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Exploring How the Emergence of Scaled Corporate MSOs Could Impact the Life Sciences Ecosystem

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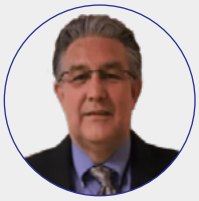

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Key Takeaways

The emergence of multi-site corporate MSOs has cascading impacts across the life sciences market.

Large scale corporate MSOs are emerging as viable players in the life sciences ecosystem. Whereas med tech and pharma companies were primarily focused on their relationships with health systems historically, corporate MSOs are also becoming credible partners.

Given that physician adoption of new devices and drugs is so critical to ultimate commercial success for these products, corporate MSOs can sometimes present an even more direct pathway, relative to working through hospital administration, to early physician feedback on the merits of contemplated new innovations, as well as physician engagement and buy-in for ultimate product commercialization.

Expect to see more corporate MSOs forming innovation and / or life science strategies, which may include:

- Corporate MSOs forming their own GPOs to work directly on drug purchasing. Precedents in the oncology space are abundant and this is expected to occur within other drug-heavy markets as corporate MSOs scale.
- Corporate MSO adoption of new medical devices and / or clinical research trials.
- Innovation requires dedicated supporting programs and infrastructure. In this sense, corporate MSOs may face challenges relative to hospitals given their, often times, thinner corporate infrastructure and competing corporate priorities. That being said:
  - New technologies are, in some cases, helping to reduce the barriers to new innovation adoption. For example, 3D printing of a new casting technology is allowing a broader portion of the physician market to adopt the latest casting innovations.
  - Intermediary interlocker organizations that can help MSOs solve specific challenge / objectives by linking these MSOs with life sciences companies offering relevant solutions. "Most people who run healthcare organizations do not have time to come to pitch deck sessions, to come to online startup showcases, and to attend 7,000 conferences a year."

Background

Suzy Engwall:

I have been working in healthcare for almost two decades. For the first half, I really tried to make changes from within hospital systems in the performance improvement arena. I became frustrated with never having any investment money or any new technology or any staff. So, I moved over to the innovation side almost ten years ago. I never looked back. I love healthcare innovation and everything about it. I mostly work within MedTech today. I work with startup companies, as well as with hospital systems to help them develop and integrate new innovation programs.

David Reese:

I am a pharmacist by background, so my contributions to the life sciences component are everything pharma. We'll talk to that a little bit later as we go through the call today. As for my background from a pharmacy and experience standpoint, I've been in the pharmacy realm for 35-plus years. I've had the opportunity and the good fortune to spend a lot of time focused on specialty pharmacy. I was afforded the opportunity to get involved in that in the early nineties. So, I have seen the true evolution and growth of the term into specialty pharmacy into what it means today. A lot of my experience was within the oncology space, so I look forward to sharing that experience as we continue to move through this discussion.

Interview

If you are a healthcare service company CEO - a large multi-site provider business regardless of type of specialty - why take an active interest in either med tech or pharma life sciences? What's driving that interest, particularly if you have an ambulatory outpatient focus?

On the MedTech side, what drives all of this is that we are behind as an industry in healthcare and we need a lot of change. I'm sure most of you who work in healthcare can look around at any given moment and find 20 things that need to be changed or need to be better to provide better care for patients and make lives easier for our clinicians and physicians. So, from my perspective, that's really what's driving it; whether it's an inpatient setting or ambulatory setting, there are so many things that need change. And I do think that nowadays, we see a lot more drive to make sure that we're keeping people out of hospitals. And I think the best way we can do that is by working with a lot of our providers and other folks in those ambulatory settings to get new products to market, to really help these patients and to help keep our costs down, to keep healthcare costs low for everybody.

Moving from theory to practice sounds good, but you deal with MedTech's new devices day in and day out, as well as every aspect of the lifecycle of MedTech, from conception funding to research to regulatory approval to commercialization. When it comes to commercialization, should one assume that it's really up to health systems to either adopt or reject new medical devices and then their respective GPOs, and providers, will through health system exposure bring those devices into ambulatory outpatient settings and promote the use of them inside those settings?

