Remote specialists and experts on demand

Improving care and saving costs.

(Revised version)

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Physician-Focused Payment Model Technical Advisory Committee (PTAC)
c/o US DHHS Asst. Secretary of Planning and Evaluation Office of Health Policy
200 Independence Ave., SW.
Washington DC 2O20I

Proposal: REMOTE SPECIALISTS AND EXPERTS ON DEMAND.
IMPROVING CARE AND SAVING COSTS. (Revised version)

Delivering healthcare is done predominantly by non-specialist providers such as visiting nurses, primary care physicians, nurse practitioners and hospital physicians. At times, problems presented to those providers are above their expertise and comfort. Unfortunately, there is no simple mechanism to assist and support those providers to care for their patients. The proposal submitted to the PTAC suggest creating a mechanism to get specialists and experts involvement early on in the care of patients. The proposal will prevent deterioration of patients' condition, improve outcome, prevent unnecessary tests and procedures, reduce escalation of care and waste of resources.

The proposal was submitted back in August 2019 suggested creating organizations that refer specialists and experts on demand. The original proposal further suggested a direct Medicare involvement in creating those organizations which will prevent further fragmentation of our healthcare system. The proposal also suggested optional cutting Medicare requirements and suggested creating a competitive market environment. Unfortunately, because of those later suggestions the proposal was rejected by the PRT. It was felt that the proposal requires "fundamental changes to the structure and operation of the Medicare program rather than an alternative physician payment methodology".

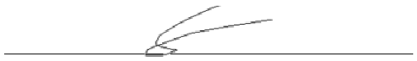
Although the author would prefer Medicare led referral organizations, the revised proposal removed those additional suggestions and the model could be based on independent organizations. The fundamental idea of this proposal has not changed. The proposal is about a payment model for remote specialists and experts on demand that will promptly respond to providers and provide consults to any patient at any level of care.

The new payment model could spark new ways to provide care, would support the current efforts to provide adequate population's health and would empower patients with more choices and control. The proposal could either cut unnecessary escalation of care or alternatively, bypass unnecessary steps of escalation that are costly and sometimes damaging.

Eitan Sobel, MD

Additional advantages of the proposed model include improving continuation of care, developing new technologies for secure communications and inspiring new technologies to support outpatient care.

Sincerely,



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Criteria:

Abstract

The proposal calls for a establishing a payment model for remote specialists and experts on demand. The proposal suggests that organizations named Regional Referral Centers (RRC) could provide remote specialists and experts for most health issues at any level of care and at any geographic location. Those specialists and experts will be offered expeditiously upon request from field providers. Patients will be empowered to choose their specialists and experts based on information, ratings and reviews posted online. Based on the given clinical presentation, the specialist or the expert will form a plan of action that is specific for the patient's 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 less qualified providers and then bundled all of them together. Technology came along and offered convenient documentation but made the system even more expensive.

