Podcast Episode Transcript: Matt Sakumoto

Travis Bias: Welcome to 3M's Inside Angle podcast. I'm your host for today, Travis Bias. I'm a family medicine physician and currently chief medical officer of the Clinician Solutions Business housed within 3M's Health Information Systems Division. In February of 2020, less than 1 percent of all patient-physician visits were conducted via telemedicine. Within about six weeks, that number was 32 percent, thanks to the COVID-19 pandemic lockdowns. Health care, already decades behind most other sectors technologically, was dragged into the future. Was this a blessing in disguise? Will this amount to a blip on health care's historical radar? If you're a patient, what has been your experience with telemedicine? If you're a physician practicing any form of telemedicine, how do you think patients would rate your web-side manner? Today, I have with me Dr. Matt Sakumoto, a virtualist primary care physician at Sutter Health in San Francisco. He is also fellowship-trained in clinical informatics at UC San Francisco with a focus on virtual care and provider efficiency tools for the electronic health record.

Matt and I were colleagues during the first year of the pandemic where we took care of patients almost fully through the use of telemedicine, delivering primary care, testing for COVID-19, advising on a wide scope of issues for mental health to acute illness to prevention, such as screening for diabetes, hypertension, and sexually transmitted infections. I saw how this could increase access. I had a patient in far Northern California who had had a tough time finding a primary care physician for whom I was able to refill many necessary chronic medications. I had another patient having difficulty accessing mental health services, and I was able to counsel her from the privacy of her car. I've seen how this kind of access can prevent hospitalizations and emergency department visits.

Yet, telemedicine is far from perfect. There are some studies showing it may actually increase costs in utilization since we're catching folks further upstream from exacerbations of their illness that may have previously prompted a trip to their primary care physician, an urgent care facility, or an emergency department further down the road. Plus there's a human element, which is why Dr. Sakumoto is with us today. Interacting through video is far from ideal, especially when discussing sensitive topics. And I think we're all over video meetings or at least webinars, especially those which really could have benefited from an in-person meeting. Dr. Sakumoto and colleagues have written about the concept of digital empathy. And so today, we're going to get into all things telemedicine, but mostly how we could do our best to ensure we're connecting sufficiently with patients, actively listening, and deploying the best of health care through the screen. Matt, welcome.

Matt Sakumoto: Thanks so much. I'm super excited to get into this.

Travis Bias: Matt, first, start off by telling us a bit about your background and journey through telemedicine.

Matt Sakumoto: Yeah, so I'm technically a biomedical engineer by training, never actually worked as an engineer, but also did a little bit of pre-med and medical school as well. But most of my telehealth and virtual care journey really started during my clinical informatics

fellowship at UCSF. So I was there from 2018 through 2020, always liked the idea of being able to provide care to patients beyond the walls of the clinic or walls of the hospital. So before, I used to think of that as population health and kind of outreach the closed care gaps, but then I really got into the virtual care and telemedicine thing during my clinical informatics fellowship. So I had a small pilot with the urgent care that I was working through. We were basically doing maybe about five visits a week. This is around December 2019. The pandemic obviously hit around March 2020. And that small clinic pilot became UCSF's video visit screening clinic for COVID patients.

So really I was able to see, one, what the reach could be because the UCSF catchment area is actually quite large. So you're able to have a very large reach with patients, and from that standpoint really solidified the impact that virtual care could have on patients. So from there, I actually graduated from the fellowship in June 2020 and kind of bounced around to a lot of different startups and really seeing the scope and the scale that other people... the way that they delivered it. So one of the first stops I had is actually tele-urgent care. So those are more one-off visits at a startup, and you're able to do discreet problems. So Travis, like you were mentioning, you could have just a cough or runny nose or an STI workup, but they're very discreet things. You see the patient, you chat, put them for 10 to 15 minutes, and then you kind of render your treatment suggestions.

Moving from there, I kind of evolved a bit to a virtual only primary care startup. And for me, I'm an internal medicine physician by training, really vibe with primary care and that continuity of care. So I really like the ability to do continuity of care with patients. So we'll see them back frequently, did a lot of managements of blood pressure, diabetes, but particularly during the pandemic, really being able to help them manage their mental health needs. And again, that's something that obviously, relationship building is super helpful as well as being able to titrate medications and check for medication effect and side effects. So that primary care backbone that platform provided was really nice for continuity of care and relationship building.

