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CLEARWAY PAIN SOLUTIONS

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A Re-Introduction to Pain Management

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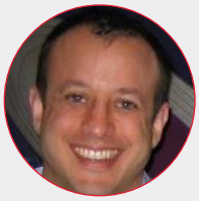

Ira Kornbluth

President at Clearway Pain Solutions

Key Takeaways

What is Pain Management's Role in the Care Delivery Ecosystem?

I think that there's been a paradigm shift in pain management where pain management is now being redefined to some extent as interventional pain management versus chronic pain management.

- We're now getting patients earlier in the pain continuum. We've positioned ourselves in large part between primary care provider and surgeons, and we have really been advocating getting the patients earlier.

Historically, referrals were being made to pain management in a few different scenarios.

- **Post-Surgeon:** Referrals were made after referrals to surgeons for potential surgical conditions. Only about 2% of back pain, maybe even less, is surgical. So, for the primary care physician to refer to the surgeon first doesn't really make sense.
- **Post Opioid Treatment:** The other big way that patients were coming to us was after primary care providers were initiating opioids and often not managing the pain situation with other tools. To use an analogy, many of the primary care providers were letting the plane take off but weren't really able to land the plane. When the plane got turbulent, then they'd make the referral to us, and that's really not the best place for us to get patients once they're already on opioids.

Where is the Market Opportunity?

Favorable Competitive Dynamics

We're now the largest pain practice in the country and I think we're probably about 1-1.5% percent of market share across the country.

We can be selective. Right now, in the marketplace, there aren't that many practices that are capable of completing an acquisition of size and scale. Some of the other organizations that aren't as big as us but are sizable are either highly leveraged or potentially over-levered, and they are not as desirable as partners as us.

Expanding Scope of Pain Procedures

When we think of pain doctors and how they're coming out of fellowship now versus even how I came out of fellowship in 2004, these doctors really bring a diverse skill set and are trained to do a lot of high-end special procedures. Many new procedures have just come to fruition in the past few years.

Significant ASC Opportunity

I think what gets me most excited is the evolution and growth in surgery centers, building surgery centers, and watching them succeed. For us, having done this so many times, it's a relatively low-risk endeavor with a high reward.

In a couple of surgery centers, we have now partnered with spine surgeons where we have the majority of equity in the center, but we're offering equity to these surgeons, and that's a move where we're going to partner with these other specialties, including perhaps podiatry and other specialties. They maintain their autonomy, and there may be some cross-referrals and opportunities to work together through our partnership at the surgery center level.

Service Line Expansion Opportunities

We would like to incorporate physical therapy on a greater scale than we currently have. We have electro-diagnostics in many of our offices. We want to expand that across our practice to have that in all of our offices.

About 75% of our book of business is spine-related pain, and we are looking to become more of a one-stop shop, so to speak. So, we're able to market ourselves to do more knee pain, shoulder pain, hip pain, muscle pain conditions, and peripheral nerve conditions.

We have had discussions about hiring orthopedic surgeons and neurosurgeons thus far. We haven't moved in that direction - I don't see us as a multi-specialty shop. It's a matter of just driving outcomes, driving excellence in the pain space, and not entering spaces where we're less familiar, where there's additional oversight and risk.

A Re-Introduction to Pain Management: A case study in how to think about quality and compliance in a highly scrutinized market

Strong Compliance Programs & Third-Party Auditing

One of the early business decisions that I made in running marketing management before we even had private equity involved was to have a strong compliance department. And that really helped me navigate some of these complex issues because there are a lot of regulatory concerns around pain management - it is not just opioids; it's running ASCs, it's DME, it's referrals to physical therapy and managing that, etc. The decision I made to build a strong compliance vertical helped protect our organization, keep us clean, let us continue to grow and thrive and play the long game, so to speak.

We have an external vendor that looks at our opioid prescribing and provides us with a report.

Another thing that we're proud of is we have a very low-dose opioid environment. Unbeknownst to patients, every patient gets a risk score attached to them, and that helps to drive how often we test patients and how comprehensive the testing is.

