

## MoS Rapid Response Transcript – Amir Rubin

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Because we have a national model of how we standardize operations at scale, we were prepared early on to serve. We had a national approach on PPE, we had to build like everybody else a national supply chain. We did some improvisation.

It's really not that different from how we work every day. We don't have pandemics every day. But in a high-growth startup, we got to move fast. We got to respond quickly.

**BOB SAFIAN:** That was Amir Rubin, CEO of One Medical, which leans on digital tools to provide health-care for employees at more than 7000 companies.

When coronavirus hit, One Medical received a deluge of outreach from members, as anxiety and uncertainty about health ailments ballooned.

The company also became a key player in testing for Covid-19, working with mayors from New York City to Seattle.

I'm Bob Safian, former editor of Fast Company, founder of The Flux Group, and host of Masters of Scale: Rapid Response.

I wanted to talk to Amir to better understand how virtual tools and testing are changing health care during the pandemic.

Re-opening the economy will depend on safely monitoring and screening workers, students, and everyone else.

And no one has clearer, on-the-ground insight about what that really means than Amir.

Let's listen in.

**[THEME MUSIC]**

**SAFIAN:** I'm Bob Safian and I'm here with Amir Rubin, CEO of One Medical, a membership-based primary care practice serving about half a million patients across the U.S. Amir is coming to us today from California, as I ask my questions from my home in New York. Amir, thanks for joining us.

**RUBIN:** Pleasure to be here with you.

**SAFIAN:** There are so many topics for us to talk through as COVID-19 has disrupted practices and raised all kinds of new questions about health and the health business. Early this year One Medical had its IPO, which is usually a triumphant moment for a business. When did you begin to get an inkling that COVID-19 might impact those plans?

**RUBIN:** It takes a lot of energy and effort to get to the IPO line, and we were shooting for the end of January. So here we are, it's January 31st, and three pieces of news come out around that day. First piece of news is, there's this weird virus in China that might impact the supply chain. Second piece of news is, looks like Brexit's happening. And the third piece of news is the president was just impeached. So I was like, "Oh, this would be a good day to do an IPO."

So actually on our IPO date, the market was really, it seems to me, most spooked about actually what we now know is COVID-19. But ironically, the other two things weren't really moving the market – or so the pundits were saying. So we pretty much knew from then that this was going to be an impact.

**SAFIAN:** And when did you start to see it in your business? You're located in major urban markets. I know in a lot of those markets, hospitals have seen booming numbers of COVID patients while their normal patient flow has slowed down.

**RUBIN:** We saw impacts in two different ways. As you mentioned in the introduction, we're this membership-based primary care platform that combines digital health and in-person care, and testing. So who knew you'd want digital health and testing during these times, right? So at some level, on the digital health and testing front, we saw increases there. And then as we went to shelter in place in a lot of communities, we saw reductions in in-person care.

You could see differences across markets. Just in our early weeks we were seeing positive rates in our tests of 15, 20-plus percent in New York City – and we were seeing 3% in Phoenix. And so it was clear to us early on that this is going to be significant, but also maybe different across the United States in different cities.

**SAFIAN:** The testing in New York, how does that get set up, that you are taking that role in the testing across a city?

**RUBIN:** We're a leading medical provider in New York City, in San Francisco, we serve 7,000 companies, we serve some well-known companies like Google or SpaceX. And frankly, we serve a lot of people, including who work in government, who signed up as individuals. And because we have a national model, The One Medical Performance System or TOPS, of how we standardize operations at scale, we were prepared early on to serve. We had interfaces with labs, we had specimen vials. Unlike most doctor's offices, we always did phlebotomy, we always did specimen collection. We had a national approach on PPE, we had to build like everybody else a national supply chain. We did a lot of running to Home Depot to get painter's suits early on; we did some improvisation.

And we have a really strong service-oriented culture. And our people were like, "Hey, if people aren't coming into the office, let's go just do this in the community." And then we started connecting up with people in different markets. We've also done this for Lyft drivers, we've done it for any healthcare worker, we just said, "We'll open up." And then I think the city governments were like, "Hey, who are these folks? Can they help us?"

**SAFIAN:** So as you describe your business, it sounds like there's the virtual business, the telehealth part of the engagement, there's onsite at companies where you do things, and then you have your own offices? And each one of those areas might have been dealing with this crisis slightly differently?