Other experiences that I've had, again, kind of over the course of the pandemic has been working at a virtual first primary care startup. I also like that model specifically because you could do most of the things at the convenience of the patient and at the convenience of the clinician. But if they needed to come in, they could come in to see me. So I think there's the level of having that connection, that hybrid model of care that is really picking up and I think a lot of people are moving into, particularly as the world opens up a little bit more as we're in a post-pandemic or tail end of pandemic world.

And then lastly, my final place that I'm currently at is with Sutter Health, and that's the ability to do, same thing, virtual first primary care but within a large health care system. So it has all of the specialists that are in network and kind of we're all on the same electronic health record. And that level of interoperability, data sharing, and warm hand offs with patients as specialist I personally know or have personally interacted with in the past just really creates a really good experience for myself and for my patients.

Travis Bias: Yeah, you mentioned the continuity of care piece, and I think that's something that telemedicine and all forms of communication that don't involve in-person care, really, telemedicine can help to be kind of that glue that kind of holds that relationship together in

between office visits, right, because you hear so many times there's so much that happens in health care between those three month spaces between office visits. And I feel like with some of these tools, we're really just getting started. So I think some organizations are doing this well, but others obviously have plenty of room for improvement.

So you mentioned the different places that you've been between smaller practices that are virtual first and larger medical groups like you're in right now. So where have you seen this done well, and how do you advise either your organization or your fellow clinicians on its use? And really, what are some areas you see as some white space, I guess, where organizations could leverage telehealth capabilities to really improve outcomes, improve the patient and the physician's experience, and lower total cost of care?

Matt Sakumoto: Oh, for sure. That's a lot of questions baked into one. And I'll take little bits and pieces of it as we go along. I think the biggest thing, we're used to episodic care, and then even for continuity of care, we're checking in, again, once every three months, once a month if you're lucky. I like to call the space or the care between the care, interstitial care, right? It's the stuff between the stuff. It's the glue that holds things together. The key to making interstitial care work is team-based care. So I think the biggest piece that I've really enjoyed... Actually, the place that you and I work together and actually currently at Sutter is like, when you have a team that you know and get to know pretty well, that help move all the pieces because the doctor will order meds, will diagnose. But let's be honest, a lot of the on-the-ground work is being done by the nurses and the care coordinators. I think having a team that you are working closely with, keeping all the pieces together, that's really what supercharges this kind of complex care coordination.

Travis Bias: Sure. And I mean, I think, as you say, one of my first practices out of residency, my medical assistant (MA), I delegated a ton of stuff to her. I mean, she would take care of probably a lot of stuff that was well beyond her scope, but because she was trained well, I thought, by me, she was confident to triage a lot of things that could be in-person visits or could be taken care of over the phone. And like you say, I think the stronger your team, the more multidisciplinary team, probably the better you're going to be at doing that. And so you mentioned where we've worked together in the past, they had, what, I guess you would term probably this virtual back office, what that really supports that team care. Can you tell us a little more about that part, I guess, and how important that is to really supporting what the physician can do for the patient?

Matt Sakumoto: For sure. And I think comparing and contrasting some of the pieces that you were talking about, with the virtual back office, it's important to have a team but also a consistent team. So exactly as you were talking about, you developed a confidence and a relationship with your MA that it's like a sports team, right? She can kind of guess your next move. If you have a team, but it's a different person in that role, that starts to create kind of some friction points, and you lose that bit of efficiency. So the concept of this virtual back office, I used to call it the turn to the left requests, right? So the nurse that was down the hall that you could turn and ask for something, that's really different as soon as everybody's virtualized and I'm sitting in my apartment, they're sitting in their apartment.

So having a really good system to have this efficient flow of information, I think really helps for that piece. So I've seen it done in different ways, Slack, Google chat. So there's different chat-based options. Some of the group, some people just even use email, which I think there's a little friction points and that becomes a little slower. But really thinking about how are you going to ensure team communication is really, really important as you're setting up a fully virtual office.

