A CONVERSATION ON HEALTH CARE

Sponsored by

with CANDACE JOHNSON, JOSEPH MCDONALD *and* THOMAS QUATROCHE JR.

ALL PHOTOS: JIM COURTNEY

Candace Johnson of Roswell Park Cancer Institute, Joseph McDonald, center, of Catholic Health and Thomas Quatroche Jr. of Erie County Medical Center met last month to discuss the innovative ways their medical systems work together.

Success depends on collaboration

THREE MAJOR HOSPITAL SYSTEMS WORK TOGETHER FOR COMMUNITY'S SAKE

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Hospitals are finding new ways to work together, crossing long-standing lines that historically have kept competing health systems apart.

Part of the credit goes to forward-looking CEOs who recognize the best way to address the needs of certain patient populations is best accomplished through partnership. The other factor stems from state and federal reforms in health care that mandate regionwide efforts to bolster better results.

The leaders of three Buffalo hospitals came together in mid-November to discuss challenges and opportunities. It was part of a Buffalo Business First leadership discussion series sponsored by Hodgson Russ LLP.

Though the participating organizations are distinctly different in many ways, all three share the same goal of improving population health in Western New York. They also face the same challenges of adapting to new reimbursement methodologies, recruiting and retraining physicians and retraining a workforce, and patients, to think differently about where and when patients seek care. It begins with the Medicaid patient population but ultimately will inform how all patients are served.

Getting that message across isn't easy, said Thomas Quatroche, CEO of Erie County Medical Center.

"The pyramid is flipped, with the hospital at the bottom and the community at the top," he said. "We're pushing people out of our building."

Candace Johnson, CEO of Roswell Park Cancer Institute, said though Roswell Park's focus is different from the region's other hospitals, there's plenty of opportunity for collaboration, especially to keep patients here for advanced care.

"We provide innovative, cutting-edge care and things unavailable elsewhere in the community," she said. "Clinical trials here make Buffalo a destination."

Joseph McDonald, CEO of Catholic Health, said collaborations among competitors to improve population health could happen more, but only when it makes sense.

"I believe competition is a powerful source for good," he said. "The better Buffalo General is, the better ECMC is, the better Catholic Health has to be. It raises the bar."

▸ HEALTH CARE FOR THE COMMUNITY

$1.2B	1898	$4M
2015 Catholic Health revenue for five hospitals and parent company	Founding of Roswell Park Cancer Institute, one of 41 comprehensive cancer centers designated by the National Cancer Institute (NCI)	2014 surplus at Erie County Medical Center, on operating revenue of $514 million

▶ How is the reform program DSRIP (Delivery System Reform Incentive Payment Program) changing the way hospitals work with each other?

JOSEPH MCDONALD
President and CEO
Catholic Health

This is a brand-new edition that has not been tried anywhere else in the country, so we're unencumbered by any experience. This perspective is another way of looking at it. And it requires a dance between the federal government and the state of New York to free up resources. We collaborate on major issues such as smoking cessation, palliative care and behavioral health in primary care offices. With the noise that folks don't collaborate, well, we do in certain areas and we compete in certain areas, so that's the nature of where we are. It's a very fragile system. The agreement by the federal government and the state of New York took a lot of political lift from our federal folks and the governor. I believe the market helps sort it out, but this also really focuses on many medically underserved areas. Frankly, there's not a lot of competition for taking care of the poor and underserved, so it is a very positive influence, too. If I can give you a visual – this program is like designing a space shuttle in flight and without necessary drawings. It's cobbling things together. Just like the Affordable Care Act, we'll have some successes and some failures.

▶ CLOSER LOOK AT THE SERIES

The conversation with Candace Johnson, Joseph McDonald and Thomas Quatroche Jr. is part of an ongoing series of discussions with business leaders.

Throughout the year, decision-makers from diverse Western New York industries meet for discussions moderated by Business First journalists.

Excerpts from the conversation are published two weeks after the event.

Upcoming topics include nonprofits, agriculture and food manufacturing and education.

The discussions, sponsored by Hodgson Russ LLP, are held at the law firm's Pearl Street offices in Buffalo.

