Novel Cohorts
Podcast Series

Dan Housman, Chief Technology Officer of Graticule, and Skip Olson from Olson Strategies discuss Implementation Science- an emerging discipline focused on translating medical innovations into real-world patient impact.

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Dan Housman (Graticule)

Hello and welcome to the Novel Cohorts Podcast. I'm here with Skip Olson from Olson Strategies, and we have an exciting episode today to talk about Implementation Science. So wanted to give Skip a chance to introduce himself. We met up in Athens at the Market Access Forum meeting, and he has some great and interesting work he's done his whole career relating to how we bring medical discoveries into the actual patient, and how to get things all the way through the complex medical system. So Skip, why don't you tell me a bit about your background, how you got involved in the work you've been doing.

Skip Olson (Olson Strategies)

So good morning, good afternoon. Dan, pleasure to be here. My route is a little bit unusual, yeah, I got a PhD in biostatistics, went straight into the pharmaceutical industry, and I designed and analyzed clinical trials for a number of years. I switched to Health Economics and Outcomes Research. Did that for a number of years. That kind of morphed into real world evidence, which morphed into integrated evidence. And as part of that, I got hooked on the topic of today's podcast, Implementation Science. And so this is what I've been focusing on over the last few years, doing a few publications to sort of bring this concept into the pharma industry.

Dan Housman

Well, I think a lot of people may be working in Implementation Science and don't even know it, and a lot also haven't heard of it, although I've recently come across a number of groups that call themselves in from like Implementation Science teams inside of Pharma. But for the folks who are listening, maybe you can give an introduction to what, what is Implementation Science. And I think there's a couple slides we have to help educate so let me see if I can bring those up.

Skip Olson

Yeah, you know it's, it goes by several different names, so it's not just Implementation Science, you know, one of the names in the US is also, you know, so related to Clinical Care Gaps. And so it goes by a lot of different acronyms and names. They're related. Maybe they're not quite the same, but anyway, it doesn't matter. But you know this as a concept in the pharma industry is so important because you know, when watching the video it is seen as a slide. I'll explain the slide now. It's just two curves, so it's pretty easy to think about. The one curve has a very slow

uptake. So this you can think about is either sales or the number of patients who are actually getting prescribed it on to a new medication. And this, the uptake is quite slow for the first five or six years. Then the uptake picks up a little bit, and then you hit peak sales. It stays at peak sales for a number of years. And then, you know, loss of exclusivity, and it drops off. So what I've I actually have on the slide here, this slow, sort of average uptake is actually based on a real medication, ENTRESTO for heart failure. They had very, very, very slow sales at the beginning. It did eventually pick up. It was very slow. The question is, or the challenge, really is, before the product actually launched. Forbes predicted what the eventual sales would be, and that graph, if you can see the graph is the blue curve looks much different. The UpTake is much quicker, the height of the peak is much higher. And what I call the sort of the implementation gap is the difference between these two curves, and here, in this particular example and in several that I've done, the gap is like three fold, if you could get up to three fold the kinds of sales if you were able to actually get a very fast uptake to much higher peak than you would normally be getting. And this gap, you know, often people think, Oh, well, you know, the outcomes weren't, you know, good enough, or they weren't convincing enough. And this is kind of a myth. A lot of times I start off my talk by saying, you know, have you ever had wonderful phase three results, and thinking, this product will sell itself, and then you discover, well, actually, it doesn't sell itself. There's something else missing, you know. So with ENTRESTO, they had a 20% reduction in mortality and hospitalization. Everyone thought, this will revolutionize the care of heart failure. Every patient will go on to ENTRESTO, and they didn't. Uptake was extremely slow, and a lot of the reasons why this uptake was slow were our implementation, issues or implementation barriers? It's not the product itself. The results were great. The issues were in different areas. For example, cardiologists on a whole, on average, thought that the medications that had been on the market for a long time were effective and they were good enough. They didn't need a new medication. Okay. Well, this is a behavioral change. They saw the results of Entresto, they saw the 20% reduction that wasn't enough to change their behavior, to say, Oh, wonderful drug. I'm going to start prescribing tomorrow. And the question is, well, this kind of behavioral change, this isn't an implementation barrier. How do you implement a new product into the marketplace? How do you ensure that the mindset is right for the prescribers that they actually prescribe? How do you ensure that the patients you know don't have any reservations and they actually want the product? How do you ensure that the payers have what they want? And a lot of times, what we do in the Pharma industry is we just flood the market with more information, more evidence. But a lot of times it's more of the same, you know, so more efficacy results. Well, the 20% is already pretty convincing, or should be. Another study showing 20% is that really what they want? Is that what they need? So the question is, okay, the old products, oh, they're okay. We don't need anything new. And, you know, the way of doing ENTRESTO, it doesn't really fit into the way I do my practice. If I have a stable patient, can I actually switch them onto a new medication? I mean, they're stable now, do I interrupt that, you know. So there are these lingering questions, not about the product or not about its efficacy and safety, but more about how to give it. Should I give it? How do I give it? When do I give it? You know, when a patient has had an event heart failure, and they're in the hospital, is that a good time to switch the patient? So these questions, all of them, were known way before launch. They could have been acted upon, but of course, they weren't, because the way things work in pharma, to simplify it is you focus on getting registration, and you really focus just on that. Then you focus on getting