I think in today's world, most startups will take their offering - and it really depends on the device and the product that they're making - but most of the time they're looking to sell directly to hospitals first and then hoping that it gets adoption from the physician groups. Although nowadays, the landscape is such that we've got these IDNs and GPOs that a lot of folks are purchasing through, and we see physician groups making those decisions on their own, not necessarily having it being driven by hospital administration. So, I think there are multiple ways to get a product to market, and really, what it's going to come down to is what is the best fit for your product, what is the easiest entry point, and who's going to adopt the product?

There are two sides to the coin with hospital systems: hospital administration can make the decision to buy a product, but if the physicians don't like it and don't adopt it, then it doesn't matter. So, it's a pretty loaded question. I could probably talk about it for the entire hour. But what we really have to do is take a very strategic look at each product that's coming down the pipeline to figure out what the best place for it is. One good example is that, at one point, I was working with a team on a brace for kids with toxic cerebral palsy, trying to help them stem their tremors when they have things they need to do with their hands, such as write at school. That's probably not a device that we would take and sell directly to a hospital system and just hope it gets farmed out to the kids. It would really be something that's done at the provider level where we're making it available to the provider, and the provider can then basically prescribe it to the child or give it to the child within their facility. So, these products can go on a lot of different paths. The majority of them will likely go through a GPO if they're a MedTech device. Not always, but it really is going to depend. I've got another company right now that's making, instead of the old school traditional casts, she is using the same plastics that they use to make Legos and their 3D printing casting right there in physician offices. That can be done in multiple settings. They can also produce things like splints. So, if you're in a specialty office, you can have a splint made right there for you. It's a really interesting concept, and I think that there's no one right answer to what the best path forward is when you're commercializing the product. It's really going to depend on the product, who's going to use it, and who's going to adopt it.

If I'm the CEO of a startup med device business and I've gone through all the first four or five obstacles and now I'm ready to commercialize my product, I'm probably very limited on resources and experience when it comes to building a sales team. I'm grateful for any GPOs that are willing to represent my product, and I'm thinking about the limited shots I have on goal. I want to make sure that a large health system picks me up as opposed to diluting myself with thousands of individual practices. The question I have is, as these practices have migrated towards multi-site MSOs, if I now represent a thousand providers or even 300 providers in a certain specialty or even a hundred providers in a certain specialty, I may be as large as a system with 3, 4, 5 hospital units in that respective specialty. So, it may be time for MSO leaders to reach out to GPOs and request the same level of service and "first look opportunities" at the best new devices that are out there.

Yeah, absolutely. If they're not already doing that or if they're not getting a look at those things through whatever health systems they might be working with, it's definitely time for that. More than anything, you've got to take the bull by the horns and learn about what's out there, and there are a lot of different ways to do that. The GPOs can provide you with a wealth of information. There are other products out there as well, but I think the more that we can get people to understand the new technologies and implement them, the better off we're all going to be. Absolutely.

David, what are your thoughts on the commercialization stage and the role that MSOs might play further up the lifecycle stage?

A lot of the same similarities. I have lived and experienced this directly, working for a large MSO with over a thousand oncologists across the country. And, you're right; it's size and scale. Do you build out your own GPO because of the leverage that you potentially hold with pharma to do your own price negotiations and term negotiations, or do you need to fall back to start with and use one of the existing GPOs that already resides within your distribution organizations? It is just a matter of what your time and resources will allow you to do and, honestly, what your return on investment can be by choosing which path to go. I'll throw in there as well from the pharmacy standpoint, the medication standpoint, it's just not a matter of gaining access to the product and knowing you're getting the best price or most competitive price possible, but you also to understand what's happening on the payer side.

That's extremely important to understand, as a provider, as the management organization of a network of providers, what each one of those regional provider groups is dealing with as it relates to their payer relationships.

There may be a product that the payer says, yeah, it's not on our formulary. Even if it's a brand-new innovative product, the payer may feel that it still has other products that are more competitive and more effective. So, you also have to ensure that everyone understands how to overcome any potential patient access barriers relative to how the payer, the PBM, is actually managing the product from their perspective in this complicated world of getting into the product to our patients.