THOMAS QUATROCHE JR.
CEO
Erie County Medical Center

As Joe said, the whole purpose of the Medicaid waiver is to get Medicaid patients the right care at the right place at the right time and to push patients out of our building and into the community setting. It's a different mindset for the community and for the way we incentivize reimbursement. If you think about our institutions and what we all have to face, it's very hard to tell that nurse by the bedside that dollars are now going to the community when we see more and more patients every single day. Our volumes have been going up steadily, so we're in two worlds right now. We're trying to move from a fee-for-service where we're getting paid for clicks of time when people come in, to more of a population health scenario. It's a paradigm shift in thought process and it's hard to do that with primary care organizations. It's hard enough to do that with a Medicare or a commercial population, let alone a Medicaid population whose issues are not just clinical but social. Back to thinking differently, the dollars have to go to the clinical and social aspects of taking care of people, so housing, transportation and those issues become just as important as clinical. As Joe said, it's a grand experiment. It's never been done like this, so we're all trying to make this work. We received about $243 million over five years, which sounds like a lot of money, but when you think about the magnitude of this problem, it's really not. We're trying to get the state to help with additional funding, which they have been very willing to do. We're working together and doing the right thing, so I've been very impressed with our community providers.

▶ Candace, what are your observations? You're sitting there on a little bit of an island. The Medicaid population you serve probably is fairly small.

CANDACE JOHNSON
President and CEO
Roswell Park Cancer Institute

About 2 percent, but it speaks to collaboration and working together. Smoking cessation is a big part of this and we're both PPS of Catholic Health and ECMC. Through our Quit Line, we provide smoking-cessation programs to PPSs around the state. It's a very important issue. We're not as involved in the palliative care, but that's also a path where we can make inroads because it's about higher quality, lower cost and population health.

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► Tom and Joe said it's too early to predict the outcome after five years, but do you see the smoking-cessation program as something that will continue with the PPSs?

CANDACE JOHNSON
Roswell Park Cancer Institute

No question. Smoking cessation is a huge part of our initiative anyway, so this helps to facilitate us doing more in that area.

► A number of years ago, different systems ran a number of clinics. Are we going back to that model as a way to better serve the Medicaid community?

THOMAS QUATROCHE JR.
Erie County Medical Center

We still serve many people in our clinic setting. There's going to be more incentive for more clinics in the community because we're going to have to keep costs down to make sure people don't get into the acute setting. Right now we have large clinics in all our organizations and we serve a lot of Medicaid patients, but we do need to provide more access.

JOSEPH MCDONALD
Catholic Health

We approach clinics from different perspectives, the same as ECMC. The religious women who built these institutions, that's one of their primary directives. So at Catholic Health, we have six major clinics. We lose anywhere from $800,000 to $1.4 million in each clinic. The Medicaid reimbursement is paltry but I still have to put good physicians in there. The challenge is young physicians may not want to make that their permanent practice, so there's always turnover. When I first got here, many of our clinics looked like places where only poor people would go, so we made a conscious decision to reinvest. I believe having those clinics look that way was a sign of disrespect. We're in the middle of our budget and there's always somebody saying, "If we didn't have these clinics …" but that's the equilibrium we have to find.

► As changes take place, how will the relationship between the local systems coalesce? Will there be more collaboration?

JOSEPH MCDONALD
Catholic Health

First answer is yes, there will be. But it's a compelling public health issue or compelling business reason. There are opportunities. We're working with Kaleida, ECMC, Niagara Falls Memorial and Catholic Health to operate a cath lab as opposed to two competing ones in Niagara County. After Mount St. Mary's became part of Catholic Health, I was able to say we want to be part of this initiative. If it doesn't create real, sustainable improvements, I won't do it. I believe competition is a powerful force for good. I was surprised when I got here about the tension and that there shouldn't be competition. Well, I just don't agree with the hypothesis. I believe the better Buffalo General is, the better ECMC has to be and the better I have to be. That's good, and if we can't rise to that new bar, then maybe we shouldn't play in this type of clinical program. One other reason to collaborate is to help our medical school grow. That's going to take every organization in this community, all the alumni, all the folks in the medical school and the health sciences schools to work together.

► Candace, Joe said Catholic Health is working with Roswell Park. How are those working out and how do you see the future with Roswell, Kaleida and ECMC?

