliance pressures, and how they create a culture and either a culture that supports well-being or one that does not. And then the external circle is the rest of society and the world in which healthcare occurs. Part of this is the whole regulatory system and our governmental regulatory system for equality in safety and our licensing and certification and accreditation bodies and all who are well-meaning in advancing all of this but all operating independently and adding more to the documentation requirements for every healthcare professional. In addition, COVID displayed this so vividly. The pressures of social attitudes and misinformation and pressures about do you believe in science or not and do you trust medicine or not and that then adds and eats away at the confidence and support of an already beleaguered healthcare system. All of this may sound like it is too complex and nothing anybody can do. Nothing can be further from the truth. There is something for everyone to do and everybody in our society exists in one of those drivers.



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Nobody in our society has a role to play. These are the goals from the report. You will see that they are echoed in the national action plan to first create positive work environments and to create positive learning environments. And also reduce administrative burden. Enable technology solutions. Provide support to clinicians and learners. Invest in research. I could not be more pleased that the Surgeon General of the United States has really stepped up and made this a major priority and it is my honor to turn it over to Dr. Vivek Murthy.

VIVEK MURTHY: Thank you so much, Chris. It is nice to be here with everybody today. I know there are many others joining us from afar through the virtual link. Welcome to all of you. I want to start by echoing the thanks that you have heard earlier today, our thanks to AAMC for hosting us today but a particular thanks to Victor and Tom and Darrell enter cochairs and Timothy, Chris, so many others who have made this possible and the steering committee and collaborative members and the staff of the national Academy of medicine as well and so many others who work day and night to share and create and build what you hear about today. I was reminded in this process of building this of a few things. Number one is that this issue is so personal for many of us and it isn't an academic issue that people capture in data tables and charts. This goes to the very heart of why many of us join the healing profession and why we got into medicine and healing and the other professions. That has been very clear and the other thing that has been clear is that change won't be easy. We did not get her overnight. Any change effort, there are folks anchored in the status quo and who don't necessarily want to change and not necessarily that they are bad people but they are used to doing things a certain way and from institutions that do it a certain way. Change won't be easy but I am convinced it is necessary if we want to continue and to support and sustain our health workers but if we also want to have a system there for people who it is meant to serve. I was walking over here today and I was thinking about a letter of recommendation that I wrote for a colleague's residency application a few weeks ago. It was interesting to read through this personal statement. If you read the personal statement, it would capture so many of the qualities we want in a doctor and we talk about the passion for wanting to understand the stories and lived experiences of patients. He spoke about how excited he was and get the privilege of sitting at a bedside and holding somebody's hand and listening to their stories and hopefully being able to help and he talked about the fascination with the science of medicine and being able to engage in this process of learning over the process of a lifetime. You talked about the incredible community he is excited to be a part of and a community of healers who came there inspired by high ideals. So many people like him around the country who are applying to medical school or nursing school or applying to these programs or applying to jobs in residency training and fellowships and have that claim still alive and burning brightly within them that inspired them to go into this profession. It reminded me of our own story which by so many was characterized by a similar excitement about people and science into stories and wanting to make people's lives better. Medicine hasn't been that for me in so many ways. Like many of you I also came to see the dark side of it as well. I came to see that we had a lot less time for patients that I imagined we would and was spending a lot more time in front of screens than the bedside and I came to see it wasn't so easy to do the right thing for patients even if you knew what the right thing was and getting in medication cleared by a insurance company and sometimes it took more time and figuring out what the medication should be in the first place. I saw getting rehab done for patients who really needed it because they couldn't go home and it was sometimes tough and you had to cut through all of the redtape. I saw that if you are honest about it, we even had a culture within the