The role of drugs within MSOs is well documented. The revenue opportunities presented through infusion and pharmaceutical purchases and the importance of getting them right within MSOs are also well-documented. What I'm curious about is that as these MSOs become larger and more mature as businesses, they can look at health systems and their approach towards new drugs, not just negotiating lower prices on established drugs but adopting the newest drugs. Do health systems look at that as a competitive opportunity to form, to combine not just the role within clinical trials but early adoption, early awareness, and the goodwill that's generated by adopting something that's straight out of the FDA approval process?

So, I guess it just depends on how vertically integrated they are. If they also have large physician groups that are embedded within the health system as a whole, then absolutely they've already got that channel to adopt a product, a brand new product right out. But, in my world, relative to specialty pharmacy, a lot of times, a lot of those products aren't necessarily an inpatient health system type product. They are more embedded in that outpatient community practice realm relative to their use where pharma wants them to be used. Definitely, the payers want them to be used in a more outpatient setting than inpatient settings. Again, there are starting to be multiple examples where, particularly with specialty pharmacies, specialty pharmacies actually negotiate directly with pharma companies to handle

all the direct distribution and direct dispensing to patients for a particularly new molecule. Again, several examples in the market where you've got specialty pharmacies, that's their niche, that's their specialty per se, is providing those new products.

Take US Oncology as an example. Think about their management team there and the newest drug out there that's relevant to their range of treatments, and their ability to (A) be aware of it, (B) purchase it and (C) maybe be engaged in some kind of exclusive relationship with a pharmaceutical company surrounding that drug. Do those types of conversations happen at US Oncology, or are they simply part of a pack of oncology groups that purchase drugs almost on a commodity-type basis?

Absolutely. I participated in that and was in the thick of multiple new drug launches by pharma and ensured that US Oncology basically worked to be ahead of the curve on how those products would be adopted and then utilized, whether it was utilized within the cancer centers, the clinics themselves as a buy and bill product versus through a pharmacy where it was dispensed directly to the patient by the pharmacy. US Oncology could be looked at as an outlier because they literally severed a distribution relationship with one of the big three distributors back in the mid-2000s and opened up their own distribution center. They wanted to control that channel. That was just another channel that they could control, extract value associated from and, more importantly, create an internal service and internal quality component that the US Oncology MSO could sell back to their physicians as a reason why you're aligned with the company – i.e., this is how we can continue to grow, evolve, and allow you to continue to grow and evolve as a practice in your community and in your region where you practice at.

An example of an MSO becoming its own GPO on behalf of its own practices.

Absolutely. Again, I've got several examples now. US Oncology probably set the template for that, but there are multiple groups, large MSOs in the oncology space essentially, where they've established their own GPOs internally - American Oncology networks down in Florida, OneOncology, you can go down the list of the ones out there who have done it. And it's interesting, that not only puts them in a position to support their own affiliated practices that are part of the MSO, but it also becomes another channel that they can also use to compete with the existing GPOs. You don't necessarily have to be a full-blown managed practice, but you can also have the ability to open up your GPO to where you're driving additional volume through your GPO, which ultimately leads to more value being extracted from the volume component of the drug you're buying.

It's interesting that when we think about revenues from both drugs and devices that might benefit an MSO, there is an inherent revenue component associated with things like infusion and things like clinical research or initiatives like building your own clinical research in-house capability. And there's the concept of the end user of the patient and their adoption of both devices and drugs and where you fit into that supply chain. But there's also this opportunity to think about the formation of a GPO that is also an available opportunity the further you dig into both drugs and devices, and in building a GPO, you build capabilities that may bring you closer to the newest, best devices and drugs that are out there, which in turn might benefit you in many other ways as well. How should an MSO think about building clinical research capabilities? Few have scaled it substantially. The clinical research space has really changed a lot over the past few decades, from hospital-based health systems to health systems plus independent outpatient. So, in that context, where do MSOs fit into a clinical research discussion?

