Remote specialists and experts on demand

Improving care and saving costs.

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Physician-Focused Payment Model Technical Advisory Committee (PTAC)
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Proposal:

Remote specialists and experts on demand.
Improving care and saving costs.

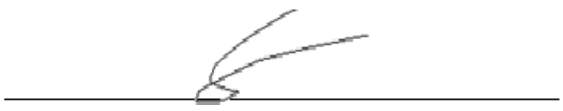
The objectives of the model are improving patient care and cutting healthcare costs.
The model suggests creating organizations of either Regional Referral Centers (RRCs) or a single National Referral Center (NRC). The RRC organization will provide remote specialists and experts for specific health issues.
Those cloud specialists and experts will be assigned upon request from a field provider. The specialists and experts will expeditiously contact the field provider and the patient and make recommendations, thereby either avoiding unnecessary escalation of care or bypassing unnecessary steps of escalation that are costly and sometimes damaging.

The proposal will greatly enhance the current structure of healthcare, will prevent unnecessary escalation of care, will improve patient care and will reduce healthcare cost.

In addition, the RRC/NRC will unite the healthcare system as a whole, will ensure secure transformation of clinical information, will become an important research tool and might inspire many other technologies to support outpatient care.

The proposal is calling for a budget and a payment structure for remote specialists and experts as well funds for developing the needed organizations and technologies.

Sincerely,



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Abstract

The model calls for a budget and a payment structure for implementation of either Regional Referral Centers (RRCs) or a single National Referral Center (NRC).

An RRC organization will provide remote specialists and experts for most health issues. Those specialists and experts will be assigned expeditiously upon request from a field provider and will be employed at any level of care and at any geographic location.

Based on the given clinical presentation, the specialist or the expert will form a plan of action that is specific for the patient needs and the most effective one.

Model Description

It is estimated that more than 50% of our healthcare cost is spent on unneeded care, excessive evaluations by multiple providers, avoidable ER visits and admissions to hospitals, unnecessary tests and diagnostic procedures and other wasteful expenses. Yet, the suggested saving goal of recent healthcare payment models is around 1%.
The proposed model objectives are cutting 30% or more of our healthcare expenditure and improving care for patients by expanding our use of technology.