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fields of clinical medicine and nursing and public health that allowed people to talk about what is happening to them. And we talked so often about wanting to see the whole patient in order to take good care of them and it does turn out it is just as important for us to see the whole health worker as well and understand all that contributes to who they are and their ability to serve. If we don't do that, and we tell our health workers that their strength is defined primarily by how many papers they can publish and how many facts they can remember or how many hours they can stay up or how hard they could work without complaining, that is only a shadow of what true strength is and we deny the humanity of individuals and we tell them that there are challenges but they are going through are being diminished. We do this despite having a good intentions. That is why this process we have been through over the past few years, to build an action plan or more broadly a movement around addressing well-being is support and it is about programs and policies bit about culture. It is about changing how we think about the people who are there delivering care and keeping our communities safe and about seeing as whole people and not simply as skill sets. When I had the privilege of serving as Surgeon General the second time around, it was clear to me at the outset that I wanted to do something to contribute to addressing health worker burnout and I am blessed by Victor and the entire team who became key friends and partners in that effort as well. You see that in fact even on what is up here on the screen and that advisory I issued earlier this year and in many ways a perfect complement to the plan you hear about today. What we were seeking to do with this advisory is to call a countries attention to this profound challenge of health worker burnout. My worry has been that many people in the public don't realize the extent of burnout and how deeply it affects public health workers and clinicians and they don't understand the impact it has for their healthcare, not just emergency but primary as well. If we really want to build in this effort to address this into a movement, we need the public with us and they have to understand consequences and urgency of this issue behind it. I won't go over all the details because Darrell will lay out all of the steps but a few broad things I will say is that if we truly want to take care of clinicians and public health workers, we have to prioritize their safety. The number of stories I have heard over the past year and a half as I travel around the country from nurses and doctors and other front-line workers who are verbally and physically abused during the pandemic, it was profound and disturbing. The other thing that we have to do in addition to the safety is make sure we provide support. I remember being on a phone call with a group of nurses from Minnesota who said many folks in the health system don't even have health insurance and how are they supposed to get healthcare and mental health care? They said even for those of us who do, when do we get it if we are working 16 hour shifts or working weekends or nights? Wind we drive 30 miles to see somebody in person? We have to get somebody to bring the care there and make it okay but we also have to change the work itself and if we are honest with ourselves, very few of us got into medicine or nursing because we had a passion for charting. Right? Very few of us thought that we would be spending twice as much time doing administrative work as we do face-to-face with patients. That's the reality is that we have to change the work itself and make it easier for clinicians when they know what patients need or when they have clinicians who can fulfill obligations as far as recording and data and we have to tear down some barriers for these authorizations which sucks up so much time and effort of clinicians without necessarily contributing to better patient care. We have to change the nature itself and we have seen in systems that when you make a concerted effort to address or eliminate some of the unnecessary and duplicative steps in healthcare, you can make progress and get rid of them, but it has to be deliberative and accountable. Finally, I will say this. This is more than a policy issue. To me this is a moral issue. We



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have people all across our country who are doing exactly what we hoped they would do and we should be doing everything is a country to support them and to give them the tools and environment they need to be able to thrive and the reality is that too many people don't have that these days and that is why we see more than 50% of clinicians saying they are burned out and public health workers as well and it's about letting clinicians and public health workers know that we have their backs as much as it is about making sure that help is available for the public when they need it. This is also about two other big things. Number one, restoring science and expertise to their proper place where they are valued and seen and respected and one of the most poignant notes I received from a nurse in New York City was one about a nurse who said she was leaving 10 years earlier than planned in the profession because all she saw in the COVID pandemic and the thing she said that stood out to her was the erosion of the respect for science and expertise and those trying to deliver care and the abuse heaped upon people and it is our job in part to help restore the value and importance of science and expertise. That is part of what this is about. But, lastly, it is about how we think of mental health. We as a country had a tough time when it comes to addressing health concerns in recent decades and it tells people it is their fault if they struggle and we see that magnified in many parts from the healthcare system as well and that is something we have to change. I do look at today and despite all of those challenges I do feel hope and a sense of promise because if you had told me 15 years ago that we would be in a room like this with thousands of people joining from across the country with his national action plan, and the advisory and members of Congress saying this is an important issue that we have to prioritize as a nation, I will say this seems far-fetched. But that is where we are at today. It is not by accident. This is the hard work and dedication of so many people including folks in this room who have made that possible. I want my children and your children and all of the kids out there in the world when they need healthcare in the future to know that that care is available because there are nurses and doctors and frontline health workers who are there to provide that care and who were inspired by high ideals and were sustained in those ideals because in the environments in which they work. If our kids are blessed and inspired enough to go to the professions themselves, I wanted them to know that these are good professions to enter and you can do good work. You don't have to sacrifice your own health and well-being in the process in order to take care of others. That is the reality we need to create for our kids and it is a reality we need to create for all of America. I am so grateful we are building this moment together and this movement is marked by awareness and engagement and change. Together we have to make sure that all three of those pieces happen as we build a movement and not only take care of our health workers but ultimately we provide help for those who enter the profession to serve. Thank you so much. With that I will turn it over to my cochair and friend, Darrell Kirch.