From my perspective, we see these innovation programs popping up at hospitals everywhere, and a lot of them are closely tied to their research departments, although there are some hospitals that don't have a lot of research that have innovation departments as well. How do we get these resources that are needed for research innovation down to the provider level? How do we leverage MSOs to implement robust services that folks who are innovative or entrepreneurial can really take advantage of? I think one of the great ways to do that would be through the MSOs providing things like training and education about how to get a product to market, providing resources where they can have access to facilities that will help them do the research that they need to do that. Partnerships with universities, things like that. In the last ten years or so, we have talked a lot about innovation inside hospitals. But a lot of these physician groups are not able to access that through a hospital connection, and even if sometimes maybe they are, they may not be able to access that type of innovation in the way that they want to. How do we leverage MSOs to create some really great and robust innovation programs that the providers can take advantage of? And I think that's where you start to bring all of this together Before you can even get to research, you've got to have something, right?

What is it that I'm building? What problem am I solving? And I think there's nobody better to talk to about the problems in healthcare than these providers who are working hand in hand with patients every single day.

David, what are your thoughts about clinical research capabilities within inside MSOs? Have you seen it developed effectively over the years? What are your do's and don'ts?

One of the halves of US Oncology was the MSO that came out of Texas Oncology. We were called Physicians Reliance Network, and essentially, the internal research program that was built and ultimately rolled up under US oncology, was actually done at PRNI. We use this term clinical research every once in a while. It's not for the faint of heart. It requires resources, it requires investment, it requires discipline. Again, it just depends on what kind of studies you want to run to have to make available to your physicians. Is it phases three and four, or are you looking for phases 1, 2, 3, 4, all the way through basically the life cycle of actually getting a drug to commercialization? The opportunity there requires commitment and will require some resources, but at the end of the day, as you build out your actual study protocols, things of that nature, obviously that's where you generate the whole economic side of it, make it worth the effort and allow and provide your physicians with access to studies that may be more difficult for them to get access to if they weren't part of an MSO.

I think a wonderful guiding light here of what's possible is provided by the health system landscape, large institutions that didn't used to be large but became large over many decades and expanded into areas like clinical research in concert with the provision of care. They used to be provider-based organizations. They became provider-based organizations, plus research, and then the benefits that derived from that. It doesn't mean that it always worked. It doesn't mean that there weren't key differences between health systems and MSOs' built-in clinical research operations. But it is a guide of sorts in terms of what's possible, especially when we're thinking about life sciences. Another component to the clinical research piece within health systems, which we've seen developed over the years, is the expansion into venture capital within health systems. Health systems building their own venture capital funds, sometimes in partnership with other GP/LP entities that have a history of venture capital, and other times independently. Do you think that that's a logical extension of where larger MSOs will go as they go down the life science continuum?

I hope so. Hospitals operating these venture arms each operate a little bit differently. Some of them only invest in things that come out of their own world or their own ecosystem, and some of them are looking to invest elsewhere. But I think when I look at the ecosystem as a whole, the hard part with getting new products to market and getting new innovative technologies in the hands of physicians and in the hands of patients where it's needed is that there's this big disconnect. The entrepreneurs are over here building things on their own kind of head down, maybe talking, hopefully talking to end users to make sure the product has a great product-market fit. Then they get to the point where they're like, okay, now we need to pilot, but we don't have any relationships with hospitals, and we don't have any relationships with people who can help give us capital to keep this going. And then they've got these hard challenges; they're banging their head against a wall. The nice part about having these funds flowing through the healthcare ecosystem or aligned with hospitals is a lot of times, if they like technology, then all of a sudden you get that pilot and that funding built-in together, which I think can really accelerate the time to market for a lot of these very much needed innovations. I would love to see the MSO organizations having these types of venture arms and having places for people to come in and test their products and make sure that they can get pilots in a way that's really beneficial for both the provider and the founder of the organization. I think it could really help accelerate things.

I think it could really help physicians to actually play a part in innovation as well, to really give them a place and some funding to get ideas and products that they have out there.

I think it's going to be really important as we move forward to make this easier for people. I'm a huge advocate for figuring out how we can pull funding together for the physicians and the founders at the very, very earliest stages. The other thing these founders need is a place to really get feedback on their products. And if you can have some type of venture fund tied to an MSO that's also tied to those providers that are starting to work with people in the innovation ecosystem that's bringing in the founders, I think you could really set things up for success and really escalate time to market.