Defined, Market-Wide Quality Measures

Our MME or morphine bill equivalents, which is a proxy for how much opioids are prescribed, tends to be about 32. In Florida, it's even lower, sometimes as low as 19 to 21. The CDC came out in 2016 and said that primary care providers should use caution above 90 in prescribing. So, we're seeing a much higher acuity complex patient with doses that are way below the CDC recommendation to any level of concern in our practice.

Market-Level Governance

I've been on the board of physicians in Maryland for seven and a half years. I don't believe I've yet seen an interventional pain doctor, a fellowship-trained pain doctor, come before the board for opioid prescribing issues.

M&A Diligence for the Right Partners

One bad acquisition, especially an acquisition of size, can set an organization like ours back for years.

The first principle we have is to know our partners. We get to know our partners well and get a lot of comfort around our partners. If we don't have the comfort that they're the right kind of people we want to partner with, that they don't have the right makeup, that they don't have the right risk tolerance, that they aren't growth-oriented, then we decide not to partner with them. We want partners who have run very clean organizations, and we want people with whom we think we can work.

A Viewpoint on Private Equity's Contributions to the MSO Market

Choosing the right partner goes beyond financial valuations.

NexPhase was not the highest bidder, but we felt most comfortable with them because, first of all, we liked them, but second of all, because of their familiarity with our industry.

Corporate MSOs as a Preferred Alternative vs. a Feared, Adverse Outcome

Favorable Physician Sentiment. I also interviewed a lot of doctors, and there used to be this apprehension among doctors about joining private equity-backed practices, but I haven't encountered that level of apprehension in the past couple of years. When I'm speaking to doctors, they now seem more accepting of private equity, and I think, to a large extent, private equity is allowing practices to have a level of independence and the providers to have a level of clinical autonomy that they may not otherwise have.

Favorable Alternative to Hospitals. I think that doctors may otherwise be scared and driven into a hospital-based model, and especially in pain management, that's not the most efficient or effective model.

A Counterbalance to Larger Payers. The consolidation of payers, I think, is really driving a good portion of elevated costs. And when private equity-backed practices get to a certain size and scale, they can serve as a counterbalance to large payers.

Background

It's an honor to be with you today. It's a privilege to be here. I'm very impressed with the organization that you've built with the connectivity and educational opportunity at SCALE. So, I'll briefly mention my educational background and then explain my journey in pain management. I completed my undergraduate at Brandeis University and then went on to do a master's program at Boston University Medical School. I took some first-year medical classes and did a research program there. I stayed an additional year after my master's program, focusing on research on Huntington's disease, and worked a couple of side jobs. I was a bouncer in a bar and moved band equipment on the weekends. Probably the most fun year I ever had; I wasn't in any formal education program, made $22,000 that year, and I think I never felt wealthier in my life after that.

I went on to Jefferson Medical College in Philadelphia and was in interested in psychiatry because my dad's a psychiatrist. I quickly realized that wasn't the right field for me. I was thinking about neurology, but I recognized that neurology was more diagnostic in nature and less focused on seeing improvement in patients from my perspective. I was introduced to physical medicine & rehabilitation, where I saw that there was a focus on improving quality of life and function, and that resonated with me. So, I decided to do a residency in PM&R, physical medicine rehabilitation. I did my internship year in Washington, DC and then went back to Jefferson for my residency. The last year, I was chief resident at Jefferson.I was deciding what realm of PM&R to go into for my career when I got introduced to pain management, which was certainly a burgeoning field at the time, and the best and brightest from PM&R were going into pain management. I asked one of the senior physicians what he thought of pain management, and his comment was, "Yeah, there are two kinds of people in this world. There are dead people and people in pain. I think you're making the right decision." So, understanding the total addressable market and pain,