DARRELL KIRCH: You are a tough act to follow. I want to make an important point. This is not the end of the journey by any means. I think it is a critically important tool in the journey. We do have a long way to go. That said, I agree with you. 15 years ago we were, I think, in a state of massive denial. And as a psychiatrist I would do see physicians as patients and they would talk about their burnout in the workplace and burnout is a workplace condition. I also would see what a short half it was from the burnout they were describing to things like depression, anxiety, and suicidality. It concerns me greatly. But we didn't talk about it. They would talk about in the privacy of a session with a psychiatrist. But they would go back to work. It was almost as if you wore your burnout as a sign of accomplishment. That you were as tough or tougher as any of your colleagues. We just didn't acknowledge the issue. Victor is at



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times inpatient. He often says we have to keep pushing and we have to get farther and I do agree with him totally. I am stumped to think about how far we have gotten in a relatively short amount of time. We went from denial to beginning to publicly acknowledge that there was an issue and the press started talking about it. The collaborative performed. But as a profession, I think we were taking a much too simplistic approach. When I would talk to a physician who was clearly burned out, often they would say it is the electronic health record and if you could get rid of the EHR I would be happy. If only it were that simple. The consensus study that Chris and Pascal cochaired was a turning point. Gave us the evidence-based information that you need to have if you are going to approach a problem. You need to unravel the systems issues that underlie it and that is what the consensus study did. I think the Surgeon General's advisory was another turning point. It framed this as it should have been framed as a public health crisis. And not just one that involved clinicians but one that ultimately affected patients seriously. And now we have the national plan. It is a great document and it is also a very long document. I won't read it to you. But I do want to hit the seven priority areas and pull out a few things that really jumped out at me. Number one, the fact that everybody debates who originated the phrase culture and culture does eat strategy every day for breakfast but creating a culture with an organization are within our professional societies is hard work and culture is tenacious in terms of trying to change it. It has to start and you notice there are onboarding programs for students and it really needs to start with the expectation, not that you should hide your burnout but that when it occurs, we need to support each other. I think one of the great things about this collaborative is it has been a zone of high interprofessional cooperation. We have far too many turf battles and practice issues. This has been something where I am not seeing professions pivot against one another. I have seen them come together as allies in a way that is rare. I think we need to imprint our learners on that from day one. The last point is this culture of reasonable performance expectations. You can only turn the treadmill up so high before people start flying off of it. The culture that says do more and do more things that you didn't have to go to medical school or nursing school or pharmacy school to learn how to do that somebody else should be doing. You can't continually load those things on people. A culture that understands people have limits and I think it will be critical. The second priority area on the next slide is that all the actors have to be willing to invest. This is not an issue that the federal government can certainly help with. Any organization needs to invest in its people. That will require resources. I would argue that in a nearly \$4 trillion a year healthcare system, there should be money available to invest in the well-being of workers in that health system.

>> The third priority area focuses on supporting mental health. As a psychiatrist I want to make a distinction in language that is important. Burnout is the work place issue and there is a code for it but really what concerns me is the path is so short of having a true mental discipline. People slip down that path to quickly and too easily. And then we have a culture, a long-standing culture, of stigma of seeking mental health. I am really pleased and hopefully you will hear more about this in the coming years. Next week I am cochairing a meeting sponsored by the Huntsman mental health Institute, a newly established group and when that board sat down and said what is the first mental health issue that we would like to attack, they chose stigma. There will be over 200 people from around the country joining together to talk about how do we start to mount a major campaign to reduce stigma? We still ask an appropriate questions over credentialing and licensure documents about whether you have ever had a mental health problem. And what a grossly inappropriate question. The question is are you medically fit



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to practice? I am hoping that the convergence of this effort together with the clinician may finally break the logjam. As a medical school being, I lost least 2, possibly three students to suicide. None of them sought help and clearly in retrospect they were depressed and afraid to admit the distress they were in. We have got to attack the stigma as a key element in this plan. The next slide, the priority area 4 is one you alluded to and certainly the consensus study and that is just the regulatory burden and the electronic health record is a problem because it was not designed to facilitate patient care as much as it was to collect data and do compliance. Again, things that none of us went to our health professional school to do. The fifth priority area focuses very much on making health I.T. user-friendly. I have really been impressed by the studies the electronic health record systems of other nations and how much more efficient and how much less time-consuming they can be. This is possible. This is a self-inflicted wound actually for the United States that we allowed the I.T. systems to go the way they did and that is why health information companies are near the top of the list of key actors. Priority area 6. This talks about values. We take an oath of some kind and we commence our work in the health professions. I don't know and I need to go back and I really haven't looked at the Hippocratic oath. But I don't think they say anything about taking care of ourselves. If those oaths we take are part of our true values, we need to call out the value of self-care and a willingness to support one another and of appreciating of the value of not letting ourselves become isolated and you wrote your beautiful book about loneliness. I think a lot of burnout relates to lonely clinicians. The last priority area, number seven is something we have come to appreciate and the convergence of the pandemic and the terrible issues it laid bare, health inequities in the country was really a call to arms for us to get even more serious about trying to create a workforce that reflects the diversity of our population but also a health profession education system that talks about the harsh realities of health disparities. They just appointed a few years ago a new Dean at George Washington law school here in DC. Her book, just medicine, is one of the most beautiful explanations of health disparities and how much work it will take us to really start to narrow that gap. If anything, income inequality as it has worsened has made health disparities even a your problem. Again, it is a rich book with a lot of specific actions and when you can go to the URL, which I think is here you can go to this and pull it down and this is what we were given today as a prepublication but I encourage you to take a look at it from the point of view of which actor am I. Some of us are actors in more than one. Which actions are within line and within my control. And then it begins to make it look possible. But 10 years ago, we were in denial about it and 10 years from now, we all can look back and say I took this and that action and it has helped improve the situation for me and my colleagues. I do think it is in reach and the fact that you are all here in person and hundreds of you in line shows we are coming together. I don't know what the next slide is. It may say finish. And timing was perfect because she just held up the one minute mark. Do we turn it over to you? There is a problem on our end. We can't hear you.