reimbursement. And figuring, if I have registration and I have reimbursement, everything else will fall in place, and it will be sold. It will be prescribed, not thinking that there are these other things. There are these other questions, more human, more behaviorally oriented, that cause issues. They cause these barriers. And a lot of times, this is what these implementation barriers are. How do I implement the product into the whole work stream within a healthcare system? And a lot of this is currently being detected. It doesn't fall under anyone's responsibility, and therefore, we come up with this huge gap between what product actually realizes, what it actually sells, and what it could sell. So there's this nice sort of implementation gap. If you go to the next slide, I'll explain a little bit more. You know this, this issue, and also be thought of as we know a lot of stuff. This is the evidence from our phase III trials. That's what we know. That's our evidence. What we do in clinical practice that's something different, okay, in Entresto's case, we knew that Entresto gives you the 20% reduction, but what they were doing in practice for a few years after the launch is they were ignoring what's known in the scientific literature, and they were continuing to prescribe what they have always prescribed. And this process takes a very long time to go from what we know to what we do and only a little bit of the research that's done actually ends up in clinical practice. So there's, there's a science behind how to speed things up and how to get things into clinical practice better and quicker. And this is what implementation science is all about. And you know, it really is a scientific study with methods that promote the systematic uptake of research findings into routine practice, and it's based a lot on more behavioral methods. And so this is why Pharma thinks, oh, I don't want to touch that. That's, you know, out of our clear cut realm of, you know, phase III randomized trial. Easy to set up, easy to interpret. Everyone's happy. This is a little bit different, okay, but it's there for solving a different issue. It's there for solving this implementation gap for addressing the implementation barriers. So it's a different tool, it's a different tactic,but it's something that shouldn't be ignored, because if you do ignore it, you end up with this implementation gap, which could end up with a lot of money being left on the table. So we're talking billions left on the table of sort of a missed opportunity of what a pharma company could have earned if they had actually addressed some of these implementation barriers.

Dan Housman

And so what do you think the big opportunity is for implementation science now? Now we're in 2025 as you know, investors are looking at, what's your AI strategy. I haven't heard a lot about investors saying, What's your implementation science strategy? Which teams are thinking about, what's the opportunity? Where do you see things going right now?

Skip Olson

You know, I'm it's sort of, start small, okay, but start Okay, and by starting small, you know, my recommendation is always, Well, okay. Do you even know what the implementation barriers are? And if you know what they are, do you know what the root cause is that setting up the barrier in the first place? And so, you know my recommendation is, Okay, put in place something that's systematic. And scientific early into the sort of drug development process, you know, back sort of phase II at the latest, to really look into, what are the implementation barriers? Can we address them? And you know, what's really causing them to know, can we

address them? Because addressing them early, i.e. before or just after launch, is really going to change the shape of that uptake of your whole sales curve. And so this is the most critical point, is to really address, what are the barriers, what are the root causes? Can we do anything about them? And if so, it's pretty easy to look at what the impact is going to be. And therefore the business case becomes very clear. And so the rationale to do it is very clear, but you have to know what it is we're up against, and where we could potentially be leaving money on the table. So my assessment is, what's the biggest opportunity? Well, identify what the barriers are in a systematic way, product by product, disease area by disease area, and that's a wonderful starting point.