**RUBIN:** It is right Bob, and it's a little more seamless across it. Our model starts with this concept of you're a member. So you're at One Medical, we're going to look after you. You want to text me, you want to message me, you want to call me, you want to video, you want to see me in person during this time? You want to see me in a parking lot and I'll stick a Q-tip up your nose? Any of those are fine. Moreover, since we know who all our members are, because they're signed up as members, we'll reach out to you, which we did. "Concerned about COVID, anybody in your house, anybody have symptoms?" And so our approach is this longitudinal relationship with people.

And certainly different modalities of how we serve people were impacted differently. So even on our digital health, for example, we always had a structured questionnaire approach. And you can have a structured conversation. Or you could always just message a provider, or you could do a video chat. Well, during this time we stood up a structured questionnaire around COVID. "Here are the symptoms, fill this out, and we'll reach out to you. And boy, then you want maybe a test? Let's schedule you, you don't have to go stand in the line."

You need to be seen in person? We took some of our offices and we transformed them into what we call respiratory care clinics. So the staff looked like the staff in emergency rooms. We're in full PPE, all the precautions. And then we had other offices that were for the non-COVID symptomatic patients. So even within the digital arena or even within the

physical arena, we did more segmentation. And then we also said, "Well, if you can't come in to see your provider, you can book a scheduled virtual visit with your provider."

**SAFIAN:** Did your patients respond the way you expected them to in the outreach about COVID-19?

**RUBIN:** Yes, they responded as we thought they would, and we were surprised by some things. I think our model makes access very frictionless. So you can get on the app – and we bundle all the on-demand digital health into the membership, so we're not charging a copay, or deductible, or billing. So in normal times, our members engage with us about seven times a year, and we have a 47% monthly active use rate, so people are on our tech every other month.

So in the first few weeks of March, oh yes, people reached out in extraordinary levels because we don't put barriers to them reaching out. Now, to help ourselves and to still perform at that amazing service level, we said, "Okay, well how about having this COVID questionnaire? We're going to ask you these questions anyhow, how about filling that online? How about we'll call you?" We did things to manage the immediate surge in demand. So while there was a great influx, it wasn't unexpected, and our members were so grateful. And part of, I think, health care is, certainly you want to help people medically when they have acute conditions or help them with chronic conditions to change. But often it's about alleviation of anxiety, it's uncertainty, "How's my child, are they going to be okay?" There's no worse feeling and there's nothing scarier. So in two or three minutes, somebody's talking to you and maybe having a video chat and maybe listening to your child. My gosh. And, "No, it doesn't sound like COVID."

We have a tight bond with our members. We have 90-plus-percent retention on our direct-to-consumer and our B2B on our enterprise clients. So they stay with us, we know them. They were very grateful in general during this time of COVID.

**SAFIAN:** You mentioned the anxiety and the uncertainty, and uncertainty is definitely a core part of the COVID experience it seems. I'm curious, you do so much testing, what kind of testing matters?

**RUBIN:** I think we need to think about testing or more broadly, screening, in terms of what are we trying to accomplish? At one level, sometimes we want to test, and screen, and assess if somebody has COVID. Then there's a separate question of how do we want to screen a population on an ongoing basis. Both are important, and we need to do both.

In an acute diagnosis, the PCR testing is really at the crux of the diagnosis. One of the important things on any of these tests is making sure the test is sensitive and specific, right? You want to capture the actual positives, and you don't want to miss any positives,

right? Early on, we were actually having many, many calls with the chief technology, or chief quality, or chief scientific officers at the labs. Because even something at a 90% sensitivity or specificity, which sounds pretty high.

But if there's... kind of a little bit of epidemiology here. If there's very little prevalence in a community — say in my community in the Bay Area, it looks like maybe there's 5%. A test that's 90% sensitive and specific will only have maybe a 50% positive predictive power.

Now you have some of these tests that actually have 100% specificity, 99% specificity. That'll tell you something else. Now, in New York City where you might have 15 to 20% prevalence in a community, a slightly lower sensitivity and specificity may give you a better result.

So one, understanding first what tests you need. By and large it was the PCR for diagnosing acute. Understanding who we're sending it to, what's their sensitivity and specificity, what platform is it on? There's a lot of trade-offs here. There's some tests that turn results quicker, but they have lower sensitivity and specificity.