CANDACE JOHNSON
Roswell Park Cancer Institute

Roswell, as you all know, is a National Cancer Institute (NCI)-designated center. Our role in this community is to provide innovative, cutting-edge care in cancer. It's where you go when there's a complex case. If you need a bone marrow transplant, if you need things that aren't available in the community, you go to Roswell Park. We have out-of-the-box physicians who are pushing that edge of innovation. We see our role in providing that to everyone in this community. I think there are ways that care is going to be different as we go forward. There are not going to be as many hospital beds; it's going to be an outpatient arena, especially in cancer. And we're already planning and thinking about that. We have to be smart about our collaborations. We have a wonderful collaboration with (Dr.) Michael Cain and the University at Buffalo where we are their oncology trainers for medical students. In pediatric oncology, we had an opportunity to recruit a new chair to replace (Dr.) Marty Brecher. He had a faculty appointment at UB and Children's Hospital, but it was more of a Roswell Park function. Recruiting this new chair, it was totally a third Children's Hospital, a third UB and a third Roswell Park. We worked together – the three women – (Dr.) Theresa Quattron and Allegra Jaros and myself in recruiting this outstanding candidate from Columbia. She is incredible. We're joint venturing the whole operation and it's going to be fantastic. Here's an instance where for the good of Western New York, we have one pediatric oncology program at Children's Hospital. There shouldn't be two. We need to do this together. Everybody doesn't have to come to Roswell Park to get treated. We'd like to provide that continuum of care using recommendations of how patients should be treated according to the latest guidelines, but they can stay in the community and get their care. They don't have to go to Roswell, so we've been talking to Catholic Health about partnering in some areas. We're excited about that. We've had conversations with ECMC to do similar sorts of things. Our community is too small to do this in silence.

THOMAS QUATROCHE JR.
Erie County Medical Center

I think there's huge opportunity for collaboration. My view is a little different on the competition. We're a public benefit corporation, a public organization. We start with an eye on the community to make sure we are good stewards of the institution and the fiduciary strength of the institution. But we start with an eye on collaboration. We are a business; health care is a business. So there is going to be competition in the process. I'll use the DSRIP process as an example and Medicaid waiver. We are dependent on one another to be successful, so if our PPS fails, Joe's PPS fails and vice versa, and as does the whole state of New York. The incentives are for the dollars with the payers and with the government. I think that's going to change, and I think you're seeing more collaboration because of those changes. That's forcing the community and the hospitals to work together. I think that's why you're seeing more community partnerships with organizations that weren't traditionally partnered with hospitals.

► All of you have challenges in hiring top-notch professionals. Does this type of collaboration help when you go out to recruit?

CANDACE JOHNSON
Roswell Park Cancer Institute

We actually don't have much trouble recruiting. Occasionally we have spouses who don't want to move where there's snow, so we have to convince them that there's not 8 feet of snow here all the time, but I think it's a telling story. If you can bring people here and show them what's going on, show them the city of Buffalo, the construction everywhere and the programs here, you don't have to say too much to people. In the pediatric sense, with a brand-new hospital, people are coming together. Pediatric oncologists are used to this multi-reporting because a pediatric oncologist is always in the department of pediatrics and maybe the hospital is owned by somebody else, so that doesn't bother them. The promise of what we want to do here is what attracts people because they want to be a part of this building and the innovation. We're in a huge recruiting phase right now and we have some really incredible people who want to move here, so it's an exciting time to be in Buffalo.

JOSEPH MCDONALD
Catholic Health

Two of us at the table are from somewhere else, so from us it's easy to sell. When I first got here, I was asked often why did I come to Buffalo, and always with a little cynicism. I joked that I wasn't part of the witness protection program; I chose to come here. I'm proud to be here but you have to constantly sell. We market this community all the time, and when we downplay or disrespect what's going on, it doesn't help anybody. I believe professionals are recruited asking themselves, one, is the work meaningful, important and relevant? And two, is this a great place for me to raise my family? Those are two very positive attributes for this region. Sometimes they will ask about politics, and then I change the subject because we do have a very robust political system in New York. Between creating a compelling vision that this is where a person can have a rewarding, professional experience working with other like-minded colleagues and having a vibrant academic program with UB and all the other colleges, it all plays into the fabric that makes it easier to sell this community.