Travis Bias: You mentioned the questions you can ask, just walking down the hall to ask a nurse or a medical assistant. I was blown away by just the use of Slack. I actually felt more supported than I had ever felt in a practice before because I was getting responses to my questions in real time. It blew my mind how you would assume that in-person care or in office care, you're going to feel that support. But I've worked at places where the case manager was only there one day a week, so I was waiting several days for a response from the case manager for a complex patient, yet with Slack, like you say, people were working remotely. And I felt like I had multiple staff members at my fingertips that were responding within minutes. And sometimes I would even send messages during the patient visits and get a response back in time before they left that visit.

I mean, there are plenty of downsides by not being able to speak to some people in person, but I think there are a ton of benefits to this remote communication as long as it's done well. I think one of the things that I would imagine this would be good for is, you mentioned the relationships, we mentioned the back office support, but there's a huge obviously emphasis transitioning from volume to value to, it really improved population-wide health. So can you talk about, I guess, a bit how you've seen that done well, like closing gaps in care and making sure people are hitting some of those quality outcomes, measures that they're trying to hit for their population?

Matt Sakumoto: No, I think, and that's the great thing about just having, I think, a virtualized staff is, again, only so many people can fit in one office or one building. So in the same way that access has really been increased for patients, because docs are around and said, "I'm more willing to jump on a 5:00 PM to 7:00 PM shift if I get to sit at home versus having to drive to a clinic and do that shift," so we've opened up access for patients. I think if people are creative with the way that they work their back office, same thing, you can spread your front desk or your virtual front desk across multiple time zones to start to push out, it's not just 8:00 to 5:00. You can start extending those hours, again, for both clinician and patient access.

And that goes to population health and care gap closure as well, right? So a lot of these outreach messages, if you're calling patients in the middle of their work day, they're not going to pick up. If you can start to have your outreach calls be closer to the evening when they have time, for patients to have time to take that call, that's one big thing. And then also just moving to that asynchronous way of conversing, right, so be it patient messaging, text messaging, starting to be able to do mass outreach. And I think that's a good way to kind of keep closing those gaps. And again, this doesn't have to be done by the clinician. Most of the time, it's done by a non-clinical staff.

Travis Bias: Sure. So it really seems like telemedicine, the capabilities have opened up kind of a whole new, I guess, solutions or ways of caring for patients and populations that we hadn't

really even thought about before, I think. So I think about things like we were forced to FaceTime in a family member or a caregiver to be part of the conversation, and it's like, why weren't we doing more of that before the pandemic? The pandemic forced a lot of this, forced a lot of this creative thinking on us. But really, why weren't we having multiple people in the conversation? So I guess, are there other ways that you've seen this, I guess, telemedicine evolution kind of forcing more creative ways of caring for patients?

Matt Sakumoto: No, it's been really interesting. And again, this kind goes back to kind of increasing access. There's only so many hours in a day, but I think group visits have been a really great way for particularly patient education. So group classes for patients with diabetes. Let's be honest, I say mostly the same thing to most patients, at least at a baseline thing. So I think that's helpful to kind of, they can all get the same message at once. And the best thing that I've seen with a lot of these group visits, blood pressure management, probably another similar thing, is there's some of the stuff that I can mention to them, but the patients learning from each other and this peer-led learning has actually been the most eye-opening thing for me. And I learn half the time. It's like, oh, there are specifics, and they each come with their own perspective. And I think, so actually that peer learning more so than whatever knowledge I'm imparting has really been the most impactful, particularly for these group visits.

Travis Bias: Yeah, no, that's a great example. And using expert patients, in models of task shifting, that's definitely a model to really use expert patients to educate and care for each other. I think also, too, just bringing in family members or friends or someone to help you take notes during the visit or what have you, as a patient, it just seems like we're opening up a whole new kind of, I guess, paradigm for patients and their expectations, I guess, with telemedicine and the way they engage with any of their clinicians. So I guess transitioning, thinking about it more from the patient angle, not every patient has the same experience with care with the telemedicine, right? So I imagine that's partially because not all telehealth platforms are created equal and there are definitely many platforms now, but also probably partially because of the physician user, I imagine. So tell us a bit more about this concept of digital empathy.