**SAFIAN:** You might have a different protocol in New York than you would have in San Francisco, because of the population.

**RUBIN:** You might ultimately. Or said slightly differently, you might have greater confidence in a result based on the sensitivity, and specificity, and the prevalence rate in the community.

Now the body generates antibodies in fighting off infections. There are some antibodies that come earlier on when it's fighting a virus, and there's some that come later on. All of this immunity talk is the antibodies that come later on, the IgG that you might've heard about. The immunoglobulin G. Then there is the IgM, which is usually produced sooner in the condition.

So there is, in theory, the PCR would pick up the condition in an earlier time frame. But if it's too early, it might miss it. So there could be logic in the acute phase to running PCR plus IgM.

Now, there were some funky things we're seeing in the results, and the testing is evolving. But conceptually, that would kind of give you a window into, call it, the first seven to 10 days. It is then now the IgG antibodies that everybody's excited about like, "Did I have it? Does that confer immunity?" We don't know really if it confers immunity, and for how long, right? And if the virus mutates. But I think the hope is at least you will have some built up tolerance antibodies to the condition. That's, I still think, the running hypothesis.

**SAFIAN:** I want to try to summarize that to make sure I understand it. There's testing that we do when it is a more acute phase, when someone is perhaps showing some symptoms. That you can do the PCR test, and you might add an antibody test to that that's looking at these earlier-stage antibodies, which would improve your confidence about the results in combination. Then there's the screening that would happen later for antibodies that would come later that might describe immunity, right?

**RUBIN:** That was right except, let's talk about the screening a little bit more. The antibodies and the immunity are the fun thing that everybody wants to know from the individual perspective, but not actually if we want to keep, in the short term, the worksite clear. We actually want to know if somebody is currently infectious, right?

Now we want to go back to work, back to school. Now, I like to say it's not really back to work. Many people are working. But back to worksite, like worksite reentry.

We have a program, we call it "One Medical Healthy Together". This is really about ongoing screening. Sure it could be about testing, but are we really going to test every person every day before and after their commute? May not be practical. At a minimum, we could screen every person every day by asking them questions: Do you have any symptoms? Anybody in your house have any symptoms? Have you traveled? Have you been exposed? Anybody in your house been exposed? By asking these questions on a routine basis... And do you have a temperature? We've actually run some machine learning models so far, and these are looking highly, highly correlated with PCR positive testing, right? So we want to be vigilant. We want to be screening.

We've built this into our app. An employer can roll this out, an employee can fill it out on a daily basis. They can also push a button and get their tests and they can get their test results. If they're positive, they can talk to a provider, right? So we have the full suite. But on the backend, we can do reporting to the employer. Here's your 5,000 employees. Here's how they're risk-assessed today. These 4,900 said, "No symptoms." These well, 100 said, "Symptoms," or somewhere in between. So testing or screening is relevant in acute diagnosis, but also in how we want to surveil a population over time.

**SAFIAN:** The new service, the new product that you've sort of created, recognize that if you have certain screening questions, that there is a high correlation in those answers, combined with temperature testing, as to whether this is someone who it makes the most sense to do a more extensive test with.

**RUBIN:** Yes. I will say, actually, pure temperature alone isn't very correlated, because the asymptomatic don't have temperatures. It's the combination of all the questions is really what it is. Having the thermal gun at the door will miss most everybody because

they're asymptomatic. By the way, they're already at the front door at work. Maybe they should have taken the temperature at home, is kind of what we would recommend, right?

The reality is we won't end up testing everybody every day before and after their commute, so you'll never be perfectly assured. In the meantime, you want to do other risk-mitigating things.

So you're still going to want to rely on kind of screening questions. You're going to still want to be smart about that. You're still going to want to rely on some social distancing. You're still going to want to rely on probably masks or double masking, right? Each of us wears a mask. It's the combination of all of these things that is risk mitigating. There is no perfect test, even though some of these are getting closer, right? You're probably not going to have continuous testing, but we can do a lot to mitigate the risk.

**SAFIAN:** Several of the executives that we've spoken to for this podcast talk about having to become medical health experts in new ways, educating themselves, that that's not necessarily their area of expertise. Are you one of those people that these business leaders are reaching out to?