CHRIS SINISKY: Here we go. Thank you so much to each of you for your heartfelt and truly inspired comments but even more so for each of your impactful actions which I think have brought us to this place that we could not have imagined 15 years ago or even five years ago. So I would like to first start with that but the first question is for you, doctor Murphy. I want to emphasize again thank you for your leadership in creating and publicizing the advisory that you released a few months ago. I think it is encapsulated in your comment about seeing healthcare workers as whole people and not just as skill sets. I will remember that comment and probably use that in future forums. So considering Senator



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Kane and his opening comments, one of the recommendations is to eliminate punitive policies for seeking mental health and substance abuse care. And the Dr. Lorna Breen foundation recently released a map of the United States. It is better than it used to be but still over half of the states in the United States are not asking their licensing questions and aim manner consistent with current recommendations. I am wondering if you can tell us any additional action you can recommend two members of this national Academy community and members of the medical community or others to catalyze these changes and is this an easy fix or have we not gotten there yet? What you think?

VIVEK MURTHY: Thank you for that question and all of your incredible leadership on this issue. You are right. One of the big barriers as many folks know being able to talk about that they feel they are being punished often for being honest and that comes through on licensing forms and questionnaires. One of the challenges with our system in the United States is that it is a federated and we have state licensing medical boards that often drive with the questionnaires look like and while we have made some progress in some states in getting those questions shifting and changed so they are not stigmatizing and not necessarily everything in your mental health history, there are other states that have not followed along yet or made those changes. This is a place where I think local advocacy matters and one of the benefits of actually a system, if you will, that is federated is that in your given state you can have a lot more impact if you are in a medical Association or nursing Association. This is where I think we really have to press on our state medical boards as a profession and make sure these changes are made and transparent and communicated well to the community of practitioners. This is the other piece of it. If changes are made and not known to practitioners, we still have a problem and sometimes you can see these changes in the ultimately filter their way down to the folks they serve so this is again were local advocacy for local organizations have a critical role to play in the advocacy and education that meet take place after. There is a lot that all of us have to do here and a lot of us in government and we laid steps here and in addition to thinking about how we look at forms, there are things that can make the work better by doing its part in terms of being in the public to reduce prior authorizations and I am glad to say that the center for Medicare Medicaid services has embarked already on that journey to help streamline and reduce administrative tasks placed on clinicians. But it is also important that the government invests in research and program implementation to help address burnout. That is why we were glad to see \$100 million plus as part of the broader effort to address burnout. We do see a lot of this as the beginning and not the end. If you told me 10 years ago that HR essay would dedicate \$10 million to this issue and looking how to reduce administrative burdens I would have said pie in the sky but that is happening because of the work of folks in this room who are joining from around the country but ongoing advocacy matters. One thing I have learned over the years I have served in government is what is important today was a focus today may not be a focus tomorrow. It depends on the volume and dedication of the voices in the community that are keeping folks accountable and whether that is leaders in government or health systems or leaders in our private payer system.

CHRIS SINSKY: Thank you. I think it was recent local action is one example in Minnesota that led to changing the state licensing questions. I would like to build on the last topic you brought up, the investments in research and direct this question to you. I do think it is important to recognize as you stated that while burnout manifests an original individuals, it manifests in systems and we have to focus our effort and understanding what is it in the work environment that drives so many healthcare workers



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to not feel that they are living up to their professional aspirations and feel they are not able to be the nurse or physician that they had intended to be. In the United States, we spent over \$130 billion every year in private and public investment in researching the tests and treatments. But we only send a fraction of 1% of that amount researching the care environment and the well-being of the workforce. And as he said, we have just increased that investment. It is still a really small amount compared to what we invest globally and in healthcare research. I am interested in hearing more from you on what can be done at the national and institutional levels to investing and to build knowledge base so we can actually improve that work environment for healthcare workers and change the culture as you see there.