I strategically wanted to be near Maryland or Washington, DC, for my pain management fellowship because I grew up in Maryland and wanted to end up back there. So, I did a fellowship with an interventional anesthesia division of a hospital in Washington, DC. I got my hands on a lot of procedures and then started my career at the predecessor of National Spine and Pain. At that time, it was called the Center for Pain Management. I was one of the first doctors there, one of the first partners, but I decided to leave after four years. I wasn't totally comfortable with some of the business decisions that were being made. So, my wife, who's in commercial real estate, drew circles around all locations; I had a large restricted covenant and we pointed to a small town called Westminster. I had never been there before and ended up going there on a Friday. I decided to buy real estate and open my first office the following Monday. It was hard- to set up an office. I was the first doctor ever to leave National Spine and Pain. It was a very bold move, and I was working really hard. My first kid was born about a week and a half after I started my practice. And then, about eight to nine months in, I was working really hard, making good connections, and delivering good medical care, but the business was kind of floundering. I recognized that and called my wife one day and said, "you need to go up there and fire my manager." And she did. I had four employees at the time. The next week, I fired two of the other employees, so I had a 75% turnover in a week. It was probably the best business decision I ever made. I brought in the right people who created the culture and the work ethic to match mine, and then we were off to the races. We started to open new offices, hired a lot of high-quality doctors, built a very good reputation, and expanded our pain management offering in multiple counties in Maryland. I was very good friends with, not the founder but the leader at the time, of Kure Pain Management. He was actually a resident when I was chief resident at Jefferson. He was at Penn but rotated a few times, so I got to know him a little bit. We started talking a lot and recognized that our businesses fit together extremely well. We had considered merging and met with some investment bankers in 2015 and decided that it was probably too complicated to go to an equity partner and, say, merge us together. So, we decided to let him transact first with his organization, Kure Pain Management. They went forward with a private equity transaction in 2015, and then in 2017, I joined them. Our private equity partner at the time was New Harbor, and that was a very solid relationship. We went to our doctors and other key stakeholders and told them that from our perspective, this was a transaction where it wasn't going to be one plus one equals two. It wasn't going to be one plus one equals three. It was going to be one plus one equals four. Two years later, we went back to the table, and we transacted again at the highest ever multiple at the time in pain management, which I think spoke to the quality of our organization, and we got a 5x return in two years for our partners. So, we had a lot of credibility with our doctors. They were fully bought into the equity model. Since then, we've continued to grow and have expanded into multiple states.

We're now the largest pain practice in the country, and there's plenty of white space. Even though we're the largest, I think we're probably about 1-1.5% percent of market share across the country. Obviously, we're looking to expand, we're acquisitive, and we're well-positioned to open more de novo and acquire solid practices. I think what we're most proud of, beyond being big, is that we've run a very clean practice. We've run a practice that is well respected and clinically well respected from a business perspective, and we are positioned to continue to be a very big player in pain management moving forward.

Describe to me Clearway Pain.

Sure. When we were speaking to equity partners or potential partners in 2019, we met with NexPhase Capital, who is our current private equity partner. NexPhase had a holding in Pensacola and surrounding areas of the panhandle in parts of Alabama, called Clearway Pain. It was much smaller at the time than Kure Smart, which was our organization, but it gave us a lot of comfort that they understood pain management and had some familiarity with pain management. NexPhase was not the highest bidder, but we felt most comfortable with them because, first of all, we liked

them, but second of all, their familiarity with our industry. So even though the prevailing management is based in Maryland, we made the decision to take on the name and brand of Clearway across the organization as a good faith measure and to give the providers and stakeholders in the existing business prior to our transaction comfort that we were going to be good partners. We now have incorporated other brands under the Clearway umbrella. Some of those have wanted to maintain their brand in their marketplace, and we have been okay with that. For example, Center for Pain Management in Alabama, is a very strong brand, so we have branded them as Center for Pain Management to maintain their identity, which is a Clearway company. The same thing happened in New Jersey and Pennsylvania. We partnered with a group called Relievus. We've maintained their name and brand in that market, and we have them positioned as Relievus, a Clearway Pain Solutions partner. In each market, we're going to look at it a little bit differently, but we're not averse to maintaining the identity of the brand if it's strong and there's some affinity to it towards the brand in that marketplace.