Matt Sakumoto: No, for sure. This has been really fun to explore. And I think from my standpoint, really getting to talk with patients and patient advocates, learning what it's like to be on the patient side, so the idea of digital empathy, empathy in and of itself, important to have as a doctor or any clinician or anyone in health care, but particularly, this digital empathy piece, we're realizing that just, things land differently when you're talking across a Zoom screen, even text messaging. I can think of many times where either e-mail or text messages have been misinterpreted without the meaning behind that. So this idea of digital empathy is, we're having new channels to communicate with, but you want to be able to preserve some of those traditional, empathetic qualities and characteristics so that a patient feels heard and that emotions and meaning are conveyed correctly.

Travis Bias: Yeah. Man, there are so many areas where digital communication of different sorts can get misinterpreted. And so I would imagine, as a patient, there's some things that need to be delivered in person. There's some things that need to be delivered over the phone. There's some things that could be delivered via a text message or e-mail or some kind of asynchronous communication. So how do you, I guess, triage the types of visits or the types of

messages that could be delivered that way? And how do you, I guess, even train your staff to really understand that at the same level you do, I guess?

Matt Sakumoto: No, excellent question, and a lot of it's kind of the onboarding piece. My spiel to patients when I chat with them for the first time, again, we have a virtual first clinic, but it's hybrid, it's not virtual only, is we're like, "Hey, we run differently than your traditional primary care clinic. And we really encourage you to message us and then these are the reasons why," so I think really doing some of that table setting. And the part about empathy piece is being able to read patients. So I think if you get a sense that like, oh, they just really want to come in to meet you for the first time, I don't put up a barrier to that. It's like, "Hey, let's meet," but then they also get to meet the team.

And I think that's the other thing that I keep stressing is, "Hey, we're a team based care. You might see messages from myself, my nurse, or a nurse practitioner, there's a lot of different names, but know that we're all coordinating behind the scenes with you." So I think a lot of it is, one, sussing out the patient, seeing where their level of comfort is and kind of understanding what channels that they want to engage with first. Again, my younger patients tend to say, "Please just text me. Don't call." And then the older patients will also kind of say, "I prefer at least a phone call." So it's sussing it out. Everything is relationship building and kind of meeting patients where they are.

Travis Bias: Sure. And I think one of the hardest things, too. Setting expectations, I would agree, is exactly the name of the game. I do think though, there are some patients that I've had who are like, "Just text me." They want to text everything, but then they're saying, "Hey, I think I had an exposure to chlamydia." And it's like, well, maybe that is at least a phone call, if not some kind of a video visit, right? And so I think that's one thing that has been hard, when the patient's expectations don't align with your own. But you're exactly right. I think back to the point of relationships and continuity of care, the better you get to know your patient population, the easier, I think, that becomes.

Matt Sakumoto: Yeah. And I think the other piece, too, just to kind of jump in and expand on that, is, particularly as you start to move towards messaging, like I said, a lot of times maybe initial messages get misinterpreted, but as you build that relationship, there's that trust. So even if I or my staff have kind of maybe a misstep in what we text message to them, again, if you have that stronger foundation, stronger relationship building, it gets smooth over easier. So I guess I would emphasize and overemphasize that relationship building piece. And that's what health care is, particularly primary care is, strong relationship and trust building with the patient.

Travis Bias: So for the clinicians, again, trying to be empathetic towards the patient experience, for clinicians to be conveying that empathy through the screen, what are, I guess, some elements of this digital empathy that I and my clinician colleagues ought to be thinking about when we're taking care of patients via telemedicine?

Matt Sakumoto: Yeah. I think the one piece that I would think about or the one phrase is kind of amplification. So it's really overemphasizing a lot of things. So as we think about the different communication channels, talking in a room face-to-face is probably the highest

fidelity transfer of information. You have lots of nonverbal cues, body language, tone of voice is easier to convey. As you move one step down, that's the video visits. You can still see them, but it tends to be either floating head. You lose some of those nonvisual cues, usually only see them from the shoulders up and maybe even just from the chin up. So there are things, to kind of almost over exaggerate, kind of the different emotions, I probably do more head nodding over video just to be able to convey, yes, I'm listening. So I think there's just taking what you usually do but amplify it by a little bit just so, again, so that that meaning is conveyed.