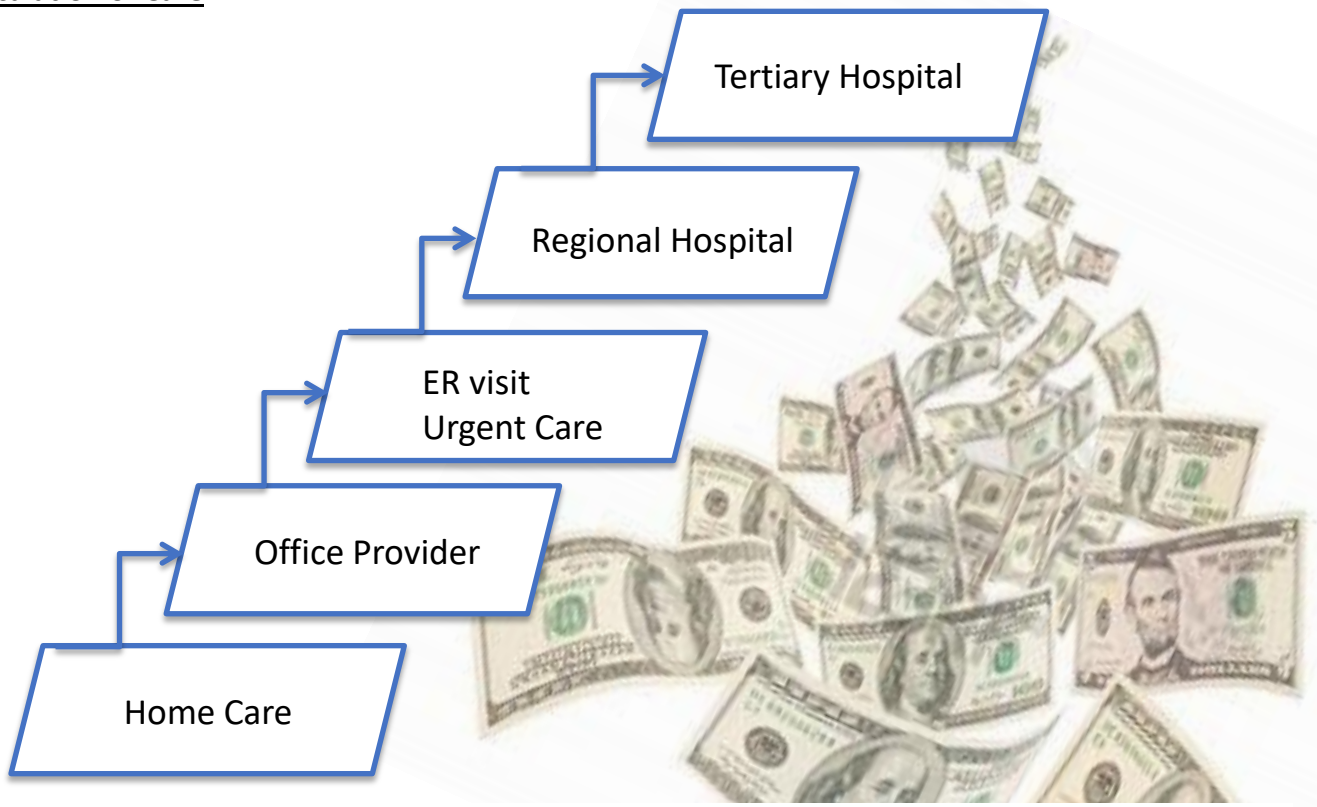
Background

Healthcare used to be a relationship between a patient and a doctor. There was trust, continuation of care and the cost was reasonable. Overtime, additional players enter the game. Initially, health insurance agencies offered guarantied payment but increase our healthcare costs. Giant pharmaceutical and medical devices corporations offered advances in healthcare at a steep cost. Healthcare expanded its scope to include home care and social support. Patient home service agencies were formed and multiple organizations were added to the game. Our administrative costs have skyrocketed with no end in sight. In an effort to save costs, we replaced doctors with providers and then bundled all of them together. Technology came along and offered convenient documentations and knowledge but made the system even more expensive.
The demographics and the culture of our country have changed. Life expectancy increased and medical care became more complex and expensive. Our aging population, the baby boomers, has high expectations from the healthcare system for which they have paid all their lives. Many of the patients admitted to the hospital are inflicted with the maladies of this generation: immaturity, addiction and narcissistic traits. They often require prolonged admissions over weeks and months just to protect them from their own doing. In a way, the healthcare system became the enabler of some of our patients.
Our patients are lost in a giant system. There is a significant loss of trust and respect, especially to the lower levels of care. Old principals like continuation of care and close personal relationship are lost in the industry of healthcare. The patients are transferred from one service to another and the transitions of care are not always smooth and consistent. Unfortunately, our EMR implementation further divided us technologically and combined with well-intended HIPAA regulations, retrieving information became complex and time-consuming. We have successfully created a giant expensive and inefficient health system.

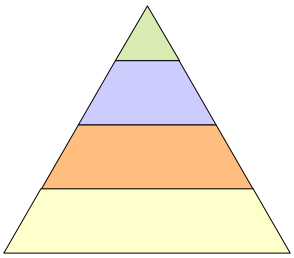
Many remedies were offered to fix the problems. Most of them are based on payment models to incentivize providers. Unfortunately, most of healthcare spending is a direct consequence of a convoluted system and providers cannot save the system.
Providers and especially physicians entered the field of medicine with a passion to care for patients and to help people. Instead, providers are facing increased workload, constant time pressures, chaotic work environments and disrespect from patients and administration. As a result, the new landscape of healthcare has intensified provider burnout.

Patients want to trust their providers but in this perplexing system they cannot, hence, dissatisfaction and mistrust. Patients want easy and convenient care and they do not want to spend too much time and money on healthcare. Some patients are looking for empowerment and obviously, multiple other factors influence patients including personality, education, culture and social factors.