Ira, you've worked for others over the decades. You've worked for yourself in an independent practice, you've merged, you've worked with private equity backing now twice, and you've also now led a national leader. How do you view those different paradigms of ownership? Their strengths and their weaknesses? Some of them get a lot more criticism than others. I know there's nostalgia across the country for independent practices, and there's acrimony and distaste amongst journalists, at least for private equity ownership in healthcare. What's been your experience? What types of ownership do you appreciate the most, and what are the weaknesses that you see that each of them offers or presents?

Well, it's clear to me that the right private equity partner can accelerate an organization's growth trajectory. Private equity brings structure, discipline, and financial rigor that independent practices just don't have around acquisitions, for instance. The level of diligence and sophistication is much superior to what you would see in an independent entity. For example, when I alluded to the fact that Kure and SMART wanted to transact back in 2015, we recognized we couldn't do that without a third party coming in and helping to coordinate the effectuation of the merger. So they certainly have strengths around that. I think private equity is also very good at aligning organizations. The executive that can take an organization from two to 10 million may not have the same skillset to take an organization from 20 to 50 million, and private equity can see the capabilities and bandwidth of the executive team.

Also, I think private equity can provide trusted counsel and support and give an independent viewpoint in some of their wisdom, which, again, independent practices just don't have.

Before we open a new center, we do detailed projections and periodically revisit those projections to see our performance versus the projections. These are all disciplines and skills that equity brings to the table that you don't have in an independent environment.

Now, when I was running Smart Pain management was certainly fun and entrepreneurial, but you make a few extra mistakes when you don't have the board and other viewpoints to help guide you along the way. And I think there's this perception that private equity involvement in medical practices is bad and is driving elevated costs. That's certainly not my viewpoint nor my experience. I interview a lot of doctors, and there used to be this apprehension among doctors about joining private equity-backed practices, but I haven't encountered that level of apprehension in the past couple of years. When I'm speaking to doctors, they now see more accepting of private equity, and I think, to a large extent, private equity is allowing practices to have a level of independence and the providers to have a level of clinical autonomy that they may not have. I think that doctors may otherwise be scared and driven into a hospital-based model, and especially in pain management, that's not the most efficient or effective model, and I think that hospitals have some discomfort with private equity because of competition for physicians. The consolidation of payers, I think, is really driving a good portion of elevated costs. When private equity-backed practices get to a certain size and scale, they can serve as a counterbalance to large payers. I think private equity is good at helping to grow organizations and recognize fat, so to speak, in organizations, and to be able to reduce excessive costs and thereby drive profit. I think that a good thing is having profitable practices where physicians can benefit and align with the equity organization, and having the right model where physicians and other key stakeholders can participate in the upside in private equity-backed practice is what allows for success and scaling to higher degrees.

You've been part of the pain landscape for several decades now. Your business has grown and grown to the point where it is a national leader. Along the way, it's been diligenced multiple times by private equity. I personally was involved in one of those due diligence processes myself and still remember how impressed I was with the level of clinical compliance infrastructure and oversight that had been built.

Why do so many pain practices get substance abuse issues and opaque pricing arrangements wrong? It seems so counterproductive, and it seems almost like an anomaly relative to the rest of the industry. What is it about pain practices that they've exposed themselves to that level of compliance risk over the years?

Great question, and I appreciate your comments about your experience in diligence in our practice previously. I think that there's been a paradigm shift in pain management where pain management is now being redefined to some extent as interventional pain management versus chronic pain management. Historically, referrals were being made to pain management in a couple of different scenarios. And I'm talking generally, referrals were made after referrals to surgeons for potential surgical conditions. Well, about 2% of back pain, maybe even less, is surgical. So, for the primary care physician to refer to the surgeon first doesn't really make sense. We can and are happy to evaluate patients or refer them to surgeons if it's appropriate and necessary for them to have a surgical opinion and surgery.