THOMAS QUATROCHE JR.
Erie County Medical Center

I agree. It's easier to recruit. I've been with ECMC for 11 years and, just in that period, recruiting physicians has changed dramatically, from the excitement that's going on in the city to investments in health care in Western New York. That's being noticed nationally. When we recruited for some of our big programs, such as the transplant program, we recruited a physician who was very excited about the opportunity to build programs. There are those out there who don't want to be part of a bigger program that's already built. They want to be part of building something and being part of the foundation. We're in this renaissance in Western New York, not only in the community but in health care, and people are excited to be part of it.

JOSEPH MCDONALD
Catholic Health

Another dimension is we have some extraordinary nurses. We have a rich tradition of nursing programs in this region, and I'm married to one.

▶ AUDIENCE MEMBER: I'm from Pittsburgh and the dominant influence there is UPMC. I see competition from other cities, Cleveland Clinic or going to New York or wherever. How do you handle that? Is it better to be unified in one dominant hospital system?

▶ JOSEPH MCDONALD
Catholic Health

My answer would be no; there's no reason to. I go back to my premise that competition is good. The other premise is the folks at UPMC, University of Rochester and Cleveland Clinic have strong clinical programs and we ought to be able to tap into them if we need them. They are not the enemy; they are caregivers who bring us different choices. With technology, we can consult with the best expert in any field on a teleconference on the other side of the world.

CANDACE JOHNSON
Roswell Park Cancer Institute

I was at the University of Pittsburgh for 12 years. I know exactly what they did there and how they built that program. Allegany is another hospital in Pittsburgh, but UPMC is the dominant force. There is no question. You know, UPMC steamrolled its way through things. No one has ever done that anywhere. They started off by transplants and built huge cash reserves, and that enabled them to build a cancer center and other specialties. But they made it revenue-driven. It was all about money for the physicians, so they lost a lot of people who weren't driven just to make more money. Pittsburgh is still a powerhouse, and, in fact, we collaborate. We have a $12 million grant with the University of Pittsburgh. One of their investigators is on that grant. We love working with them; they have some great people there. We have collaborations with the Cleveland Clinic, and I agree with Joe: We need to reach out and collaborate with these individuals and not be afraid of them. They are not going to walk in here and take over.

JOSEPH MCDONALD
Catholic Health

We did a strategic plan five years ago because we had other Catholic hospitals and I was able to get the database of all patients admitted in Pennsylvania. I identified which ZIP codes they came from, so I knew how many came from Western New York and it's not busloads of people, like going to a casino. It's a very, very small group of people.

THOMAS QUATROCHE JR.
Erie County Medical Center

One thing they have done is talk about their outcomes. I think all of us believe that we lead with quality and everything else will find its way with regard to the finances. There are always opportunities to collaborate. Call me naive or call me a believer. I think we have just as good, if not better, clinical quality in Western New York. We can build similar types of reputations and systems based on our outcomes and data. To the point that there are busloads of people going to other centers, there are a lot of people staying here receiving unbelievable care in Western New York. Some of it is branding and some is marketing from these other cities. We're getting better in Western New York at pointing out the data to the public to let them know that, in many cases, we're of higher clinical quality.

CANDACE JOHNSON
Roswell Park Cancer Institute

We've had patients going to Memorial Sloan Kettering, Pittsburgh and the Cleveland Clinic for a second opinion. The patients are asked, "Why are you leaving Roswell Park?" They tell them, "We would give you exactly the same thing Roswell is telling you to do." Do you really want to stay in a hotel during your 30 days of treatment? You really should just stay with Roswell. We would do the same thing for someone who came to us, as well, so there's more collaboration between centers than you think.

▶ AUDIENCE MEMBER: In January, telemedicine is going to be a bigger part of our world. What are we doing locally along those lines?

JOSEPH MCDONALD
Catholic Health

I'm a little worried that we believe that telemedicine is a silver bullet. The University of Georgia probably had the most demonstrated expansion of telemedicine and they've been in it for 15 years. It's got a use. The new way, frankly, is the relationship between the use of telemedicine in helping with behavioral health issues, and specifically short-term areas where we don't have enough psychiatrists or other programs. I think it's one of the tools in the tool bag, but I don't believe it's the specific silver bullet.

▶ AUDIENCE MEMBER: Joe, how do we address the absence of a robust set of options for families who are dealing with substance abuse, drug addiction and heroin issues? There seems to be such a limited choice and limited opening for care for these individuals.