Dan Housman

Can you think of things that would actually help? I guess I'm trying to figure out what the practical result of the implementation of science. Or examples that you may have thought of, of places where you insert either evidence or tools. What does it look like, even if we haven't done it successfully yet? Because I think that's something we can talk about, because we tried some stuff, you know, what do you think it could look like?

Skip Olson

So I mean identifying what the barriers are. This can be done in one of a number of different ways. You know, one of the ways that I've it's in one of my papers I've proposed is, you know, health economics normally does an early value dossier where they look at different impacts and values and different opportunity costs, it would be relatively easy to insert into something like an early value red dossier, sort of an assessment on the implementation barriers in this particular area. It uses that kind of contextual analysis to identify what are the barriers and what are the root causes, and relies a little bit on methods that aren't unfamiliar to health economics, but maybe not practiced all the time. So sometimes it's surveys, sometimes it's Delphi panels, sometimes it's doing a very research study, all of these put together and or literature review. I mean, all of these put together, you know, all of these put together really give us what we're looking for. You know, are there barriers? Are they important? Barriers that are really going to hold us back from getting the kind of uptake that we're looking for. So that's what we really need to be doing, you know, early on, to identify what the problems are.

Dan Housman

So once you have the problems, how do you solve them? I think when we're doing normal, real build evidence, we're doing evidence on patients, right? When we're trying to do implementation science, it seems like you're both generating evidence on health system behavior, patient and physician behavior. And you know, maybe there's economic barriers, other things that are complex. How do you go about fixing them and making investments above and beyond just pointing a finger at a potential problem?

Skip Olson

Yeah, so it depends. Obviously, it depends on what the issue is. It depends on the disease area, you know, it could range anywhere from, you know, sort of adding things. And, of course, clinical

development hates to hear this, but adding things to a phase III trial to look at more in detail, things around patient experience. So that has to be expanded to really look into different kinds of endpoints. Are not the clinical endpoints, but really the implementation endpoints. Is this something the patient likes? Is this something that they find easy to deal with, is there something they're going to continue it as well, asking the staff of the clinical trial itself, the site staff, Asking them detailed questions about their experience and with the lens to is the process move is giving other things that need to be improved, changed to eventually further down the line, help smooth out these, these, these bumps, these barriers. Okay, so, so doing things like this and asking the sites what their experience is, these kinds of things that aren't currently done, they're easy enough to do. Everyone worries about the patient burden in the clinical trial. People also worried about, you know, the site personnel burden, but with a little bit of discussion about how this information will be used in the future, I'm sure that this kind of an issue can be overcome. So that's sort of one approach. You know, another approach is to do a kind of a study. We talk about hybrid one, two and three studies, mixed method approaches with the hybrid studies, they either focus on clinical outcomes and have implementation outcomes as secondary, or flip it around, and you have implementation outcomes as primary, and you do also measure, maybe not with the intention of testing for the clinical outcomes, you know. So there are different ways of collecting information on an implementation strategy, and the implementation strategy is what will be needed to ensure that the drug is taken up into the healthcare system. Now this might mean that the patient flow through an actual site needs to be modified. With this modified approach to, you know, a pathway through the site, how a patient is dealt with that can be tested. Current approach, new approach, so this implementation strategy can be tested and you find out, okay, does this gain us anything? Is it helping to implement things quicker? It could entail specific forms of education. It can entail a lot of different things as specific strategies to overcome these barriers, and they can be put out in a different number of ways, either through studies or through simple things, like, you know, you know, a Delphi panel or a survey doesn't always have to be a Classical study,

Dan Housman

As you know, here at graticule, we do everything. EHR, what can we do within the medical record? Some of that's real world data. Some of that's how can we adjust the decision support functions of the EHR? How do you see the EHR fitting into implementation science?