The other big way that patients were coming to us was after primary care providers were initiating opioids and then kind of not managing the pain situation with other tools. To use an analogy, many of the primary care providers were letting the plane take off but weren't really able to land the plane. When the plane got turbulent, then they'd make the referral to us, and that's really not the best place for us to get patients once they're already on opioids. The best way to prevent an opioid situation with patients is not to start a patient on opioids in the first place. Of course, patients may need opioids, but starting the patient on opioids as an early line of treatment before they're evaluated by someone like a pain specialist is usually not the best course; if you're continuing patients for a prolonged period of time on opioids without offering them other treatments is almost always not the best way.

We're now getting patients earlier in the pain continuum. We've positioned ourselves in large part between primary care and surgeons, and we have really been advocating getting the patients earlier.

I think also many primary care providers are now less apt to start patients on opioids and especially to continue to escalate opioid doses. Therefore, we're getting patients earlier as well.

I've been on the board of physicians in Maryland for seven and a half years. I don't believe I've yet seen an interventional pain doctor, a fellowship-trained pain doctor, come before the board for opioid prescribing issues. I've seen a few doctors come before for behavioral issues and other issues but not for prescribing issues. Whereas, before the board, we've disciplined dozens of doctors, especially primary care doctors, for opioid prescribing, not having proper documentation, not offering alternatives, co-prescribing opioids with benzos, excessively, et cetera. I think the re-positioning is really important for our field.

One of the early business decisions that I made in running marketing management before we even had equity involved was to have a strong compliance division and a strong compliance department. And that really helped me navigate some of these complex issues because there are a lot of regulatory concerns and pain management. It is not just opioids; it's running ASCs, it's DME if you're dispensing meds to patients, it's referrals to physical therapy and managing that, etc. The decision I made to build a strong compliance vertical helped protect our organization, keep us clean, let us continue to grow and thrive and play the long game, so to speak. And I think some pain docs have not recognized the importance of having a strong compliance voice at the table, and sometimes they've made decisions for short-term financial gain over building and scaling an organization playing the long game, so to speak,

Bridging that with acquisitions. So, I imagine Clearway has been highly acquisitive beyond pure pain over the years. What are the cardinal rules that your organization won't break when it looks at an opportunity regardless of price?

I think the first principle we have is to know our partners. We get to know our partners well and get a lot of comfort around our partners. If we don't have the comfort that they're the right kind of people we want to partner with, that they don't have the right makeup, that they don't have the right risk tolerance, that they aren't growth-oriented, then we decide not to partner with them. We want partners who have run very clean organizations, and we want people with whom we think we can work.

Keeping our eye on the ball with making sure that we're keeping a clean organization and one that does the right things medically I think is really important for us and we really diligence that part of the business as well. It's not just the financials, of course; you have to have a meeting of the mind on financials and valuation, and there needs to be an upside for everybody involved, but if the other parts don't work if the medical compliance part doesn't work, if the medical culture doesn't work if the business culture doesn't work, then we're not moving forward. So, we will turn down many more opportunities than we get involved with on the diligence side and transact because we need to make sure that we are picking the right partners. One bad acquisition, especially an acquisition of size, can set an organization like ours back for years, and we know that, and we're very choosy in our partners.

Does that translate to extended due diligence processes? I imagine if you see something banked, the whole goal of hiring an investment banker is to accelerate the process. How do you push back on a banker who wants exclusivity periods that are short, closing dates that are weeks away post a signed LOI?

We need to make sure that we have our time to do the diligence that we need to do so we will push back. Again, we can be selective. Right now, in the marketplace, there aren't that many practices that are capable of completing an acquisition of size and scale right now. Some of the other organizations that aren't as big as us but are sizable are either highly leveraged or potentially over-levered, and they are not as desirable as partners as us. We recognize that. So we need to make sure that we have the time that we need to do all of the diligence that we need to do. The diligence, as you can imagine, is extensive before we get to the finish line and effectuate a transaction with a potential partner.

That's a really good point to be as aspirational as a buyer. Instead of a skew towards the seller's benefit to balance it out by being a buyer that a seller actually wants to partner with, it's a good test of how differentiated you are and what the seller's willing to do.