And then obviously as you go further and further down the list of communication channels, audio only. They can't see you nodding, so kind of being able to go with those semi-verbal cues of, "Mm," or, "Yes, I hear you," just so it doesn't sound like there's a silence on the other end. So I think it's things that you have to think about to try to do intentionally the first couple times, and then it starts to become more natural. But I think on the front end, as you're first starting to do these, again, particularly as you're going through the telephone only or messaging with patients, really being mindful of how that empathy comes across is important.

Travis Bias: Yeah, you bring up two things. One that I found myself in this telemedicine practice doing a lot more, kind of summarizing and reframing and saying, "So what I just heard you say is this." And these are tools that I probably should have been using more, even in in-person visits if we're being honest. But it was something I found myself doing, "Just to make sure I'm clear, this is what you're telling me." So that's definitely one thing that I noticed. But the other thing, you mentioned the nonverbals, I'm totally guilty of something that I would imagine other telemedicine physicians are. A lot of the burden that we deal with throughout the day is documenting in the electronic health record.

And I found actually that the beauty of this, so in the in-person visit, it's distracting when I'm staring at the computer screen. With the telemedicine visit, it's actually convenient and desired that I'm staring at the screen, yet I might not be on the window looking at my patient. And that's something that actually, at front, I thought, wow, this makes me much more efficient. This is great. I'll get all my charts done. Yet at the same time, I started to struggle with, okay, I probably ought to be looking them in the eye especially when I'm hearing about mental health struggles or something like that. So I mean, are you toggling back and forth, or how do you master this?

Matt Sakumoto: Yep. And this is actually two excellent topics. One is just kind of, what is the platform you're on, right? Some of them facilitate this a little better than others. And then two is actually practice. There's a level of muscle memory that has to go into this. So I'll take each in turn. So the platform, it's nice when you have kind of the video screen integrated with whatever you're charting with, right, because you need something for talking, something for typing, are basically the two main pieces of a telehealth platform. Some have done it better than others. I won't name names. But I think the overall design piece is really being able to have both available without having to click around too much, to be able to just move with your eyes.

Then that goes to the second piece is, I kind of call it cockpit control. So in the same way that a pilot has to kind of look where they're going, look at how fast they're going, kind of maybe look at the GPS, in a similar way, you're talking to the patient, you're listening, but you're also

maybe checking to see what was their last PHQ-9 score or are they seeing a therapist or, "I put in a therapist referral last month. What is the status of that referral?" So there are things that you are kind of wanting to look and look up. So the more that you can have a heads up display and then coordinate that between looking at the video screen to make that eye contact with the patient but also checking things...

And I think talking while you're moving, saying, "Hey, just so you know," this goes back to that overcommunication piece, it's like, "Hey, let me just check to see if that referral went through. I'm going to be looking at that." So kind of, if you're going to be looking away or if you're going to be kind of typing or seem distracted, say what you're doing. So I think just keeping those lines of communication and overcommunication also helps kind of smooth some of that over.

Travis Bias: I think, yeah, by telling someone what you're doing, that's interesting because I think I notice when I'm FaceTiming with someone, and their eyes are darting somewhere else, I'm like, "Okay, they're looking at another window." And so with a patient visit, yeah, it was a very interesting mix that I had to get used to where, on one hand, I was able to look around the computer screen pretty naturally, and I didn't feel too rude, but at the same time, I would be clear like, "Hey, let me look that up one second. I'm looking that up while you and I are talking." And I think there's a way to handle that. But I think you just have to be aware of that.

So you and I have learned a lot of this from experience, right? And I guess you learned it in your two-year clinical informatics fellowship. Are there other places where these concepts are being taught? Is this being taught in medical school now? Should it be taught in medical school now? Is it being taught in residency programs, even in fellowship training? And even beyond that, is this partially about physicians simply being tech savvy? Because obviously, there's a wide variation in comfort levels between physicians with the use of tech technology and even comfort with audio, video, data storage, even. But where is this being taught, and what's the room to grow there?