Escalation of Care

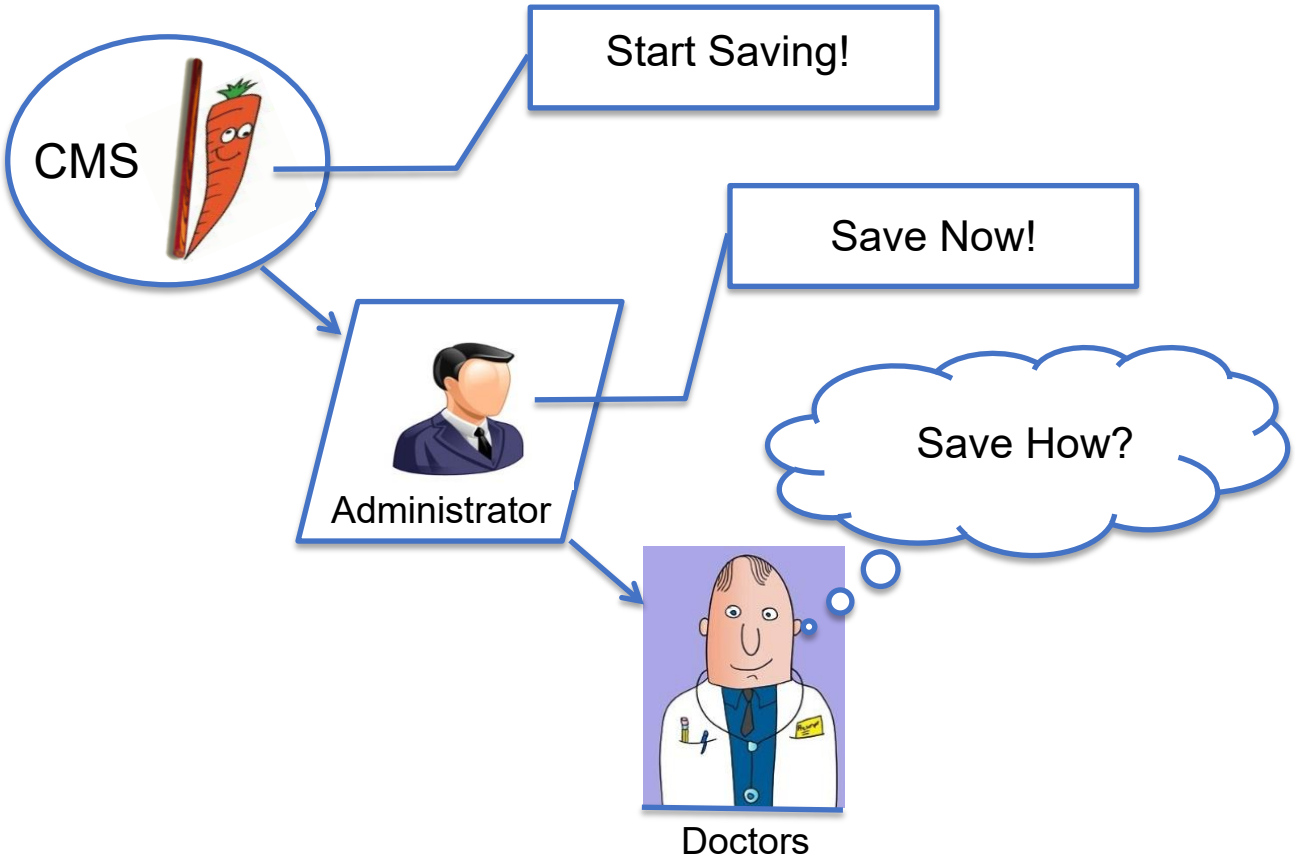


Escalation of care is a stepwise approach of our health care system. Escalating care means duplication of care and breaking continuation of care. Escalation of care means poor patient satisfaction and lack of trust in the care. Escalation of care could mean bad medicine, defensive medicine and probably delaying necessary care while waiting for transition.



At any given time, one can imagine the patients that need involvement of a specialist as a pyramid.
Only the top of the pyramid gets the necessary specialist while others wait in line for their turn.

Cutting healthcare costs



Providers did not create our healthcare crises. Yet, the responsibility of saving healthcare dollars is shifted toward the providers. No matter how substantial are the incentives offered to the providers, the truth is that the providers are very limited in their ability to save the system. There are too many factors that providers cannot control:

- High administrative costs and wages.
- Expensive testing and diagnostic procedure
- Costly prescription drugs, medical devices and technologies.
- Social costs
- Costs of defensive medicine
- Costs caused by laws, regulations and guidelines.

The model proposed hereby to the PTAC does not fix many of the maladies of healthcare. Yet, the model has a potential to reduce healthcare spending by a third or more. The proposal will flip the pyramid upside-down and will revolutionize the escalation of care game. The model might partly restore continuation of care and might increase trust and patient satisfaction. Implementation of the model could be significantly enhanced by digital communication technologies and by telemedicine.

The mission is saving the American healthcare for all of us. It cannot be accomplished without your passionate support, patients' approval as well as providers and payers' endorsement.