**RUBIN:** Yes, they are. Thankfully, we have incredible medical leaders, epidemiologists, public health experts. I'm just the parakeet here, repeating what I've learned from my experts. Now, I do have a degree in public health myself. But we actually have experts on this. Those people came out and they're like, "Here I am."

This program, we call it Healthy Together, is just that. We're working with employers on their programs, and it's this screening approach. It's this testing. It's thinking about cohorts and how to bring people back.

Look, many organizations, ourself included, have been running the whole time. We were out there doing testing. We had to do PPE. There's others who are in manufacturing.

Employers have gotten up the learning curve. Society is moving up the learning curve. So we're having really great discussions with banks, with technology companies, with manufacturing companies, with professional services companies. How do you mitigate and manage risk, but keep your mission alive and keep doing what you're doing, and address your community and ultimately, your employee base, right? How do you keep them confident and comfortable and manage their anxiety and stress during this? These are the kind of things we're working with on employers.

**SAFIAN:** When I think back to your IPO, which was not that long ago, and it sounds like you have a whole range of new businesses. Am I thinking of that the right way?

**RUBIN:** Yeah. I would characterize it as further features, and proof points on our core model. So, our model was always membership-based, relationship based. We always had enterprise relationships. We always met with those enterprise leaders. We were typically talking about Breast Cancer Awareness Month or Mental Health Awareness Month. And we would roll out initiatives for that. Or we would do in-app screening, or we'd do outbound population health, or certain areas of focus. We added pediatrics. We've added more virtual behavioral health. Now we had to add locations in parking lots. Okay, we didn't think about that. That was new, but we always did testing. We always had locations. We always engaged with employers.

I think this is partly what's allowed us to move so quickly and serve at scale during this time. At some level I'd say not only not miss a beat, but probably in its own twisted way, get energized by this and be able to move faster. Because this is consistent with what we want to do and who we are. Yes, we did have to roll out new features. We did have to recode things on our software. Like, how do you schedule in a parking lot? Which room do you book them into? Parking slot 97? How are we going to do that? So all of that we had to do on the fly.

But we had this operating system, this framework of how we work. We had a culture, we had a mission that all of that was very aligned to. So that maybe shrunk the gap of the change that it might've felt like to the organization.

**SAFIAN:** I can imagine some continuing new areas, like I don't know, testing at a hotel as people are coming in as part of a hotel package.

**RUBIN:** Well, I don't know if that was just a riff, Bob, but we just had a press release two days ago with the Montage Hotels, and that's what we're doing. We're offering this to their guests because during this time for travelers is safety and health high of mind? Yes. So, that is actually something we are doing. We just had our earnings call last week. We were growing nicely in the first quarter. I call that BCE. That's Before the COVID Era, and also in CE, in the COVID Era. And so, now there's also just these further proof points.

Also during this time we had a paper published in JAMA network, *The Journal of the American Medical Association*, that showed that our model took out 45% of the health benefits cost. 45% of the health benefits costs for an employer account. So, that's another proof point.

It's just building on the core of what it is we do. And our model is well positioned because it is multimodal. It's not just digital. It's not just inbound, responsive, virtual. It's outbound, proactive, digital health. It's not just virtual video. It's messaging, it's text. It's apparently not just an office, but can be in parking lots. Because the people are flexible and the tech was flexible. So that was all within our DNA coming into this.

**SAFIAN:** There are a lot of businesses that are struggling with the uncertainty about planning for the future. For you guys, you obviously feel like you're on a trend where you're going to be growing anyway. How do you plan out and look at what the future is going to be?

**RUBIN:** A few things, one we're always looking towards what's next. Right as we were in the first few weeks of this, as we were working on how do we get PPE and how do we stand this up? We were also thinking about how are we going to get people to return to work? And then we were thinking about, well, hopefully there'll be an antiviral. And then eventually there'll be a vaccine. So, we're thinking about all of those phases. Partly, not because we're such great prognosticators, that's actually how most diseases work, right? There is Tamiflu, and there is a flu vaccine. And we do administer those things and people do get them, and there are analogs in other conditions. We hope those come soon, and we don't know exactly when these things are going to come, but those are not unreasonable future states to think about.

How would we be prepared? How would our tech platform need to adapt? How would the physical location need to adapt? Gosh, if in this country we need to vaccinate 350 million people, maybe we're opening the parking lots again, right?