Matt Sakumoto: Oh, for sure. I think not formally or not widespread, there are a couple places that are doing it well. I think specifically Thomas Jefferson University actually has a full fellowship in telehealth. So there are places that are putting a year-long curriculum in place, lots of experiential things. They're the exception, not the rule, I think by far. So I think most of this tends to be learning by watching someone do it. And I'll be honest, sometimes it's the blind leading the blind, right, where the attending is newly learning how to do telehealth, while the med student is kind of watching them do it. So I think there's a bit of co-learning that's going on. My hope is that we will start to codify some of these things into either formal competencies, formal curriculum.

And the analogy that I'll use is when the electronic health record came out, right? That was kind of a brand new thing. Docs were used to handwriting orders, maybe doing dictation, and the EHR just became so ubiquitous that that is something that I actually learned how to talk and type during medical school. We had courses where I'd be like, make sure you turn this screen this way and so that you're able to keep eye contact with the patient, because it was recognized that the electronic health record was going to be so ubiquitous. My guess, if I had

to bet on this, is that telehealth, and virtual care in general, is going to be ubiquitous enough that I think it will be put in at the med school and residency level. We're definitely not even close to their yet though.

Travis Bias: Yeah. I mean, that's a tough one. I think even in in-person visits, this seems like something that's very important for there to be feedback, right, from either an expert in this area or from someone who's more senior to you in your field. And I feel like it gets harder. Actually, the in-person visits, it's actually hard for someone to really observe you in those visits. I remember trying to do that in residency, the consent that you have to get from your patients. But then you add in the telemedicine, I mean, it's hard for... I mean, a third party on the screen would be very challenging. So I imagine it's hard to give people feedback on how they're performing through telemedicine, but that's got to be a piece of this. Now, but I've heard you talk about telehealth literacy. How does that differ from the digital empathy? And is that kind of what we're talking about here, what you think ought to be put into medical school or residency curriculum?

Matt Sakumoto: Yeah. And it's a little bit of both. I kind of think of it as really having a strong foundation of knowledge and skills just in where do I click to open the window or to share my screen or to minimize my screen? So there's just baseline, I think, technical literacy. And then there's a level of kind of health literacy. So the combination of those two really is telehealth literacy, right? So from the clinician side, how do you marry those two? But I think step one, before you can even show empathy over the screen, it's like, do you feel comfortable sitting on your side of the screen talking with the patient? So I think that's what telehealth literacy is to me, is being able to understand that bit.

Travis Bias: And you mentioned the cockpit. How do I set up my cockpit and get ready to go? I mean, your preparation for the office visit is very different than what it is for an in-person office visit. And I think that's something to be aware of. So once I become comfortable with telehealth tools and practicing telemedicine, I think there's probably a bit of a, I guess, learning curve or gap between how I make diagnostic decisions when I'm in the room with a patient versus how I make those decisions when I'm separated by the screen. I would imagine there are a bunch of assumptions I'm making in the office visit that are probably dangerous to make through telemedicine. So does that open me up to making diagnostic errors, or are there ways that I can, I guess, prevent against that and, again, use telemedicine to my advantage rather than having that as, I guess, a threat to my quality as a clinician?

Matt Sakumoto: Oh, great question. And I think two pieces, one that you actually mentioned earlier, is that patients tend to present earlier. The barrier to having to show up to a telemedicine visit is significantly lower than having to take time off of work and drive to a clinic. So they're actually even presenting with symptoms that are different than what you would see in urgent care or in the office, so I think, one, just kind of recalibrating that piece. And that comes with experience. I think the other piece that I really want to encourage people to think about is to not think of everything as encounter-based. In the office, we felt the need to have some sort of answer or plan at the end of that 15-minute visit because, again, patient took the time to come here, and the chance of following up with them is very low.

The nice part about virtual care is that you can start to blur those boundaries. I'll talk to the patient for 10 to 15 minutes, but I have the chance to message them one to three days later. So you don't have to make that decision there. So the two pieces I give is, time makes up for touch. So even though I can't physically examine the patient, I can spend more time getting a good history with them. And then the second part is, time is the best diagnostic tool. So having that follow-up one day later, three days later, letting the disease process declare itself, that's a luxury that we have in the telemedicine world that we did not have in the in-clinic episodic based care.