Stories

Story #1

A typical story of atypical chest pain:

John presented with atypical chest pain

Primary care provider, Dr. Brown did not take any risk and sent him directly to the ER by an ambulance.

John spent 4 hours in the ER waiting for a decision. The ER physicians did not take any risk and admitted the patient.
John was admitted by Dr. Gray, the hospitalist. Three sets of cardiac enzymes, ECG, CXR, echo and extensive blood tests were ordered.

The next day, Dr. Heart saw the patient in consultation.

Unfortunately, Dr. Heart saw the patients late in the day and the patient stayed in the hospital for another day.

Or alternatively, the patient did not have any transportation back home. The patient stayed at the hospital for another day.

Or yet another ending of the story, there was a myxomatous thickening of the mitral valve. Dr Gray was concerned about endocarditis and ordered blood cultures X4. One of the blood cultures came back positive for Staphylococcal infection. The patient was started on IV vancomycin. 2 days later it turned out to be a contamination. The patient spent 5 days in the hospital because of atypical chest pain.

Dr. Gray, hospitalist

Dr. Heart, cardiologist

Alternative Story #1

A different atypical chest pain story:

RRC – Regional Referral Center using **Communication 24/7**

John presented with atypical chest pain

Dr. Heart, cardiologist

Primary care provider, Dr. Brown requested a cardiologist

Dr. Brown continued to care for john in the clinic.
The cardiologist reviewed the case with Dr. Brown and spoke with the patient via video call technology.

John was instructed to take ASA and to stay in the waiting room for now.
Dr. Heart requested another troponin and ECG within four hours.
Tests were negative and John was sent home.

John was instructed to come back to the lab for a third set of cardiac enzyme in 6 hours. The test was negative as well.

An outpatient stress test was scheduled and a cardiology follow-up appointment.

Story #2

Weakness of legs:

John suffers from headache and weakness of his legs.

Primary care provider, Dr. Brown did not take any risk and sent him directly to the ER by an ambulance.

In the ER, at best case scenario, the patient was admitted.

However, with diagnosis of “weakness”, there is a good chance that John would have been sent home with Motrin and Flexeril for his “old back pain” and would be instructed to F/U with his PCP and PT.

Even if John were admitted, there are no neurologists on call at the regional hospital.

The hospitalist, Dr. Gray, completed a comprehensive work up including lab tests CT head, brain MRI, lumbar spine MRI and EEG. Nothing is found.

John spent 4 days in the hospital and eventually ‘improved’. He was discharged home with an appointment for PT/OT and follow up by his primary care provider.

John had a tumor of the thoracic spine. He became paralyzed and returned to the ER.

This time, The ER contacted Dr. Weiss, neurologists at a tertiary care hospital.

From there, John was sent to Dr. Smith, a neurosurgeon. John underwent a spine operation.

Unfortunately, John remained paralyzed.

Dr. Gray, hospitalist

Dr. Weiss, neurologist

Dr. Smith, neurosurgeon

Alternative Story #2

A different story of legs weakness:

John suffers from headache and weakness of legs.

Primary care provider, Dr. Brown requested a neurologist

RRC – Regional Referral Center using **Communication 24/7**

Dr. Weiss, neurologist

Dr. Brown was involved in the assessment and follow up.
MRI of Thoracic and Lumbar spine were ordered by Dr. Weiss.
Since the hospital is a part of the regional saving program agreement, the order was given proper urgency and the MRI was done within a day,
John was transferred to Dr. Smith care for a definite procedure.

Dr. Smith, neurosurgeon

Story # 3

A stroke

John suffers from an acute stroke

Primary care provider, Dr. Brown did not take any risk and sent him directly to the ER by an ambulance.

John was admitted.
He stays in the hospital for 3 days.

John was monitored and MRI, Echo CT angio were done.

John was evaluated by PT/OT/ST.

There are no neurologists on call at the regional hospital.

John was sent to a local rehab center.
At the local rehab center, all the hospital records were reviewed.

John was evaluated again by a new PT/OT/ST team and by the physician at the local rehab center.

The end result: John was evaluated by multiple physicians and providers.

Later, when John developed complication as a result of his stroke, John was referred to Dr. Weiss, neurologist at a tertiary care center.