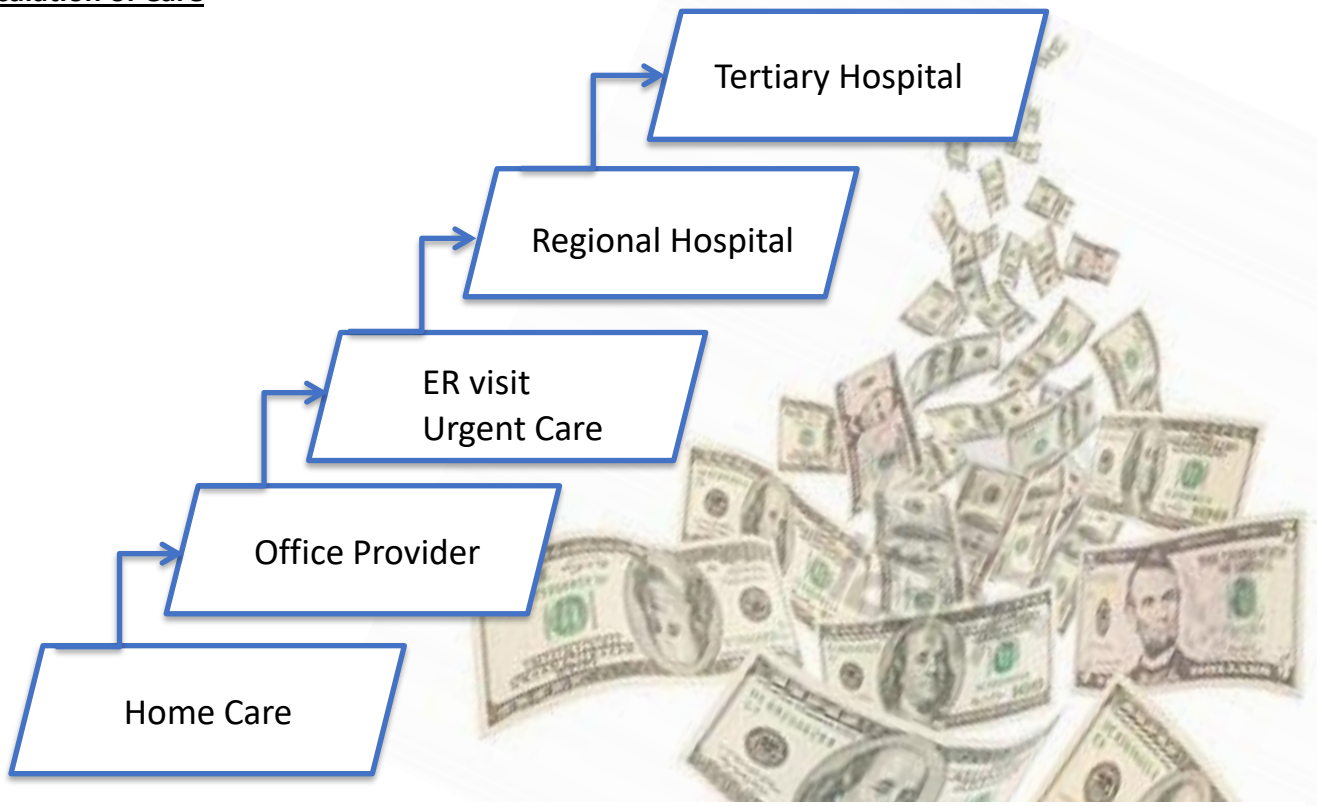
The demographics and the culture of our country have changed. Life expectancy increased and medical care became more complex and expensive. Our aging populations, the baby boomers, have high expectations from the healthcare system for which they have paid all their lives. Many of the patients admitted 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 has become an 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 healthcare system.

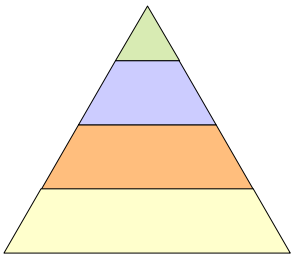
Many remedies were offered to fix the problems. Most of them are based on payment models to incentivize providers. Unfortunately, most of healthcare spending is a direct consequence of a convoluted system and providers cannot save the system.
Providers and especially physicians entered the field of medicine 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