Travis Bias: Yeah. I love thinking about the time thing because in ambulatory primary care, so many things get better on their own within a few days or if not a week. We've talked about that before. So I wonder if just simply decreasing the amount of unnecessary antibiotics prescribed, I think, would be a great example of that. "Let's see how you do over the next four to seven days. You know you can get a hold of me very easily, much more easily probably than you could have in my in-person clinic eight years ago, 10 years ago." And so I love that concept of time making up for touch, but also, again, this is able to hold together, pull together that important relationship, and that makes for stronger, better care in my opinion. So finally, okay, let's end with the lightning round, three questions to round us out and finish up here. Number one, I talked about how telemedicine visits increased, thanks to the pandemic. Is there an ideal chunk or number of patient-physician interactions that ought to leverage telemedicine or chat?

Matt Sakumoto: If I think of a number, you could actually probably do 80 percent virtual, 20 percent in person.

Travis Bias: Wow.

Matt Sakumoto: It's a high split. I use the phrase, if you think about kind of business life, "This meeting could have been an email." Think about how many times you've been in meetings that could have been emails. In this same way, a lot of this can be shifted. So I think that things, particularly in primary care that truly need to be seen in person, is pretty low. And actually, and I say 80-20 because that actually is my current setup. I have four days that I get to work from home and then one day a week that I'm in clinic. And in terms of patient access, patient care, I think it's worked out fine so far.

Travis Bias: Yeah. And that's the opposite of what's going on out there across the country, I think. And so it might depend on how you measure that number, I guess. Okay. Number two, should we be paying the same for a video visit as we do for an in-person visit? And is that even the way to think about it?

Matt Sakumoto: Definitely more than a lightning round question, but I'll give by a short answer on this one. I think pay parity has been a big piece that people have been looking at. To be honest, the capitated payment works the best. It's that value-based care where, what do we need to do to take care of this concern that the patient has, be it in person, be it just a message, or be it video? That being said, in the short term, I'm a big supporter of pay parity just because I think that'll just get more people on board. Travis, to your point, most places are bottoming out around 10 percent now, kind of which is higher than a baseline of 3 percent of

virtual care but significantly lower than I think what we could do. So as we live in a mostly fee-for-service world, I would support pay parity just at least to keep the momentum going on video visit adoption for both patients and clinicians.

Travis Bias: Sure. I think if we're paying for quality outcomes, then it doesn't matter how the care is delivered, period. Okay. Final question, what's next in telemedicine? What's something coming in the telemedicine world that I likely haven't even imagined yet?

Matt Sakumoto: Yeah. I think the biggest thing for me, it's this idea of ambient continuous monitoring. I used to say, "'Some data, good, more data, better' is not always true," but I think in this case, there's actually brand new insights that we haven't been able to get at before. So an example I'll use is hemoglobin A1Cs. Usually we check it once every six months, maybe once every three months to see how things are going. So we're getting time points at Q three-month intervals. Continuous glucose monitors I think are really, really great for seeing like, oh, there are spikes at night. Wednesdays are really bad. So there are these insights that both help with a patient from a biofeedback standpoint. And then I think on the clinician, just insights that we wouldn't have had otherwise. So I can think of a lot of different examples. So we have lots of ambient listening devices in our homes, a lot of things that are on our phones, on smart watches, and things like that, that there's new insights to be gleaned. And I think particularly for these kind of chronic care improvement, chronic illness improvement as well as wellness that are there that we just haven't unlocked yet.

Travis Bias: Well, Matt, thank you so much. This has been an absolute pleasure having you on, and I appreciate you sharing some of your knowledge from your experience around the importance of digital empathy and telehealth literacy. And I look forward to seeing how you are able to train our fellow clinicians really across your organization and across the country so that the health care delivery experience can be improved, not only for physicians, but ultimately for better patient outcome. So thanks for being with us today.

Matt Sakumoto: Thanks so much. I had a great time.