JOSEPH MCDONALD
Catholic Health

Several years ago we went through our own evaluation of whether we should go into the behavioral health business. We're revisiting that again because of the requirements of the population's health. We have the experience in the region of having an ACO, being experienced and not having adequate behavioral health capacity. That's a problem for us, too. It's a tough body of health care to be able to fund afloat with it. ECMC has a strong program. You have Brylin. We have a very large methadone maintenance program that's both here and in Rochester. We have an alcoholic program at Mount St. Mary's, but we're going through our own paradigms. How do we reconfigure as we think about putting chronic behavioral health resources in the primary offices, too. It is a huge challenge. All our emergency rooms, I guarantee you, will have a behavioral crisis going on sometime in the next 12 hours. This time last year we had the snowstorm and all of our methadone maintenance clinics were closed. We couldn't get to them so guess where all the patients showed up? In the emergency room.

THOMAS QUATROCHE JR.
Erie County Medical Center

As you know, ECMC has a large behavioral health and substance abuse program and we partner with a lot of other organizations in the city. It's part of our DSRIP process and Medicaid waiver process. Some laws that exist today – and Joe mentioned between behavioral health and primary care – inhibit our ability to partner with those practitioners to treat patients. The other issue is obviously it comes down to resources and the ability for people to get into the business. It is a very difficult business. I welcome anyone to come into our behavioral health units, both inpatient and outpatient. Those people are doing God's work. They are facing medication compliance, social issues and very, very difficult cases. Our adult psychiatric program is always full. Our substance abuse programs are mostly full but, again, back to what qualifies somebody to get into those programs. Those types of issues need to be looked at and what is reimbursed around those types of things. I've had conversations with the state about that and I think they are getting more focused on it. It's a health care and a community issue. We need to rely on the people who are on the ground doing the work because they know. They have a lot of the answers and they can help the system reform itself. Law enforcement is obviously a big piece of this, as well as the health care professionals, but there's no easy answer to it.

MICHAEL CAIN
Vice president for health sciences, University at Buffalo;
dean, Jacobs School of Medicine and Biomedical Sciences, University at Buffalo

This becomes a good example of the very magicical opportunities we

have in Buffalo to collaborate and do some very, very special things. We are a medical school and we're accredited to do one thing and that is to train medical students. We're part of a university that's an AAU research-intensive university, so we elect to have very, very strong and strengthening of research programs. We have over 600 full-time physician faculty and almost 800 faculty. We have hospital partners and four health science schools.

So if you take the issue of opiate addiction and working together, what we can accomplish are educational programs for the medical, nursing dental, pharmacy, occupational therapy and physical therapy students. We have programs that involve all of our hospitals called interprofessional education where you teach students how much your other health professional colleague knows, so that you can use that person to the full measure of their license.

We have continuing medical education where we educate the community as a group. We have graduate medical education with 800 interns, residents and fellows who populate the major hospitals in Buffalo. We strive as a school to make sure all students receive a similar education, and that's where special faculty, hospitals work together on a uniform continuum. This is the advantage of an integrated system.

I can't graduate 144 physicians who are all taught differently. It doesn't work in 2015. There are no apprenticeships anymore; it's evidence-based medicine that needs to be practiced everywhere we send our students. We demand our faculty practice those.

All of us who have been involved in writing guidelines realize that when guidelines come out in the New England Journal of Medicine or in Circulation for Heart Disease, the data and the rules about how you treat people are already two years old. The good centers realize that you need to have that research arm that says we realize these guidelines are better than the ones published five years ago, but we better start working on the next five years because they are still inadequate. As small as we think sometimes Buffalo is, we have an NIH-NCI designated cancer center. As all of you know, in August a consortium led by and run by UB – we're a clinical translational science institute that's designed to do this – and so we recruit very special faculty. The people who work in the inpatient psychiatric unit and run the behavioral are our full-time faculty. This is what UB brings to the community. We have some 70 faculty at Roswell Park. We have this magical opportunity in Buffalo with the physical adjacencies that are occurring, and the infrastructure of the super NIH-designated center to really make some major differences here.

► AUDIENCE MEMBER: Over the last 10 to 12 years, there seems to be a strong community consensus that the consolidation of first-class medical facilities in the medical corridor has been a positive. What are your views, given that Roswell is there and ECMC is a bit removed. How does that affects your institutions?