So, we have what we call strategic alignment and deployment. So how do we across all of our departments have some alignment on what these future states might be, and how do we have cross-functional teams planning of that? Then, how do we do improvement and innovation work? Think about that as lean and agile and design thinking approaches. And how do we think about always from the user perspective on out, we put the member at the center of everything we do. And then the third area we call active daily management.

It's great to have a strategy and goal or a perspective on the future. It's even fun to have some improvement teams, but what do we do each and every day, always that you can execute at scale at 90th-percentile-plus performance. We have to develop standards. We have to hardcode it. We have to train. We have to onboard. We have to every day go to the field and observe.

I do put my mask on and go to our clinics and observe, but we do all a lot of Zoom observations as well. And because we have that approach, we can stand up sometimes overnight. What we talked about today on testing. That's all evolving every day. Well, we go out to our thousands of team members, and in a day or two, we've got the new approach or how we're going to disinfect in an office or how we're going to run a respiratory care clinic or how a person who works at the front desk is going to don and doff PPE. How do you get thousands of people trained in that quickly? Well, you can't, not easily, unless you have an operating system.

Because we're able to roll that out in a standard way nationally, quickly, that also prepares us to adapt quickly. So, one is we think about scenarios for the future, but then two, we build a framework and it's the same on our technology stack. It's built in a modern way with modern APIs, and working with agile teams we reposition some of those teams.

And it's really not that different from how we work every day. Yeah, we don't have pandemics every day. And so, usually the future states are a little more predictable, but in a high growth, if you will, startup or early IPO mentality, we got to move fast. We got to respond quickly. So this is again the kind of way we should be responding every day. And frankly, maybe that's even some of the fun lessons for this from us. Like, oh, we can move even faster.

**SAFIAN:** I want to pivot a little bit and ask a little bit about your personal experience. You mentioned that you go to clinics, and you visit and observe. I'm curious what that experience is like for you.

**RUBIN:** Yeah, so I'd say the first thing is I'm not doing anything special. I would say much of what I've been doing is remote, and during this later times, I've made some visits. But this is less about me and what I'm doing. It's really, how do we run our company? And we want to be a company that we're connected to each other, that we're connected to our members, we're connected to our clients. You can do it through Zoom. You can do it through, in-person. We're seeing COVID patients, and that's what we do. So we need to do that thoughtfully and not mix inappropriate people, and we've done it very thoughtfully. But I'd say the broader point is how do we keep our ear to the ground of what's going on with our amazing team members who are out there on the front line.

We also have our physicians in New York City who have volunteered in the hospital wards and in the ERs because in addition to our own clinics and testing sites, they're like, "Hey, we have some more capacity." They're the amazing heroes. My putting on a mask and come and saying "hi" is irrelevant.

So, I have been tested, but part of what I wanted to see when we rolled out the app, how the result came in, what it looked like, what the experience was. I wanted to go do it myself. I wanted to get the in-clinic experience. And it's not like I'm secret shopping. We do this all the time. This is what we were doing in our process improvement.

It's not like I know what the magical answer is, but you get more perspective on it. You're like, "Oh okay, that worked pretty well." I would tweak this thing, and I try not to be the annoying CEO who says, "Well, what about these five features?" But it's not just me, when the whole company is doing that, you have much greater insight into the experience. We want to get close to the experience, close to the process, close to the team who's doing the work. How would we make this work easier for our team

members? What would we need to do to make them feel more comfortable during this time, to build up their confidence? How's it working? Those are the things that we learn by going and seeing.

**SAFIAN:** I take it your test turned out okay. I just want to ask that question.

**RUBIN:** Yeah. I tested positive for loquaciousness.

**SAFIAN:** You mentioned earlier the challenges about anxiety and stress in this time. Are you stressed?

**RUBIN:** Probably the short answer is no. I like to say I have a lot to do with the very short amount of time and a whole heck of a lot is riding on it. But there's no stress. But I feel very, very fortunate to work in an incredible organization with an incredible team that has a mission that's to transform healthcare. And at the crux, we want to be human-centered and technology-powered. And I see an amazing window of opportunity here, A, as a company, not just in this COVID time.

We're post IPO, we're growing. This is an opportunity to be transformative in healthcare and to be transformative in people's lives. I think that's super exciting, and to me it's very energizing.