The average MSO CEO is dealing with staff-related issues, payer-related issues, logistical issues, and practices that are closed due to bad weather. So, there's the day-to-day, which is highly time-consuming. Then there's the medium-term change in ownership through private equity funding that requires a view that is limited to roughly five years. And we're talking about building venture capital within MSOs to fund life science initiatives. We're talking about initiatives that would take quite a while to build, and then once built even longer to actually monetize, to actually create new devices and new drugs. We're talking decades. I think it's a beautiful thing to have a long, long-term vision for some components of your business that you can work towards, but it's certainly noted that for many CEOs, that's going to be a luxury, not necessarily something that they can afford to spend time on. The group that you described that offers as-needed clinical training for the adoption of new devices. Can you just share more about this group with us?

When we leverage that group, it's a group called the Clinician Exchange, we typically will work with them because they've got thousands of physicians that can give feedback on products, but that can also partner with a product to help leverage and deploy a product into a hospital system. So instead of a small company having to hire a whole slew of salespeople and then just wait for something to happen for them to go out and provide the sales training and everything else that they need to do, we can leverage these folks, give them the training they need in a short timeframe, and then they can go out and train the trainer, so to speak. So, there are a lot of ways to leverage these types of fractional resources in this space, which I think would be very beneficial to MSOs. But even on a more level playing field, I think it would be great for the MSOs, in general, to start offering pieces of innovation programs that the CEOs don't necessarily have to lead, but they can leverage those resources from the MSO and pull those in. So whether it's, "hey, I have this problem in my practice, and I need to find a technology, I need to do an innovation challenge to find a technology, can you help me?" I feel like MSOs should be offering those types of services at some point. We are offering other types of services, so why not offer these innovation capabilities? And there are so many ways that you can customize them so that it's not overwhelming for the practices that you're working with.

In an area where differentiation becomes easily obtained versus the provision of a service, it is sometimes harder to highlight key differentiation attributes. So, there are benefits to trying to spend time and resources building these kinds of capabilities. And to your point, it is interesting when considering the biggest obstacles out there that one fears before one spends time in life sciences, to remember that this is an existing ecosystem. You're not the first med device provider that has had to solve for things like distribution, solve for things like clinical research, solve for things like training. All these problems have been faced by many thousands of innovators in the past, and so there is an ecosystem waiting to be adopted. David, what are your thoughts on listening to all that?

The experience, and I guess the leverage, that US Oncology brought to the table was as pharma with a new molecule. Many times, US Oncology had also done the pivotal studies that allowed the commercialization of those molecules. But that said, pharma was essentially required to channel that launch strategy if US Oncology wasn't already directly helping them with that launch strategy; they had to channel that through basically the MSO, and then it was our job as resources of the MSO then to come up with what the internal launch strategy for that new product was going to be. Basically, that included training on what was going to happen when a new patient was prescribed that medication. And again, what that did was that you created the internal efficiency on how new products got adopted. It allowed for more rapid adoption of new products because if you didn't do that, then you could end up with three or four new products per year, maybe five in the oncology space, and you'd end up with five, six different groups that were coming to you trying to get out to all your practices, et cetera, to get that information in their hands. And we just said, yeah, time out. That's just not efficient for us. It's not going to drive what we believe is a great product and innovation in the treatment of cancer. So, you got to channel that through us. So we are there, we're doing that driving, and oh, by the way, we will show you how quickly we are adopting and the progress that we're making on getting your product into the market and into the patient.

I think this space lends itself to a lot of physician-clinician goodwill opportunities. Both in terms of early adoption of best-in-class new solutions, which I imagine is generally greatly appreciated, as well as in terms of participation in clinical research, which is going to be highly appealing for a certain subsect of the clinical staff. And lastly, in terms of potential investment opportunities, which obviously is a slippery slope when things don't pan out, but again, for some clinicians, the ability to participate in an MSO fund is another - it would be considered a plus. And I know that hospital health systems have been looking for ways to develop further goodwill, loyalty, and long-term relationships with their clinicians and have explored these avenues for years. How is the environment changing for life sciences from a competitive perspective, regulatory perspective, and technology perspective. So what would a new entrant into life sciences expect to see happening over the next few years that might give them pause for thought and might give them reason for optimism?