Dr. Gray, hospitalist

Dr. Weiss, neurologist

Alternative Story #3

A different story of a stroke:

John suffers from an acute stroke

RRC – Regional Referral Center using **Communication 24/7**

Primary care provider, Dr. Brown requested a neurologist

Dr. Weiss, neurologist

Dr. Brown and Dr. Weiss discussed the care of John.
Same day MRI was ordered as well as CT angio.
Out patient remote cardiac monitoring was started and John was sent to a rehab center.
John was followed by the same team lead by Dr. Brown.
There was really no need for an admission.
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Story # 4

A specialist visit

John suffers a chronic disease

Primary care provider - Dr. Brown

John has a chronic disease. It could be a heart condition, chronic lung condition, chronic abdominal condition and so forth.

The patient has an exacerbation of his condition.
Dr. Brown saw the patient.
The patient was referred to Dr. Scott located at a tertiary care center.

It took about two months to get this first appointment.
John had to take a day off to travel to see the specialist.
Dr. Scott requested several tests, some of them are ordered by Dr. Brown at the local clinic.

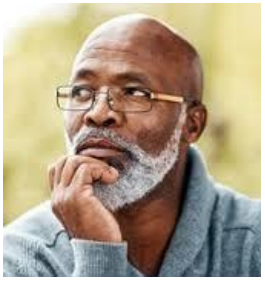
Dr. Brown scheduled another appointment in which he reviewed Dr. Scott long note and ordered the requested tests.

A follow up appointment was made by Dr. Scott but John had to sign a release form and to wait several hours at the tertiary care center while the secretary was getting the tests results.

Additional tests were needed and John was asked to go back to Dr. Brown.

It took four to six months to evaluate John. Now John has to start treatment.

John is discouraged and frustrated.



Dr. Scott – a specialist

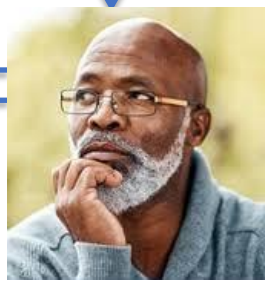
Alternative Story #4

A different specialist story:

John suffers a chronic disease

RCC– Regional Call Center using **Communication 24/7**

Primary care provider, Dr. Brown requested a specialist.



Dr. Scott – a specialist

John was seen by Dr. Brown and was sent home. Dr. Scott. Called Dr. Brown and discussed with him the case. Dr. Scott. also called John and had a telemedine evaluation of his complaints.

Appropriate tests were ordered. Dr. Scott was updated in a timely fashion.

John is aware of the ongoing involvement of Dr. Scott and when tests results are back, Dr. Scott made a video call with John and discussed with him treatment options.

Saving the American healthcare system.

The rising healthcare cost is a result of many factors such as administrative costs, wages, drug costs, expensive tests, procedures and defensive medicine. In addition, healthcare became a political issue. One school of thoughts believes in government controlled system and regulations and the other one believes in free market and competition. As a result of our constant shifting political powers, no school of thoughts has power long enough to show results.

Although we may have different political philosophies, we all agree that we do not want to rationalize healthcare. We all believe in our right to choose our doctor and the level of care we want. We all believe in medical progress and research. We want to preserve the good in the American healthcare system but we all agree that our system is too expensive.

A main cause for our overpriced healthcare system is escalation of care which leads to avoidable admissions and at times to life-threatening delay of care. A wise physician once said that "It is very hard to discharge a patient that from the very start had no reason to be admitted". Many of those unwarranted admissions are also associated with an enormous cost of difficult social issues. Escalation of care means loss of continuation of care and duplication of care as multiple teams deal with the same patient and with the same problems. In addition, escalation of care is associated with unnecessary tests and incorrect diagnostic procedures usually ordered by less qualified providers. Escalation of care is also linked to branding and defensive medicine. We could all agree, regardless of our different points of view, that escalation of care is a central element of healthcare spending.

Our objectives are improving healthcare for our patients and saving a third or more of our healthcare expenditure.

The structural problem of our healthcare

The fact is that our healthcare system, although not owned by the government, it is heavily regulated and controlled by the government. Yet, the organizations of our healthcare system such as hospitals are independent entities. Those organizations are run by administrators who are focused on their own branding and revenues. Savings for the system as a whole is not their top priority. In fact, savings for one organization might result in losses for the system as a whole.

Our organizations have competitive/collaborative relationships. Often, those organizations have different technologies, EMRs and other IT implementations making transfer of data complex and expensive.

At times, organizations may not trust each other. The NIH syndrome – "not invented here" is a reason for repeating tests and procedures.