THOMAS QUATROCHE JR.
Erie County Medical Center

I don't view the medical corridor as a location; I think it's a system and a network of health care providers. If you look at UPMC or other places, it's not necessarily a place. The corridor and the adjacency are very powerful and very impactful on our community. But you can't provide all care there. It's not necessarily a geographic location for us. It's a system of care and is the hub, in many cases. So if you look at the things we do that are the only ones in town such as trauma care, behavioral health and transplant, to name a few, you see that there's a need for, obviously, other places in town. So we're not threatened by that. We're partners with everybody in the corridor. It's been an unbelievable vision for our city and it's done unbelievable things to raise the image and renaissance of the community.

CANDACE JOHNSON
Roswell Park Cancer Institute

I agree with Tom that if people are going to go where there is excellency when it's across the way, I think the good thing about having all of the adjacencies is it makes getting together better, easier, perhaps because you don't have to get in your car and drive somewhere. It helps to facilitate those things, but I think we can still interact with ECMC even though they are not right next door.

► AUDIENCE MEMBER: Most people in hospitals are acute patients. They don't care what your facility has as long as the floors are clean and they think the're going to feel better. What that tells me is that's really about the staff. It's about how (patients) are approached and how they are cared for in their moment of need. What do you do to make sure that your staff, who are fundamentally the caregivers, are happy working in your facilities?

CANDACE JOHNSON
Roswell Park Cancer Institute

Well, that occupies a huge amount of my time. My style is to try to instill into every person – whether they clean the floor, empty the trash, the very skilled nursing people in the ICU or whoever it is – that they are part of this team to provide the best care. That's what you have to do to get people to buy into the mission of what you're doing, so that they have as much pride in keeping that floor clean and making sure that those patients are treated well as anybody does.

THOMAS QUATROCHE JR.
Erie County Medical Center

To the patient, the least important person in the building is me. It's that housekeeper, the nurse, the doctor in front of him. We spend a tremendous amount of time, as Candace said, on letting them know how important their role is in continuing care for that patient. Whether they are serving food or providing bedside care, everybody has a humongous role in the patient's care and how they are going to get better. The clean room is also infection control. We spend a lot of time helping employees understand how critical they are to the process. Obviously the nurses understand that but, again, it's not for the nurses; it's not just their clinical role. It's the emotional role and the communication with the patients and the families. And we spend time with our physicians talking about that interaction and how important that interaction is so they make sure they are giving the right type of input and they are not in a position where people don't want to give them that kind of communication. So it's probably the most important thing we're doing in the building is making sure that people who are taking care of our patients are trained well, are communicating well and providing really, really good customer service. And now, since the federal government has decided to do value-based purchasing, we actually get reimbursed for doing that or money taken away, less money taken away if we provide those types of services. So there's a definite focus in the patient experience is what we all call it. There's a huge focus for hospitals across the country right now and I think in the end, patients have obviously benefited from that focus. But to your point, the excellence in clinical care is kind of what is expected from the patient, so all of the other types of things that patients experience in the hospital, we have to make sure that their image and perception of what we are doing is at the forefront of the clinician's mind, in addition to providing good care.

► What do you see for health care in Western New York and how it affects your institution and consumers?

CANDACE JOHNSON
Roswell Park Cancer Institute

Health care is going to change because it's going to be more outpatient, and we're preparing for that. The other thing that goes to everything that you hear and read about around the country is lower cost, higher quality, higher quality, higher quality. We spend a huge amount of time on quality. We have a book that we published. You can get a copy of it if you want – it may even be online – that gives you all the quality measures for all of our disease sites. The good, the bad and the 2ugly. It's right out there, but when you do this you make yourself better because nobody wants to be in that book and not in a good way. So quality is of the utmost importance and each one of us, no matter what system you are or where you are, quality, as Tom said, is the most important thing. I think as we go forward there will be some sort of sand shifting, where we want to be a better partner to the university and we want to do more things with the university and like the pediatric oncology recruitments that we described. We want to partner more with our community physicians. We're actively looking at how we can do that better so that it's not this us-and-them kind of thing with the community where they think we are taking their patients. I think the future for Buffalo in health care is bright. How couldn't it be with all the development going on and all the excellence in the recruitment, the city? Things are going to get better. It's not like we're on the brink of war or anything. I think the future is bright for us all.