I think a lot of what's going to happen over the next few years is going to be dictated by the types of technologies that are coming to market. I mean, five years ago, we weren't talking as much about things like AI. We were talking about robotics, but maybe not in the same way.

I think as technologies emerge, the industry has to find ways to keep up with that. And I think right now, people are trying to figure out how we focus.

There's a huge focus on AI. We all know that and how do we figure out the best way to not only leverage it to make it better for hospital systems but also regulate it so that we're not doing unintended or we're not ending up with unintended consequences that may damage the ecosystem, damaging practices. There's got to be multiple ways of doing things. I think we're going to see things changing based on the types of technologies and the level of sophistication that we're looking at. I still think there's a lot of

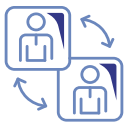
bureaucratic red tape; some of it is necessary, and some of it is not. I do hope that even as we start to see things like AI doing things that maybe will help speed up time to market on the ways that we evaluate different technologies, it's going to be interesting, I think, next five years, there's a lot of great things that I think we're going to see coming down the pipeline that may change the way that regulatory needs to work. I don't see a lot of changes right now, and maybe that's different on the pharma side, but it's going to be interesting to see. And I think as we start looking more toward even the funding side of things, there are shifts in the way that companies are being funded and the way products are getting to market now, where five or six years ago, or especially right before the pandemic VC was the big thing, and now people are turning more and more to private equity. They're turning more and more to family offices, more angel investors because the VC landscape has sort of dried up and maybe in what was needed as a correction because a few years ago, they were pouring money into companies, and a lot of times it just didn't make sense. So, I think that the biggest shift you're seeing right now, at least for me, is on the funding side of things. I still see a lot of the same things happening in the regulatory space and in the manufacturing space. But I don't know.

I do think AI might help lower the cost of research substantially, accelerate the findings of research, and substantially improve the value of that research. I think that's exciting. Where I scratch my head is that you still end up with patient trials, which are incredibly expensive and very drawn out, and then you still end up with regulators as your partners in those patient trials. Regulators are incredibly expensive and incredibly drawn out. So, I just don't know how AI fixes that problem. David, what were your thoughts?

I would reinforce that on the pharma side, the AI component, as it starts to get embedded inside pharma and particularly how it's applied to the research side will change the process for discovering new molecules. What I know is there is no way it cannot make at least the identification of a molecule of an agent more efficient than what they've been doing in the past and how it's been handled in the past. There's been a certain search strategy applied to agents and chemicals over the years. Okay, we looked at this drug, this chemical, 20 years ago; now let's look at it again. And again, there are search engines, and there are engines that go out and do that. With AI, that process of trying to find those quote needles in a haystack, the hope is that that will absolutely change the landscape of how you can go back and look at different molecules as they play out. I think in the pharma space and the new drug space, it's obviously high stakes and can be a high return on investment area, a lot of dollars. So yeah, the competition is fast and furious. The ability to be efficient relative to how we could support an MSO, how we could support the capital arms that are looking for opportunities, is what I think can start to differentiate us and separate us from some of the existing players that are already in the field and all.

What does your process look like when it comes to filtering, introducing, and adopting new medical technology? I would assume it's working closely with groups like incubators, accelerators, and investment groups that are focused on life sciences and health systems. And then the second part of the question is, do you work with, or how often do you work with MedTech that is pre-FDA approval?

It's interesting because there are a couple of ways that we can go about things. When you're early on, the best indicator of what I think is going to go the furthest is really looking to, number one, is the idea is a good idea to truly meet a need. And number two, does the founder have the resilience, flexibility, and humility to listen to what other people have to say to make their product get to that great product market fit? So the first thing I'm looking for is if I think they're going, they either have or are going to get to product market fit. That's the first thing. When we get to the point where they're FDA-approved and ready to go out to market, I'm working with several startups that are already on the market. In fact, one just got a contract with the hospital system last week. It's really about where I see this product fitting into the market. Who do we need to approach? On the other hand, I try not only to work with startups but also with health systems in multiple different ways so that I understand the challenges that they're having. I would love to partner with MSOs to do this, too. What are the biggest challenges you have? Let me go out and tell you if their startups are already working on this and what things you could adopt and try. That's really the best way to make these arrangements. Most people who run healthcare organizations do not have time to come to pitch deck sessions, to come to online startup showcases, and to attend 7,000 conferences a year. How do we get these technologies in front of them in a way that makes sense?