Talk to me about Clearway in the context of the muscular-skeletal space ecosystem. One thing that we see time and time again with all participants in MSK is that they love to become multidisciplinary across the MSK spectrum. So, from neuro to ortho, from ortho to pain, from pain to physical therapy to podiatry, from podiatry to hand surgery, they rarely stay put. How have you thought about what that means as an opportunity and whether it's worth diversifying in that way, looking back and looking forward?

Yeah, I see us becoming more of a comprehensive MSK practice over time, and that means that we would like to incorporate physical therapy on a greater scale than we currently have. We have electro-diagnostics in many of our offices. We want to expand that across our practice to have that in all of our offices. We are repositioning ourselves right now. About 75% of our book of business is spine-related pain, and we are looking to become more of a one-stop shop, so to speak. So, we're able to market ourselves to do more knee pain, shoulder pain, hip pain, muscle pain conditions, and peripheral nerve conditions. So, our capabilities as an organization are there, and we'll continue to expand in that aspect. I don't necessarily see us diluting our pain focus to have it be more of a multi-specialty type of arrangement. We have had discussions about hiring orthopedic surgeons and neurosurgeons thus far. We haven't moved in that direction. That is a consideration, and perhaps that happens at some point, but I don't see us as a multi-specialty shop.

Where I do see us potentially moving is having multispecialty surgery centers, as we're developing more surgery centers. In a couple of surgery centers, we have now partnered with spine surgeons where we have the majority of equity in the center, but we're offering equity to these surgeons, and that's a move where we're going to partner with these other specialties and perhaps podiatry and other specialties. They are not under the practice umbrella but in the surgery center, where we're partners. They maintain their autonomy, and there may be some cross-referrals and opportunities to work together through our partnership at the surgery center level.

Interesting. How large is Clearway pain in terms of the number of states, number of practices, and number of providers?

Right now, we're in six states, and we have heavy density in five of the six states. So, I'd rather have 50 offices in one state than one office in 50 states. We're in six states with heavy density between surgery centers, offices, physical therapy locations, and drug testing labs. We have over a hundred doors now. In terms of the number of providers; it's fluid because, for example, it's hiring season. We just hired a couple of additional doctors just in the past week. We have between 65 to 70 doctors and about 140 to 145 total providers under Clearway right now.

Keeping that divide at the practice level – meaning keeping other MSK physicians away from the practice. What is the concern there? Is it the question of distraction and complexity versus the ability to really fine-tune execution? Is that what's driving that decision? The need to really invest, continue to invest in clinical outcomes and risk management as you scale further?

I think there's so much to do in pain management, and there's so much evolution and growth in pain management. We want to be a focused pain management practice. We want to position ourselves as a focused pain management practice. Again, we're open to some of those partnerships that you've mentioned under the Clearway practice umbrella, but it hasn't been our primary focus right now and probably won't be in the near term where we think we can partner with these other practices in the surgery centers.

It's a matter of just driving outcomes, driving excellence in the pain space, and not entering spaces where we're less familiar, where there's additional oversight and risk.

We also have thought about potential implications for referrals. For example, if we're partnering with orthopedic surgeons in a couple of our facilities in a certain geography how that would translate to referrals from multiple doctors across the entire region if they understand that there may be competition if they make a referral to us by a doctor of the same discipline under the same roof.