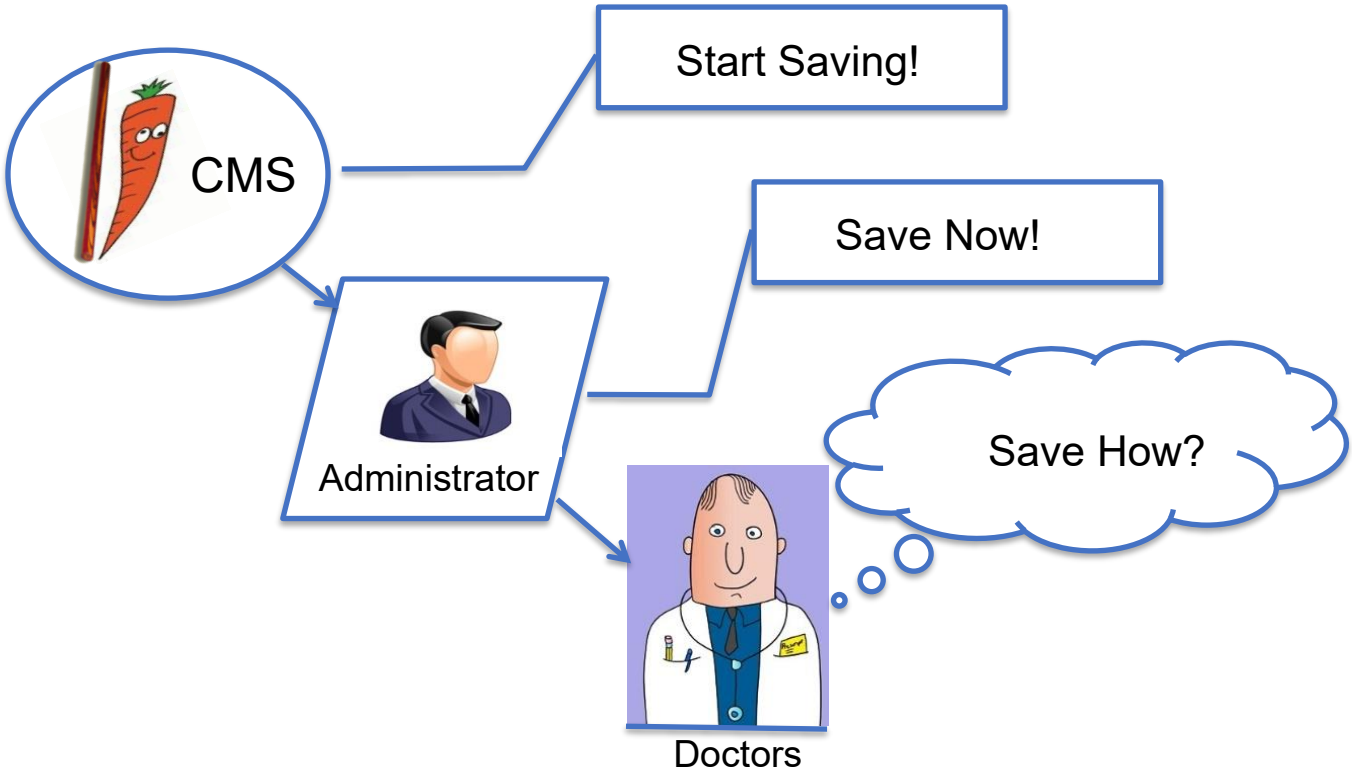


Escalation of care is a stepwise approach of our health care system. Escalating care means duplication of care and breaking continuation of care. Escalation of care means poor patient satisfaction and lack of trust in the care. Escalation of care could mean bad medicine, defensive medicine and probably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



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 the incentives offered to the providers are, 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.

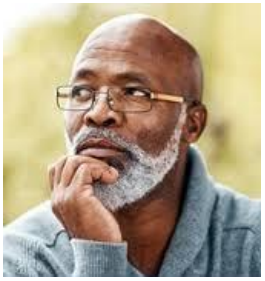
Dr. Brown scheduled another appointment in which he reviewed Dr. Scott long note and ordered the requested tests.

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

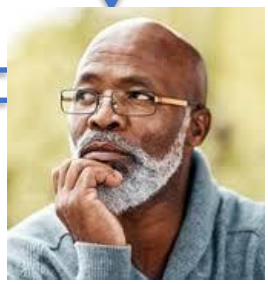
Alternative Story #4

A different specialist story:

John suffers a chronic disease

RCC– Regional referral 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 the result of many factors such as administrative costs, wages, drug costs, expensive tests, procedures and defensive medicine. In addition, healthcare became a political issue controlled by state and federal regulations.

Although we may have many different ideas how to save the American healthcare system, 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 proposed solution

The proposal is focused on one aspect of healthcare cost namely escalation of care. 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. Specialists and experts will 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 additional support for our healthcare providers will revolutionize patient experience and will change the landscape of healthcare. The assistance provided will restore trust in lower levels of care and will increase patient satisfaction.

Cloud based referral center

The process of consulting specialists and experts should be simple and responsive. Therefore, we should create referral centers that receive requests from field providers. The author of this document named those future organizations Regional Referral Centers (RRCs). RRCs are about efficiency, continuation of care, communication, coordination, patient satisfaction and trust.

How many RRCs are needed

Unless regulated, any organization would be able to create a 'Telemedicine' consulting service and thee could be a proliferation of those organizations. However, the author of this document believes that no geographic area should have more than one RRC. 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.

Working for the RRCs

Working for the RRCs should be an attractive alternative job for many specialty 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.

Empowering patients

Imagine healthcare being offered like products on Amazon. Consumers ratings, remarks and credentials are displayed like in a real free competitive market. The referral center could offer patients and field providers several available specialists and experts for each request. The patients could be involved in selecting their own preferred provider.