Solutions misconceptions

Recently, there is a proliferation of ACO organizations believing that financially incentivized providers will result in healthcare saving.

Solutions for the problem of healthcare cost should consider the cost for the whole system. Some solutions might save cost saving in one aspect of healthcare only to increase cost in another. While trying to save the system, we should keep our American principals intact, e.g., not denying care and not rationalizing care.

Specialists and experts spend more money than basic healthcare providers. Obviously, by the time patients are evaluated by specialists and experts, they are very sick and therefore, their care is very expensive. In addition, tests and diagnostic procedure ordered by specialists and experts are necessary expenses as it is not our goal to cut care or to rationalize care.

Care coordinators for high risk patients and visiting nurses seem to be an inexpensive solution but they are the least qualified healthcare link. They act alone in the field without support. Escalation of care depends on their personality and their experience. Overconfident providers might delay care and provide bad medicine. Under-confident providers might escalate care unnecessarily.

The proposed solution

Specialists and experts should be involved at any level of care of patients. Those cloud specialists and experts will provide almost immediate support to field providers like visiting nurses, community providers, PCPs, hospital doctors and others.

The ability to involve specialists and experts at any level of care starting with home care will Improve care. The support provided will restore trust in lower levels of care and will increase patient satisfaction. Furthermore, this cloud service will reduce the power of outsized care institutions that have been squeezing our healthcare system based on their “branding” and “reputation”.

Specialists and experts would provide the best evidence based care for patients. If appropriate, escalation of care would be avoided. Alternatively, when escalation is required, unnecessary steps of escalation that might delay care and waste money could be bypassed.

This modified structure of our healthcare system will revolutionized patient experience and will change the landscape of healthcare.

Cloud based referral center

The process of consulting specialists and experts should be simple and fast. Therefore, we should create referral centers that receive requests from field providers and refer specialists and experts. The author of this document named those future organizations Regional Referral Centers (RRCs) or alternatively, a National Referral Center (NRC).

RRCs and NRC are about efficiency, continuation of care, communication, coordination, patient satisfaction and trust.

How many RRCs and NRC are needed

The author of this document believes that no geographic area should have more than one RRC or NRC. Multiple referral centers would be confusing for providers and patients alike. In contrast, one call center could unite multiple organizations and entities under one umbrella. In addition, one call center means less administrative costs. Furthermore, the larger the organization, the predictability of the number of specialists and experts needed at any given time will be more accurate and consistent. The later will translate to efficiency and lower operating costs.

The RRCs or NRC goal is to unify the system as a whole because our healthcare cost saving should be measured as a whole.

Multiple health insurance

Currently, there are multiple payers and healthcare insurances involved in the game. There is no point to create RRC for each payer. Once the advantages of the new system are proven, private insurances will follow and will pay for the services provided by the RRCs.

Administrative costs and efficiency of the RRCs

Following once school of thoughts, the RRC could be owned by the government and led by government employees. Following the other school of thoughts, the RRCs/ NRC would be managed by a contracted team that could be replaced based on performance and cost.

Wages of specialists and experts

Working for NRC/RRCs should be an attractive alternative job for many providers. It is certainly a great part-time job for retired specialists and active specialists and experts. The specialists and experts working for the RRC should be experienced and should be familiar with the system. The cost of those specialists and experts will be easily covered by the saving it will generate. There will be less need for field specialists and less need to escalate care.

Optional: Documentations requirements

The author of this document is calling to abolish the requirement to write a traditional medical consult notes according to Medicare rules. The objectives of the specialists and experts involvement are to make their recommendations, plan of care and to follow the patient. Documentation of the medical history, past medical history, medication list, Social history, family history and exam by the specialist or the expert is unnecessary and in fact, it is a duplication of information already documented by the lower level provider.

It should be noted that technology will document the time spent with patients and field providers and those interactions could be also recorded.

Optional: Patient choice

Potentially, the referral center could offer patients and field providers several available specialists and experts for each referral. The patients will be empowered with information about their credentials and previous patient experience reviews.

Specialists and experts payments

Service payments by Health insurance companies are traditionally decided based on CPT codes. According to this system all providers are paid the same fees.

The RRCs/NRC could use the traditional payment system. Specific CPTs could be used for payments. Furthermore, the time spent with the field provider and the patient and the time of writing the recommendations will be all documented and possibly even recorded and could be used to justify payments.