When we think of pain doctors and how they're coming out of fellowship now versus even how I came out of fellowship in 2004, these doctors really bring a diverse skill set and are trained to do a lot of high-end special procedures. And many of these procedures have just come to fruition in the past few years. The offerings that we have are many, multiple minimally invasive procedures for back pain, for example, that can conflict with orthopedic surgeons. So if you're a pain doctor and you go practicing in an orthopedic surgery practice, they're probably not going to allow you to do the full scale of pain management offerings that you can often do in a pain practice such as ours. Orthopedic surgeons in our practice may even feel a level of competition from our pain doctors. I can go through some of the specializations of procedures that our doctors are able to do now. For vertebral genic pain, there's a procedure called Intracept that has just come to fruition in the past few years. Endoscopic rhizotomy for facet-mediated pain where patients have not responded to traditional facet rhizotomy. and We're putting stimulator leads for Reactiv8 along the multifidi in the back for ongoing chronic low back pain. We can perform Vertex for spinal stenosis, Minuteman for spinal stenosis, Mild for spinal stenosis, vertebroplasty for vertebral fractures, OsteoCool for painful vertebral tumors. For example, somebody who has prostate cancer has a tumor in the spine may benefit from OsteoCool whereas a couple of years ago, you were limited to providing opioids. Now, you can actually go ablate the tumor. So, we're getting referrals from urologists.Dorsal root ganglion procedures can be done for very targeted neuropathic pain. The technologies in spinal cord stimulation are burgeoning and really impressive. When I came out of fellowship, there were two or three spinal cord stimulator companies; now there are six or seven, and the technologies are really evolving, and the capabilities of spinal cord stimulation are great.

Now, you can put a proprietary treatment into a disc for degeneration, and that has come to our doctors in the past year or two. Sacroiliac fusions can be done for ongoing sacroiliac pain. When I came out of fellowship, we were doing just sacroiliac injections; then, we started doing rhizotomy of sacroiliac joints. Now, many doctors are doing fusions in pain management practices and peripheral nerve stimulation for specific peripheral nerves. So, the offerings in pain management are growing, and I think we need to be able to focus on what we can offer in pain and not dilute ourselves too far. But still, as you mentioned, we need to be open to some of those potential partnerships if they make sense for all parties involved.

It's very exciting that the way that pain continues to reward you, as long as the principles that you maintain are the most important over time. And it seems like that's exactly the relationship you have with the pain category to the point where you've become the aspirational buyer. You are the buyer that a practice wants to see walk through their door when they're looking for a partnership. When you look at six-seven different growth opportunities that Clearway has in front of it - value-based care, strategic partnerships with health systems, ASCs, new patient markets, new geography, new procedures, new payer categories such as targeting the self-insured, other ancillary revenues that are underdeveloped, clinical research, the use of technology, etc. There's a long list of potential ways to grow the business, and many that I haven't named. Which one gets you most excited and why?

I think what gets me most excited is the evolution and growth in surgery centers, building surgery centers, and watching them succeed. For us, having done this so many times, it's a relatively low-risk endeavor with a high reward.

I think that our core competency is ASC development. I think the procedure shift and watching the young doctors and some of the experienced doctors advance their skills is really exciting to me. I also love the fact that we have redefined ourselves, and we are no longer seen as people who just manage opioids and work to reduce opioids. We're now, at least from what I can tell, seen very much as part of the solution with regard to the opioid problem in this country. We also are seeing fewer opioid patients coming to us on fewer opioids, which is exciting to us. And just giving context to that because made that comment a few times during this question and answer time, we have an external vendor that looks at our opioid prescribing and provides us a report. In Maryland, for example, our MME or morphine bill equivalents, which is a proxy for how much opioids are prescribed, tends to be about 32. In Florida, it's even lower, sometimes as low as 19 to 21. The CDC came out in 2016 and said that primary care providers should use caution above 90 in prescribing. So, we're seeing a much higher acuity complex patient with doses that are way below the CDC recommendation to any level of concern in our practice.

Another thing that we're proud of is we have a very low-dose opioid environment. We have a whole paradigm to recognize when we should test patients. Unbeknownst to them, every patient gets a risk score attached to them, and that helps to drive how often we test patients and how comprehensive the testing is. We continue to have that low opioid environment with a nice procedure shift and driving volume into surgery centers. I think that's what the future is for us in large part, and I think what gets me most excited is opening new centers, especially new surgery centers, and making them centers of excellence with broad offerings.

When you were talking about at the end in terms of opioid use, I didn't hear any kinds of partnerships or programs that you had for mental health or addiction management. I'm assuming that you are seeing some drug seekers and that you're trying to figure out what to do with them unless you're taking care of that yourself. Everyone has them, but my assumption is you probably have more so than most other practices. How are you addressing that? Are you partnering with and finding help for those patients, for those kinds of services that you may not provide?