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 would be very important for the success of the proposal. The technology should be tied to other systems and work as if all are working with the same application. 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 how it is accomplished, 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.

PTAC evaluation of the proposal

Value Considerations

The proposal will empower patients and provide them with choices. Patients can review the consultants' rating and comments and make an informed selection. Patients can also add ratings and comments and receive responses from providers.

Transparent models

The name of the game is free competition based on service performance, patients' satisfaction and feedback, driven through choices and supported by outcome data.

Accountability

Behaviors of Specialists and experts will be affected by the exposure to free market. In essence, the consultants will have a virtual private office on-line and their success depends on their performances. Good medical care, respect to patients, close follow-up, responsiveness will be rewarded by good reviews and high ratings.

Patients as Consumers

Patients will benefit by choosing specialists and experts on-line. The patients will not have to spend days traveling to the consultants' offices, waiting there until being seen with no other alternative available. Patients' time and involvement will be respected, and their problems will be promptly addressed.

Providers as Accountable Patient Navigators

Without specialists and experts' referral center, field providers will escalate care. Nurses will send patients to the ER. PCPs will admit their patients to the hospital and hospital physicians will transfer their patients to tertiary hospitals. The proposal will allow providers to keep the patient at their level and to be more involved in their patients' care. Trust and respect to lower level providers will be restored.

Prevention of disease before it occurs

One of the major issues of care by less qualified providers is deterioration of the disease simply because the provider had no readily available support system. The proposal might solve this issue. Patients with unexplainable pain will not have to wait months in useless follow up visits and early diagnosis could potentially save lives, could prevent complications and would save money.

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 limited 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. 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)

The payment methodology based on fee-for-service (FFS) rates for remote consults. The fees schedule could include:

1) Fees for a consult based on level of care.
2) Additional fees for acute condition that may result in sending patients to the Emergency room or a hospital.
3) Additional fees for bypassing unnecessary care and admission to a hospital.
4) Additional fees for replacing the need for an office visit of specialist in the same field.
5) Incentives for prompt response to providers request and to early assessment and plan.
6) Incentives for after-hours care.
7) Follow up fees for consultants or their coverage.
8) Technology could record the time spent with patients and providers which could be used in justifying payments.

3. Criterion: Quality and Cost (High Priority)

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

1) Participating providers will report on selected quality measures.
2) Quality and outcomes will affect fees schedule and future participation in the remote specialists and experts' program.
3) Patients' satisfaction would be incorporated to the fees scale.
4) satisfaction gauge and real time cost of care could be an integral part of a communication technology.

4. Criterion: Value over Volume

Value means that the patient gets the care needed in a timely fashion, there is good communication among the provider, the patient and the referring provider. Most importantly, there is good outcome. Unnecessary trips to specialists' offices are eliminated, avoidable admissions are saved and expensive tests are spared. The technologies today allow patient to provide feedback and ratings about providers, just like Amazon website where products are offered, and consumers ratings and comments are posted on line.

5. Criterion: Flexibility

The flexibility of the RRCs is obvious. This is an organization that refer specialists and experts on demand. The consumer (the patient) can select a provider that he or she likes. Care decisions are made case by case based on clinical data together with the patient and the requesting providers.

6. Criterion: Ability to Be Evaluated

As describe already in this document, the RRCs 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 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:

The RRCs will coordinate care by creating a central referral service for several and hopefully 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 would support populations health by providing the necessary support to lower level providers such as care coordinators, visiting nurses, providers in the field and office and providers in hospitals that do not have the consult services.

The services provided by the RRCs will complement many other populations health plans that at the present time do not have an adequate support system. The RRCs could contract with those organizations and improve their efficiency and safety.

9. Criterion: Patient Safety

The model of RRCs will enhance patient safety. Without the support of specialists and experts, critical decisions 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:

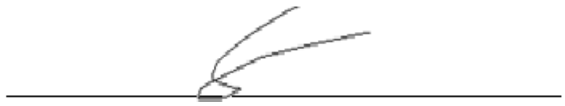
1) Information technology is a center piece of the plan. The plan could not be accomplished just 10 years ago when patients were not accustomed to technology like smart phones.
2) Information technology will allow the RRCs to coordinate remote support.
3) Information technology will allow evaluating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