This is a stressful time for a lot of people, because there's some terrible things going on. People are getting sick, people are dying, people are losing their jobs, and that gives me great anxiety. I have friends who have been sick. I know people who have died, I have many colleagues and friends who have lost their jobs. That is very stressful. And seeing that suffering, that is tough. And we're seeing it in our membership base, and we're seeing it in society. So we're seeing the rise, hundreds of percent increase in our diagnosis across our members of anxiety and depression. Not surprising, right?

We've also expanded our services as a result there, we call it Mindset by One Medical. We've always had actually these group sessions or group visits that use cognitive behavioral therapy and coaching techniques. And now we have those virtually, and we have virtual coaches, and we have therapists. And we're seeing a rise in that need.

Look, there's a lot being thrown at people and people are dealing with a lot of stress and anxiety. So we recognize that, we recognize it in our employers and their employee bases. We have to recognize it in our own team members. We have physicians there on the flat lines putting PPE in the early stage of this thing. That's scary.

I think also frankly, it's why I like getting into things when you get into it. It's like if you think back to your school days, you were stressed and anxious when you were not studying and waiting until the last minute. Once you jumped into it, you're in it. I like to

get in it, and I don't have time to think about anything else, I'm just in it. I got to do these things, and I enjoy doing those things. But we do have to recognize what's going on for our society, our world really, and be cognizant of that.

**SAFIAN:** For listeners who are feeling stressed and anxious right now, do you have any advice for them, any suggestions about how to manage that stress?

**RUBIN:** Yeah. Actually maybe why I feel like I'm managing it well is I've used the One Medical programs. We have a great program called Shift, which is a group visit session, and now it's virtual, so you could do it online. I also recommend putting a half an hour of a Seinfeld rerun too. That works for me too, just to keep it light as well.

**SAFIAN:** We all need respite in all of this. Are there things that are about the coronavirus era specifically that accelerates some things, that make some things easier?

**RUBIN:** I would say that even before COVID, the current system was not meeting the needs of all of its stakeholders. Spending 18% of GDP in the U.S. on healthcare, many studies show over a third of it is considered waste. We actually under invest in primary care and healthcare. In the U.S. we spend about five to 7% of the premium dollar on primary care versus about close to 14% in OECD nations. The average wait time to a family practitioner in the U.S. is about 29 days. So we spend a lot of money, and the average premium for a family is \$20,000.

So we spend a lot of money, there's a lot of waste, and it's really hard to see anybody. Now, we have excellent providers, excellent hospitals, and for those who can have access, there can be really high quality care. But that's frustrating to all the key stakeholders – 50% of family practitioners in the U.S. show symptoms of burnout. They're typically compensated on a fee-for-service basis. They get paid for every visit. So what does that economically incentivize? Very short visits and refer everything out to a specialist. Not only does it cost more money, but they're not productive.

And physicians are frustrated by the... we call it the burdens of desktop medicine, all this electronic health record and billing and coding and authorizations. And that's not what they got into this for. And then we see the health networks, the health systems, the plans, they're trying to develop these coordinated care networks, but they're frustrated. They're spending a lot of money, but the care isn't more coordinated. So we come in and we say we transform healthcare for all those stakeholder groups. And now, we're showing that we can take out costs.

So really changing the healthcare ecosystem for consumers and employers, but also then for the supply side. So for providers, we said, even though most of the U.S. and the world frankly pays a fee for every visit, we're not paying you a fee for every visit at One Medical. You're on straight salary.

So we'll do whatever's the right thing, Bob. And that ends up driving lower utilization, and it actually is more rewarding work for providers. We spend more time. And then we built kind of a virtual team that can intercede in between sessions, so we can work on chronic diseases. And then we built our own technology that shows we have about 44% less work in our electronic health record than you'd see in other ones. So the providers are happier.

And then finally we interfaced into the existing ecosystem. We accept insurance, we built digital interfaces to the hospital systems and the specialists, so we can help coordinate across a continuum of care. Fundamentally why healthcare transformation is hard, is there's so many stakeholder groups. And what we've done is we've taken a human-centered and technology-powered model, and tried to address some of the needs of each of the stakeholder groups simultaneously. And that is what's so powerful about our model, and why I think we can excel into the future.

**SAFIAN:** I really appreciate, thank you for spending so much time with us and for sharing all your thoughts and ideas. Amir, really appreciate it.

**RUBIN:** Bob, it was a pleasure. Great being with you. Take care.