We don't want to be a practice that does addiction treatment as well. We made that decision a long time ago. Now, there are a few patients here and there where we're prescribing suboxone, but it's not a core focus of our practice, and it's not where we want to position ourselves in the market. So if we have an abuser that is noted on drug testing, sometimes, depending on the level, we'll just discharge a patient and provide them referrals to others that we think are better equipped and more suited for that individual patient. Very often, we will let the patient know that we need to wean them down and that we will no longer prescribe them opioids and send them a letter reflecting and memorializing that, and then also make a referral to a mental health provider that can help them cope with the reasons and understand the reasons for them. Early on during my practice, I did have a psychologist who managed many of these issues, and I felt eventually as though it was probably best for us not to hire a small army of psychologists and manage them but to have resources that we can point to for our patients and make those referrals. We have a psychologist in-house who does mostly spinal cord stimulator evaluations and clearances for us and periodically will help in this realm, but he's primarily focused and busy on spinal cord stimulation. It is important, and I fully appreciate the question, to get these patients to help they need, but we've made the decision that we don't have to have that necessarily under our roof.

In your network, are you using so-called pharma-grade or European-based cannabidiol or CBD to be used as a non-opioid alternative?

We are not. I personally am not averse to that at all, but it's not something we're doing right now, and I think that's something that we can evaluate and be open to moving forward.

I want to double back on this question of opioid addiction and the statistics that I saw. Maybe they've changed since I last read about it, but there was something like 2 million addicted to some opioid-type substance here in the US, and from that, tens of thousands die on an annual basis. Have we peaked in terms of the opioid crisis? Has the clinical community been able to absorb the reality of this point and build the infrastructure to try to mitigate those numbers? What should we anticipate over the next ten years?

Now, keep in mind that many of the opioid deaths that are cited there are not tied back to opioid prescriptions from doctors. I know that people point back to the medical community and doctors as prescribing opioids as a big contributor to the problem, and it certainly is and has been a problem – and, more so years ago, since the level of opioid prescribing is down significantly.

The medical community's contribution to the problem is reduced, which is phenomenal.

Being on the board of physicians in Maryland, when we looked at this number of years ago, we saw that actually 68% of the opioids in that state were prescribed by primary care providers. So, tampering down on opioids for all providers, I think, is a good thing.

Again, many of the deaths that are cited there are not tied back to opioid prescriptions from doctors. You can get opioids from many different places. There are certainly drugs coming across the border. There are drugs you can get online and drugs from many other places. I'd say the medical community's contribution is less now certainly than it was five to 10 years ago.

When I was training, there was a philosophy that pain is a fifth vital sign that you should treat to the effect that you don't necessarily worry about overprescribing opioids. If patients are complaining of pain, you should continue to titrate up until you satisfy their pain with opioids. And then there was a recognition that was a flawed philosophy that the level of opioids needs to be less. In fact, many times opioids are not indicated or not helpful in chronic pain situations. So early on in my career, it was not that crazy to see patients get 30 milligrams of oxycodone for breakthrough pain. I remember when I was practicing near Hopkins; sometimes, we saw patients even coming from Hopkins at 800 milligrams of morphic equivalents. Now, it would be exceedingly rare to see a patient on 30 and even 15 milligrams of oxycodone for breakthrough pain. I think the dose frequency of opioids is much less. So, I'm comfortable with where we are and where we're heading. I'm certainly uncomfortable with where we were as a medical community and now in society beyond the medical community component. It absolutely continues to be a big problem and one that I think, as a society, we need to continue to work on and do better.

It seems like we're left with a massive recreational drug use problem and almost a disconnect among users of the true risks that they face engaging in this type of drug use. It seems like we go through different waves of drug use and some drugs, depending on whether it's the sixties with LSD or the eighties with crack cocaine or now with opioids - at every stage, it takes a while for the older generation, the parental generation, and the younger generation to appreciate the extent to which they really can't afford to take those kinds of risks. So, it seems, we're still in the middle stages of understanding the true extent of opioid hazards.