Skip Olson

Yeah, it's a good question. It's a similar question that I asked to someone a few years ago who has a system on social media, listening, putting it into a structured, you know, panel, kind of from social media listening. This is mostly from a patient point of view. But I said I'm not interested in the Yeah. Now the more common things about, you know, sort of efficacy and safety. I really want to know about, you know, sustainability. I want to know about acceptability, more things that are going to ensure that the uptake is there, that the product is actually implemented. So when it comes to an EHR system, you know, this is normally, you know, the physician would be writing things about the patient. It would be great to have some fields, I say fields, you know, but it could be sort of information extracted from notes, but it would be a

different kind of note. What about the physicians opinion themselves, and not necessarily about the patient and how the patient is doing, but like, Oh, my God, I can't stand, you know, dealing with patients on this medication, because they always have this problem, this problem and this problem, or there's too much paperwork to fill out with the patients on this medication. I can't stand the extra effort and burden, or, you know, this requires an infusion, and I'm just not set up for it. It's causing problems. I can only do one page. So it's these kinds of insights that would add tremendously to these sort of implementation issues. The implementation barriers are in knowledge of them and are relative to the root cause behind them. So I'll flip the question back to you, Dan to sort of ask you, well, okay, you know, you know the EHR systems a whole lot better than I do, where could this information even either be a) put in or b) extracted from existing

Dan Housman

Well, as you frame it, it's tricky, because you're asking a physician to enter in a medical record, which is very patient centered. Be like using a CRM system for your sales team and asking them to suddenly enter, you know, what makes it hard to sell? They're only going to enter this particular person I contacted last week, so there isn't a field to put it in. I think there's probably opportunities within the EHR to put in notes. I mean, I have seen, and I think this is an interesting part that I looked at at AMIA, which is the American Medical Informatics Association, where they review different research people have done, and they do research into clinical decision support, specifically because clinical decision support, which is those pesky alerts, from the doctor's perspective, often where they're being flashed with 100 little warning lights on a patient, and the immediate reaction is this is about as useful as the warning lights in my car. If it says my TPS sensor is off, but my tires seem full, I'm going to ignore that for the rest of my life. I bring that up because they do have within the clinical decision support world systems that they've built to provide feedback on those alerts, to say this alert isn't useful. This kind of information isn't useful. This information was useful to be able to track not just what people's response are, but what's the quality of the information being delivered to the physician. Because, I think, increasingly electronic health records, especially with tools like AI, especially with tools like application programming interfaces to interact with the physician to guide them a little bit more on the patient, to the current evidence base, which is ever changing. All those systems need to be controlled. So I think an opportunity area to work in is the clinical decision support realm, which is not a uniform thing. One thinks of clinical decision support as just an alert, but clinical decision support are things like order sets, ways to support a referral. They're lists you generate on patients who have a care gap. Back to the question of care gaps, and in those supporting tools, you might be able to get some of that feedback when you're asking the physicians to provide feedback on the tool. So that's one thought. I'd also say, while we might not get the direct answer from the data in the EMR. We certainly can test a lot of hypotheses about what's really going on. We could say, how often does a referral occur here? How often does a patient end up in an infusion center when they should versus not? And we can see if we were to build a patient journey map or something that looks like what our hypothesized journey of how someone gets access to medication should work. The real journeys don't look like that. And we can go into once we have the evidence from the real journeys being different from the idealized journeys, then we can go back to the clinicians and start asking those questions with

data in hand to say, Why is this happening? Why is it that all these patients aren't being referred from the dermatology practice to the allergist, and the allergist has the tools to prescribe a monoclonal antibody, whatever the problem is, right? That's why I think we can use the EMR. But, you know, I want to be open minded, because there's probably ways to implement just general feedback systems as well, if we think it through like there's ways to communicate to doctors, because they have surveys we could put out. You can get things through the medical record to classes of physicians to build in feedback loops. So I guess a couple other questions, maybe taking in another direction is, how do you think groups can cost justify these investments and implementation science? Because I know that there's, there's a big tightening of the belt in pharma due to macroeconomic issues. Do you think it's going to be a big headwind for moving science forward, or is it the opposite? Well, you know, you got to make more of each drug if you're going to have pressure in terms of price.