DARRELL KIRCH: For decades we have actually been investing significant amounts nationally to track mental health in our general population. We know how to do good longitudinal research. It is depressing to see those numbers getting worse and the pandemic has been a key element. It is especially concerning to see the impact on children. I think they talk about adverse childhood experiences and I think we have gone through a period in which every child in the United States has experienced an adverse experience. We know how to track mental health issues and I am a strong advocate of the notion that we should use the same approach and track a physician burnout and do a better job, not just counting the numbers of the professionals but through good sampling technique and survey techniques and track their well-being and the degree of burnout and their related mental health status. And that would give us a sense of where we are nationally. But there are a number of people in this room and online who serve as chief wellness officer. And I often hear them use the expression all burnout is local and you could have two units doing similar work and one is for that and the other is not. And that is a generalization but it does indicate to me that the role of chief wellness officer will be critical for any organization of any size to be able to do diagnostics at the local level and as you track burnout within the organization, that you identify the hotspots the same way we talk about pockets of problem patients and doing hot spotting related to burnout. And then have the equivalence of a rapid response that can get into a unit and work with people in the unit and really start to deal with whatever the corrosive elements are and they could be short staffing or it could be a problem in one unit or it could be a very toxic supervisor in another unit. It could just be lack of social cohesion and failure of people within the unit to pull together with mutuality of support. I think we need that national investment in tracking longitudinally and in the local investment which needs to focus on hot spotting in those areas.

CHRIS CASSEL: I want to add a quick observation to Darrell's point. The fact that this issue is receiving so much attention right now and as you pointed out there is a number of newly appointed chief wellness officers and other kinds of attention to the issue and it's a perfect opportunity for a natural experiment that as the federal agencies that now have the resources to do this research, I wanted to add that it could not be a more perfect time for researchers to begin thinking of creative ways of using real-time data analysis to really understand what works and what doesn't and help the learning and healthcare system address the problem more quickly rather than waiting for big national studies to be complete.

CHRIS SINSKY: Thank you, Chris. I think you are so right that we do have an opportunity to understand what interventions work and what doesn't by looking at those locally and more globally. The next question is for you, Chris. Given your role not only as a leader at the national Academy with the work on clinician well-being but your previous role as the founding Dean of a new medical school. Thinking of Dr. Murphy's thoughts about the recommendation for that dedicated medical student and hoping we don't



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extinguish those professional aspirations among that medical student and others. Are there some practical things that can be done for nursing and medical schools that will begin to set the culture at an early stage, a culture that is so forgiving rather than not self compassionate or one that doesn't have or foster the imposter syndrome culture that makes it okay to say, listen, for these demands I need these resources? What you think and where do we start?

CHRIS CASSEL: It is a perfect place to start and thank you for asking. I do want to remind us that in our report and in this problem more broadly, we are talking about the whole healthcare workforce. We had on our committee physicians and nurses, pharmacists, dentists, many others who are facing this problem. So in our schools of health professions, I would say two things. Number one is, as we consider exposing the idealistic students who come into our system to our healthcare delivery system which is where they learn that is how we do our teaching, we need to be very mindful of the kind of impressions they are getting and not the so-called hidden curriculum. Really understand that deans and program directors need to have E. coli's on where they are training physicians and how to use those and perhaps opportunities to progress those issues in real time because students are going there. Because residents are going there. The second thing, and we did this at the Kaiser Permanente school of medicine when I helped it get started is to create a universal availability of coaching for every medical student and meets with a coach and it is not called a psychiatrist and not even called counseling. You learn that from the business community where high-powered executives and management and leadership under a lot of pressure are expected to ask for help and get feedback on how do I deal with difficult situations. I think it is an important step for medical schools, to normalize the seeking of help and a better way to do that than having it just be available for the students and have it be available for the faculty as well. It becomes part of the culture of a learning organization.

CHRIS SINSKY: Again, I want to thank each of you and I believe we can continue a robust conversation for quite some time. But we are at our time. Each of you has worked in a way that we are no longer in a state of massive denial to use your term, Darrell. And we have come so far, Dr. Vivek Murthy . Who would have imagined that we would have had your advisory or the national plan and many other professional organizations working together and I am very optimistic for our future and thank each of you for what you have done. [Applause]