Additional value based incentives could be applied including patient experience, efficiency and projected cost reduction, however, the calculations of those factors could be complex and resulted again in increased administrative costs.

Optional: Individual Contracts

Calculating payment model becomes more and more complex increasing administrative costs and control. The complexity of the calculations brings uncertainty and could frustrate providers. The author of this document is puzzled how a CPT code accounts to one's education, background, experience, wisdom, reputation and knowledge. Equal pay for equal CPT is not always fair. There are also different types of consults. There are repetitive well known problems and solutions and there are challenging mysterious diagnoses requiring lifelong experience intuition and wisdom. Furthermore, equal pay is expensive and wasteful. The idea of incentives for value sounds good but truthfully, if a provider does not provide value than maybe that provider should not work for the RFCs.

The author of this document thinks that negotiating individual contracts with specialist and experts would be the least expensive way to hire the needed personnel. There should be clear expectations of high quality services, mutually agreed payment for services and ability to replace people that do not get job done.

In this regard, an additional option is to consider private pay for concierge services as a way to improve service, increase competition and reduce cost.

Technology

Technology is a key component of the plan which was not possible only ten years ago. Today, most people have smart phones and most of us are accepting digital communication as a part of our social life. Digital communication is concise, effective and allows multitasking.

The lessons of the implementation of the EMRs should not be forgotten. Unfortunately, today we are technologically divided with different EMRs and healthcare technologies. Transition of care and transformation of data is difficult and adding additional unnecessary burden to our uncoordinated healthcare system. We will have to spend now additional colossal amounts of money just to create systems that will transfer data among different technologies.

The technology chosen by the RRCs or the NRC must allow other systems to be tied directly to the RRC digital communication system as if they are all the same application. A simpler solution would be to make the RRC technology available for all for "free" or for a relatively low cost.

The features of the system should be attractive for entities and organizations so they will be able to use the technology both internally for their own in organization communications and externally with other organizations.
Needless to say, the selected technology must be secured, HIPAA compliant and monitored.

Supportive outpatient testing and diagnostic procedures

The success of the plan depends on a responsive system of outpatient testing and diagnostic procedure.
Currently, hospitals give preference to their own patients. However, our healthcare savings should be viewed as a whole. The priority of a test or a diagnostic procedure must be determined by clinicians and not by organizations' interests.
This obstacle could be addressed in several ways. One school of thoughts might support adding more regulations that require hospitals to change their priority system while the other school of thoughts might eliminate regulations and encourage competitive testing centers and private diagnostic centers.
Regardless of political worldview, waiting time and cost for outpatient testing and diagnostic procedure must be reasonable.

Outpatient technologies

Today, many monitoring technologies that so far existed only in hospitals could be done as outpatient basis. Monitoring vital signs, cardiac rhythm, QTc intervals, seizure activity, ambulation status, compliance monitoring and patient supervision could be done remotely.
Solutions for safe outpatient of administration of medications and locked infusion systems that do not allow misuse and abuse could replace prolonged admissions to hospitals.
Appropriate policies by the payers could bring proliferation of those technologies and American ingenuity could lead the world. The costs of remote monitoring and advanced outpatient treatments will be negligent comparing to the cost of admissions to hospitals with all the expenses associated with those admissions

Research benefits

The RRCs could be an incredible research tool to study escalation of care management using evidence based decisions.

Criteria

1. Criterion: Scope (High Priority)

The current policy of Medicare limits reimbursement for remote care. Medicare pays for live, two-way video interaction between a patient and a provider but payments for other modes of communications such as regular analog communications, store-and-forward communications digital texting may not be compensated. In addition, remote monitoring compensations are essential for ongoing follow up, continuation of care, trust and patient satisfaction.

Medicare has also limits the geographic location of patients, requiring then to be in 'Health Professional Shortage Areas'. In addition, Medicare limits the type of facility where patients may receive remote services. Home setting, for example, was not included in the list until now. Recently substance abuse disorders were permitted remote home treatments beginning July,1 2019.

Clearly, the policies and regulations of CMS should allow the formation of RRCs/NRC. Those regulations should be revised to allow remote specialists and experts at any level of medical care, any facility and any geographic location.

2. Criterion: Payment Methodology (High Priority)

Medicare could certainly use traditional fixed CPTs codes for remote specialists and experts. Fixed CPT fees are convenient for the government, but to the opinion of the author of this document, fixed CPTs fees promote mediocracy and are essentially more expensive.