Skip Olson

Yeah. I mean, it's, it's easy and it's not. It should be easy, but oftentimes it's not. And the way it goes is okay. You think of these two curves that either showed or described at the beginning, you know, you have this kind of standard looking uptake curve, which, you know, kind of slow at the beginning, then you hit a peak, and then it drops off. It's easy enough, although people don't do it, to think about, okay, if I do a particular action, particular activity, specifically designed to change some of the inflection points on such a curve. Then what could I change that curve to? Now I have an activity, has a cost, and I have an impact of that activity, a new sales curve. Okay, now I can easily calculate a return investment, or, like you know, the whole development organization does. I could calculate an expected net present value of ENPV, and I can show that, you know this, however many million dollar investments are going to add, you know, whatever, 10% onto the total. But you know, we're only talking about blockbuster dryers, because that's all Pharma looks at now, you know, and then 10% something that is earning 1 billion in each year at peak. You know, 10% of that is a lot of money, and it clearly outweighs the few millions that you're going to be putting into place to overcome some of these barriers. So, the economic argument is easy, but I use the comparison to health economics. You know, health economics, we have, you know, sort of cost effectiveness and the budget impact. So the cost effectiveness is there, you know, making the investment will give the return, fine, but there's the budget impact. The budget across pharma portfolio is, of course, limited and has an upper boundary year after year, which means that you have to make a very good business case in the manner that I just explained to put forward to say, okay, investing money here is going to be better than investing the money somewhere else where you have a lower return investment. Therefore we should be getting the money, and that is how you should be overcoming the budget impact part of it. But teams normally aren't sophisticated enough to actually do the sort of the business case and in a convincing enough way. With us, there's no one to really champion this. You know, it can be health economics is going to be the marketing team? Is it going to be medical affairs? There's no one really driving implementation barriers forward as a part of their kind of list of activities responsibilities to say, I'm going to take responsibility. I'm going to drive this forward, because this is important for patients and for our bottom line. So these two combined, you know, kind of holding things back, but it can be done relatively easily. I think this is what the industry has to come to grips with, and has to do a better job.

Dan Housman

AI is such a big factor, the big change agent in today's world. Everyone's used some chat, GPT here and there. Do you see that helping the implementation science world in some way, or in some particular way, that that moves, moves the moves the thought process, or the tools available forward.

Skip Olson

I mean, I see AI being used everywhere, across the pharma industry. And, you know, certainly just for the easiest thing, if you go into any disease area and ask the likes of chat GPT, you know, what are the implementation barriers in this particular disease era, you have to be specific about not just saying, you know, heart failure, for example, but you have to specify what type of heart failure, blah, blah, blah. And you know, it might depend on the country, so you might have to say in the US healthcare system, whatever, and it will give you answers, okay, and you know, so from a starting point of view, use it to get insights, but combine those with, you know, insights that you already have, because the medical team, anyway, is going to be talking with, you know, KOLs in the field, etc, as Well as, you know, whatever kinds of surveys or whatever that you decide to implement that with. So that's the easy kind of thing that anyone can do immediately. The question is, how can AI really be used to enhance, to simplify, to bring implementation scientists a little bit further along within the pharma setting. And I'll leave that, you know, sort of as an open thought. I'm, you know, in the middle of looking into ways of applying AI there. I'm certainly open to any kind of suggestions, you know? So if you have any want to move forward to hear them. Otherwise, people can get in touch with me and say, oh, you know, I think AI would be useful here, here and here, and I'd be happy to hear from them.

Dan Housman

Well, it certainly comes to the next question, which I think everyone talks about when we try to propose solutions to an implementation gap, which is the scale question. So if we find a gap, we can go work with the XYZ health system, we can prove that it's possible to overcome this gap, but that's one health system. And unlike when you generate evidence about biology, given this drug, the patient's hair changes color, it doesn't matter. It's pretty definitive. Each health system is its own independent operating framework, and transplanting operating rules at a health system is really hard. So, you know, I'm curious what you think about other ways to, to scale implementation science or scale the results of it, you know, to get to real change, because it is different than, I think, just presenting evidence in a paper presentation.

Skip Olson

Yeah, in most cases you're absolutely right. So I like to think of it in three different ways. The one is, you said biology. I refer to it as sort of a universal implementation barrier. One that resonates across healthcare systems, whether it's different healthcare systems in the US or different geographies, like, you know, Germany, France, UK, China, whatever, sometimes there will be universal barriers. These are common to many healthcare systems, okay? And these might be the ones that you decide to prioritize, to actually address, because they're