The best way to do that is to partner with somebody who understands your strategic priorities and your biggest challenges. Then let's go out and source for those instead of having you just sit and hope you find a technology that makes sense to you.

I think that's really part of my process. The other thing that I'll do even at an earlier stage is if there is nothing out there that meets the need, I had a health system here in SoCal call me a couple of weeks ago, and they said there's nothing on the market for this problem we're having, and we have an idea. Can you help me find somebody that can make a prototype? And I need a textile guy. So, how do we find the right people to help solve these challenges? So I hope that answers the first part of your question. Then tell me again what the second question you had is.

The second part is how often you work with groups that are pre-FDA approval.

That's probably the majority of the people that I'm working with. They'll come to me, and I sit down for 30 minutes trying to understand what they're doing and where they want to go, what their target market is, and what kind of resources they need. And then, if I can't provide them with those resources, I will find them someone who can. So that's one of my areas of expertise. I would say I'm more of a generalist in this field. I don't only help on the sales side.

I help with so many other aspects of what the startups are doing, and I'm really good at helping them find the right partner, even if it's not me. And that's really the goal: how do we work together?

How do I work with other consultants in this crazy ecosystem to make sure that these startups are getting the best guidance?

Can you speak to some of the engineering and manufacturing capabilities that you've been able to bring to bear on occasion?

So, I try to partner with folks that I know are really great and that work well with startups. And it's very interesting because I've got one guy, for example, here in SoCal. A lot of the work that he does is based on sensors and laser technologies. He does a lot in the ophthalmology space. He's got this nice little niche that he's carved out. I work with another group up in the Puget Sound area, and basically, all they do is textiles. And when I say textiles, I mean they're finding or creating or inventing these amazing fabrics. Back in the day, they used to only work for professional sports teams and make things that you and I don't have access to. So they're creating things out of textiles that can be used for healthcare. They actually created a whole healthcare group around this. So there are a lot of people that will come to me and say, "Hey, I need prototyping, but I need this specific type of thing." So trying to find the right specialists for that. And then I also work with groups like one group in Costa Rica that does manufacturing and distribution, and what they do is they've got, they've got this economic development corporation that I can call them and say, "Hey, I need manufacturing within North America. Can you help me?" This is the exact thing that this company needs. And they can go out to all of this slew of manufacturers and distributors and say, here's what this company needs. Can you help? So, everything from sterilization to becoming their manufacturing partner for North America is really just about tying this ecosystem together, so we've got great resources that we can leverage for all of that.

A good example of how anyone involved in new med devices is going to come with their suitcase full of prior proven capabilities. Whether it's a large accelerator fund, a VC fund, or someone such as yourself who really loves to consult and develop these young companies - you're going to come with capabilities all across the world that will move things along. And it's important to note. David, I want to turn to you on that question as well, the due diligence selection process on the new molecule. Are there certain things that you look for at different stages?

The first thing you're looking at is it is truly a new innovation from a treatment standpoint. Is it filling a gap that just does not exist? And in my mind, that's kind of check box number one. If it's a new drug that is going to go into a space that already has some treatment options, the question then becomes, okay, how's this treatment going to differentiate itself from existing treatments? And I'll be the first to admit that. Sometimes, I put the clinician hat on, and when I see a new drug, and they advertise, and it comes out, and well, it adds ten days to life expectancy. Something that I really question is sometimes, but that is what it is. But at the same time, something comes out three months, six months, again, that starts to say, okay, this is new. This offers true differentiation relative to the science. That really upfront initial science that's coming into play as it relates to the new medication that you're looking at. And then you start to think about, okay, what's this going to mean down and upstream? What's the payer going to say? How will this product be distributed to the provider? What provider is going to actually provide the product? Is this going to be a product that's provided by the physician in an infusion center, or is this going to be a product that basically gets channeled to the specialty pharmacy marketplace and will be dispensed directly to the patient? Again, those are all kinds of the food chain, the supply chain per se, that comes into play with a new pharmaceutical, and then ultimately, how it goes from the science to the actual patient.