The author of this document suggests individual contracts. The idea is competition, proven value and results. The effectiveness of expensive specialists and experts could be measured against less expensive ones. Hopefully, individual contracts will encourage smart effective specialists and experts to work effectively for the proposed RRCs/NRC.

Limiting wages to specialists and experts of the RRCs/NRC could result in shortage of personnel and allow hiring only less qualified providers. Medicare should be focused on improving patient care and on the savings brought by the service as a whole.

The payment methodology could be a combination of several methods of compensation above including fixed CPTs fees and individual contracts.

3. Criterion: Quality and Cost (High Priority)

The model of RRCs/NRC is expected to improve outcome and decrease cost.

Quality measure could be incorporated into the technology of the RRCs/NRC. For example: real time trust and satisfaction gauge and real time cost of care could be an integral part of a communication technology. Feedback from the requesting providers in the field could also be a quality measure. Obviously outcome measurements and escalation of care monitoring are crucial for the success of our mission.

4. Criterion: Value over Volume

The value of specialists and experts support on demand is revolutionary and unparalleled to any other system anywhere in the world. Unfortunately, in other countries, healthcare savings are achieved by delaying and denying care for the people.

Value and volume are not contradictory terms. We expect our specialists and experts to make the right decision for our patients on a case by case basis. We respect their education, experience and wisdom. We need to respect their clinical decisions as those are made as advocates for the patients. We will provide them the means to do their job in the most efficient way possible and we will provide them the required testing and diagnostic procedures in a timely fashion. We are not going to waste their time on unneeded administrative requirements to satisfy non clinical criteria. We need to respect the integrity of our providers as we use to do in the past. We need to enable them to make multiple decisions on multiple patients and to follow them efficiently.

5. Criterion: Flexibility

The flexibility of the RRCs/NRC is obvious. This is a clinical body that makes decision based on clinical data, not based on cold, detached administrative regulations. The case by case care exemplifies the flexibility required for high quality health care delivery.

6. Criterion: Ability to Be Evaluated

As describe already in this document, the RRCs/NRC depend on digital technology that could provide hard data in real time. Time spent with patients and providers could be traced and even recorded. . Time spent on writing digital communications and plan of care could be monitored. Individual outcomes could be easily monitored and tracked. The performance of RRCs/NRC could be evaluated by patients and field providers. Overtime, the overall impact on the system in terms of number of admissions could be measured against historic number of admissions.

7. Criterion: Integration and Care Coordination:

Unfortunately, the current EMRs do not include communication component. Recently, hospitals and organizations have purchase communication applications. Unfortunately, the same error that was done by our EMRs implementation is being replicated by communication applications implementation.

The RRCs/NRC will coordinate care by creating a central referral service for all the organizations in the area. The technology implementation should support direct communications among all providers in the area both internally within an institution and externally with other institutions.

8. Criterion: Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

The RRCs/NRC will support health populations by providing the support to care coordinators, visiting nurses and to providers in the field who care for patients in the community and in facilities.

The RRCs/NRC supports the unique needs and preferences of individual patients as the consults, recommendations and plans of care provided by specialists and experts are individually formulated.

9. Criterion: Patient Safety

The model of RRCs/NRC will enhance patient safety. Without the support of specialists and experts, critical decisions and escalations of care are left in the hands of less quailed providers in the field. The specialists and experts are expected to follow their patients and provide continuation of care which will enhance patient safety.

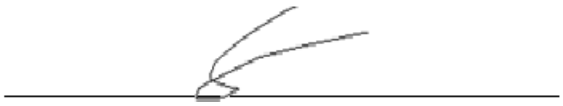
10. Criterion: Health Information Technology:

Information technology is a center piece of the plan. The plan could not be accomplished just 10 years ago when patients were not accustomed to technology like smart phones.
Information technology will allow the RRCs/NRC to coordinate remote support.
Information technology will allow evaluating the quality of the work done by the specialists and experts.
Information technology will allow evaluating patients trust and satisfaction.
Information technology will unite the system as a whole.
Information technology could be used for research and improve care delivery.

Conclusions

The Physician Focused Payment Model Technical Advisory Committee (PTAC) is facing an epic task of healing our expensive and convoluted healthcare system. Yet, this undertaking is possible and achievable. Critical thinking, constant search for better solutions and innovations are the backbone of progress.
Let's save the American healthcare system and make it better.

Sincerely,



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