automatically at scale, okay? And so if those exist, those really the ones that you want to prioritize, the next level down is sort of, you know, in the US, within any country, it doesn't matter to help with scaling up. It's often extremely important to partner, even if you find a sort of a universal implementation barrier, you're going to want to partner anyway. But if there isn't one, and you have to go to a couple individual healthcare systems, you're going to want to partner with a Patient Association, with the Medical Association, with any kind of association that has some kind of authoritative voice that could help with the message of you know, these are the problems, not really specific, specific, but you don't know these are the problems we're seeing in these healthcare systems. These solutions have worked. We think that these or similar solutions will work. These are the kinds of things that you should be bringing to your healthcare systems. And this will lead to better care, you know. So these kinds of indirect but very influential kinds of ways of spreading the message we see as extremely helpful. So there's one way. The other way is to get involved with this kind of modeling project to say, okay, what are the important parameters in this healthcare system versus another one? What have they done here? What have they done there? What could other healthcare systems do? Would they do if they did the same thing as the healthcare system a) would they also see the kind of benefit that healthcare systemated, you know? So this kind of, you know, thought about modeling this out and predicting, you know, what a different healthcare system might achieve. This is something that hasn't been tapped into at all and should be. Could be

Dan Housman

Well, certainly in a world where data is more liquid, or analytics is more liquid, or, you know, the cheaper and easier we can do those modeling activities, the more we could maybe get those pieces to not be so complex, because I think that's one of the issues. There aren't a lot of spare dollars inside of a health system to say, let's go model all these Entresto let's go model Entresto's adoption. They'll say, Well, we did. That's not my problem. We have other things to do, but I like your idea that, and we've always tried to work through this, but it is complex, because there comes a multi ball pool shot to figure out how to work with both the medical associations and the patient advocacy organizations, because they do have the convening capacity as well as the distribution capacity To put things in that I'll avoid a whole lot of concerns about business and ethics and other stuff about how you're going to interact on behalf of the patient and the clinicians. So I think that's a big, important piece, maybe the last question, and because I know we have to get going, and I hope everyone who's listened, I've always found it fascinating to hear about new things and Skip you have such a great background in it is, you know, where should people go to learn what others are doing in Implementation Science? What do you think is needed? Maybe it doesn't even exist for implementation science, because it's, you know, I can go to an RWE conference. I can go to a medical affairs conference, I wouldn't really necessarily know, other than to bump into you and some other disciples in various different places where to go.

Skip Olson

Yeah. So, I mean, you know not to you know, you know, push more business to me, or whatever. But, you know, a simple way of seeing how important implementation science is in

pharma, how it can have an impact. Also, to give an idea about the sort of the business case, I have a couple of short tutorials that have been published, so just sort of Google my name with implementation science, and you'll come up with a couple of very easy to read introductory things, just to learn a little bit more about implementation science and pharma, to find out what other people are doing, there is on LinkedIn, a consortium on implementation science that is open. You might have to request to join, but certainly you'll be granted access if you do request that. So it's called Consortium on Implementation Science. They do offer some webinars. So what is coming up on November 4, with a professor who I've worked with a lot, from Duke. Then there are things like, I'm working with the Swiss Implementation Science Network. We have a conference coming up in February in Zurich, where one of the topics will be at a pre conference workshop to say, Okay, what is it that people, especially in the industry, need, in terms of, do we need a compendium of case studies that people can refer to? Where could this be put? How can we put together these kinds of solutions we're just thinking about, we're just, you know, about ready to act, to put these things together. But certainly the Consortium, or just, you know, read a couple of my quick articles, that's a great way of starting.

Dan Housman

Well, I think it's been wonderful to hear from you Skip, and I really do love this space, because I've always been a fan of better living through data, and I think that kind of is secondary to better living through chemistry, if we're thinking of the pharma industry, and so implementation science can can get us there past when these phase three studies and all these other studies come out to really both benefit the sponsors as well as benefit the patients, to get things in the hands of doctors faster and get things in patients faster. So I think you're doing great work.

Skip Olson

I mean, it's not going to be the magic silver bullet which solves all problems, okay, but the incremental value is significant. It's another approach. It's another tool. It's another way for reaching more patients faster and making things easier for a product to actually get into a patient's hands, and that should be our goal in what we do with the pharmaceutical science is to ensure that patients actually receive the product only then can they benefit from it. And this, you know, approach of implementation science is one way of notching up our effort to make sure that actually happens.

Dan Housman

Okay, any, any last words

Skip Olson

I think I just made it. Yeah,

Dan Housman

Awesome. Well thank you so much Skip. And you know, I'm sure we'll be talking again soon, and for everyone who's listening, thanks for your time and hope. Hope we'll see each other around

Skip Olson

Perfect thanks for having me, and yeah, we'll be in touch. Like you said,